

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
**** ----- MEDICAID ANALYTIC EXTRACT (MAX) PERSON SUMMARY RECORD	REC	2604	1	2604	<p>THE MEDICAID ANALYTIC EXTRACT (MAX) PERSON SUMMARY FILE CONTAINS A RECORD FOR EACH UNIQUE PERSON, BASED ON MSIS IDENTIFICATION NUMBER. MEDICAID ENROLLEES ARE INCLUDED REGARDLESS OF THEIR LENGTH OF ENROLLMENT DURING THE YEAR. THE FILE ALSO INCLUDES RECORDS FOR PERSONS WHO WERE ENROLLED IN A TITLE XXI STATE CHILD HEALTH INSURANCE PROGRAM (SCHIP). IF THE PERSON WAS ENROLLED IN A MEDICAID-EXPANSION SCHIP PROGRAM (M-SCHIP), THERE WILL BE MEDICAID ENROLLMENT DURING THE YEAR. M-SCHIP ENROLLMENT WILL BE INDICATED (SEE DATA ELEMENT #50, VALUE = 2). FOR PERSONS ENROLLED IN NON-MEDICAID STAND-ALONE (SEPARATE) SCHIP PROGRAMS (S-SCHIP) ONLY, REPORTING IN MSIS IS OPTIONAL FOR STATES. FOR S-SCHIP ENROLLEES, THERE WILL BE NO MEDICAID ENROLLMENT. S-SCHIP ENROLLMENT WILL BE INDICATED (SEE DATA ELEMENT #50, VALUE = 3). THERE MAY BE NO UTILIZATION OR PAYMENT RECORDS FOR S-SCHIP ENROLLEES.</p> <p>THE PERSON SUMMARY RECORD INCLUDES A SUMMARIZATION OF ELIGIBILITY, UTILIZATION AND MEDICAID PAYMENTS FOR EACH PERSON IDENTIFIED IN THE FILE. THERE ARE ROUGHLY 20 PERCENT OF ENROLLEES WHO DO NOT USE ANY SERVICES DURING A YEAR. FOR THESE INDIVIDUALS, SERVICE-BASED AND PAYMENT-BASED DATA ELEMENTS ARE BLANK. THERE ARE ALSO A SMALL NUMBER OF ENROLLED PERSONS FOR WHOM THERE ARE SERVICES AND PAYMENTS REPORTED IN MSIS, BUT NO ENROLLMENT DATA WERE REPORTED FOR THE PERSON. THESE PERSONS ARE IDENTIFIED BY THE DATA ELEMENT "MISSING ELIGIBILITY DATA SWITCH".</p> <p>MSIS RECORDS WITH TYPE OF CLAIM = 4 AND/OR THOSE WITH THE FIRST CHARACTER OF THE ELIGIBLE IDENTIFICATION NUMBER HAVING VALUE "&" - AMPERSAND (SERVICE TRACKING CLAIMS) ARE EXCLUDED FROM ALL MAX FILES. IN ADDITION, MSIS RECORDS WITH TYPE OF CLAIM = 5 (SUPPLEMENTAL PAYMENT) ARE EXCLUDED FROM MAX IP AND LT FILES. DATA FOR THESE CLAIMS ARE EXCLUDED FROM DATA ELEMENTS IN THE PERSON SUMMARY FILE.</p> <p>RECORDS FROM THIS FILE HAVE BEEN LINKED TO THE MEDICARE ENROLLMENT DATA BASE (EDB) TO BETTER IDENTIFY MEDICAID ENROLLEES WHO ARE ALSO ENROLLED IN MEDICARE (SO CALLED DUAL OR CROSSOVER ENROLLEES). THE PROCESS FOR LINKING A MAX RECORD TO AN EDB RECORD OCCURS IN TWO STEPS, AS FOLLOWS:</p> <p><u>STEP 1 - FOR AGED ENROLLEES: THE ENROLLEE'S SOCIAL SECURITY NUMBER - SSN (DATA ELEMENT #5) AND SEX (DATA ELEMENT #10) MUST MATCH EXACTLY.</u></p> <p>FOR DISABLED ENROLLEES: EITHER (1) THE ENROLLEE'S SSN AND DATE OF BIRTH (DATA ELEMENT #8) MUST MATCH EXACTLY, OR (2) THE ENROLLEE'S SSN, SEX MUST MATCH EXACTLY AND TWO OF THE THREE ELEMENTS IN DATE OF BIRTH (DAY, MONTH AND YEAR) MUST MATCH EXACTLY.</p>

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	
<p><u>STEP 2 - FOR ALL UNMATCHED SSNs FROM STEP 1, THERE IS AN ATTEMPT TO MATCH</u> THESE SSNs TO A CLAIM ACCOUNT NUMBER (CAN) FROM THE HEALTH INSURANCE CLAIM (HIC) DATA ELEMENT ON THE MEDICARE EDB. THIS IS DONE BECAUSE SOME ELIGIBLES INCORRECTLY USE THE CAN FROM AN ACCOUNT ON WHICH THEY RECEIVE AUXILIARY BENEFITS (AS A SPOUSE, WIDOW, CHILD, ETC) AS THEIR OWN SSN. THE CHECK ON GENDER AND DATE OF BIRTH ASSURES A CORRECT MATCH IS MADE.</p>				
<p>FOR LINKED RECORDS, SELECTED EDB DATA ELEMENTS ARE ADDED TO THE MAX FILES:</p>				
<p>ELIGIBLE HEALTH INSURANCE CLAIM (HIC) NUMBER (DATA ELEMENT #7) MEDICARE RACE/ETHNICITY (DATA ELEMENT #12) ELIGIBLE MEDICARE LANGUAGE CODE (DATA ELEMENT #13) ELIGIBLE MEDICARE DEATH DATE (DATA ELEMENT #16) ELIGIBLE MEDICARE DEATH DAY SWITCH (DATA ELEMENT #17) ELIGIBLE MEDICARE BENEFICIARY MONTHS COUNT (DATA ELEMENT #29) MEDICARE ORIGINAL ENTITLEMENT REASON CODE (DATA ELEMENT #31) MONTHLY ELIGIBLE MEDICARE BENEFICIARY (DATA ELEMENT #36)</p>				
<p>IN ADDITION, ELIGIBLE MEDICARE CROSSOVER CODES (DATA ELEMENTS #25 AND #27) NOW HAVE ADDITIONAL CODE VALUES TO REFLECT THE MAX/EDB LINK.</p>				
<p><u>MAX TYPE OF SERVICE CHANGES FOR 1999:</u></p>				
<p>THE LIST OF MAX TYPES OF SERVICE (TOS) HAVE BEEN EXPANDED FOR 1999 TO INCLUDE:</p>				
<p>51 = DURABLE MEDICAL EQUIPMENT (DME) AND SUPPLIES (INCLUDES EMERGENCY RESPONSE SYSTEMS AND HOME MODIFICATIONS) 52 = RESIDENTIAL CARE 53 = PSYCHIATRIC SERVICES (EXCLUDING ADULT DAY CARE), AND 54 = ADULT DAY CARE</p>				
<p>THESE TYPES OF SERVICE HAVE BEEN ADDED TO THE EXISTING LIST AND ARE NOW REPORTED FOR THE FOLLOWING DATA ELEMENTS: DATA ELEMENTS #78-83</p>				
<p>FEE-FOR-SERVICE (FFS) RECIPIENT INDICATOR (DATA ELEMENT #78), FFS CLAIM COUNT (DATA ELEMENT #79), FFS MEDICAID PAYMENT AMOUNT (DATA ELEMENT #80), FFS CHARGE AMOUNT (DATA ELEMENT #81), FFS THIRD PARTY PAYMENT AMOUNT (DATA ELEMENT #82), AND ENCOUNTER RECORD COUNT (DATA ELEMENT #83)</p>				

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
**** ELIGIBLE SUMMARY REGION	REGION	1052	1	1052	SUMMARIZED INFORMATION FROM MSIS AND MEDICARE ELIGIBILITY FILES.
**** ELIGIBLE IDENTIFYING DATA ELEMENT GROUP	GROUP	70	1	70	DATA ELEMENTS USED TO IDENTIFY A MEDICAID ELIGIBLE.
1. MSIS IDENTIFICATION NUMBER	CHAR	20	1	20	UNIQUE IDENTIFICATION NUMBER USED TO IDENTIFY A MEDICAID ELIGIBLE IN THE MEDICAID STATISTICAL INFORMATION SYSTEM (MSIS). SOURCE: MSIS ELIGIBILITY FILES: "MSIS-IDENTIFICATION-NUMBER"
2. STATE ABBREVIATION CODE	CHAR	2	21	22	U. S. POSTAL SERVICE 2-CHARACTER ABBREVIATION FOR THE STATE MEDICAID AGENCY SUBMITTING THE DATA. CODES: AL = ALABAMA AK = ALASKA AZ = ARIZONA AR = ARKANSAS AS = AMERICAN SAMOA CA = CALIFORNIA CO = COLORADO CT = CONNECTICUT DE = DELAWARE DC = DISTRICT OF COLUMBIA FL = FLORIDA GA = GEORGIA GU = GUAM HI = HAWAII ID = IDAHO IL = ILLINOIS

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	
				IN = INDIANA
				IA = IOWA
				KS = KANSAS
				KY = KENTUCKY
				LA = LOUISIANA
				ME = MAINE
				MD = MARYLAND
				MA = MASSACHUSETTS
				MI = MICHIGAN
				MN = MINNESOTA
				MS = MISSISSIPPI
				MO = MISSOURI
				MT = MONTANA
				NE = NEBRASKA
				NV = NEVADA
				NH = NEW HAMPSHIRE
				NJ = NEW JERSEY
				NM = NEW MEXICO
				NY = NEW YORK
				NC = NORTH CAROLINA
				ND = NORTH DAKOTA
				OH = OHIO
				OK = OKLAHOMA
				OR = OREGON
				PA = PENNSYLVANIA
				PR = PUERTO RICO
				RI = RHODE ISLAND
				SC = SOUTH CAROLINA
				SD = SOUTH DAKOTA
				TN = TENNESSEE
				TX = TEXAS
				UT = UTAH
				VT = VERMONT
				VI = VIRGIN ISLANDS
				VA = VIRGINIA
				WA = WASHINGTON
				WV = WEST VIRGINIA
				WI = WISCONSIN
				WY = WYOMING

SOURCE: MSIS ELIGIBILITY FILES

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS			CONTENTS
		LENGTH	BEG	END	
3. MAX YEAR DATE	NUM	4	23	26	<p>CALENDAR YEAR COVERED BY THE MAX PERSONAL SUMMARY FILE</p> <p>4 DIGITS EDIT-RULES: YYYY</p> <p>USER NOTE: THIS DATA ELEMENT WAS CHANGED TO 4 CHARACTERS IN 1996</p> <p>SOURCE: MSIS ELIGIBILITY FILES</p>
4. ELIGIBLE SOCIAL SECURITY NUMBER	CHAR	9	27	35	<p>SOCIAL SECURITY NUMBER OF THE MEDICAID ELIGIBLE.</p> <p>USER NOTE: NOT AVAILABLE FOR SOME NEW YORK ELIGIBLES IN 1999. WHERE SOCIAL SECURITY NUMBER IS UNAVAILABLE, THIS DATA ELEMENT IS 9-FILLED.</p> <p>SOURCE: MSIS ELIGIBILITY FILES: "SOCIAL-SECURITY-NUMBER"</p>
5. ELIGIBLE STATE CASE NUMBER	CHAR	12	36	47	<p>STATE-ASSIGNED NUMBER WHICH UNIQUELY IDENTIFIES THE MEDICAID CASE TO WHICH THE ENROLLEE BELONGS ON THE LAST DAY OF THE FEDERAL FISCAL YEAR.</p> <p>USER NOTE: THIS DATA ELEMENT MAY INCLUDE ALPHA CHARACTERS, BUT IT DOES NOT NECESSARILY LINK ALL FAMILY MEMBERS TOGETHER. MAY CHANGE OVER TIME. THE DEFINITION AND AVAILABILITY VARY ACROSS STATES. THERE ARE SINGLE-PERSON CASES (MOSTLY AGED AND BLIND/DISABLED) AND MULTI-PERSON CASES (MOSTLY TANF) IN WHICH EACH MEMBER OF THE CASE HAS THE SAME CASE NUMBER, BUT A UNIQUE MSIS IDENTIFICATION NUMBER. THIS MSIS DATA ELEMENT IS NOT AVAILABLE BEFORE 10/98.</p> <p>SOURCE: MSIS ELIGIBILITY FILES: "MSIS-CASE-NUMBER"</p>
6. MEDICARE HEALTH INSURANCE CLAIM (HIC) NUMBER (FROM MEDICAID)	CHAR	12	48	59	<p>THE ELIGIBLE'S HEALTH INSURANCE CLAIM (HIC) NUMBER FROM MEDICAID (MSIS). THIS NUMBER IS APPLICABLE ONLY TO MEDICAID ELIGIBLES WHO ARE ALSO ELIGIBLE FOR MEDICARE AND IS ASSIGNED TO AN ELIGIBLE BY THE MEDICARE PROGRAM.</p> <p>USER NOTE: AN ELIGIBLE'S HIC NUMBER MAY CHANGE AS HIS/HER MEDICARE ELIGIBILITY STATUS CHANGES. THE ACCURACY OF REPORTING OF HIC NUMBERS IN MEDICAID ELIGIBILITY DATA IS UNKNOWN. THIS MSIS DATA ELEMENT IS NOT AVAILABLE BEFORE 10/98.</p> <p>SOURCE: MSIS ELIGIBILITY FILES: "HIC-NUMBER"</p>

