

Healthcare and Family Services Transparency Glossary

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

- 1. AABD Adults:** A historical term (an acronym for ‘Aid to the Aged, Blind and Disabled’) for individuals now called Seniors and Persons with Disabilities (SPD). *See also* [Seniors and Persons with Disabilities \(SPD\)](#) and [Disabled Adults \(DA\)](#).
- 2. Abortion:** A medical or surgical procedure intended to terminate a pregnancy; a medical procedure included as a unique category within the data set in keeping with federal guidelines on type of service classifications.
- 3. Adjudication:** A process prior to reimbursement in which Medicaid officially determines whether a service for which payment is requested (a claim) is covered, medically necessary, and properly documented and approved for payment; only those claims for services rendered within the experience period and that are approved for payment (fully adjudicated) are included in the provider-level data. *See also* [Claim](#).
- 4. Admission Date:** The date (expressed in the form MM/DD/YYYY) that a recipient enters a healthcare facility as an inpatient or long term care facility as an institutionalized patient.
- 5. Adult with Disabilities:** Individual who is over 18 and under 65 years of age, who meets the definition of blind or disabled under Section 1614(a) of the Social security Act (42 U.S.C.1382), and whose Medicaid eligibility is based on meeting that definition. *See also* [Disabled Adults](#).
- 6. Affordable Care Act:** The health insurance reform legislation President Obama signed into law on March 23, 2010, [Public Law 111-148 \(pdf\)](#), as amended through May 1, 2010 by [Public Law 111-152 \(pdf\)](#).
- 7. Age band:** A range of ages (where age is in integers, rounded down) condensed from the ages of recipients as of the anchor date or last eligibility date. Age bands divide recipients into those aged less than 1 year old; 1 to 18 years old; 19 to 20 years old; 21 to 44 years old; 45 to 64 years old; and 65+ years old.
- 8. Aged Waiver:** A full benefits program for low-income elderly persons (aged 60+), providing services, including in-home services, designed to allow individuals who fit criteria for institutionalization to remain in their homes and communities; one of several categories of benefits that provide payment for more services than are typically covered by Medicaid. *See also* [Aged Waiver Claims](#). For more information on the [Aged Waiver](#).
- 9. Aged Waiver Claims:** Payment requests submitted by a waiver provider and adjudicated under the aged waiver; typically, claims for services that Medicaid would not pay for a recipient not enrolled in a waiver. *See also* [Aged waiver](#) and [Waiver](#).
- 10. 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](#), and [All Kids Web site](#).

**Healthcare and Family Services
Transparency Glossary**

11. **Anchor date:** The date used to report information subject to change over time. For this data set, this is the last day of the experience period, December 31, 2010. *See also* [Last Eligibility Date](#).
12. **Beneficiary:** A recipient. *See also* [Recipient](#).
13. **Benefits:** Assistance that provides payment for services rendered by a provider to a recipient. *See also* [Covered Services](#).
14. **Benefits program:** Any program that provides healthcare coverage. *See also* [Benefits](#) and [Recipient](#).
15. **Brain Injury Waiver:** A full-benefits program for persons who have experienced brain injuries, providing services designed to allow individuals who fit criteria for institutionalization to remain in their homes and communities; one of several categories of benefits that provide payment for more services than are typically covered by Medicaid. Also referred to as a ‘Traumatic Brain Injury (TBI) Waiver.’ *See also* [Brain Injury claims](#) and [Waiver](#). For more information on the [Brain Injury Waiver](#).
16. **Brain Injury Waiver Claims:** Payment requests submitted by a waiver provider and adjudicated under the brain injury waiver; typically, claims for services that Medicaid would not pay for a recipient not enrolled in a waiver. Also referred to as a ‘Traumatic Brain Injury (TBI) Waiver claim.’ *See also* [Brain Injury waiver](#) and [Waiver](#).
17. **Category of Service:** A variable describing the service that was provided to a recipient. Category of Service does not directly appear in the Data Set but is used to determine Type of Service. *See also* [Provider Type](#) and [Type of Service](#).
18. **Centers for Medicare and Medicaid Services (CMS):** The federal agency that is responsible for the administration of the Medicare program and, in partnership with the states, administers Medicaid, the State Children’s Health Insurance Program (CHIP), and HIPAA. *See also* [Children’s Health Insurance Program \(CHIP\)](#) and the [Health Insurance Portability and Accountability Act \(HIPAA\)](#).
19. **Child:** For the purposes of the data sets, a person who has not yet reached their nineteenth birthday. Please note that age classification for portions of the data sets (including diagnostic and waiver information) create age groups that vary from this age classification.
20. **Children’s Health Insurance Program (CHIP):** A federal program, authorized in Illinois by the Children’s Health Insurance Program Act, that provides matching funds to states’ Medicaid programs for children (aged 0 to 18 years) who qualify as members of families who meet eligibility criteria based on income. *See also* [All Kids](#).
21. **Chronic Renal care:** *See also* [State Chronic Renal Care Program](#).
22. **Chronic Illness and Disability Payment System (CDPS):** A system for assigning chronic disease indicators to Medicaid recipients’ data, based on diagnosis and pharmacy codes and demographic data. *Please see* [CDPS documentation for further information](#).
23. **Claim:** a request for payment for a service. Unless otherwise specified, this refers to adjudicated claims. *See also* [Adjudication](#).

Healthcare and Family Services Transparency Glossary

24. **Claims payment:** A payment associated with a specific recipient and healthcare service that flows through our claims system. Because they are associated with a particular recipient and service, these payments *are* included in the data sets as a component of the costs in the Total Cost field. *See also* [Non-claims Payments](#) and [Supplemental Payments](#).
25. **Client:** Any individual receiving benefits; only those clients who receive full benefits are included in the data set. A term not used in the CCIP data release; the term “recipient” is favored in its place. *See also* [Recipient](#).
26. **Comprehensive benefits:** *See also* [Full benefits program](#).
27. **Cost:** the financial expenditure associated with a particular healthcare service or encounter, expressed in U.S. dollars.
28. **County:** One of 102 geographic and administrative areas within the state of Illinois, denoted by a proper name; data that is not cleaned or revised by HFS prior to data release. This is typically based on the county of the public aid office where the recipient is enrolled, but when the aid office is not associated with a specific county, this information reflects the county associated with the recipient’s zip code. The county may be inaccurate, outdated, or incorrectly reported with respect to the recipient’s true current address. Please note that county codes included in the data sets are not FIPS codes or Environmental Protection Agency codes.
29. **Covered services:** Benefits and services provided to medical assistance Clients as defined under the Illinois State Plan and HCBS Waivers. *See also* [Benefits](#).
30. **Critical Access Hospital:** a hospital, defined by the Balanced Budget Act of 1997, as a facility located in a rural area that provides emergency services, 25 or fewer inpatient beds, and inpatient care typically lasting 96 hours or less; a facility entitled to specialized payments not available to other healthcare facilities. This item is recorded in [Data Set I provider information](#).
31. **Current eligibility indicator:** Indicates that the recipient was eligible for Medicaid or other full-benefit medical program as of the anchor date.
32. **Current Procedural Terminology (CPT):** Nomenclature for medical procedures and services for insurance reporting purposes; used for assigning type of service for a select number of services captured in the data set. A uniform coding system published and revised annually by the American Medical Association that consists of numeric codes and descriptive phrases for a wide variety of services provided by medical doctors and other healthcare professionals; this terminology is used for filing claims to Medicaid, and is included in the data sets as part of Type of Service data. *See also* [Healthcare Common Procedure Coding System](#). *See also* [Procedure Codes](#).
33. **Data release:** HFS’ provision in 2012 of data sets to health organizations who will integrate this information into [CCE or MCCN proposals](#).
34. **Data set:** A data table or several related data tables designed for a specific purpose, such as providing information to help [CCEs and MCCNs prepare proposals](#).

