Frequently Asked Questions
Medicare-Medicaid Alignment Initiative Data Release

Overview

1. **What is the purpose of this data set?**
   This data set was developed to assist potential care coordination partners in understanding the healthcare needs of their population(s) of interest, identifying potential provider-partners, developing pricing for a care coordination proposal, and initiating the planning process for care management delivery – generically described as 'preparation of a Care Coordination Innovations proposal' in the Data Use Agreement.

2. **Why is detailed enrollment and claims data not provided?**
   Data Set I contains summarized enrollment and claims data. The enrollment and claims data is summarized in such a way that analysts should be able to very quickly gain population-level and sub-population insights into their population of interest for preparing a Care Coordination Innovations proposal. Were we to pass detailed enrollment and claims data to potential partners, it would likely take months for the potential partners to sort the data and create meaning. Additionally, every potential partner would do it their own way, creating proposals that are impossible to compare. We want our partners to have an easy and consistent understanding of the data.

3. **Why is calendar year 2010 summarized?**
   It takes approximately a year before we can more or less reliably describe a year of enrollment and claims. Therefore the calendar year 2010 summarized in Data Set I is the most current year for which we can provide reliable data.

4. **Why is only one year of data summarized?**
   We acknowledge that additional historical years may provide marginal additional insights. We are considering providing additional years in future data releases. However, for now, one year was the most that we could prepare and test on such a short timeline. We believe that potential partners would rather get started with one year than wait for multiple years.

Data Security

5. **Why is a Data Use Agreement required? What identifying data is included in the data sets?**
   The Data Use Agreement is required because the data sets include information that could be used to identify specific recipients. Data sets containing potentially identifiable information are referred to under HIPAA as 'limited data sets;' limited data sets require a Data Use Agreement under current law.

6. **What security standards are appropriate for this data?**
   First, consult the Data Use Agreement and your own counsel. In general, the data should be securely stored, it should only be used for the purpose of preparing a Care Coordination Innovations proposal, and you should not try to identify recipients. Since the data is not 'identified' as per Health Insurance Portability and Accountability Act (HIPAA) standards, it does not require the same standard of care as clinical and other identified data. Applying clinical data standards is, however, acceptable.

7. **Is my organization allowed to use the data for projects other than the stated Medicare-Medicaid Alignment Initiative project?**
   No. While we recognize that the data may provide valuable insight for any number of healthcare activities, our Data Use Agreement stipulates that you use the data for the purpose of assessing providers for the Medicare-Medicaid Alignment Initiative project.

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

First, consult the Data Use Agreement and your own counsel. In general, the data should be securely stored, it should only be used for the purpose of preparing a Care Coordination Innovations proposal, and you should not try to identify specific patients whose providers are included here. Since the data is not 'identified' as per Health Insurance Portability and Accountability Act (HIPAA) standards, it does not require the same standard of care as clinical and other identified data. Applying clinical data standards is, however, acceptable.

Technical Details

9. How is data delivered?

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

10. What software can be used to analyze data?

Data will be provided as a .txt file. This can be imported into Excel, Access, SPSS, SAS, Stata, SQL, and possibly other statistical analysis programs. The choice of program is up to the organization receiving data. We highly recommend using a database tool that allows you to replace source data and refresh reports. This will save you considerable effort if we need to re-release data to correct an error or if you request a new data set in order to modify an attribute used to select your population of interest.

11. What tech support is available to partner organizations?

A limited amount of technical support is available from Healthcare and Family Services (HFS). This is intended to ensure that data conforms to partner organizations' requests and is delivered in useable condition. Because HFS' human resources are limited, the amount of technical support available to partner organizations will correlate inversely with the number of organizations requesting data.

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

Heathcare and Family Services (HFS) has created documentation on the contents of the data sets; the data sets' exclusions and limitations; and some business terminology underlying data categories. This documentation is intended to ensure clarity as to what various data fields signify. Please see the data dictionary for more information.

Choice of data analysis method is left to the partner organizations. Please see below.

For further questions, please contact the HFS contact identified in the cover sheet accompanying your data. As human resources are limited, the amount of assistance available to partner organizations will correlate inversely with the number of organizations requesting data.