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS			CONTENTS
		LENGTH	BEG	END	
7. ELIGIBLE MEDICARE HEALTH INSURANCE CLAIM (HIC) NUMBER (FROM MEDICARE)	CHAR	11	60	70	<p>THE ELIGIBLE'S HEALTH INSURANCE CLAIM (HIC) NUMBER FROM MEDICARE (MDB). THIS NUMBER IS APPLICABLE ONLY TO MEDICAID ELIGIBLES WHO ARE ALSO ELIGIBLE</p> <p><i>USER NOTE: AN ELIGIBLE'S HIC NUMBER MAY CHANGE AS HIS/HER MEDICARE ELIGIBILITY STATUS CHANGES. THIS IS THE CURRENT HIC FROM THE MEDICARE EDB. IN ORDER TO FIND ALL MEDICARE CLAIMS FOR THIS PERSON, THE USER MUST FIND ALL OF THE CROSS REFERENCES (THE SET OF ALL BIC EQUATED HICS) FOR THIS PERSON. THIS CAN BE DONE USING DESY. IF THE ELIGIBLE SOCIAL SECURITY NUMBER (ELEMENT #4) REPORTED BY MEDICAID IS NOT FOUND IN THE MEDICARE ENROLLMENT DATA BASE (EDB) OR IS INVALID, THIS HIC WILL BE BLANK-FILLED.</i></p> <p>SOURCE: MEDICARE ENROLLMENT DATA BASE (EDB), BENEFICIARY CLAIM ACCOUNT NUMBER AND BENEFICIARY IDENTIFICATION CODE.</p>
**** ELIGIBLE DEMOGRAPHIC DATA ELEMENT GROUP	GROUP	48	71	118	<p>DEMOGRAPHIC DATA FOR THE ELIGIBLE.</p>
8. ELIGIBLE BIRTH DATE	NUM	8	71	78	<p>BIRTH DATE OF THE MEDICAID ELIGIBLE.</p> <p>8 DIGITS EDIT-RULES: YYYYMMDD</p> <p>SOURCE: MSIS ELIGIBILITY FILES: "DATE-OF-BIRTH". MSIS DATES WITH 8- OR 9-FILL VALUES ARE CHANGED TO 0-FILL (ZERO-FILL).</p>
9. ELIGIBLE AGE GROUP CODE	NUM	1	79	79	<p>AGE GROUP OF THE MEDICAID ELIGIBLE.</p> <p>1 DIGIT CODES: 0 = UNDER 1 1 = AGES 1 TO 5 2 = AGES 6 TO 14 3 = AGES 15 TO 20 4 = AGES 21 TO 44 5 = AGES 45 TO 64 6 = AGES 65 TO 74 7 = AGES 75 TO 84 8 = AGES 85 AND OVER 9 = UNKNOWN/ERROR</p> <p>SOURCE: RECODED FROM MSIS ELIGIBILITY FILE USING ELIGIBLE BIRTH DATE (DATA ELEMENT #8) AND DECEMBER 31 OF THE FILE YEAR TO CALCULATE AGE GROUP.</p>

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS			CONTENTS
		LENGTH	BEG	END	
10. ELIGIBLE SEX CODE	CHAR	1	80	80	<p>GENDER OF THE MEDICAID ELIGIBLE.</p> <p>1 CHARACTER CODES: F = FEMALE M = MALE U = UNKNOWN/ERROR</p> <p>USER NOTE: THESE CODES ARE 1 (FEMALE), 2 (MALE) AND 9 (UNKNOWN) IN THE 1996-98 MSIS DATA.</p> <p>SOURCE: MSIS ELIGIBILITY FILES: "SEX-CODE"</p>
11. ELIGIBLE RACE/ETHNICITY CODE	CHAR	6	81	86	<p>RACE/ETHNICITY OF THE MEDICAID ELIGIBLE.</p> <p>1 DIGIT, LOCATED IN POSITION 81</p> <p>CODES: 1 = WHITE (WAS "WHITE, NOT OF HISPANIC ORIGIN" THROUGH 9/98) 2 = BLACK OR AFRICAN AMERICAN (WAS "BLACK, NOT OF HISPANIC ORIGIN" THROUGH 9/98) 3 = AMERICAN INDIAN OR ALASKAN NATIVE 4 = ASIAN (WAS "ASIAN OR PACIFIC ISLANDER" THROUGH 9/98) 5 = HISPANIC OR LATINO - NO RACE INFORMATION AVAILABLE (WAS "HISPANIC" THOROUGH 9/98) 6 = NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER (NEW CODE BEGINNING 10/98) 7 = HISPANIC OR LATINO AND ONE OR MORE RACES (NEW CODE BEGINNING 10/98) 8 = MORE THAN ONE RACE (NEW CODE BEGINNING 10/98) 9 = UNKNOWN</p> <p>USER NOTE: SINCE SPECIFICATIONS FOR CODE VALUES = 7 AND 8 WERE NOT ISSUED UNTIL MAY 2000, THESE CODE VALUES MAY NOT APPEAR. THE METHODS OF COLLECTING INFORMATION ON RACE AND ETHNICITY DIFFER SUBSTANTIALLY ACROSS STATES AND TIME PERIODS. THIS DATA ELEMENT IS 6 CHARACTERS IN LENGTH TO ALLOW FOR FUTURE CHANGES IN RACE/ETHNICITY REPORTING. POSITIONS 82-86 ARE BLANK-FILLED.</p> <p>SOURCE: MSIS ELIGIBILITY FILES: "RACE-ETHNICITY-CODE"</p>

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS			CONTENTS
		LENGTH	BEG	END	
12. MEDICARE RACE/ETHNICITY CODE	NUM	1	87	87	RACE/ETHNICITY OF THE MEDICARE ELIGIBLE. CODES: 0 = UNKNOWN 1 = WHITE 2 = BLACK 3 = OTHER 4 = ASIAN 5 = HISPANIC 6 = NORTH AMERICAN NATIVE SOURCE: MEDICARE ENROLLMENT DATA BASE (EDB), BENEFICIARY RACE.
13. MEDICARE LANGUAGE CODE	CHAR	1	88	88	IDENTIFIES THE LANGUAGE SSA USES FOR BENEFICIARY NOTICES. CODES: C = CHINESE D = GERMAN E = ENGLISH F = FRENCH G = GREEK I = ITALIAN J = JAPANESE N = NORWEGIAN P = POLISH R = RUSSIAN S = SPANISH V = SWEDISH W = SERBO-CROATIAN BLANK = UNKNOWN, PRESUME ENGLISH SOURCE: MEDICARE ENROLLMENT DATA BASE (EDB), BENEFICIARY SSA LANGUAGE.

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS			CONTENTS
		LENGTH	BEG	END	
14. ELIGIBLE SEX-RACE CODE	NUM	1	89	89	<p>GENDER AND RACE OF THE MEDICAID ELIGIBLE.</p> <p>1 DIGIT</p> <p>CODES:</p> <p>1 = WHITE, MALE 2 = WHITE, FEMALE 3 = NON-WHITE, MALE 4 = NON-WHITE, FEMALE 5 = RACE UNKNOWN, MALE 6 = RACE UNKNOWN, FEMALE 7 = SEX UNKNOWN, WHITE 8 = SEX UNKNOWN, NON-WHITE 9 = SEX AND RACE UNKNOWN</p> <p><i>USER NOTE: THESE CODE VALUES ARE BASED ON MSIS RACE AND ETHNICITY CODING PRIOR TO THE ADDITION OF EXPANDED RACE ("RACE-CODE-1" TO "RACE-CODE-5") AND ETHNICITY ("ETHNICITY-CODE") REPORTING IN MSIS BEGINNING IN FISCAL 2005.</i></p> <p>SOURCE: RECODED FROM MSIS ELIGIBILITY FILES. CROSSWALK: MSIS RACE=1 MAPS TO WHITE, MSIS RACE=2,3,4,5,6,7 AND 8 MAPS TO NON-WHITE, MSIS RACE=9 MAPS TO UNKNOWN. MSIS SEX=2 OR M MAPS TO MALE. MSIS SEX=1 OR F MAPS TO FEMALE. MSIS SEX=9 OR U MAPS TO UNKNOWN.</p>
15. ELIGIBLE MEDICAID DEATH DATE NUM		8	90	97	<p>DEATH DATE OF THE MEDICAID ELIGIBLE.</p> <p>8 DIGITS</p> <p>EDIT-RULES: YYYYMMDD</p> <p>USER NOTE: THIS DATA ELEMENT SHOULD BE USED WITH CAUTION SINCE THERE MAY BE UNDERREPORTING OF DEATHS IN THE MSIS ELIGIBILITY FILES.</p> <p>SOURCE: MSIS ELIGIBILITY FILES: "DATE-OF-DEATH". MSIS DATES WITH 8- OR 9-FILL VALUES ARE CHANGED TO 0-FILL (ZERO-FILL).</p>

1

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS			CONTENTS
		LENGTH	BEG	END	
16. ELIGIBLE MEDICARE DEATH DATE	NUM	8	98	105	DEATH DATE OF THE MEDICARE BENEFICIARY. 8 DIGITS EDIT-RULES YYYYMMDD <i>USER NOTE: THIS DATE OF DEATH HAS BEEN ADDED TO THE MAX FILE BECAUSE THE ELIGIBLE MEDICAID DEATH DATE (DATA ELEMENT #15) MAY BE UNDERREPORTED OR UNRELIABLE. THIS MEDICARE DATE OF DEATH DATA ELEMENT MAY CONTAIN ONLY A VALID YEAR AND MONTH. IN THESE CASES, THE PERSON'S DAY OF DEATH IS SET TO THE END OF THE MONTH. IT IS POSSIBLE TO DETERMINE WHETHER THE DAY OF DEATH IS ACTUALLY THE END OF THE MONTH OR THE DAY OF DEATH WAS NOT VALID (AND WAS SET TO THE END OF THE MONTH) BY CHECKING THE ELIGIBLE MEDICARE DEATH DAY SWITCH (DATA ELEMENT #17). IF THE ELIGIBLE SOCIAL SECURITY NUMBER (ELEMENT #4) REPORTED BY MEDICAID IS NOT FOUND IN THE MEDICARE ENROLLMENT DATA BASE (EDB) OR IS INVALID, THE ELIGIBLE MEDICARE DEATH DATE WILL BE 8-FILLED.</i> SOURCE: MEDICARE ENROLLMENT DATA BASE (EDB), BENEFICIARY DEATH DATE.
17. ELIGIBLE MEDICARE DEATH DAY SWITCH	CHAR	1	106	106	INDICATES WHETHER THE MEDICARE BENEFICIARY'S EXACT DAY OF DEATH HAS BEEN VERIFIED. 1 CHARACTER CODES: N = DAY OF DEATH WAS NOT VERIFIED Y = DAY OF DEATH WAS VERIFIED <i>USER NOTE: THIS DATA ELEMENT SHOULD BE USED WITH THE ELIGIBLE MEDICARE DEATH DATE (DATA ELEMENT #16). IF THE ELIGIBLE SOCIAL SECURITY NUMBER (ELEMENT #4) REPORTED BY MEDICAID IS NOT FOUND IN THE MEDICARE ENROLLMENT DATA BASE (EDB) OR IS INVALID, THE SWITCH WILL BE BLANK-FILLED.</i> SOURCE: MEDICARE ENROLLMENT DATA BASE (EDB), VERIFY BENEFICIARY DEATH DAY SWITCH.

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS			CONTENTS
		LENGTH	BEG	END	
18. ELIGIBLE RESIDENCE COUNTY CODE	CHAR	3	107	109	FEDERAL INFORMATION PROCESSING STANDARD (FIPS) CODE INDICATING THE ELIGIBLE'S COUNTY OF RESIDENCE. CODES: FIPS NUMERIC COUNTY CODES, OR 000 = ELIGIBLE RESIDES OUT OF STATE 999 = UNKNOWN/ERROR SOURCE: THIS CODE WAS DERIVED BY USING QUARTERLY OBSERVATIONS OF ELIGIBLE RESIDENCE "COUNTY-CODE" FROM THE MSIS ELIGIBILITY FILE AND SELECTING THE FIRST MEANINGFUL CODE (NOT 0- OR 9-FILLED) BEGINNING WITH THE OCTOBER TO DECEMBER QUARTER AND MOVING BACKWARDS IN TIME QUARTER BY QUARTER.
19. ELIGIBLE RESIDENCE ZIP CODE	NUM	9	110	118	UNITED STATES POSTAL ZIP CODE OF THE MEDICAID ELIGIBLE'S RESIDENCE. 9 DIGITS, LOCATED IN POSITIONS 88 TO 92 USER NOTE: MSIS VALIDATION ACTIVITIES WILL ACCEPT ZERO-FILLED RECORDS, SO FOR MAX, IF THE MSIS RECORD IS EITHER ZERO-FILLED OR BLANK-FILLED, THE MAX VALUE SHOULD BE RECODED AS 9-FILLED ('99999'). THIS DATA ELEMENT IS 9 CHARACTERS IN LENGTH TO ALLOW FOR FUTURE CHANGES TO CAPTURE "ZIP+4" CODES. POSITIONS 114-118 ARE BLANK-FILLED. SOURCE: THIS CODE WAS DERIVED BY USING QUARTERLY OBSERVATIONS OF ELIGIBLE RESIDENCE "ZIP-CODE" FROM THE MSIS ELIGIBILITY FILE AND SELECTING THE FIRST MEANINGFUL CODE (NOT 0- OR 9-FILLED) BEGINNING WITH OCTOBER TO DECEMBER QUARTER AND MOVING BACKWARDS IN TIME QUARTER BY QUARTER.

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS			CONTENTS
		LENGTH	BEG	END	
**** ANNUAL ELIGIBLE MEDICAID AND OTHER HEALTH INSURANCE	GROUP	13	119	131	MEDICAID AND OTHER HEALTH INSURANCE ELIGIBILITY DATA FOR THE ELIGIBLE.
20. STATE SPECIFIC ELIGIBILITY CODE - MOST RECENT	CHAR	6	119	124	STATE SPECIFIC ELIGIBILITY CODE CLASSIFICATION UNDER WHICH THE MEDICAID ELIGIBLE IS COVERED - MOST RECENT OBSERVATION.