Healthcare and Family Services Transparency Glossary

35. **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.
36. **Date of birth:** The date on which a recipient was born; the basis for determination of the age of a recipient as of the anchor date. Date of birth will not be included in the data sets that HFS releases in 2012.
37. **Date of death:** The date on which a recipient died, where available. Date of death will be included in the data sets for recipients who are recorded as deceased as of the anchor date. For those recipients who have not died, a death date of 12/31/2099 will be entered in the data sets.
38. **Date of service:** A date associated with healthcare services rendered to a given recipient, expressed in the form MM/DD/YYYY. For services that occur within a single day only, date of service is the date the service was rendered. For most inpatient hospital stays, date of service is the date of admission. For long term inpatient hospital stays, dates of service are the admission date for the first claim and the first date of the billing period for all subsequent claims. For long term care stays, the dates of service are the admission date and the first day of the month for every month thereafter, until the patient is discharged.
39. **Department of Children and Family Services (DCFS):** [DCFS Web site](#) The Illinois state agency responsible for providing social services to children and their families, and public child welfare services. Services delivered by DCFS are set forth in 89 Illinois Administrative Code, Parts 302 and 304, and include the capacity to remove children from parental custody, at which point they and their guardians can become eligible for Medicaid by virtue of their DCFS statuses. Several programs are recognized, including Adoption Assistance, Foster Care, Subsidized Guardianship, and other cases administered and enrolled; these full-benefits programs are included in data sets.
40. **Department of Human Services (DHS):** [DHS Web site](#) The Illinois state agency responsible for the provision of various social service programs. The Divisions of Rehabilitation Services (DHS-DRS), Developmental Disabilities (DHS-DDD), Mental Health (DHS-DMH), and Alcohol and Substance Abuse (DHS-DASA) are located within DHS. Although DHS has responsibility for some functions associated with Medicaid, the data sets released by HFS do not contain most data that DHS collects.
41. **Department of Juvenile Justice:** A state governmental entity concerned with appropriate treatment of youth in Illinois correctional facilities; a small number of people under age 18 who are not incarcerated but are under the supervision of the court are eligible for Medicaid benefits. These enrolled individuals are captured in the data sets.
42. **Developmental Disabilities:** Physical or mental impairments that are lifelong, apparent before age 18, and disabling to a person's capacity for independence, self-sufficiency, self-expression, self-direction, self-care, learning, and/or mobility; a category of disabilities that makes recipients eligible for HCBS Waivers via MR/DD claims. *See also* [Home and Community Based Services](#); and [Waivers](#).
43. **Developmental Disabilities Residential Waivers for Children and Young Adults:** A full benefits program to developmentally disabled persons aged 3 through 21 years who require

Healthcare and Family Services Transparency Glossary

specialized residential care; one of several categories of benefits that provide payment for more services than are typically covered by Medicaid. This category covers services not covered by Developmental Disabilities Supportive Services Waivers for Children and Young Adults. *See also* Developmental Disabilities Supportive Services Waivers for Children and Young Adults. For more information on the [Developmental Disabilities Residential Waivers for Children and Young Adults waiver](#).

44. **Developmental Disabilities Supportive Services Waiver Claims:** Payment requests submitted by a waiver provider and adjudicated under the waiver for any of the three subcategories of Developmental Disabilities waivers; typically, claims for services that Medicaid would not pay for a recipient not enrolled in a waiver. *See also* [Developmental Disabilities Supportive Services Waivers for Children and Young Adults](#), [Developmental Disabilities Residential Waivers for Children and Young Adults](#), [Developmental Disabilities Waivers for Adults](#), and [Waiver](#).
45. **Developmental Disabilities Supportive Services Waivers for Children and Young Adults:** A full-benefits program to developmentally disabled persons aged 3 through 21 years, providing specialized services designed to allow individuals who fit criteria for institutionalization to remain in their homes and communities; one of several categories of benefits that provide payment for more services than are typically covered by Medicaid. This category covers services not covered by Developmental Disabilities Residential Services Waivers for Children and Young Adults. *See also* [Developmental Disabilities Residential Services Waivers for Children and Young Adults](#). [For more information on the Developmental Disabilities Residential Services Waivers for Children and Young Adults](#).
46. **Developmental Disabilities Waivers for Adults:** A full benefits program to developmentally disabled persons over 18 years old, providing specialized services designed to allow individuals who fit criteria for institutionalization to remain in their homes and communities; one of several categories of benefits that provide payment for more services than are typically covered by Medicaid. [For more information on the Developmental Disabilities Waivers for Adults waiver](#).
47. **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, and applicable to the provider data via the Type of Service. HFS currently uses DRG Grouper Version 12. *See also* [Type of Service](#).
48. **Disabled adult:** An individual who is over 18 and under 65 years of age, who meets the definition of blind or disabled under Section 1614(a) of the Social security Act (42 U.S.C.1382), and who is eligible for Medicaid; this definition does not include Seniors (those over age 65). This definition differs from the term Seniors and Persons with Disabilities (SPD). *See also* [AABD](#) and [Seniors and Persons with Disabilities](#).
49. **Disability:** An umbrella term for impairments and restrictions in behavior or action arising from a physical, mental, emotional, or developmental cause.
50. **Disabled status:** A descriptor for any person who is contextually defined, under law and/or program regulations, as having a disability. Disabled people do not necessarily have disabled status. Most references to disability and ‘disabled’ in the Solicitation and data sets are with respect to people with disabled status. *See also* [Disability](#).