Providers

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

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

As providers are a non-protected group under Health Insurance Portability and Accountability Act (HIPAA), HFS is able to release providers' names, zip code and county,

and National Provider Identifier (NPI) (or, if this is not available, a randomized "Key ID"). Additional information on specialty, Primary Care Case Management (PCCM) enrollment, Critical Access status, and reimbursement type is also included.

In Data Set II, claims-level data will include information on the providers utilized for each healthcare event.

14. How are provider types included in the FAQs?

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

15. What data is not included in the data set?

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

16. Are there any providers excluded from the data sets?

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

17. How are Nursing Facilities identified in the data sets?

Nursing Facilities in Illinois often change ownership. This causes them to change provider IDs. Therefore, Healthcare and Family Serives (HFS) maintains a building ID code that is used for tracking Nursing Facilities across ownership changes. This information is not included in the data sets. As the experience period is only one year, we expect that ownership changes will not have a significant impact on the data. We might add this as a supplement to provider number for future releases, and we invite your feedback on this point.

Types of Services

18. What Type of Service data is included in the data sets?

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

Please see our Type of Service documentation for further information on this portion of our data.

19. How is prescription drug information captured in the data sets?

Data on prescription drugs is captured in aggregate as a Type of Service.

20. What is an event?

An event is a term used in the data sets to quantify the services rendered to recipients. In some informal contexts, an event may be referred to as a "visit." Generally, this is the healthcare use that occurs by one recipient, on one day, with one provider. Exceptions occur for emergency room care (where the event includes one recipient, on one day, in one emergency room); inpatient care or institutionalization (for which the event is admission); and pharmacy use (for which each individual prescription is an event, even if multiple prescriptions are filled on the same day). Please see the table below in the next question.

21. What is a unit?

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

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

22. How are hospital services included in the data sets?

Inpatient hospital care is found in six Types of Service. These types are Maternity Delivery, Maternity Non-delivery, Psychiatric care, Substance Use Disorders, and 'Other' Services (all other hospital care), all of which are preceded by 'IP Hosp' in the data sets. The sixth inpatient Type of Service is Emergency Care to Undocumented Aliens. (Please see below for further information on the care included in this Type of Service.)

Outpatient care is included in other Types of Service. Please see the data dictionary for details.

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

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

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

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

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

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

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

Services excluded from MCO coverage are represented elsewhere in the data sets. For example, a recipient enrolled in MCO who gets dental care from A Medicaid-affiliated provider who provides dental care to someone who is enrolled in an MCO but who is necessarily seeking dental care, an excluded service, outside the MCO, will have this service recorded as a distinct Type of Service, irrespective of the MCO enrollment of the person receiving that service.

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

The premiums paid to MCOs will be listed under The Type of Service 'Health Insurance Payments: MCOs.'

26. How are Institutes for Mental Diseases (IMDs) included in the data sets?

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

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

27. How are quality measures and measures of recipient and provider satisfaction included in the data sets?

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

Costs

28. What is a claim?

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

29. Is claims-level data included in the data sets?

Claims level data is not included in Data Set I. Data Set II will add claims-level data for in-patient, long-term care, emergency room, and prescription drug claims. Data Set I instead provides summarized claims data. Claims are summarized by Type of Service and within Type of Service by events, units, and total costs.

30. How are costs calculated?

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

31. Are non-claims payments included in the data sets?

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

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

32. What are add-on payments?

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

These payments affect the claims for service accessed by approximately 7,300 of the 2.8 million recipients in our file. These payments affect claims for inpatient care, including labor and delivery.

Claims are in the CCIP data sets in the costs category. Add-on payments are included as a separate data point. Both are included in Total Costs.

33. What are encounter claims, and how are they included in the data sets?
Encounter claims refer to documentation of services provided by a Managed Care Organization (MCO) that receives a capitation payment from Healthcare and Family Services (HFS). In this case, a 'claim' is not defined as 'a request for payment from a healthcare facility or provider for healthcare services rendered to a benefits recipient.' Rather, 'encounter claim' is a euphemistic term for notification of the provision of services to the recipients enrolled in the MCO. These will appear in our data sets with the payment amount equal to $0.

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

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

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

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

Feedback

37. Can I give feedback on these data sets?
Please note that Healthcare and Family Services (HFS) considers this data release a pilot. Also, we appreciate your questions and feedback on how data contents, format, and exclusions impacted a proposal. Please contact the HFS contact identified in the cover sheet accompanying your data.