USER NOTES: THESE SOURCE CODES ARE GENERALLY NOT APPLICABLE FOR MOST RESEARCH ACTIVITIES. THE DATA ELEMENT VALUES CHANGE OVER TIME, VARY ACROSS STATES IN TERMS OF THE LEVEL AND TYPE OF ELIGIBILITY DESCRIBED, REQUIRE A DETAILED KNOWLEDGE OF MEDICAID ELIGIBILITY AND REQUIRE AN UNDERSTANDING OF THE IDIOSYNCRACIES OF INDIVIDUAL STATE ELIGIBILITY SYSTEMS. THESE CODES HAVE BEEN MAPPED INTO MAX UNIFORM ELIGIBILITY CODES. THEREFORE, MOST USERS WILL WANT TO USE MAX UNIFORM ELIGIBILITY CODES. THROUGH 9/98 THIS DATA ELEMENT WAS 4 CHARACTERS IN LENGTH, LEFT-JUSTIFIED AND BLANK FILLED (TWO RIGHT POSITIONS). BEGINNING IN 10/98, IT IS 6 CHARACTERS IN LENGTH. THIS CODE VALUE IS APPENDED TO EACH CLAIM RECORD FOR THE ELIGIBLE PERSON, FROM THE MAX PERSON SUMMARY FILE. THEREFORE, THIS CODE MAY NOT MATCH THE ELIGIBILITY GROUP IN WHICH THE PERSON WAS ENROLLED IN THE MONTH THE SERVICE WAS DELIVERED. FOR THIS REASON, SOME USERS MAY WANT TO USE THE STATE SPECIFIC ELIGIBILITY CODE FROM THE MAX PERSON SUMMARY FILE.

SOURCE: THIS CODE WAS DERIVED BY USING MONTHLY OBSERVATIONS OF STATE SPECIFIC ELIGIBILITY ("ELIGIBILITY GROUP") FROM THE MSIS ELIGIBILITY FILE AND SELECTING THE FIRST MEANINGFUL CODE (NOT 0- OR 9-FILLED) BEGINNING WITH DECEMBER AND MOVING BACKWARDS IN TIME MONTH BY MONTH. IT HAS NOT BEEN RECODED FROM THE MSIS ELIGIBILITY FILE.

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS			CONTENTS
		LENGTH	BEG	END	
21. MAX UNIFORM ELIGIBILITY CODE - MOST RECENT	CHAR	2	125	126	STATE MEDICAID RESEARCH FILES (MAX) UNIFORM ELIGIBILITY CODE FOR THE MEDICAID ELIGIBLE - MOST RECENT OBSERVATION

2 DIGITS

CODES:

00 = NOT ELIGIBLE
11 = AGED, CASH
12 = BLIND/DISABLED, CASH
14 = CHILD (NOT CHILD OF UNEPLOYED ADULT, NOT FOSTER CARE CHILD),
ELIGIBLE UNDER SECTION 1931 OF THE ACT
16 = CHILD OF UNEMPLOYED ADULT, ELIGIBLE UNDER SECTION 1931 OF THE ACT
15 = ADULT (NOT BASED ON UNEMPLOYMENT STATUS), ELIGIBLE UNDER SECTION
1931 OF THE ACT
17 = UNEMPLOYED ADULT, ELIGIBLE UNDER SECTION 1931 OF THE ACT
21 = AGED, MN
22 = BLIND/DISABLED, MN
24 = CHILD, MN (FORMERLY AFDC CHILD, MN)
25 = ADULT, MN (FORMERLY AFDC ADULT, MN)
31 = AGED, POVERTY
32 = BLIND/DISABLED, POVERTY
34 = CHILD, POVERTY (INCLUDES MEDICAID EXPANSION SCHIP CHILDREN)
35 = ADULT, POVERTY
3A = INDIVIDUAL COVERED UNDER THE BREAST AND CERVICAL CANCER PREVENTION
ACT OF 2000, POVERTY
41 = OTHER AGED
42 = OTHER BLIND/DISABLED
48 = FOSTER CARE CHILD
44 = OTHER CHILD
45 = OTHER ADULT
51 = AGED, SECTION 1115 DEMONSTRATION EXPANSION
52 = DISABLED, SECTION 1115 DEMONSTRATION EXPANSION
54 = CHILD, SECTION 1115 DEMONSTRATION EXPANSION
55 = ADULT, SECTION 1115 DEMONSTRATION EXPANSION
99 = UNKNOWN ELIGIBILITY

USER NOTE: MSIS MAINTENANCE ASSISTANCE STATUS (MAS) IS IN POSITION #1 AND BASIS OF ELIGIBILITY (BOE) IS IN POSITION #2. CODING IS THE SAME AS IN 1996-98 SMRF FILES, EXCEPT THAT VALUES 51-55 ARE ADDED FOR 1999 AND VALUE 3A IS ADDED FOR 2000. THERE MAY BE SMALL NUMBERS OF RECORDS WITH INCONSISTENT VALUES BECAUSE MSIS HAS NO MAS/BOE CONSISTENCY CHECKS. PRIOR TO THE END OF THE AFDC PROGRAM, GROUPS 14-17 WERE AFDC CASH RECIPIENTS.

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS			CONTENTS
		LENGTH	BEG	END	
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					SOURCE: RECODED USING "MAINTENANCE-ASSISTANCE-STATUS" (MAS) AND "BASIS-OF-ELIGIBILITY" (BOE) FROM MSIS ELIGIBILITY FILES. THIS CODE WAS DERIVED BY USING MONTHLY OBSERVATIONS OF MAX UNIFORM ELIGIBILITY GROUP AND SELECTING THE FIRST MEANINGFUL CODE (NOT 0- OR 9-FILLED) BEGINNING WITH DECEMBER AND MOVING BACKWARDS IN TIME MONTH BY MONTH.
22. MISSING MEDICAID ELIGIBILITY DATA SWITCH	CHAR	1	127	127	INDICATES PERSON FOR FOR WHOM NO MONTHS OF ENROLLMENT IN MEDICAID WERE FOUND.
					<p>CODES:</p> <p>BLANK = MEDICAID ENROLLMENT MONTHS WERE FOUND</p> <p>1 = NEITHER MEDICAID ENROLLMENT MONTHS NOR S-SCHIP (SCHIP CODE = 3) ENROLLMENT MONTHS WERE FOUND.</p> <p>2 = S-SCHIP ENROLLMENT MONTHS (SCHIP CODE = 3) WERE FOUND, BUT NO MEICAID ENROLLMENT MONTHS WERE FOUND.</p> <p>USER NOTES: MONTHS OF MEDICAID ENROLLMENT ARE DEFINED AS MONTHS WITH MSIS MASBOE VALUES 11-17, 21-25, 31-35,3A, 41-45,48 OR 51-55. CHILDREN WITH S-SCHIP ONLY ENROLLMENT (SCHIP CODE = 3) ARE INCLUDED BECAUSE THEY DO NOT HAVE ANY MONTHS OF MEDICAID ENROLLMENT.</p> <p>SOURCE: RECODED USING MSIS ELIGIBILITY FILES</p>
23. ELIGIBLE MONTHS COUNT	NUM	2	128	129	TOTAL NUMBER OF MONTHS THE INDIVIDUAL WAS ELIGIBLE FOR MEDICAID DURING THE CALENDAR YEAR.
					<p>2 DIGITS</p> <p>USER NOTE: THIS IS A NUMBER FROM 0 TO 12. IT IS GIVEN VALUE > 0 BASED ON THE NUMBER OF MONTHS WITH MSIS MAS/BOE VALUES 11-17, 21-25,31-35, 3A, 41-45, 48 OR 51-55. IF THERE ARE NO MONTHS WITH THESE MAS/BOE VALUES, IT IS CODED WITH VALUE = 00. IF THERE IS NO ELIGIBILITY RECORD, IT IS CODED WITH VALUE = 99 (UNKNOWN). NOTE THAT INDIVIDUALS ENROLLED ONLY IN S-SCHIP (STAND-ALONE NON-MEDICAID SCHIP PROGRAMS, SCHIP CODE = 3) WILL HAVE VALUE = 00 AND ARE NOT CONSIDERED TO HAVE ANY MONTHS OF MEDICAID ENROLLMENT.</p> <p>SOURCE: RECODED USING MSIS ELIGIBILITY FILES</p>

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS			CONTENTS
		LENGTH	BEG	END	
24. ELIGIBLE PRIVATE INSURANCE MONTHS COUNT	NUM	2	130	131	TOTAL NUMBER OF MONTHS THE MEDICAID ELIGIBLE HAD PRIVATE INSURANCE COVERAGE DURING THE CALENDAR YEAR. 2 DIGITS USER NOTE: THIS IS A NUMBER FROM 0 TO 12. IT IS GIVEN VALUE>0 BASED ON THE NUMBER OF MONTHS WITH VALUE = 2 (ELIGIBLE HAD PRIVATE HEALTH INSURANCE COVERAGE PURCHASED BY A THIRD PARTY), 3 (ELIGIBLE HAD PRIVATE HEALTH INSURANCE COVERAGE PURCHASED BY THE STATE) OR 4 (BOTH 2 AND 3 APPLY) IN THE MSIS DATA ELEMENT "HEALTH-INSURANCE" SOURCE: RECODED USING MSIS ELIGIBILITY FILES
**** ELIGIBLE MEDICARE CROSSOVER DATA - OLD VALUES	GROUP	5	132	136	INDICATES WHETHER THE ELIGIBLE IS COVERED BY MEDICARE (KNOWN AS CROSSOVER, DUAL OR MEDICARE ELIGIBILITY). THE CODES IN THIS GROUP PROVIDE CONSISTENCY WITH SMRF CODING PRIOR TO 1999.
25. ELIGIBLE MEDICARE CROSSOVER CODE - ANNUAL OLD VALUES	NUM	1	132	132	INDICATES WHETHER THE ELIGIBLE IS COVERED BY MEDICARE (KNOWN AS CROSSOVER, DUAL OR MEDICARE ELIGIBILITY), ACCORDING TO MEDICAID (MSIS), MEDICARE (EDB) OR BOTH. 1 DIGIT CODES: 0 = NO CROSSOVER 1 = IN MSIS, THE DUAL ELIGIBILITY FLAG HAS A VALUE OF 1 (MEANING THAT THE PERSON IS COVERED BY MEDICARE) 2 = IN MSIS, MEDICARE DEDUCTIBLE OR COINSURANCE WAS PAID BY MEDICAID ON AT LEAST ONE CLAIM DURING THE YEAR. 3 = IN MSIS, BOTH 1 AND 2 APPLY 4 = A RECORD WAS FOUND IN THE MEDICARE ENROLLMENT DATA BASE (EDB) FOR THE ELIGIBLE, AND NEITHER 1 NOR 2 APPLY. 5 = A RECORD WAS FOUND IN THE MEDICARE ENROLLMENT DATA BASE (EDB) FOR THE ELIGIBLE, AND 1 APPLIES. 6 = A RECORD WAS FOUND IN THE MEDICARE ENROLLMENT DATA BASE (EDB) FOR THE ELIGIBLE, AND 2 APPLIES. 7 = A RECORD WAS FOUND IN THE MEDICARE ENROLLMENT DATA BASE (EDB) FOR THE ELIGIBLE, AND BOTH 1 AND 2 APPLY. 9 = ELIGIBLE'S MEDICARE STATUS IS UNKNOWN

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	
<p>USER NOTE: BEGINNING IN 10/98, MSIS CAPTURES GREATER DETAIL ON DUAL ELIGIBILITY. GIVEN THE IMPORTANCE OF CROSSOVER STATUS FOR SOME DATA USERS, THE EXPANDED DETAIL APPEARS AS DATA ELEMENT #27 IN THIS FILE. TO PROVIDE CONSISTENCY WITH EARLIER CODES FOR OTHER DATA USERS, THESE 2 CHARACTER CODES HAVE BEEN MAPPED INTO THE CODES LISTED ABOVE. SEE DATA ELEMENT #27 FOR DETAILS.</p>				
<p>CODE VALUES = 0, 1, 2 AND 3 IN THIS DATA ELEMENT HAVE BEEN CREATED USING THE FOUR QUARTERLY VALUES OF THE CROSSOVER ENROLLMENT (DATA ELEMENTS #26-29). THE CODE VALUE IS SET = 0 FOR THIS DATA ELEMENT IF THE CODE VALUE = 0 FOR ALL FOUR QUARTERS. THE CODE VALUE IS SET = 1, 2, OR 3, RESPECTIVELY IF THE SAME CODE VALUE APPEARS IN ANY OF THE FOUR QUARTERS.</p>				
<p>SOURCE: THE DUAL ELIGIBILITY FLAG IS OBTAINED FROM MSIS ELIGIBILITY FILES AND DEDUCTIBLE OR COINSURANCE PAID AMOUNTS ARE OBTAINED FROM MAX CLAIMS DATA. MEDICARE INFORMATION FOR VALUES = 4 TO 7 IS OBTAINED FROM THE MEDICARE ENROLLMENT DATA BASE (EDB).</p>				