**Healthcare and Family Services
Transparency Glossary**

51. **Disenrollment:** The process by which an individual enrolled in a benefits program ceases participation, either voluntarily or by loss of eligibility. As with enrollment, the program from which the recipient disenrolled must be specified. *See also* [Eligibility](#) and [Enrollment](#).
52. **Division of Developmental Disabilities (DHS/DD):** The Division within DHS that operates programs for persons with developmental disabilities.
53. **Division of Specialized Care for Children (DSCC):** An Illinois healthcare agency, organized under the Title V Program for Children with Special Health Care Needs (CSHCN), funded by the Federal Title V Maternal and Child Health Block Grant and operating at the University of Illinois at Chicago that coordinates care for children with special healthcare needs throughout the state of Illinois.
54. **Dual diagnosis:** A term describing a person who has a diagnosis of mental illness and also a diagnosis of substance use disorder; a near-synonym to the preferred term ‘Mental Illness/Substance Abuse (MISA).’ This term has no relationship with the term ‘dual eligible,’ and for this reason the shortened term ‘dual’ should be clearly explicated or replaced. Additionally, it is not a synonym to the more inclusive term ‘comorbidity,’ and should not be used as such.
55. **Dual eligible:** A Client who receives services through both the Medicare (Parts A and/or B) and the Medicaid Program; within the database, a recipient who has enrolled in both types of benefits during the experience period. Sometimes referred to as ‘duals.’ This category excludes recipients for whom we pay for only Medicare premiums and Medicare cost sharing, but do not directly cover any services, as well as persons who receive limited services but who are not Medicaid recipients (a ‘partial benefits recipient’). *See also* [Partial Benefits](#).
56. **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT):** A free program provided to all children who are enrolled in an HFS medical benefits program, consisting of scheduled periodic visits with a pediatrician to assess a child’s overall well-being and provide preventive care, treatment and referrals to specialists; a category of service folded into the appropriate types of services in the data sets.
57. **Eligible/Eligibility:** A) the accepted possession of any characteristic(s) that allow one to enroll in a Medicaid program or other health program; OR B) the assumed eligibility of a recipient for healthcare services by virtue of being enrolled in a Medicaid program or other health program. Although eligibility can be imputed for enrollment, eligibility is distinct from enrollment. This data set only examines the recipients eligible and enrolled for full benefit programs. *See also*, [Enrollee](#), and [Eligibility span](#).
58. **Eligibility criterion:** A personal or family characteristic that makes an individual able to enroll into a benefits program that bears entry restrictions. Eligibility always requires meeting income standards. It may require meeting standards with respect to assets, family structure, disability, and/or other family or individual circumstances.
59. **Eligibility determination:** Assessment of all financial and non-financial information needed to establish an individual’s qualifications to receive program benefits, and, when appropriate, to establish the benefits for which a person can enroll; of those who have passed eligibility determination, only individuals who enroll in a full benefits program are included in the data set.

**Healthcare and Family Services
Transparency Glossary**

- 60. Eligibility span:** A misnomer for the period of time, as expressed by a start date and end date, that a recipient was enrolled in a program; recipients may experience several non-overlapping full benefit eligibility spans over time and the current span may be ongoing as of the last day of the data set's experience period, December 31, 2010. Eligibility spans are associated with both Medicaid enrollment and with individual Medicaid programs, such as waiver programs.
- 61. Emergency Services Program:** A partial-benefits program that covers the cost of emergency services for noncitizens who meet qualifications for benefits as Seniors and Persons with Disabilities or low-income recipients, except that they lack qualifying immigration status.
- 62. Encounter Claims:** Services paid for by a Managed Care Organization (MCO) under their at-risk contract with HFS. The MCO in turn submits a record of the service to HFS for informational purposes. The record is referred to as an encounter claim. Technically encounter claims are not claims as they are neither adjudicated nor paid by HFS. These differ greatly from Encounter Rate Claims. *See also* [Claims](#) and [Encounter Rate Claims](#).
- 63. 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* [Claims](#) and [Encounter Claims](#).
- 64. Enrollee:** A recipient who is eligible and completed any additional processes necessary to be enrolled in an HFS program. Any reference to enrollee should specify the program. Enrollees are also known as recipients and sometimes clients. Any proposal using the term Enrollee should make clear which definition is intended. *See also* [Recipients](#), and [Clients](#).
- 65. Enrollment:** The bureaucratic process by which an individual found to be eligible can commence receiving healthcare services funded by Medicaid or another program at the appropriate level of benefits; a criterion for the inclusion of data on such individuals in the data set. Any use of the term enrollment should specify the program.
- 66. Enrollment program group:** A description of the most comprehensive program in which the enrollee is enrolled; since only recipients with full benefits are included in the data set, the enrollment program group description in the data set will be a full benefit program. Please note that this program is the program which allows the recipient to be eligible for other programs.
- 67. Enterprise data warehouse:** an HFS central facility that stores and manages electronic data on Medicaid recipients, healthcare providers, and their claims; the facility from which deliverable data sets will be obtained.
- 68. Ethnicity:** The recipient's self-reported identification with the Hispanic/Latino ethnic group; a distinct category from race. No information on any other ethnicity is included in the data set. *See also* [Race](#).
- 69. Event:** A term used together with "unit" to quantify the services rendered to recipients. Generally, this is the healthcare use that occurs by one recipient, on one day, with one provider (or, in the case of emergency care, one recipient, on one day, in one emergency room). Exceptions occur for inpatient care (for which the event is admission), institutionalization (for which one month is one event) and pharmacy (for which each prescription is an event). Sometimes informally referred to as "visits." *See also* [Unit](#).

Healthcare and Family Services Transparency Glossary

70. **Experience period:** The dates associated with the eligibility spans within the overall period included in the data set (January 1, 2010 to December 31, 2010). If an eligibility span crosses the beginning and/or ending date of the experience period is truncated at the beginning and/or ending date of the experience period.
71. **FamilyCare:** ([FamilyCare Web site](#)) A full-benefits program that offers health insurance to the parents and caretaker relatives of children 18 years old or younger who meet income and other guidelines; benefits are provided at various levels of income under subprogram names “Assist,” “Share,” “Premium Level 1,” and “Rebate.” Some recipients in the “Assist” subprogram (for those at lowest income) may also receive monthly cash assistance. A full-benefits program included in the data sets.
72. **Family Case Management (FCM):** A program administered by DHS which is available to some low-income Medicaid recipients. No data on this program is included in the data sets.
73. **Federal Poverty Level (FPL):** An income threshold that the U.S. federal government updates yearly; multiple federal, state and local agencies commonly use this threshold and percentages thereof to determine individuals’ and families’ eligibilities for benefits.
74. **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](#).
75. **Fee for Service (FFS):** The method of billing under which a Provider charges and HFS pays for each encounter or service rendered; a flag applied to recipients in Data Set I who were not enrolled in HMO plans.
76. **Flag:** A synonym for indicator. *See also* [Indicator](#).
77. **Full benefit plan:** A Medicaid or Medicaid-like plan (e.g., Children’s Health Insurance Plan), administered by HFS, which provides comprehensive health insurance, including hospital, physicians, and pharmacy, for essentially all medical problems that the recipient may have; a level of benefits that all recipients in the data sets receive, via a variety of specific programs. Also referred to as ‘full benefits,’ ‘full benefits program’ or ‘comprehensive benefits.’ HFS does not necessarily, however, pay for comprehensive benefits as recipients with full benefit plans may have significant other insurance coverage via Medicare or Third Party Liability. *See also* [Dual Eligible](#).
78. **Gender:** The self-reported gender of an individual; classified as male, female or unknown.
79. **Hard of hearing:** Having deficient ability to hear; having a hearing impairment.
80. **Health Benefits for Workers with Disabilities ([HBWD Web site](#)):** A program providing comprehensive healthcare coverage to disabled individuals who are working, in replacement of Medicaid for which they are ineligible as a result of their income. Recipients with this benefit are an excluded population for this Solicitation, and therefore healthcare records from this program are not included in the CCIP data release.
81. **Healthcare Effectiveness Data and Information Set (HEDIS):** A grouping of quality assurance measures established by the National Committee for Quality Assurance (NCQA) and used by