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	
*** QUARTERLY ELIGIBLE MEDICARE DATA - OLD VALUES	GROUP	4	133 136	<p>INDICATES WHETHER THE ELIGIBLE WAS COVERED BY MEDICARE (KNOWN AS CROSSOVER CROSSOVER, DUAL OR MEDICARE ELIGIBILITY). THE CODES IN THIS GROUP PROVIDE CONSISTENCY WITH SMRF CODING PRIOR TO 1999. THE DATA ARE REPORTED FOR FOUR QUARTERS IN THE CALENDAR YEAR, AS NOTED. THE EXAMPLE IS FOR THE FIRST QUARTER, JANUARY TO MARCH.</p> <p>QUARTER 1 - JANUARY TO MARCH (POSITION 133) QUARTER 2 - APRIL TO JUNE (POSITION 134) QUARTER 3 - JULY TO SEPTEMBER (POSITION 135) QUARTER 4 - OCTOBER TO DECEMBER (POSITION 136)</p>
26. QUARTERLY ELIGIBLE MEDICARE CROSSOVER CODE - OLD VALUES	NUM	1	133 133	<p>INDICATES WHETHER THE ELIGIBLE WAS COVERED BY MEDICARE (KNOWN AS CROSSOVER, DUAL OR MEDICARE ELIGIBILITY), ACCORDING TO MEDICAID (MSIS) IN THE CALENDAR QUARTER.</p> <p>1 DIGIT</p> <p>CODES:</p> <p>0 = IN MSIS, NO CROSSOVER 1 = IN MSIS, THE DUAL ELIGIBILITY FLAG HAS A VALUE OF 1 (MEANING THAT THE PERSON IS COVERED BY MEDICARE) 2 = IN MSIS, MEDICARE DEDUCTIBLE OR COINSURANCE WAS PAID BY MEDICAID ON AT LEAST ONE CLAIM DURING THE QUARTER. 3 = IN MSIS, BOTH 1 AND 2 APPLY 9 = IN MSIS, THE ELIGIBLE'S MEDICARE STATUS IS UNKNOWN</p> <p>USER NOTE: USE OF THESE DATA ELEMENTS IS NOT ADVISED BECAUSE THEY MAY BE AN INACCURATE WAY TO IDENTIFY CROSSOVER (OR DUAL) ENROLLEES. BEGINNING IN 10/98, MSIS CAPTURES GREATER DETAIL ON DUAL ELIGIBILITY. GIVEN THE IMPORTANCE OF CROSSOVER STATUS FOR SOME DATA USERS, THE EXPANDED DETAIL APPEARS AS DATA ELEMENT #28 IN THIS FILE. TO PROVIDE CONSISTENCY WITH EARLIER CODES FOR OTHER DATA USERS, THESE 2 CHARACTER CODES HAVE BEEN MAPPED INTO THE CODES LISTED ABOVE, AS FOLLOWS:</p>

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	

				TO FROM MAX MSIS FY99 CODE CODE (DUAL-ELIGIBLE-FLAG) 0 = 00 ELIGIBLE IS NOT A MEDICARE BENEFICIARY. 1 = 01 ELIGIBLE IS ENTITLED TO MEDICARE - QMB ONLY 1 = 02 ELIGIBLE IS ENTITLED TO MEDICARE - QMB AND FULL MEDICAID COVERAGE 1 = 03 ELIGIBLE IS ENTITLED TO MEDICARE - SLMB ONLY 1 = 04 ELIGIBLE IS ENTITLED TO MEDICARE - SLMB AND FULL MEDICAID COVERAGE 1 = 05 ELIGIBLE IS ENTITLED TO MEDICARE - QDWI 1 = 06 ELIGIBLE IS ENTITLED TO MEDICARE - QUALIFYING INDIVIDUAL (1) 1 = 07 ELIGIBLE IS ENTITLED TO MEDICARE - QUALIFYING INDIVIDUAL (2) 1 = 08 ELIGIBLE IS ENTITLED TO MEDICARE - OTHER DUAL ELIGIBLE 1 = 09 ELIGIBLE IS ENTITLED TO MEDICARE - DUAL ELIGIBILITY CATEGORY UNK. 9 = 99 ELIGIBLE'S MEDICARE STATUS IS UNKNOWN ONCE THIS MAPPING IS COMPLETED, VALUE = 0 IS CHANGED TO VALUE = 2 AND VALUE = 1 IS CHANGED TO VALUE = 3 IF THERE WAS MEDICARE DEDUCTIBLE OR COINSURANCE PAID BY MEDICAID FOR AT LEAST ONE CLAIM DURING QUARTER-1. SOURCE: THE "DUAL-ELIGIBILITY-FLAG" IS OBTAINED FROM MSIS ELIGIBILITY FILES AND DEDUCTIBLE OR COINSURANCE PAID AMOUNTS ARE OBTAINED FROM MAX CLAIMS DATA ELEMENTS "MEDICARE-DEDUCTIBLE-PAYMENT" AND "MEDICARE -COINSURANCE-PAYMENT".

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS			CONTENTS
		LENGTH	BEG	END	
**** ELIGIBLE MEDICARE CROSSOVER DATA - NEW VALUES	GROUP	10	137	146	INDICATES WHETHER THE ELIGIBLE IS COVERED BY MEDICARE (KNOWN AS CROSSOVER, DUAL OR MEDICARE ELIGIBILITY) AND THE TYPE OF MEDICARE ELIGIBILITY. THE CODES IN THIS GROUP ARE BASED ON THE NEW MSIS CODES BEGINNING IN FISCAL YEAR 1999.
27. ELIGIBLE MEDICARE CROSSOVER CODE - ANNUAL NEW VALUES	CHAR	2	137	138	INDICATES THAT THE ELIGIBLE IS COVERED BY MEDICARE (KNOWN AS CROSSOVER, DUAL OR MEDICARE ELIGIBILITY), ACCORDING TO MEDICAID (MSIS), MEDICARE (EDB) OR BOTH. 2 CHARACTERS CODES: 00 = IN MSIS, ELIGIBLE IS NOT A MEDICARE BENEFICIARY 01 = IN MSIS, ELIGIBLE IS ENTITLED TO MEDICARE-QMB ONLY 02 = IN MSIS, ELIGIBLE IS ENTITLED TO MEDICARE-QMB AND FULL MEDICAID COVERAGE 03 = IN MSIS, ELIGIBLE IS ENTITLED TO MEDICARE-SLMB ONLY 04 = IN MSIS, ELIGIBLE IS ENTITLED TO MEDICARE-SLMB AND FULL MEDICAID COVERAGE 05 = IN MSIS, ELIGIBLE IS ENTITLED TO MEDICARE-QDWI 06 = IN MSIS, ELIGIBLE IS ENTITLED TO MEDICARE-QUALIFYING INDIVIDUALS (1) 07 = IN MSIS, ELIGIBLE IS ENTITLED TO MEDICARE-QUALIFYING INDIVIDUALS (2) 08 = IN MSIS, ELIGIBLE IS ENTITLED TO MEDICARE-OTHER DUAL ELIGIBLES 09 = IN MSIS, ELIGIBLE IS ENTITLED TO MEDICARE-DUAL ELIGIBILITY CATEGORY UNKNOWN 50 = A RECORD WAS FOUND IN THE MEDICARE ENROLLMENT DATA BASE (EDB) FOR THE ELIGIBLE AND CODES 01-09 DO NOT APPLY 51 = A RECORD WAS FOUND IN THE MEDICARE ENROLLMENT DATA BASE (EDB) FOR THE ELIGIBLE AND CODE 01 APPLIES 52 = A RECORD WAS FOUND IN THE MEDICARE ENROLLMENT DATA BASE (EDB) FOR THE ELIGIBLE AND CODE 02 APPLIES 53 = A RECORD WAS FOUND IN THE MEDICARE ENROLLMENT DATA BASE (EDB) FOR THE ELIGIBLE AND CODE 03 APPLIES 54 = A RECORD WAS FOUND IN THE MEDICARE ENROLLMENT DATA BASE (EDB) FOR THE ELIGIBLE AND CODE 04 APPLIES 55 = A RECORD WAS FOUND IN THE MEDICARE ENROLLMENT DATA BASE (EDB) FOR THE ELIGIBLE AND CODE 05 APPLIES 56 = A RECORD WAS FOUND IN THE MEDICARE ENROLLMENT DATA BASE (EDB) FOR THE ELIGIBLE AND CODE 06 APPLIES 57 = A RECORD WAS FOUND IN THE MEDICARE ENROLLMENT DATA BASE (EDB) FOR THE ELIGIBLE AND CODE 07 APPLIES

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	
				58 = A RECORD WAS FOUND IN THE MEDICARE ENROLLMENT DATA BASE (EDB) FOR THE ELIGIBLE AND CODE 08 APPLIES
				59 = A RECORD WAS FOUND IN THE MEDICARE ENROLLMENT DATA BASE (EDB) FOR THE ELIGIBLE AND CODE 09 APPLIES
				98 = A RECORD WAS FOUND IN THE MEDICARE ENROLLMENT DATA BASE (EDB) FOR THE ELIGIBLE AND CODE 99 APPLIES
				99 = IN MSIS, ELIGIBLE'S MEDICARE STATUS IS UNKNOWN
<p><i>USER NOTE: THIS DATA ELEMENT IS TAKEN DIRECTLY FROM THE MSIS DATA ELEMENT "DUAL-ELIGIBLE-FLAG". IF THERE IS NO ELIGIBLE RECORD FOR THE ENROLLEE, IT IS BLANK-FILLED.</i></p>				
<p>SOURCE: CODES 01-09 ARE DERIVED FROM MSIS ELIGIBILITY FILES. IN MSIS, THERE ARE FOUR QUARTERLY OBSERVATIONS OF THE DUAL ELIGIBILITY FLAG. THIS ANNUAL VALUE OF THE DUAL ELIGIBILITY FLAG WAS DERIVED BY USING THE QUARTERLY OBSERVATIONS AND SELECTING THE FIRST MEANINGFUL CODE BEGINNING WITH THE OCTOBER TO DECEMBER QUARTER AND MOVING BACKWARDS IN TIME QUARTER BY QUARTER. MEDICARE INFORMATION FOR CODES 50-59 IS OBTAINED FROM THE MEDICARE ENROLLMENT DATA BASE (EDB).</p>				

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS			CONTENTS
		LENGTH	BEG	END	
*** QUARTERLY ELIGIBLE MEDICARE DATA -NEW VALUES	GROUP	4	139	146	INDICATES WHETHER THE ELIGIBLE WAS COVERED BY MEDICARE (KNOWN AS CROSSOVER CROSSOVER, DUAL OR MEDICARE ELIGIBILITY). THE DATA ARE REPORTED FOR FOUR QUARTERS IN THE CALENDAR YEAR, AS NOTED. THE EXAMPLE IS FOR THE FIRST QUARTER, JANUARY TO MARCH. QUARTER 1 - JANUARY TO MARCH (POSITION 139-140) QUARTER 2 - APRIL TO JUNE (POSITION 141-142) QUARTER 3 - JULY TO SEPTEMBER (POSITION 143-144) QUARTER 4 - OCTOBER TO DECEMBER (POSITION 145-146)
28. QUARTERLY ELIGIBLE MEDICARE CHAR CROSSOVER CODE - NEW VALUES		2	139	140	INDICATES WHETHER THE ELIGIBLE WAS COVERED BY MEDICARE (KNOWN AS CROSSOVER, DUAL OR MEDICARE ELIGIBILITY) CROSSOVER, DUAL OR MEDICARE ELIGIBILITY), ACCORDING TO MEDICAID (MSIS) IN THE CALENDAR QUARTER. 2 CHARACTERS CODES: 00 = IN MSIS, ELIGIBLE IS NOT A MEDICARE BENEFICIARY 01 = IN MSIS, ELIGIBLE IS ENTITLED TO MEDICARE-QMB ONLY 02 = IN MSIS, ELIGIBLE IS ENTITLED TO MEDICARE-QMB AND FULL MEDICAID COVERAGE 03 = IN MSIS, ELIGIBLE IS ENTITLED TO MEDICARE-SLMB ONLY 04 = IN MSIS, ELIGIBLE IS ENTITLED TO MEDICARE-SLMB AND FULL MEDICAID COVERAGE 05 = IN MSIS, ELIGIBLE IS ENTITLED TO MEDICARE-QDWI 06 = IN MSIS, ELIGIBLE IS ENTITLED TO MEDICARE-QUALIFYING INDIVIDUALS (1) 07 = IN MSIS, ELIGIBLE IS ENTITLED TO MEDICARE-QUALIFYING INDIVIDUALS (2) 08 = IN MSIS, ELIGIBLE IS ENTITLED TO MEDICARE-OTHER DUAL ELIGIBLES 09 = IN MSIS, ELIGIBLE IS ENTITLED TO MEDICARE-DUAL ELIGIBILITY CATEGORY UNKNOWN 99 = IN MSIS, ELIGIBLE'S MEDICARE STATUS IS UNKNOWN SOURCE: MSIS ELIGIBILITY FILES. THIS DATA ELEMENT IS TAKEN DIRECTLY FROM THE MSIS DATA ELEMENT "DUAL-ELIGIBILITY-FLAG". IF THERE IS NO ELIGIBLE RECORD FOR THE ENROLLEE, IT IS BLANK-FILLED.