Healthcare and Family Services Transparency Glossary

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

82. **Healthcare and Family Services ([HFS Web site](#)):** 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 CCIP data sets. In the Solicitation, HFS is also referred to as the 'department.'
83. **Healthcare Common Procedure Coding System ([HCPCS General Information](#)):** A standardized coding system used to identify healthcare services, procedures and products. The system has two levels (I and II), where level I is Current Procedural Terminology (CPT) and level II is additional codes identifying items not included under CPT. *See also* [Current Procedural Terminology](#) and [Procedure Codes](#).
84. **Health Insurance Portability and Accountability Act (HIPAA):** Also known as the Kennedy-Kassebaum Bill, the Kassebaum-Kennedy Bill, K2, or [Public Law 104-191 \(pdf\)](#), 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 healthcare data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for healthcare 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 healthcare information. A law affecting health data privacy and security that affects the manner and specificity with which HFS can release data and how data recipients can use and must protect the data. *See also* [Limited Data Set](#).
85. **Health Maintenance Organization (HMO):** A health maintenance organization as defined in the Health Maintenance Organization Act (215 ILCS 125/1-1 et seq.). A healthcare organization licensed by the Department of Insurance to provide a combination of healthcare to a defined subpopulation for predetermined capitated premiums, utilizing various cost-saving strategies to optimize healthcare quality and manage risk. *See also* [Managed Care Organization](#) and [Voluntary Managed Care](#).
86. **HIV/AIDS Waiver:** A full benefits program to persons living with HIV/AIDS of any age, providing services designed to allow individuals who fit criteria for institutionalization to remain in their homes and communities; one of several categories of benefits that provide payment for more services than are typically covered by Medicaid. *See also* [HIV/AIDS claims](#) and [Waiver](#). For more information on the [HIV/AIDS Waiver](#).
87. **HIV/AIDS Waiver Claim:** Payment requests submitted by a waiver provider and adjudicated under the HIV/AIDS waiver; typically, claims for services that Medicaid would not pay for a recipient not enrolled in a waiver. *See also* [HIV/AIDS waiver](#) and [Waiver](#).
88. **Home and Community-Based Services Waivers ([HCBS Web site](#)):** 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

Healthcare and Family Services Transparency Glossary

qualify for the level of care provided in an institution but who, with special services, may remain in their homes and communities. *See also* [Waivers](#).

89. **Home Healthcare:** A wide range of services, including nursing, allied health, and social services, delivered to recipients in their residences rather than inside a healthcare facility.
90. **Illinois Breast and Cervical Cancer Program ([IBCCP Web site](#)):** A program providing free mammograms, breast exams, pelvic exams and Pap tests to eligible women, as well as treatment benefits to women in whom reproductive or breast pathology is present; a program excluded in the CCIP data release.
91. **Illinois Cares Rx:** A partial-benefits program that provides assistance with prescription drug costs for low-income disabled persons between 16 and 65 years old and low-income seniors; a program from which no data has been captured in the CCIP data set.
92. **Illinois Client Enrollment Broker (ICEB):** The entity contracted by the department to conduct enrollment activities for Potential Enrollees, including providing impartial education on healthcare delivery choices (MCOs, CCEs, MCCNs, etc.) providing enrollment materials, assisting with the selection of a PCP and MCO, CCE, or MCCN, and processing requests to change MCOs, CCEs or MCCNs. The ICEB also processes Recipient enrollment into the Integrated Care Program. *See also* [Integrated Care Programs](#).
93. **Illinois Health Connect (IHC):** The state's Primary Care Case Management Program; a statewide program, mandatory for most recipients, whereby the recipients must choose or are assigned to a PCP as their medical home, unless they otherwise are eligible and enrolled in a voluntary MCO. This program operates through a State Plan Amendment pursuant to 42 CFR Section 438. *See also* [Primary Care Case Management](#).
94. **Illinois Healthy Women:** [IHW Web site](#) A partial-benefits program that covers family planning (birth control) and various other reproductive health services for female Illinois residents ages 19-44 who meet income requirements and are not pregnant; a program excluded from the CCIP data release.
95. **Illinois Hemophilia Program:** A partial-benefits program providing coverage of anti-hemophilic factors, annual comprehensive medical visits and other medical expenses for hemophiliacs; a program for which no data has been captured in the CCIP data set. The data set, however, does contain data for hemophiliacs who are enrolled in full benefit (Medicaid and CHIP) programs.
96. **Illinois Veterans Care:** [Veterans Care Web site](#) A program providing care to veterans and their dependents if they are eligible under rules on income level; this program is captured in the data sets.
97. **Illinois Warrior Assistance Program:** [Warrior Assistance Web site](#) A post-deployment partial benefits transitional program for veterans; data from this program is not included in the CCIP data release.
98. **Indicator:** The term used in the data sets to refer to a data field that can contain '1,' to signal that the given attribute is present, or '0,' to signal that the attribute is absent, from a given observation. The word 'flag' is a synonym with 'indicator' with respect to the data sets; however, 'indicator' is the preferred term and is used in the data set output files. *See also* [Flag](#).