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MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS			CONTENTS
		LENGTH	BEG	END	
**** ----- MEDICARE BENEFICIARY DATA - FROM MEDICARE	GROUP	4	147	150	INFORMATION FROM THE MEDICARE ENROLLMENT DATA BASE (EDB) ON CROSSOVER ENROLLEES.
29. ELIGIBLE MEDICARE BENEFICIARY MONTHS COUNT	NUM	2	147	148	TOTAL NUMBER OF MONTHS THE MEDICAID ELIGIBLE WAS A MEDICARE BENEFICIARY. ACCORDING TO MEDICARE (EDB) 2 DIGITS USER NOTE: THIS IS A NUMBER FROM 0 TO 12. IF THE ELIGIBLE SOCIAL SECURITY NUMBER (ELEMENT #4) REPORTED BY MEDICAID IS NOT FOUND IN THE MEDICARE ENROLLMENT DATA BASE (EDB) OR IS INVALID, THIS COUNT WILL HAVE VALUE = 0. SOURCE: MEDICARE ENROLLMENT DATA BASE (EDB), CALCULATED USING BENEFICIARY PART A ENTITLEMENT START AND TERMINATION DATES.
30. FUTURE USE	CHAR	12	149	160	
31. MEDICARE ORIGINAL ENTITLEMENT NUM REASON CODE	NUM	1	161	161	THE ORIGINAL REASON THE PERSON WAS ENTITLED TO MEDICARE BENEFITS. 1 DIGIT CODES: 0 = ENTITLED DUE TO AGE 1 = ENTITLED DUE TO DISABILITY 2 = ENTITLED DUE TO END STAGE RENAL DISEASE (ESRD) 3 = ENTITLED DUE TO DISABILITY AND CURRENT ESRD 8 = NOT APPLICABLE (NOT ENTITLED TO MEDICARE) 9 = NO ATTEMPT WAS MADE TO MATCH THE RECORD FOR THIS PERSON TO THE EDB, BECAUSE THERE WAS NO SSN REPORTED BY MEDICAID (E.G. PERSONS FOR WHOM THERE WERE MEDICAID CLAIMS BUT NO MEDICAID ELIGIBILITY DATA). SOURCE: MEDICARE ENROLLMENT DATA BASE (EDB) FOR VALUES = 0 TO 3. IF NO MEDICARE RECORD WAS FOUND, THE DEFAULT VALUE = 8. IF NO MATCH WAS ATTEMPTED, THE DEFAULT VALUE = 9.
32. FILLER	CHAR	1	162	162	

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS			CONTENTS
		LENGTH	BEG	END	
**** MONTHLY STATE SPECIFIC ELIGIBILITY	GROUP	72	163	234	<p>STATE SPECIFIC ELIGIBILITY CODE CLASSIFICATION UNDER WHICH THE MEDICAID ELIGIBLE IS COVERED FROM JANUARY THROUGH DECEMBER. THE EXAMPLE IS FOR JANUARY.</p> <p>JANUARY (POSITIONS 163 TO 168) FEBRUARY (POSITIONS 169 TO 174) MARCH (POSITIONS 175 TO 180) APRIL (POSITIONS 181 TO 186) MAY (POSITIONS 187 TO 192) JUNE (POSITIONS 193 TO 198) JULY (POSITIONS 199 TO 204) AUGUST (POSITIONS 205 TO 210) SEPTEMBER (POSITIONS 211 TO 216) OCTOBER (POSITIONS 217 TO 222) NOVEMBER (POSITIONS 223 TO 228) DECEMBER (POSITIONS 229 TO 234)</p>
33. STATE SPECIFIC ELIGIBILITY CODE	CHAR	6	163	168	<p>STATE SPECIFIC ELIGIBILITY CODE CLASSIFICATION FOR THE MEDICAID ELIGIBLE AND FOR THE MONTH</p> <p>6 CHARACTERS</p> <p><i>USER NOTES: THESE SOURCE CODES ARE GENERALLY NOT USEFUL FOR MOST RESEARCH ACTIVITIES. THE DATA ELEMENT VALUES CHANGE OVER TIME, VARY ACROSS STATES IN TERMS OF THE LEVEL AND TYPE OF ELIGIBILITY DESCRIBED, REQUIRE A DETAILED KNOWLEDGE OF MEDICAID ELIGIBILITY AND REQUIRE AN UNDERSTANDING OF THE IDIOSYNCRACIES OF INDIVIDUAL STATE ELIGIBILITY SYSTEMS. THESE CODES HAVE BEEN MAPPED INTO MAX UNIFORM ELIGIBILITY CODES. THEREFORE, MOST USERS WILL WANT TO USE MAX UNIFORM ELIGIBILITY CODES. THROUGH 9/98 THIS DATA ELEMENT WAS 4 CHARACTERS IN LENGTH, LEFT-JUSTIFIED AND BLANK FILLED (TWO RIGHT POSITIONS). BEGINNING IN 10/98, IT IS 6 CHARACTERS IN LENGTH. THIS CODE VALUE IS APPENDED TO EACH RECORD FOR THE ELIGIBLE PERSON, FROM THE MSIS ELIGIBILITY FILES.</i></p> <p>SOURCE: MSIS ELIGIBILITY FILES: "ELIGIBILITY-GROUP"</p>

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS			CONTENTS
		LENGTH	BEG	END	
**** MONTHLY MAX UNIFORM ELIGIBILITY GROUP	GROUP	24	235	258	<p>MEDICAID ANALYTIC EXTRACT (MAX) UNIFORM ELIGIBILITY CODE FOR THE MEDICAID ELIGIBLE FROM JANUARY THROUGH DECEMBER. THE EXAMPLE IS FOR JANUARY.</p> <p>JANUARY (POSITIONS 235 TO 236) FEBRUARY (POSITIONS 237 TO 238) MARCH (POSITIONS 239 TO 240) APRIL (POSITIONS 241 TO 242) MAY (POSITIONS 243 TO 244) JUNE (POSITIONS 245 TO 246) JULY (POSITIONS 247 TO 248) AUGUST (POSITIONS 249 TO 250) SEPTEMBER (POSITIONS 251 TO 252) OCTOBER (POSITIONS 253 TO 254) NOVEMBER (POSITIONS 255 TO 256) DECEMBER (POSITIONS 257 TO 258)</p>
34. MAX UNIFORM ELIGIBILITY CODE	CHAR	2	235	236	<p>MEDICAID ANALYTIC EXTRACT (MAX) UNIFORM ELIGIBILITY CODE FOR THE MEDICAID ELIGIBLE AND FOR THE MONTH</p> <p>2 DIGITS</p> <p>CODES:</p> <p>00 = NOT ELIGIBLE 11 = AGED, CASH 12 = BLIND/DISABLED, CASH 14 = CHILD (NOT CHILD OF UNEPLOYED ADULT, NOT FOSTER CARE CHILD), ELIGIBLE UNDER SECTION 1931 OF THE ACT 16 = CHILD OF UNEMPLOYED ADULT, ELIGIBLE UNDER SECTION 1931 OF THE ACT 15 = ADULT (NOT BASED ON UNEMPLOYMENT STATUS), ELIGIBLE UNDER SECTION 1931 OF THE ACT 17 = UNEMPLOYED ADULT, ELIGIBLE UNDER SECTION 1931 OF THE ACT 21 = AGED, MN 22 = BLIND/DISABLED, MN 24 = CHILD, MN (FORMERLY AFDC CHILD, MN) 25 = ADULT, MN (FORMERLY AFDC ADULT, MN) 31 = AGED, POVERTY 32 = BLIND/DISABLED, POVERTY 34 = CHILD, POVERTY (INCLUDES MEDICAID EXPANSION SCHIP CHILDREN) 35 = ADULT, POVERTY 3A = INDIVIDUAL COVERED UNDER THE BREAST AND CERVICAL CANCER PREVENTION ACT OF 2000, POVERTY</p>

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	
				41 = OTHER AGED
				42 = OTHER BLIND/DISABLED
				48 = FOSTER CARE CHILD
				44 = OTHER CHILD
				45 = OTHER ADULT
				51 = AGED, SECTION 1115 DEMONSTRATION EXPANSION
				52 = DISABLED, SECTION 1115 DEMONSTRATION EXPANSION
				54 = CHILD, SECTION 1115 DEMONSTRATION EXPANSION
				55 = ADULT, SECTION 1115 DEMONSTRATION EXPANSION
				99 = UNKNOWN ELIGIBILITY
<p>USER NOTE: MSIS "MAINTENANCE-ASSISTANCE-STATUS" (MAS) IS IN POSITION #1 AND "BASIS-OF-ELIGIBILITY" (BOE) IS IN POSITION #2. CODING IS THE SAME AS IN 1996-98 SMRF FILES, EXCEPT THAT VALUES 51-55 ARE ADDED FOR 1999 AND VALUE 3A IS ADDED FOR 2000. THERE MAY BE SMALL NUMBERS OF RECORDS WITH INCONSISTENT VALUES BECAUSE MSIS HAS NO MAS/BOE CONSISTENCY CHECKS. PRIOR TO THE END OF THE AFDC PROGRAM, GROUPS 14-17 WERE AFDC CASH RECIPIENTS.</p>				
<p>SOURCE: RECODED USING MAINTENANCE ASSISTANCE STATUS (MAS) AND BASIS OF ELIGIBILITY (BOE) FROM MSIS ELIGIBILITY FILES.</p>				

1

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS			CONTENTS
		LENGTH	BEG	END	
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**** MONTHLY ELIGIBLE PRIVATE INSURANCE GROUP	GROUP	12	259	270	INDICATES WHICH MONTHS THE MEDICAID ELIGIBLE HAD PRIVATE INSURANCE COVERAGE FROM JANUARY THROUGH DECEMBER. THE EXAMPLE IS FOR JANUARY. JANUARY (POSITION 259) FEBRUARY (POSITION 260) MARCH (POSITION 261) APRIL (POSITION 262) MAY (POSITION 263) JUNE (POSITION 264) JULY (POSITION 265) AUGUST (POSITION 266) SEPTEMBER (POSITION 267) OCTOBER (POSITION 268) NOVEMBER (POSITION 269) DECEMBER (POSITION 270)
35. ELIGIBLE PRIVATE INSURANCE CODE	NUM	1	259	259	CODE INDICATING IF THE ELIGIBLE HAD PRIVATE INSURANCE DURING THE MONTH 1 DIGIT CODES: 0 = NOT ELIGIBLE FOR MEDICAID 1 = NO PRIVATE INSURANCE COVERAGE 2 = PRIVATE INSURANCE PURCHASED BY THIRD PARTY 3 = PRIVATE INSURANCE PURCHASED BY STATE 4 = EITHER (1) BOTH 2 AND 3 APPLY <u>OR</u> (2) 2 AND 3 APPLY AND FUNDING SOURCE UNKNOWN 9 = INVALID OR MISSING DATA SOURCE: MSIS ELIGIBILITY FILES: "HEALTH-INSURANCE"

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS			CONTENTS
		LENGTH	BEG	END	
** ELIGIBLE MONTHLY MEDICARE BENEFICIARY GROUP	GROUP	12	271	282	INDICATES WHICH MONTHS THE MEDICAID ELIGIBLE WAS A MEDICARE BENEFICIARY BASED ON FINDING A BENEFICIARY RECORD FOR THE ELIGIBLE ON THE MEDICARE ENROLLMENT DATA BASE. THE EXAMPLE IS FOR JANUARY. JANUARY (POSITIONS 271) FEBRUARY (POSITIONS 272) MARCH (POSITIONS 273) APRIL (POSITIONS 274) MAY (POSITIONS 275) JUNE (POSITIONS 276) JULY (POSITIONS 277) AUGUST (POSITIONS 278) SEPTEMBER (POSITIONS 279) OCTOBER (POSITIONS 280) NOVEMBER (POSITIONS 281) DECEMBER (POSITIONS 282)
36. MONTHLY ELIGIBLE MEDICARE BENEFICIARY	NUM	1	271	271	CODE INDICATING WHETHER THE MEDICAID ELIGIBLE WAS COVERED BY MEDICARE DURING THE MONTH (BASED ON FINDING A BENEFICIARY RECORD FOR THE ELIGIBLE ON THE MEDICARE ENROLLMENT DATA BASE FOR THE MONTH) 1 DIGIT CODES: 0 = THERE WAS NO RECORD OF ELIGIBILITY FOR THE MONTH FOUND ON THE MEDICARE ENROLLMENT DATA BASE. 1 = THERE WAS A RECORD OF ELIGIBILITY FOR THE MONTH FOUND ON THE MEDICARE ENROLLMENT DATA BASE, FOR MEDICARE PART A (HOSPITAL INSURANCE). 2 = THERE WAS A RECORD OF ELIGIBILITY FOR THE MONTH FOUND ON THE MEDICARE ENROLLMENT DATA BASE, FOR MEDICARE PART B (SUPPLEMENTARY MEDICAL INSURANCE). 3 = THERE WAS A RECORD OF ELIGIBILITY FOR THE MONTH FOUND ON THE MEDICARE ENROLLMENT DATA BASE, FOR BOTH MEDICARE PART A AND PART B (BOTH HOSPITAL AND SUPPLEMENTARY MEDICAL INSURANCE). <i>USER NOTE: IF THE ELIGIBLE SOCIAL SECURITY NUMBER (ELEMENT #4) REPORTED BY MEDICAID IS NOT FOUND IN THE MEDICARE ENROLLMENT DATA BASE (EDB) OR IS INVALID, THIS DATA ELEMENT WILL HAVE VALUE = 0.</i> SOURCE: MEDICARE ENROLLMENT DATA BASE (EDB), CALCULATED USING BENEFICIARY ENTITLEMENT START AND TERMINATION DATES.