Healthcare and Family Services Transparency Glossary

99. **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.
100. **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.
101. **Institutionalization:** A) Residence in a facility that provides long term care to individuals who are unable, due to disease, disability, or advanced age, from efficiently and safely performing a significant amount of activities of daily living; B) the administrative and clinical process by which such residence begins.
102. **Inter-Governmental Transfer (IGT):** A category of reimbursement used to augment federal funding to state governments for certain healthcare services provided at those hospitals that operate under Per Diem payments; an item that is included in Data Set IIB: Hospital in the Add-on Code field, but that has not been dispensed since March 2011.
103. **Intermediate Care Facilities for the Mentally Retarded (ICFs/MR):** A public or private facility that is designed to provide care for Mentally Retarded or Developmentally Disabled persons who require long term care for multiple disabilities and health conditions and who are Medicaid-eligible.
104. **Last Eligibility Date:** The last day during the experience period on which a recipient was enrolled in a Medicaid program or other full-benefit health program, used to capture data items that are subject to change on recipients who were no longer enrolled as of the anchor date. [See also Eligibility span.](#)
105. **Limited Data Set:** A data set which complies with HIPAA and HIPAA regulations by excluding names, addresses, and other direct identifiers, but including information that allows for the possible identification of individuals through indirect identifiers; a category of data confidentiality to which the CCIP data sets belong as a result of the included geographic information. (For more information on HIPAA, see “[Summary of the HIPAA Privacy Law.](#)” For the text of the law to which this section refers, please see “[164.514: Other requirements relating to uses and disclosures of protected health information \(pdf\).](#)”)
106. **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.
107. **Long-term care table:** A data table provided in Data Set II that includes more detailed information on utilization of long term care services by Medicaid recipients during the experience period.
108. **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 healthcare services within Illinois and that provides or arranges primary, secondary and tertiary managed healthcare services under contract with the department exclusively to persons participating in

Healthcare and Family Services Transparency Glossary

programs administered by the department. MCCNs are regulated and licensed by HFS and not the Department of Insurance. While they may operate much like a HMO, they are not considered HMOs. *See also* [Managed Care Organization](#), [Health Maintenance Organization](#), and [Voluntary Managed Care](#).

109. **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 \(MCCN\)](#).
110. **Medicaid:** The program under Title XIX of the Social Security Act that provide medical benefits to groups of low-income people.
111. **Medicaid-like program:** Any program administered by HFS providing state-funded or federally funded health insurance benefits to a selected population; a program that is not a part of Medicaid, but is administered in a similar way.
112. **Medicaid Presumptive Eligibility (MPE):** A program available to pregnant women based on income level, irrespective of their immigration status; the program provides extensive primary healthcare and hospital services, including labor and delivery to expectant mothers not otherwise eligible for Medicaid. It is however a partial-benefits program that is excluded from the CCIP data set. This program is sometimes referred to as Presumptive Eligibility (PE), although this is also a separate program. *See also* [Moms and Babies](#) and [Presumptive Eligibility](#).
113. **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](#).
114. **Medically Fragile, Technology Dependent (MFTD) children:** Individuals under 21 years of age who are eligible for Home and Community-Based Services waivers under [89 Ill. Adm. Code 120.530](#), entitling them to special services not normally granted to Medicaid recipients; a category of patients who are identified as such as in the data set. A patient group for who care is coordinated by the Division of Specialized Care for Children (DSCC), a Title V agency operating at the University of Illinois at Chicago. Sometimes called The Home Care Program.
115. **Mental Health Screening Only:** *See also* [Screening, Assessment and Support Services \(SASS\)](#).
116. **Mental Illness and Substance Abuse (MISA):** A term referring to patients who are both psychiatrically ill and dependent on drugs or alcohol. These recipients are commonly referred to as ‘dual diagnosis’ patients. A group of patients who are not specifically flagged as such, but who can be identified via the CDPS chronic condition flags and/or the use of certain types of services. Occasionally, the equivalent acronym “MHSA” (“mental health and substance abuse”) is used.
117. **Moms & Babies:** A program covering all outpatient healthcare and inpatient hospital care, including labor and delivery, for women not otherwise eligible for Medicaid during pregnancy and for 60 days following the birth of their infant. This program is not included in the CCIP data sets. *See also* [Medicaid Presumptive Eligibility](#).
118. **Money Follows the Person (MFP):** Also known as the Money Follows the Person (MFP) Rebalancing Demonstration. A five-year (2007-2011) demonstration program, now extended to

Healthcare and Family Services Transparency Glossary

2016, designed to assist disabled Medicaid recipients in the state of Illinois to transition from long term care to home- and community-based service use, using specialized transitional services. A program captured in the data sets in much the same way as the waiver programs.

- 119. MR/DD:** An acronym for Mentally Retarded/Developmentally Disabled, used by agencies that receive federal funding under Title XIX of the Social Security Act of 1965; a code for a category of claim included in the data set. *See also* [Developmental Disabilities](#), [Developmental Disabilities, Supportive Services Waivers for Children and Young Adults](#), [Developmental Disabilities Residential Waivers for Children and Young Adults](#), [Developmental Disabilities Waivers for Adults and Waiver](#).
- 120. National Committee for Quality Assurance (NCQA):** A private 501(c) 3 not for profit organization dedicated to improving healthcare quality and has a process for providing accreditation, certification and recognition, e.g., health plan accreditation.
- 121. National Drug Code (NDC):** A numeric code 11 digits in length that identifies a specific prescription drug; a code used by Medicaid to process claims. A code used with the CCIP data release to augment Chronic Illness and Disability Payment System data on specific illnesses. *See also* [Chronic Illness and Disability Payment System](#).
- 122. National Provider Identifier (NPI):** a 10-digit numeric identifier assigned to an individual healthcare 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](#).
- 123. Net liability:** The amount of money that Medicaid is ultimately responsible for paying for a claim; as the payer of last resort, Medicaid is typically liable for the portion of claims that is not covered by additional insurance or Medicare. *See also* [Dual Eligible](#).
- 124. Non-claims payments:** A payment that is not associated with a specific recipient and healthcare service or otherwise does not flow through our claims system. These payments include but are not limited to hospital Supplemental Payments. The payments are also known as C-13 voucher payments. Because they cannot be associated with a particular recipient and service these payments are **not** included in the data sets as a component of the costs in the Total Cost field. *See also* [Claims Payments](#) and [Supplemental Payments](#).
- 125. Non-disabled adult:** A term used by HFS to refer to adults aged 19 to 64 whose Medicaid eligibility is not based on their disability status, irrespective of any disabilities or health problems they may experience; typically, parents or other primary caregivers of Medicaid-eligible children.
- 126. 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.
- 127. Non-priority adults:** Any recipient over age 18 and under age 65 whose Medicaid eligibility is not based on their disability status, irrespective of any disabilities or health problems they may experience; adults who do not qualify as a Senior or Person with Disability (SPD). A term

**Healthcare and Family Services
Transparency Glossary**

synonymous with ‘other adult’ and similar to ‘TANF adult’ and ‘non-disabled adult (AA).’ Typically, these are parents or primary caregivers of Medicaid-eligible children.

- 128. Open end date:** A term used to describe an attribute, classification, or circumstance that is applicable from the present moment to an undefined point in the future. Those eligibilities, enrollments, and other attributes within the data set that have an open end date are treated the same as those that end 12/31/2010, the last day of the experience period.
- 129. ‘Other’ adults:** Any recipient aged 19 to 64 whose Medicaid eligibility is not based on their disability status, irrespective of any disabilities or health problems they may experience; adults who do not qualify as a Senior or Person with Disability (SPD). A term synonymous with ‘non-priority adult’ and similar to ‘TANF adult’ and ‘non-disabled adult (AA).’ Typically, these are parents or primary caregivers of Medicaid-eligible children. [See also Non-priority adult](#), [TANF adult](#), and [Non-disabled adult \(AA\)](#).
- 130. Other IHC Adults:** Illinois Health Connect (IHC) Adults whose eligibility for Medicaid is not based on a disability and are between the ages of 19 and 64 years of age. [See also ‘Other’ Adults](#).
- 131. Partial benefit plans:** A program administered by HFS that provides less than comprehensive benefits (such as IL Cares Rx), restrict the recipient to treatment of only a certain condition (such as rape victim services), or pays the premiums and/or cost sharing for another insurance program (including Medicare) but does not directly cover any services.
- 132. Patient:** In general usage, a person who receives healthcare services from a healthcare provider; for the purposes of the data sets, a recipient. A term that is not used in the Solicitation. In any document using the term “patient,” we advise all data users to clarify the intended meaning. [See also Beneficiary](#) and [Recipient](#).
- 133. Pending Asylees or Torture Victims:** A category of Medicaid-eligible persons who qualify for benefits by virtue of their seeking asylum via the federal Department of Homeland Security, as well as their low-income status.
- 134. Per Member per Month (PMPM):** A metric for healthcare costs that averages costs across all recipients of a particular health benefit program or other healthcare service for a given month. A figure not specifically included in CCIP data release cost data.
- 135. 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.
- 136. Person with Disabilities:** [See also Adults with Disabilities](#), [Disabled Adults](#), and [Disability](#).
- 137. Physical Disabilities Waiver:** A full benefits program to disabled persons aged 0 to 59 years old, providing services designed to allow individuals who fit criteria for institutionalization to remain in their homes and communities; one of several categories of benefits that provide payment for more services than are typically covered by Medicaid. [See also Waiver Program](#) and [Waiver](#). For more information on the [Physical Disabilities Waiver](#).

**Healthcare and Family Services
Transparency Glossary**

- 138. Physical Disabilities Waiver claim:** Payment requests submitted by a waiver provider and adjudicated under the disabilities waiver; typically, claims for services that Medicaid would not pay for a recipient not enrolled in a waiver. [See also Waiver Program](#) and [Waiver](#).
- 139. Physician:** A person licensed to practice medicine in all its branches under the [Medical Practice Act of 1987](#).
- 140. Presumptive Eligibility (PE):** A program available to children (aged 0 to 18) based on income level, irrespective of their immigration status; the program provides extensive primary healthcare and hospital services. It is however a partial-benefits program that is excluded from the CCIP data set. This program is maybe referred to as Temporary All Kids benefits or similar names. It should not be confused with Medicaid Presumptive Eligibility (MPE), a separate program for expectant mothers. [See also Medicaid Presumptive Eligibility](#).
- 141. Primary Care Case Management (PCCM):** A system of primary managed care based on designating an office-based primary care provider as a “medical home” for a Medicaid recipient, mandated for most recipients who have full benefits, are not dual eligible, and are not enrolled in managed care (including the [Integrated Care Program](#)).
- 142. Primary care provider (PCP):** A healthcare provider, including physicians, Federally Qualified Health Center (FQHCs), Rural Health Clinics (RHCs), nurse practitioners, hospital-based clinics, local health departments, school based clinics, and Women’s Health Care Providers (WHCPs), who within the Provider's scope of practice and in accordance with state certification requirements or state licensure requirements, is responsible for providing all preventive and primary care services to his or her assigned Enrollees in the CCE or MCCN. [See also Medical home](#).
- 143. Priority population:** The population who *must* be included in the population served by care coordination entities (CCEs) and managed care coordination networks (MCCNs); Seniors and persons with disabilities. [See also Seniors and Persons with Disabilities](#).
- 144. 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](#).
- 145. Programs:** Various assistance plans that the State of Illinois administers to individuals who qualify, based on various eligibility criteria; variances between programs include type and level of benefits, target population, intended outcomes, and funding source. Medicaid itself is a program. One person may therefore be in multiple programs, such as Medicaid, a waiver program, and (in the future) coordinated care.
- 146. Protected Health Information:** Information about the health conditions, healthcare needs, and healthcare services rendered to individuals that, under the Health Insurance Portability and Accountability Act, is considered worthy of special protections (such as identity masking and secure storage) to ensure that it remains private. [See also Health Insurance Portability and Accountability Act \(HIPAA\)](#).

**Healthcare and Family Services
Transparency Glossary**

- 147. Provider:** A person enrolled with the department to provide Covered Services to a Client; any individual who provides healthcare 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.
- 148. Provider ID:** Medicaid-specific number that all providers must have, even those providers who do not have a NPI for reasons related to professional licensing standards. Use of this ID predates NPI and is embedded in HFS records keeping. The Provider ID for some providers is a Social Security number and therefore must be masked.
- 149. Provider Key ID:** A 10-digit number assigned at random to any provider who does not have a NPI or who has not provided this figure to Medicaid. This number has no relationship with the Provider ID, which may include a provider's social security number or other direct identifiers and is therefore unsuitable for wide release.
- 150. Provider type:** A classification of providers as defined by their role (and typically their license) in the healthcare system.
- 151. Provider visit:** Any single event, typically associated with a single date of service, in which a healthcare provider gives care to a Medicaid recipient; the data associated with such an event, as reflected in the CCIP data set. *See also* [Event](#).
- 152. Qualified Individual-1 (QI-1):** An individual with countable income over 120-135% of the federal poverty level (FPL) with assets at or below \$6,600 for an individual or \$9,910 for a couple, for whom Medicaid will pay the monthly Medicare Part B premium or an equivalent sum towards a Medicare Advantage (Part C) plan.
- 153. Qualified Medicare Beneficiaries (QMB):** A category of recipients who are eligible to receive Medicaid assistance with the costs of Medicare, including the Medicare Part B premium, annual Part B deductible, coinsurance costs and Medicare Part A premium, plus an amount equal to the Medicare Part B premium, deductible and coinsurance for those Medicare recipients who opt to enroll in a Medicare Advantage Plan (Part C). A partial benefits program.
- 154. Quality measure:** A quantifiable measure to assess how well an organization carries out a specific function or process or achieves desired outcomes. Information on quality measures is not found in the CCIP data sets.
- 155. Race:** the recipient's self-reported identification with one or more groups within the following list: White; African-American; American Indian or Alaskan Native; Asian or Pacific Islander; Multiracial; or Refused to Answer/Unknown. This term is distinct from the term "Ethnicity." *See also* [Ethnicity](#).
- 156. 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 CCIP data set. *See also* [Client](#).