1

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
**** ELIGIBLE PRE-PAID PLAN MONTHS COUNT	GROUP	14	283	296	<p>TOTAL NUMBER OF MONTHS THE MEDICAID ELIGIBLE WAS ENROLLED IN A PRE-PAID OR PRIMARY CARE CASE MANAGEMENT (PCCM) PLAN DURING THE CALENDAR YEAR. MSIS CAPTURES INFORMATION ON EIGHT (8) TYPES OF PRE-PAID OR PCCM PLANS. DATA ARE PRESENTED FOR THE FIRST SEVEN TYPES OF PLANS. DATA ARE NOT PRESENTED FOR THE EIGHTH TYPE OF PRE-PAID PLAN (OTHER MANAGED CARE) BECAUSE THIS IS A "CATCH-ALL" CATEGORY FOR ANY TYPE OF PLAN NOT REPORTED IN THE OTHER TYPES. THE EXAMPLE IS FOR THE FIRST OCCURRENCE, COMPREHENSIVE MANAGED CARE PLANS.</p> <p>COMPREHENSIVE MANAGED CARE PLANS - E.G. HMOs (POSITIONS 283 TO 284) DENTAL MANAGED CARE PLANS (POSITIONS 285 TO 286) BEHAVIORAL MANAGED CARE PLANS (POSITIONS 287 TO 288) PRENATAL/DELIVERY MANAGED CARE PLANS (POSITIONS 289 TO 290) LONG-TERM CARE MANAGED CARE PLANS (POSITIONS 291 TO 292) ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) PLANS (POSITION 293 TO 294) PRIMARY CARE CASE MANAGEMENT PLANS (PCCMs) (POSITIONS 295 TO 296)</p>
37. ELIGIBLE PRE-PAID PLAN MONTHS COUNT	NUM	2	283	284	<p>TOTAL NUMBER OF MONTHS THE MEDICAID ELIGIBLE WAS ENROLLED IN THE PARTICULAR TYPE OF PLAN DURING THE CALENDAR YEAR.</p> <p>2 DIGITS</p> <p>USER NOTE: THIS IS A NUMBER FROM 0 TO 12. IT IS GIVEN VALUE > 0 BASED ON THE NUMBER OF MONTHS THE ELIGIBLE IS ENROLLED IN THIS TYPE OF PLAN. SINCE MSIS CAPTURES INFORMATION ON ENROLLMENT IN UP TO FOUR TYPES OF PLANS EACH MONTH, THE TOTAL NUMBER OF MONTHS ACROSS ALL TYPES OF PLANS MAY EXCEED 12. THE NUMBER OF MONTHS COUNTED HERE WILL BE VALUE = 0 FOR ANY OF THE "ELIGIBLE PREPAID PLAN TYPE CODES" (DATA ELEMENTS 38, 40, 42 AND 44) THAT CONTAIN A CODE VALUE = 99 (ELIGIBLE'S MANAGED CARE PLAN STATUS IS UNKNOWN THIS MONTH).</p> <p>SOURCE: CREATED USING MSIS ELIGIBILITY FILES</p>

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS			CONTENTS
		LENGTH	BEG	END	
**** MONTHLY ELIGIBLE PRE-PAID PLAN GROUP	GROUP	672	297	968	INDICATES WHICH MONTHS THE MEDICAID ELIGIBLE WAS ENROLLED IN AN HMO OR OTHER PRE-PAID PLAN FROM JANUARY THROUGH DECEMBER. THE EXAMPLE IS FOR JANUARY. JANUARY (POSITIONS 297 TO 352) ELIGIBLE PRE-PAID PLAN TYPE-1 CODE (POSITIONS 297 TO 298) ELIGIBLE PRE-PAID PLAN IDENTIFIER-1 (POSITIONS 299 TO 310) ELIGIBLE PRE-PAID PLAN TYPE-2 CODE (POSITIONS 311 TO 312) ELIGIBLE PRE-PAID PLAN IDENTIFIER-2 (POSITIONS 313 TO 324) ELIGIBLE PRE-PAID PLAN TYPE-3 CODE (POSITIONS 325 TO 326) ELIGIBLE PRE-PAID PLAN IDENTIFIER-3 (POSITIONS 327 TO 338) ELIGIBLE PRE-PAID PLAN TYPE-4 CODE (POSITIONS 339 TO 340) ELIGIBLE PRE-PAID PLAN IDENTIFIER-4 (POSITIONS 341 TO 352) FEBRUARY (POSITIONS 353 TO 408) ELIGIBLE PRE-PAID PLAN TYPE-1 CODE (POSITIONS 353 TO 354) ELIGIBLE PRE-PAID PLAN IDENTIFIER-1 (POSITIONS 355 TO 366) ELIGIBLE PRE-PAID PLAN TYPE-2 CODE (POSITIONS 367 TO 368) ELIGIBLE PRE-PAID PLAN IDENTIFIER-2 (POSITIONS 369 TO 380) ELIGIBLE PRE-PAID PLAN TYPE-3 CODE (POSITIONS 381 TO 382) ELIGIBLE PRE-PAID PLAN IDENTIFIER-3 (POSITIONS 383 TO 394) ELIGIBLE PRE-PAID PLAN TYPE-4 CODE (POSITIONS 395 TO 396) ELIGIBLE PRE-PAID PLAN IDENTIFIER-4 (POSITIONS 397 TO 408) MARCH (POSITIONS 409 TO 464) ELIGIBLE PRE-PAID PLAN TYPE-1 CODE (POSITIONS 409 TO 410) ELIGIBLE PRE-PAID PLAN IDENTIFIER-1 (POSITIONS 411 TO 422) ELIGIBLE PRE-PAID PLAN TYPE-2 CODE (POSITIONS 423 TO 424) ELIGIBLE PRE-PAID PLAN IDENTIFIER-2 (POSITIONS 425 TO 436) ELIGIBLE PRE-PAID PLAN TYPE-3 CODE (POSITIONS 437 TO 438) ELIGIBLE PRE-PAID PLAN IDENTIFIER-3 (POSITIONS 439 TO 450) ELIGIBLE PRE-PAID PLAN TYPE-4 CODE (POSITIONS 451 TO 452) ELIGIBLE PRE-PAID PLAN IDENTIFIER-4 (POSITIONS 453 TO 464) APRIL (POSITIONS 465 TO 520) ELIGIBLE PRE-PAID PLAN TYPE-1 CODE (POSITIONS 465 TO 466) ELIGIBLE PRE-PAID PLAN IDENTIFIER-1 (POSITIONS 467 TO 478) ELIGIBLE PRE-PAID PLAN TYPE-2 CODE (POSITIONS 479 TO 480) ELIGIBLE PRE-PAID PLAN IDENTIFIER-2 (POSITIONS 481 TO 492) ELIGIBLE PRE-PAID PLAN TYPE-3 CODE (POSITIONS 493 TO 494) ELIGIBLE PRE-PAID PLAN IDENTIFIER-3 (POSITIONS 495 TO 506) ELIGIBLE PRE-PAID PLAN TYPE-4 CODE (POSITIONS 507 TO 508) ELIGIBLE PRE-PAID PLAN IDENTIFIER-4 (POSITIONS 509 TO 520)

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	

				MAY (POSITIONS 521 TO 576)
				ELIGIBLE PRE-PAID PLAN TYPE-1 CODE (POSITIONS 521 TO 522)
				ELIGIBLE PRE-PAID PLAN IDENTIFIER-1 (POSITIONS 523 TO 534)
				ELIGIBLE PRE-PAID PLAN TYPE-2 CODE (POSITIONS 535 TO 536)
				ELIGIBLE PRE-PAID PLAN IDENTIFIER-2 (POSITIONS 537 TO 548)
				ELIGIBLE PRE-PAID PLAN TYPE-3 CODE (POSITIONS 549 TO 550)
				ELIGIBLE PRE-PAID PLAN IDENTIFIER-3 (POSITIONS 551 TO 562)
				ELIGIBLE PRE-PAID PLAN TYPE-4 CODE (POSITIONS 563 TO 564)
				ELIGIBLE PRE-PAID PLAN IDENTIFIER-4 (POSITIONS 565 TO 576)
				JUNE (POSITIONS 577 TO 632)
				ELIGIBLE PRE-PAID PLAN TYPE-1 CODE (POSITIONS 577 TO 578)
				ELIGIBLE PRE-PAID PLAN IDENTIFIER-1 (POSITIONS 579 TO 590)
				ELIGIBLE PRE-PAID PLAN TYPE-2 CODE (POSITIONS 591 TO 592)
				ELIGIBLE PRE-PAID PLAN IDENTIFIER-2 (POSITIONS 593 TO 604)
				ELIGIBLE PRE-PAID PLAN TYPE-3 CODE (POSITIONS 605 TO 606)
				ELIGIBLE PRE-PAID PLAN IDENTIFIER-3 (POSITIONS 607 TO 618)
				ELIGIBLE PRE-PAID PLAN TYPE-4 CODE (POSITIONS 619 TO 620)
				ELIGIBLE PRE-PAID PLAN IDENTIFIER-4 (POSITIONS 621 TO 632)
				JULY (POSITIONS 633 TO 688)
				ELIGIBLE PRE-PAID PLAN TYPE-1 CODE (POSITIONS 633 TO 634)
				ELIGIBLE PRE-PAID PLAN IDENTIFIER-1 (POSITIONS 635 TO 646)
				ELIGIBLE PRE-PAID PLAN TYPE-2 CODE (POSITIONS 647 TO 648)
				ELIGIBLE PRE-PAID PLAN IDENTIFIER-2 (POSITIONS 649 TO 660)
				ELIGIBLE PRE-PAID PLAN TYPE-3 CODE (POSITIONS 661 TO 662)
				ELIGIBLE PRE-PAID PLAN IDENTIFIER-3 (POSITIONS 663 TO 674)
				ELIGIBLE PRE-PAID PLAN TYPE-4 CODE (POSITIONS 675 TO 676)
				ELIGIBLE PRE-PAID PLAN IDENTIFIER-4 (POSITIONS 677 TO 688)
				AUGUST (POSITIONS 689 TO 744)
				ELIGIBLE PRE-PAID PLAN TYPE-1 CODE (POSITIONS 689 TO 690)
				ELIGIBLE PRE-PAID PLAN IDENTIFIER-1 (POSITIONS 691 TO 702)
				ELIGIBLE PRE-PAID PLAN TYPE-2 CODE (POSITIONS 703 TO 704)
				ELIGIBLE PRE-PAID PLAN IDENTIFIER-2 (POSITIONS 705 TO 716)
				ELIGIBLE PRE-PAID PLAN TYPE-3 CODE (POSITIONS 717 TO 718)
				ELIGIBLE PRE-PAID PLAN IDENTIFIER-3 (POSITIONS 719 TO 730)
				ELIGIBLE PRE-PAID PLAN TYPE-4 CODE (POSITIONS 731 TO 732)
				ELIGIBLE PRE-PAID PLAN IDENTIFIER-4 (POSITIONS 733 TO 744)

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	

SEPTEMBER (POSITIONS 745 TO 800)				
	ELIGIBLE	PRE-PAID	PLAN	TYPE-1 CODE (POSITIONS 745 TO 746)
	ELIGIBLE	PRE-PAID	PLAN	IDENTIFIER-1 (POSITIONS 747 TO 758)
	ELIGIBLE	PRE-PAID	PLAN	TYPE-2 CODE (POSITIONS 759 TO 760)
	ELIGIBLE	PRE-PAID	PLAN	IDENTIFIER-2 (POSITIONS 761 TO 772)
	ELIGIBLE	PRE-PAID	PLAN	TYPE-3 CODE (POSITIONS 773 TO 774)
	ELIGIBLE	PRE-PAID	PLAN	IDENTIFIER-3 (POSITIONS 775 TO 786)
	ELIGIBLE	PRE-PAID	PLAN	TYPE-4 CODE (POSITIONS 787 TO 788)
	ELIGIBLE	PRE-PAID	PLAN	IDENTIFIER-4 (POSITIONS 789 TO 800)
OCTOBER (POSITIONS 801 TO 856)				
	ELIGIBLE	PRE-PAID	PLAN	TYPE-1 CODE (POSITIONS 801 TO 802)
	ELIGIBLE	PRE-PAID	PLAN	IDENTIFIER-1 (POSITIONS 803 TO 814)
	ELIGIBLE	PRE-PAID	PLAN	TYPE-2 CODE (POSITIONS 815 TO 816)
	ELIGIBLE	PRE-PAID	PLAN	IDENTIFIER-2 (POSITIONS 817 TO 828)
	ELIGIBLE	PRE-PAID	PLAN	TYPE-3 CODE (POSITIONS 829 TO 830)
	ELIGIBLE	PRE-PAID	PLAN	IDENTIFIER-3 (POSITIONS 831 TO 842)
	ELIGIBLE	PRE-PAID	PLAN	TYPE-4 CODE (POSITIONS 843 TO 844)
	ELIGIBLE	PRE-PAID	PLAN	IDENTIFIER-4 (POSITIONS 845 TO 856)
NOVEMBER (POSITIONS 857 TO 912)				
	ELIGIBLE	PRE-PAID	PLAN	TYPE-1 CODE (POSITIONS 857 TO 858)
	ELIGIBLE	PRE-PAID	PLAN	IDENTIFIER-1 (POSITIONS 859 TO 870)
	ELIGIBLE	PRE-PAID	PLAN	TYPE-2 CODE (POSITIONS 871 TO 872)
	ELIGIBLE	PRE-PAID	PLAN	IDENTIFIER-2 (POSITIONS 873 TO 884)
	ELIGIBLE	PRE-PAID	PLAN	TYPE-3 CODE (POSITIONS 885 TO 886)
	ELIGIBLE	PRE-PAID	PLAN	IDENTIFIER-3 (POSITIONS 887 TO 898)
	ELIGIBLE	PRE-PAID	PLAN	TYPE-4 CODE (POSITIONS 899 TO 900)
	ELIGIBLE	PRE-PAID	PLAN	IDENTIFIER-4 (POSITIONS 901 TO 912)
DECEMBER (POSITIONS 913 TO 968)				
	ELIGIBLE	PRE-PAID	PLAN	TYPE-1 CODE (POSITIONS 913 TO 914)
	ELIGIBLE	PRE-PAID	PLAN	IDENTIFIER-1 (POSITIONS 915 TO 926)
	ELIGIBLE	PRE-PAID	PLAN	TYPE-2 CODE (POSITIONS 927 TO 928)
	ELIGIBLE	PRE-PAID	PLAN	IDENTIFIER-2 (POSITIONS 929 TO 940)
	ELIGIBLE	PRE-PAID	PLAN	TYPE-3 CODE (POSITIONS 941 TO 942)
	ELIGIBLE	PRE-PAID	PLAN	IDENTIFIER-3 (POSITIONS 943 TO 954)
	ELIGIBLE	PRE-PAID	PLAN	TYPE-4 CODE (POSITIONS 955 TO 956)
	ELIGIBLE	PRE-PAID	PLAN	IDENTIFIER-4 (POSITIONS 957 TO 968)