**Healthcare and Family Services
Transparency Glossary**

- 157. Recipient Key ID:** An ID assigned to the recipient for identification purposes within this data table only; a series of digits that neither reflects any other ID number assigned to the recipient nor identifies any other characteristic of the recipient.
- 158. Refugee:** An individual who has sought asylum and been granted refugee status in a country outside his or her country of origin due to fear of persecution due to his or her race, religion, nationality, political opinion, or social group membership; a type of individual who is not specifically flagged in the data sets, but who may receive full benefits for a limited time under the Refugee and Repatriation Assistance program. *See also* [Refugee and Repatriation Assistance](#).
- 159. Refugee and Repatriation Assistance (RRA):** A program, consisting of the Refugee Resettlement Program (RRP) and Repatriate Program, that provides short-term full medical benefits to refugees and selected others; a program that is captured in the data sets. *See also* [Refugee](#).
- 160. Reimbursement:** payment for medical services rendered to a benefit recipient on a fee for service basis. *See also* [Fee for Service](#) and [Claims](#).
- 161. 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](#).
- 162. Screening, Assessment and Support Services (SASS):** A partial-benefits program that serves children 0 to 18 years who are experiencing mental health crises and who may need hospitalization for mental healthcare; a program not specifically indicated in the CCIP data release, but possibly providing services to some full-benefit pediatric Medicaid or All Kids recipients.
- 163. Seniors:** A Client who is 65 years of age or older. Only seniors who were enrolled in Medicaid within the experience period are represented in the data set.
- 164. Seniors and Persons with Disabilities (SPD):** A term favored by HFS to refer to recipients over age 65 and adults 19-64 who are eligible for Medicaid by virtue of disability; a near-synonym for the CDPS term Disabled Adult (DA). This is a priority population for this solicitation. *See also* [Disabled Adult and Disabled Adult \(DA\)](#).
- 165. Serious mental illness (SMI):** A Client who is at least 18 years of age and whose emotional or behavioral functioning is so impaired as to interfere with their capacity to remain in the community without supportive treatment. The mental impairment is severe and persistent and may result in a limitation of their capacities for primary activities of daily living, interpersonal relationships, homemaking, self-care, employment or recreation. The mental impairment may limit their ability to seek or receive local, state or federal assistance such as housing, medical and dental care, rehabilitation services, income assistance and food stamps, or protective services. For purposes of enrolling Target Populations, the following diagnoses will be used schizophrenia (295.xx), schizophreniform disorder (295.4), schizo-affective disorder (295.7), delusional disorder (297.1), shared psychotic disorder (297.3), brief psychotic disorder (298.8), psychotic disorder (298.9), bipolar disorders (296.0x, 296.4x, 296.5x, 296.6x, 296.7, 296.80, 296.89, 296.90), cyclothymic disorder (301.13), major depression (296.2x, 296.3x), obsessive compulsive disorder (300.30), anorexia nervosa (307.1), and bulimia nervosa (307.51).

**Healthcare and Family Services
Transparency Glossary**

- 166. Services:** assistance provided as part of a benefits program; includes healthcare, social services, and other forms of aid to eligible individuals.
- 167. Service units:** A term that can be used in place of ‘units,’ in the context of itemized services provided associated with a given healthcare service event. *See also* [Units](#) and [Events](#).
- 168. Specified Low-Income Medicare Beneficiaries (SLIB):** Recipients with monthly countable income between 100% and 120% of the federal poverty level (FPL) with assets at or below \$6,600 for an individual or \$9,910 for a couple, for whom Medicaid will pay the monthly Medicare Part B premium or an equivalent sum towards a Medicare Advantage (Part C) plan.
- 169. Spend-down:** The policy that allows an individual to qualify for Medicaid by incurring medical expenses at least equal to the amount by which his or her income or assets exceed eligibility limits. A spend-down cost is similar to deductibles in private insurance, in that the spend-down amount represents medical expenses the individual is responsible to pay.
- 170. Spend-down recipients:** Individuals who are eligible for Medicaid despite having income in excess of the limit defined by law within a given time period, by consideration of their income minus medical expenses for which they must bear personal responsibility. Even though they have full benefits when eligible, these recipients have eligibilities that cycle on and off, often monthly. They are excluded from this data release.
- 171. State:** The State of Illinois, as represented through any agency, department, board, or commission, and in any documentation, Web sites and data sets.
- 172. State Chronic Renal Disease Program:** A category of Medicaid benefits provided to persons who are experiencing renal impairment to such a degree that dialysis is necessary to maintain life. A partial-benefits program that covers only dialysis treatments received in a dialysis treatment center, hospital outpatient setting and at home, for people who have chronic renal diseases requiring lifesaving care, but who do not qualify for Medicaid, spend-down Medicaid, or All Kids.
- 173. State-operated Developmental Centers:** Public or private facilities that provide long term care services to people with developmental disabilities who have severe medical and/or behavioral needs who are Medicaid-eligible.
- 174. Sterilization:** A surgical procedure that eradicates an individual’s capacity to conceive children; a form of permanent contraception; a medical procedure included as a unique category within the data set in keeping with federal guidelines on type of service classifications.
- 175. Substance Use Disorders:** A category of diagnoses connected with a specific subset of Types of Services; this category includes but is not limited to drug dependence, alcohol dependence, substance misuse, and alcohol- and drug-induced mental disorders. In specific contexts, this term may be appropriately substituted with ‘substance abuse,’ ‘addiction,’ and a wide variety of other terms; therefore, proposals analyzing Substance Use Disorder data and/or describing target population needs should clarify the intended meaning of this term and related terms used.
- 176. Supplemental Payments:** One form of a non-claims payment. Payments (also known as static payments) that are made to hospitals and that are not linked to either capitation payment or fee-

Healthcare and Family Services Transparency Glossary

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

177. **Supportive living facility (SLF):** A housing option combining apartment-like living with specialized medical, social, and housekeeping services, for low-income Seniors and Persons with Disabilities who would otherwise dwell in a Nursing Facility or other institutional setting; a cost covered only through the SLF waiver program. *See also* [SLF claims](#) and [SLF waiver](#).
178. **Supportive Living Facility (SLF) waiver:** A special dispensation unavailable to Medicaid recipients as a whole that permits low-income elderly and disabled individuals to receive specialized medical, social, and housekeeping services in an apartment-like housing facility rather than dwelling in a nursing home. *See also* [Supportive Living Facility](#) and [SLF claims](#).
179. **Supportive Living Facility (SLF) waiver claims:** Claims submitted by a waiver provider and adjudicated under the SLF waiver; typically, claims for services that would not be paid for by Medicaid for a recipient not enrolled in a waiver. *See also* [Supportive living facility \(SLF\)](#) and [SLF waiver](#).
180. **TANF Populations:** A historical term, no longer in common use, for Temporary Aid to Needy Families (welfare). To the extent that it is still used, it refers to Medicaid children and their Medicaid-covered parents, guardians, or other primary caregivers. It excludes adults who qualify for Medicaid by virtue of being elderly and adults and children who qualify by virtue of disability. *See also* '[Non-priority adults](#)' and '[Other](#)' adults.'
181. **Title XIX:** The portion of Social Security Amendments of 1965 (Public Law 89-97) that created Medicaid and Medicare.
182. **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](#).
183. **Total Enrolled Days:** The total number of days, inclusive of any and all eligibility spans, during the experience period that a particular individual was enrolled in Medicaid or other full-benefit health programs.
184. **Transitional Assistance (City of Chicago):** A partial-benefits program providing temporary assistance to very low-income persons who live within the city of Chicago only; a program that is not included in the data sets.
185. **Transitional Medical Assistance (TMA):** A program that allows families who have recently become ineligible for Medicaid due to increased earnings to access benefits for a limited amount of time; a program that provides full benefits and is included in the data sets.
186. **Transportation Services:** Services that provide specialized vehicular transit (via medivans, ambulances, and other vehicles) to healthcare facilities for recipients with impaired mobility or emergency transport needs.
187. **Traumatic Brain Injury Waiver:** *See also* [Brain Injury Waiver](#).

**Healthcare and Family Services
Transparency Glossary**

- 188. Type of Service:** A classification of the healthcare services rendered by providers to recipients; a classification used to describe healthcare service patterns of both providers and recipients in Data Sets I and II. This classification is largely determined from a combination of provider type and the category of service. *See also* [Provider Type](#) and [Category of Service](#).
- 189. Unborn Child State Plan Amendment (SPA):** A program funded by the State Children’s Health Insurance Plan that allows Family Care plans (which approve recipients for benefits based on their income level) to offer full-benefits plans to undocumented aliens, incarcerated women and those with income less than 200% of the federal poverty level (FPL).
- 190. Unit:** The number of itemized services (generally defined by procedure codes) associated with a given healthcare service event; used together with “event” quantify the services rendered to recipients. For most services, one unit is one distinct procedure code; for emergency room (ER) services, one unit is one ER visit. Given a single event spanning multiple days, such as an inpatient hospitalization, long term care institutionalization, and prescription drug use, the units recorded are equal to the number of days the event lasts. *See also* [Service Units](#) and [Event](#).
- 191. Veterans Service Officers/Veterans Care:** An administrative program assisting veterans with benefits enrollment.
- 192. Voluntary Managed Care:** An optional medical home program available for the recipients of All Kids, Moms & Babies and FamilyCare who wish to enroll. This program makes use of Managed Care Organizations (MCOs). *See also* [Managed Care Organizations \(MCOs\)](#).
- 193. Waiver program:** One of several programs offering services that allow Medicaid recipients to remain in their homes and in the community, despite fitting criteria for nursing facility or long term care residence by providing benefits not normally covered by Medicaid. *See also* [Home and Community-Based Service Waivers](#).
- 194. Waiver recipient:** A recipient who is enrolled in a waiver program. Waiver enrollment is secondary to Medicaid enrollment. *See also* [Waiver Program](#) and [Enrollment](#).
- 195. Women’s Health Care Provider (WHCP):** A healthcare provider specializing by certification or training in primary care, obstetrics, or gynecology, whose practice focuses on care to adult females. A provider type included in a few Types of Service in Data Set I.
- 196. Zip code:** The five-digit geographic identifier on file for the recipient as of the anchor date or last eligibility date, including any inaccurate, null, or incorrectly reported zip codes; data that is not cleaned or revised by HFS prior to data release.

**Healthcare and Family Services
Transparency Glossary**

Acronyms Found in this Glossary

AABD:	Aid to the Aged, Blind and Disabled
ACA:	Affordable Care Act
AIDS:	Acquired Immunodeficiency Syndrome
CCE:	Care Coordination Entity
CHIP:	Children Health Insurance Plans
CMS:	Centers for Medicare and Medicaid Services. Also known as Federal CMS.
CPT:	Current Procedural Terminology
DRG:	Diagnosis Related Groups
DSCC:	Division of Specialized Care for Children
DSH:	Disproportionate Share Hospital
EIS:	Eligibility Information Systems
EPSDT:	Early and Periodic, Screening, Diagnosis and Treatment
ER:	Emergency Room
FFS:	Fee for Service
FPL:	Federal Poverty Level
FQHC:	Federally Qualified Health Center
FCM:	Family Case Management
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
HBWD:	Health Benefits for Workers with Disabilities
IBCCP:	Illinois Breast and Cervical Cancer Program
ICEB:	Illinois Client Enrollment Broker
ICFs/MR:	Intermediate Care Facilities for the Mentally Retarded
IGT:	Inter-Governmental Transfer
IHC:	Illinois Health Connect
LTAC:	Long-Term Acute Care (Hospital)
LTC:	Long-term Acute Care (Hospital)
LTCH:	Long-term (Acute) Care Hospital
MCO:	Managed Care Organization
MFTD:	Medically Fragile, Technology Dependent (children)
MFP:	Money Follows the Person
MHVA:	Medicaid High Volume Adjustment
MI:	Mental Illness
MISA:	Mental Illness and Substance Abuse
MPE:	Medicaid Presumptive Eligibility
MR/DD:	Mentally Retarded/Developmentally Disabled
NDC:	National Drug Code
NIPS:	Non-institutional providers
NPI:	National Provider Identifier
OTC:	Over the Counter (drug)
PE:	Presumptive Eligibility
POA:	Present on Admission
PCCM:	Primary care case management

**Healthcare and Family Services
Transparency Glossary**

PCP:	Primary care provider
PMPM:	Per Member per Month
QI-1:	Qualified Individual-1
QMB:	Qualified Medicare Beneficiary
RHC:	Rural Health Center
RRA:	Refugee and Repatriation Assistance
RRP:	Refugee Resettlement Program
SASS:	Screening, Assessment and Support Services
SLF:	Supportive living facility
SLIB:	Specified Low-Income Medicare Beneficiaries
SMI:	Serious Mental Illness
SPA:	State Plan Amendment
SPD:	Seniors and Persons with Disabilities
TANF:	Temporary Aid to Needy Families
TMA:	Transitional Medical Assistance
WHCP:	Women's Health Care Provider