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS			CONTENTS
		LENGTH	BEG	END	
38. ELIGIBLE PRE-PAID PLAN TYPE-1 CODE	NUM	2	297	298	<p>CODE INDICATING THE TYPE OF THE FIRST OF UP TO FOUR MANAGED CARE PLAN TYPES IN WHICH THE ELIGIBLE WAS ENROLLED DURING THE CALENDAR MONTH.</p> <p>2 DIGITS</p> <p>CODES:</p> <p>00 = INDIVIDUAL WAS NOT ELIGIBLE FOR MEDICAID THIS MONTH.</p> <p>01 = ELIGIBLE IS ENROLLED IN A MEDICAL OR COMPREHENSIVE MANAGED CARE PLAN THIS MONTH (E.G. HMO)</p> <p>02 = ELIGIBLE IS ENROLLED IN A DENTAL MANAGED CARE PLAN THIS MONTH.</p> <p>03 = ELIGIBLE IS ENROLLED IN A BEHAVIORAL MANAGED CARE PLAN THIS MONTH.</p> <p>04 = ELIGIBLE IS ENROLLED IN A PRENATAL/DELIVERY MANAGED CARE PLAN THIS MONTH.</p> <p>05 = ELIGIBLE IS ENROLLED IN A LONG-TERM CARE MANAGED CARE PLAN THIS MONTH.</p> <p>06 = ELIGIBLE IS ENROLLED IN A PROGRAM FOR ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) PLAN THIS MONTH.</p> <p>07 = ELIGIBLE IS ENROLLED IN A PRIMARY CARE CASE MANAGEMENT (PCCM) PLAN THIS MONTH.</p> <p>08 = ELIGIBLE IS ENROLLED IN AN OTHER MANAGED CARE PLAN THIS MONTH.</p> <p>88 = NOT APPLICABLE, INDIVIDUAL IS ELIGIBLE FOR MEDICAID, BUT NOT ENROLLED IN A MANAGED CARE PLAN THIS MONTH.</p> <p>99 = ELIGIBLE'S MANAGED CARE PLAN STATUS IS UNKNOWN THIS MONTH.</p> <p>SOURCE: MSIS ELIGIBILITY FILES: "PLAN-TYPE-1"</p>
39. ELIGIBLE PRE-PAID PLAN IDENTIFIER-1	CHAR	12	299	310	<p>THE STATE ASSIGNED MANAGED CARE PLAN IDENTIFICATION NUMBER ASSOCIATED WITH PLAN TYPE-1 IN WHICH THE ELIGIBLE WAS ENROLLED DURING THE MONTH.</p> <p>12 CHARACTERS</p> <p>SOURCE: MSIS ELIGIBILITY FILES: "PLAN-ID-1"</p>

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS			CONTENTS
		LENGTH	BEG	END	
40. ELIGIBLE PRE-PAID PLAN TYPE-2 CODE	NUM	2	311	312	<p>CODE INDICATING THE TYPE OF THE SECOND OF UP TO FOUR MANAGED CARE PLAN TYPES IN WHICH THE ELIGIBLE WAS ENROLLED DURING THE CALENDAR MONTH.</p> <p>2 DIGITS</p> <p>CODES:</p> <p>00 = INDIVIDUAL WAS NOT ELIGIBLE FOR MEDICAID THIS MONTH. 01 = ELIGIBLE IS ENROLLED IN A MEDICAL OR COMPREHENSIVE MANAGED CARE PLAN THIS MONTH (E.G. HMO) 02 = ELIGIBLE IS ENROLLED IN A DENTAL MANAGED CARE PLAN THIS MONTH. 03 = ELIGIBLE IS ENROLLED IN A BEHAVIORAL MANAGED CARE PLAN THIS MONTH. 04 = ELIGIBLE IS ENROLLED IN A PRENATAL/DELIVERY MANAGED CARE PLAN THIS MONTH. 05 = ELIGIBLE IS ENROLLED IN A LONG-TERM CARE MANAGED CARE PLAN THIS MONTH. 06 = ELIGIBLE IS ENROLLED IN A PROGRAM FOR ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) PLAN THIS MONTH. 07 = ELIGIBLE IS ENROLLED IN A PRIMARY CARE CASE MANAGEMENT (PCCM) PLAN THIS MONTH. 08 = ELIGIBLE IS ENROLLED IN AN OTHER MANAGED CARE PLAN THIS MONTH. 88 = NOT APPLICABLE, INDIVIDUAL IS ELIGIBLE FOR MEDICAID, BUT NOT ENROLLED IN A NAMED CARE PLAN THIS MONTH. 99 = ELIGIBLE'S MANAGED CARE PLAN STATUS IS UNKNOWN THIS MONTH.</p> <p>SOURCE: MSIS ELIGIBILITY FILES: "PLAN-TYPE-2"</p>
41. ELIGIBLE PRE-PAID PLAN IDENTIFIER-2	CHAR	12	313	324	<p>THE STATE ASSIGNED MANAGED CARE PLAN IDENTIFICATION NUMBER ASSOCIATED WITH PLAN TYPE-2 IN WHICH THE ELIGIBLE WAS ENROLLED DURING THE MONTH.</p> <p>12 CHARACTERS</p> <p>SOURCE: MSIS ELIGIBILITY FILES: "PLAN-ID-2"</p>

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS			CONTENTS
		LENGTH	BEG	END	
42. ELIGIBLE PRE-PAID PLAN TYPE-3 CODE	NUM	2	325	326	<p>CODE INDICATING THE TYPE OF THE THIRD OF UP TO FOUR MANAGED CARE PLAN TYPES IN WHICH THE ELIGIBLE WAS ENROLLED DURING THE CALENDAR MONTH.</p> <p>2 DIGITS</p> <p>CODES:</p> <p>00 = INDIVIDUAL WAS NOT ELIGIBLE FOR MEDICAID THIS MONTH. 01 = ELIGIBLE IS ENROLLED IN A MEDICAL OR COMPREHENSIVE MANAGED CARE PLAN THIS MONTH (E.G. HMO) 02 = ELIGIBLE IS ENROLLED IN A DENTAL MANAGED CARE PLAN THIS MONTH. 03 = ELIGIBLE IS ENROLLED IN A BEHAVIORAL MANAGED CARE PLAN THIS MONTH. 04 = ELIGIBLE IS ENROLLED IN A PRENATAL/DELIVERY MANAGED CARE PLAN THIS MONTH. 05 = ELIGIBLE IS ENROLLED IN A LONG-TERM CARE MANAGED CARE PLAN THIS MONTH. 06 = ELIGIBLE IS ENROLLED IN A PROGRAM FOR ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) PLAN THIS MONTH. 07 = ELIGIBLE IS ENROLLED IN A PRIMARY CARE CASE MANAGEMENT (PCCM) PLAN THIS MONTH. 08 = ELIGIBLE IS ENROLLED IN AN OTHER MANAGED CARE PLAN THIS MONTH. 88 = NOT APPLICABLE, INDIVIDUAL IS ELIGIBLE FOR MEDICAID, BUT NOT ENROLLED IN A MANAGED CARE PLAN THIS MONTH. 99 = ELIGIBLE'S MANAGED CARE PLAN STATUS IS UNKNOWN THIS MONTH.</p> <p>SOURCE: MSIS ELIGIBILITY FILES: "PLAN-TYPE-3"</p>
43. ELIGIBLE PRE-PAID PLAN IDENTIFIER-3	CHAR	12	327	338	<p>THE STATE ASSIGNED MANAGED CARE PLAN IDENTIFICATION NUMBER ASSOCIATED WITH PLAN TYPE-3 IN WHICH THE ELIGIBLE WAS ENROLLED DURING THE MONTH.</p> <p>12 CHARACTERS</p> <p>SOURCE: MSIS ELIGIBILITY FILES: "PLAN-ID-3"</p>

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS			CONTENTS
		LENGTH	BEG	END	
44. ELIGIBLE PRE-PAID PLAN TYPE-4 CODE	NUM	2	339	340	<p>CODE INDICATING THE TYPE OF THE FOURTH OF UP TO FOUR MANAGED CARE PLAN TYPES IN WHICH THE ELIGIBLE WAS ENROLLED DURING THE CALENDAR MONTH.</p> <p>2 DIGITS CODES:</p> <p>00 = INDIVIDUAL WAS NOT ELIGIBLE FOR MEDICAID THIS MONTH. 01 = ELIGIBLE IS ENROLLED IN A MEDICAL OR COMPREHENSIVE MANAGED CARE PLAN THIS MONTH (E.G. HMO) 02 = ELIGIBLE IS ENROLLED IN A DENTAL MANAGED CARE PLAN THIS MONTH. 03 = ELIGIBLE IS ENROLLED IN A BEHAVIORAL MANAGED CARE PLAN THIS MONTH. 04 = ELIGIBLE IS ENROLLED IN A PRENATAL/DELIVERY MANAGED CARE PLAN THIS MONTH. 05 = ELIGIBLE IS ENROLLED IN A LONG-TERM CARE MANAGED CARE PLAN THIS MONTH. 06 = ELIGIBLE IS ENROLLED IN A PROGRAM FOR ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) PLAN THIS MONTH. 07 = ELIGIBLE IS ENROLLED IN A PRIMARY CARE CASE MANAGEMENT (PCCM) PLAN THIS MONTH. 08 = ELIGIBLE IS ENROLLED IN AN OTHER MANAGED CARE PLAN THIS MONTH. 88 = NOT APPLICABLE, INDIVIDUAL IS ELIGIBLE FOR MEDICAID, BUT NOT ENROLLED IN A MANAGED CARE PLAN THIS MONTH. 99 = ELIGIBLE'S MANAGED CARE PLAN STATUS IS UNKNOWN THIS MONTH.</p> <p>SOURCE: MSIS ELIGIBILITY FILES: "PLAN-TYPE-4"</p>
45. ELIGIBLE PRE-PAID PLAN IDENTIFIER-4	CHAR	12	341	352	<p>THE STATE ASSIGNED MANAGED CARE PLAN IDENTIFICATION NUMBER ASSOCIATED WITH PLAN TYPE-4 IN WHICH THE ELIGIBLE WAS ENROLLED DURING THE MONTH.</p> <p>12 CHARACTERS</p> <p>SOURCE: MSIS ELIGIBILITY FILES: "PLAN-ID-4"</p>

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
**** MONTHLY MANAGED CARE COMBINATIONS DATA	GROUP	24	969	992	INDICATES WHETHER THE MEDICAID ELIGIBLE WAS ENROLLED IN MORE THAN ONE TYPE OF MANAGED CARE FOR EACH MONTH FROM JANUARY THROUGH DECEMBER. THE EXAMPLE IS FOR JANUARY. JANUARY (POSITION 969-970) FEBRUARY (POSITION 971-972) MARCH (POSITION 973-974) APRIL (POSITION 975-976) MAY (POSITION 977-978) JUNE (POSITION 979-980) JULY (POSITION 981-982) AUGUST (POSITION 983-984) SEPTEMBER (POSITION 985-986) OCTOBER (POSITION 987-988) NOVEMBER (POSITION 989-990) DECEMBER (POSITION 991-992)
46. MEDICAID MANAGED CARE COMBINATIONS	NUM	2	969	970	THE TYPES OF MANAGED CARE THE ELIGIBLE WAS ENROLLED IN FOR THE MONTH. 2 DIGITS CODES: 00 = INDIVIDUAL WAS NOT ELIGIBLE FOR MEDICAID THIS MONTH 01 = COMPREHENSIVE PLAN ONLY 02 = DENTAL PLAN ONLY 03 = BEHAVIORAL PLAN ONLY 04 = PRIMARY CARE CASE MANAGEMENT (PCCM) PLAN ONLY 05 = OTHER MANAGED CARE PLAN ONLY 06 = COMPREHENSIVE PLAN AND DENTAL PLAN 07 = COMPREHENSIVE PLAN AND BEHAVIORAL PLAN 08 = COMPREHENSIVE PLAN AND OTHER MANAGED CARE PLAN 09 = COMPREHENSIVE PLAN, DENTAL PLAN AND BEHAVIORAL PLAN 10 = PRIMARY CARE CASE MANAGEMENT (PCCM) AND DENTAL PLAN 11 = PRIMARY CARE CASE MANAGEMENT (PCCM) AND BEHAVIORAL PLAN 12 = PRIMARY CARE CASE MANAGEMENT (PCCM) AND OTHER MANAGED CARE PLAN 13 = PRIMARY CARE CASE MANAGEMENT (PCCM), DENTAL PLAN AND BEHAVIORAL PLAN 14 = DENTAL PLAN AND BEHAVIORAL PLAN 15 = OTHER COMBINATIONS 16 = FEE FOR SERVICE (NO MANAGED CARE PLAN REPORTED) 99 = ELIGIBLE'S MANAGED CARE PLAN STATUS IS UNKNOWN THIS MONTH

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	

THE FOLLOWING IS HOW MSIS DATA ELEMENTS PLAN-TYPE-1 TO PLAN-TYPE-4 ARE MAPPED INTO THE CODE VALUES FOR THIS DATA ELEMENT:				
MAX MSIS				
CODE CODE				
00 = 00 IN ALL FOUR PLAN TYPES THIS MONTH - PERSON WAS NOT ELIGIBLE FOR MEDICAID THIS MONTH				
01 = 01 ELIGIBLE IS ENROLLED IN A MEDICAL OR COMPREHENSIVE MANAGED CARE PLAN THIS MONTH (E.G. HMO), AND NO OTHER TYPE OF PLAN				
02 = 02 ELIGIBLE IS ENROLLED IN A DENTAL MANAGED CARE PLAN THIS MONTH, AND NO OTHER TYPE OF PLAN				
03 = 03 ELIGIBLE IS ENROLLED IN A BEHAVIORAL MANAGED CARE PLAN THIS MONTH, AND NO OTHER TYPE OF PLAN				
04 = 07 ELIGIBLE IS ENROLLED IN A PRIMARY CARE CASE MANAGEMENT MANAGED CARE PLAN THIS MONTH, AND NO OTHER TYPE OF PLAN				
05 = 04 ELIGIBLE IS ENROLLED IN A PRENATAL/DELIVERY MANAGED CARE PLAN THIS MONTH, OR				
05 = 05 ELIGIBLE IS ENROLLED IN A LONG-TERM CARE MANAGED CARE PLAN THIS MONTH, OR				
05 = 06 ELIGIBLE IS ENROLLED IN A PROGRAM FOR ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) THIS MONTH, OR				
05 = 08 ELIGIBLE IS ENROLLED IN AN OTHER MANAGED CARE PLAN THIS MONTH, OR				
05 = (ONE OR MORE OF THE MSIS CODES 04, 05, 06, 08 THIS MONTH)				
06 = 01 AND 02				
07 = 01 AND 03				
08 = 01 AND (ONE OR MORE OF THE MSIS CODES 04, 05, 06, 08 THIS MONTH)				
09 = 01 AND 02 AND 03				
10 = 07 AND 02				
11 = 07 AND 03				
12 = 07 AND (ONE OR MORE OF THE MSIS CODES 04, 05, 06, 08 THIS MONTH)				
13 = 07 AND 02 AND 03				
14 = 02 AND 03				
15 = ALL OTHER COMBINATIONS OF MANAGED CARE PLAN CODES THIS MONTH (INCLUDING 99 AND ONE OR MORE OTHER MSIS CODES)				
16 = 88 IN ALL FOUR MSIS PLAN TYPES THIS MONTH - PERSON WAS ELIGIBLE THIS MONTH BUT NOT ENROLLED IN MANAGED CARE				
99 = 99 IN ALL FOUR MSIS PLAN TYPES THIS MONTH - ELIGIBLE'S MANAGED CARE PLAN STATUS IS UNKNOWN THIS MONTH				
SOURCE: CREATED FROM MSIS ELIGIBILITY FILES USING "PLAN-TYPE-1 TO -4"				

1

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	
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**** MONTHLY ELIGIBLE DAYS OF ELIGIBILITY GROUP		24	993 1016	INDICATES THE NUMBER OF DAYS THE MEDICAID ELIGIBLE WAS ENROLLED IN MEDICAID FROM JANUARY THROUGH DECEMBER. THE EXAMPLE IS FOR JANUARY. JANUARY (POSITION 993-994) FEBRUARY (POSITION 995-996) MARCH (POSITION 997-998) APRIL (POSITION 999-1000) MAY (POSITION 1001-1002) JUNE (POSITION 1003-1004) JULY (POSITION 1005-1006) AUGUST (POSITION 1007-1008) SEPTEMBER (POSITION 1009-1010) OCTOBER (POSITION 1011-1012) NOVEMBER (POSITION 1013-1014) DECEMBER (POSITION 1015-1016)
47. ELIGIBLE DAYS OF ELIGIBILITY NUM		2	993 994	THE NUMBER OF DAYS THE ELIGIBLE WAS ENROLLED IN MEDICAID DURING THE MONTH. 2 DIGITS SOURCE: MSIS ELIGIBILITY FILES: "DAYS-OF-ELIGIBILITY"

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	
**** MONTHLY ELIGIBLE TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) CASH FLAG GROUP		12	1017 1028	INDICATES WHETHER THE ELIGIBLE RECEIVED TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) BENEFITS FROM JANUARY THROUGH DECEMBER. THE EXAMPLE IS FOR JANUARY. JANUARY (POSITION 1017) FEBRUARY (POSITION 1018) MARCH (POSITION 1019) APRIL (POSITION 1020) MAY (POSITION 1021) JUNE (POSITION 1022) JULY (POSITION 1023) AUGUST (POSITION 1024) SEPTEMBER (POSITION 1025) OCTOBER (POSITION 1026) NOVEMBER (POSITION 1027) DECEMBER (POSITION 1028)
48. ELIGIBLE TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) CASH FLAG	NUM	1	1017 1017	INDICATES WHETHER THE ELIGIBLE RECEIVED TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) BENEFITS DURING THE MONTH. 1 DIGIT CODES: 0 = INDIVIDUAL WAS NOT ELIGIBLE FOR MEDICAID AT ANY TIME DURING THE MONTH. 1 = INDIVIDUAL DID NOT RECEIVE TANF BENEFITS DURING THE MONTH. 2 = INDIVIDUAL DID RECEIVE TANF BENEFITS DURING THE MONTH (STATES SHOULD ONLY USE THIS VALUE IF THEY CAN ACCURATELY SEPARATE ELIGIBLES RECEIVING TANF BENEFITS FROM OTHER SECTION 1931 ELIGIBLES REPORTED INTO MAS VALUE = 1. 9 = INDIVIDUAL'S TANF STATUS IS UNKNOWN. USER NOTE: AVAILABILITY OF THIS DATA ELEMENT VARIES FROM STATE TO STATE. SOURCE: MSIS ELIGIBILITY FILES: "TANF-CASH-FLAG"

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	
**** MONTHLY ELIGIBLE RESTRICTED BENEFITS FLAG GROUP		12	1029 1040	INDICATES THE SCOPE OF MEDICAID BENEFITS TO WHICH AN ELIGIBLE IS ENTITLED FROM JANUARY THROUGH DECEMBER. THE EXAMPLE IS FOR JANUARY. JANUARY (POSITION 1029) FEBRUARY (POSITION 1030) MARCH (POSITION 1031) APRIL (POSITION 1032) MAY (POSITION 1033) JUNE (POSITION 1034) JULY (POSITION 1035) AUGUST (POSITION 1036) SEPTEMBER (POSITION 1037) OCTOBER (POSITION 1038) NOVEMBER (POSITION 1039) DECEMBER (POSITION 1040)
49. ELIGIBLE RESTRICTED BENEFITS FLAG	CHAR	1	1029 1029	INDICATES THE SCOPE OF MEDICAID BENEFITS TO WHICH AN ELIGIBLE IS ENTITLED FOR THE RESPECTIVE MONTH. 1 DIGIT CODES: 0 = INDIVIDUAL IS NOT ELIGIBLE FOR MEDICAID DURING THE MONTH. 1 = INDIVIDUAL IS ELIGIBLE FOR MEDICAID DURING THE MONTH AND IS ENTITLED TO THE FULL SCOPE OF MEDICAID BENEFITS. 2 = INDIVIDUAL IS ELIGIBLE FOR MEDICAID DURING THE MONTH BUT ONLY ENTITLED TO RESTRICTED BENEFITS BASED ON ALIEN STATUS (INCLUDING ILLEGAL ENTRANTS AND LEGAL ENTRANTS DURING THE 5-YEAR WAITING PERIOD). 3 = INDIVIDUAL IS ELIGIBLE FOR MEDICAID DURING THE MONTH BUT ONLY ENTITLED TO RESTRICTED BENEFITS BASED ON MEDICAID DUAL ELIGIBILITY STATUS (E.G. QMB ONLY OR SLMB ONLY). 4 = INDIVIDUAL IS ELIGIBLE FOR MEDICAID DURING THE MONTH BUT ONLY ENTITLED TO RESTRICTED BENEFITS FOR PREGNANCY-RELATED SERVICES. 5 = INDIVIDUAL IS ELIGIBLE FOR MEDICAID DURING THE MONTH BUT ONLY ENTITLED TO RESTRICTED BENEFITS FOR REASONS OTHER THAN ALIEN, DUAL ELIGIBILITY OR PREGNANCY-RELATED STATUS (E.G. RESTRICTED BENEFITS BASED UPON SUBSTANCE ABUSE, MEDICALLY NEEDED OR OTHER CRITERIA). 6 = INDIVIDUAL IS ELIGIBLE FOR MEDICAID, BUT ONLY ENTITLED TO RECEIVE FAMILY PLANNING SERVICES (BEGINNING IN 2001) 9 = INDIVIDUAL'S BENEFIT RESTRICTIONS ARE UNKNOWN. X = INDIVIDUAL IS ELIGIBLE FOR MEDICAID DURING THE MONTH BUT ONLY ENTITLED TO RECEIVE PRESCRIPTION DRUG BENEFITS (BEGINNING IN 2003)

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	
				<p>Y = INDIVIDUAL IS ELIGIBLE FOR MEDICAID AND MEDICARE DURING THE MONTH BUT ONLY ENTITLED TO RECEIVE PRESCRIPTION DRUG BENEFITS AND RESTRICTED BENEFITS BASED ON MEDICAID DUAL ELIGIBILITY STATUS (E.G. QMB ONLY, SLMB ONLY, OR QDWI OR QI). (BEGINNING IN 2003)</p> <p>Z = INDIVIDUAL IS ELIGIBLE FOR MEDICAID AND MEDICARE DURING THE MONTH BUT ONLY ENTITLED TO RECEIVE PRESCRIPTION DRUG BENEFITS. THE EDB LINK FOUND THAT THE INDIVIDUAL WAS ALSO ELIGIBLE FOR MEDICARE, BUT THE MEDICAID PROGRAM WAS NOT PAYING RESTRICTED BENEFITS BASED ON MEDICAID DUAL ELIGIBILITY STATUS (E.G. QMB ONLY, SLMB ONLY, QDWI OR QI). (BEGINNING IN 2003)</p> <p>USER NOTES: X IS ASSIGNED WHEN WE FIND A MONTHLY PHARMACY PLUS STATE SPECIFIC ELIGIBILITY CODE AND MONTHLY ELIGIBLE MEDICARE BENEFICIARY CODE VALUE = 0. Y IS ASSIGNED WHEN WE FIND A MONTHLY PHARMACY PLUS STATE SPECIFIC ELIGIBILITY CODE AND MONTHLY ELIGIBLE MEDICARE BENEFICIARY CODE VALUE = 1, 2, OR 3 AND ANNUAL MEDICARE CROSSOVER CODE NEW VALUE = 51, 53 OR 56. Z IS ASSIGNED WHEN WE FIND A MONTHLY PHARMACY PLUS STATE SPECIFIC ELIGIBILITY CODE AND MONTHLY ELIGIBLE BENEFICIARY CODE VALUE = 1, 2, OR 3 AND ANNUAL MEDICARE CROSSOVER CODE NEW VALUE IS NOT = 51, 53, OR 56.</p> <p>SOURCE: MSIS ELIGIBILITY FILES: "RESTRICTED-BENEFITS-FLAG"</p>

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	
**** MONTHLY CHILD HEALTH INSURANCE PROGRAM (SCHIP) CODE GROUP		12	1041 1052	INDICATES WHETHER THE INDIVIDUAL WAS ELIGIBLE FOR THE CHILD HEALTH INSURANCE PROGRAM (SCHIP) FROM JANUARY THROUGH DECEMBER. THE EXAMPLE IS FOR JANUARY. JANUARY (POSITION 1041) FEBRUARY (POSITION 1042) MARCH (POSITION 1043) APRIL (POSITION 1044) MAY (POSITION 1045) JUNE (POSITION 1046) JULY (POSITION 1047) AUGUST (POSITION 1048) SEPTEMBER (POSITION 1049) OCTOBER (POSITION 1050) NOVEMBER (POSITION 1051) DECEMBER (POSITION 1052)
50. ELIGIBLE STATE CHILD HEALTH INSURANCE PROGRAM (SCHIP) CODE	NUM	1	1041 1041	INDICATES WHETHER THE INDIVIDUAL WAS ELIGIBLE FOR THE CHILD HEALTH INSURANCE PROGRAM (SCHIP) IN THE RESPECTIVE MONTH. 1 DIGIT CODES: 0 = INDIVIDUAL WAS NOT A MEDICAID ELIGIBLE AND NOT ELIGIBLE FOR SCHIP DURING THE MONTH. 1 = INDIVIDUAL WAS A MEDICAID ELIGIBLE, BUT WAS NOT INCLUDED IN EITHER A MEDICAID EXPANSION SCHIP OR A SEPARATE TITLE XXI CHIP PROGRAM DURING THE MONTH. 2 = INDIVIDUAL WAS ENROLLED IN THE MEDICAID EXPANSION SCHIP PROGRAM (M-SCHIP) AND SUBJECT TO ENHANCED FEDERAL MATCHING FUNDS DURING THE MONTH. 3 = INDIVIDUAL WAS NOT A MEDICAID ELIGIBLE, BUT WAS INCLUDED IN A NON- MEDICAID EXPANSION TITLE XXI SCHIP PROGRAM DURING THE MONTH (S-SCHIP). REPORTING OF MSIS ELIGIBILITY RECORDS FOR THESE NON-MEDICAID SCHIP INDIVIDUALS IS OPTIONAL FOR STATES. 9 = SCHIP STATUS IS UNKNOWN SOURCE: MSIS ELIGIBILITY FILES: "CHIP-CODE"

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	
**** RECIPIENT CLAIMS SUMMARY REGION	REGION	1552	1053 2604	SUMMARIZED UTILIZATION AND PAYMENT DATA (INCLUDING PREMIUM PAYMENTS) FOR THE RECIPIENT FOR THE CALENDAR YEAR FROM MSIS CLAIMS FILES. UNLESS OTHERWISE NOTED, THESE DATA ELEMENTS EXCLUDE ENCOUNTER RECORDS (TYPE OF CLAIM = 3) AND SERVICE TRACKING CLAIMS (TYPE OF CLAIM = 4) AND INCLUDE ALL OTHER TYPES OF CLAIMS. SEE THE DATA DICTIONARY FOR THE 1999 CLAIMS FILES FOR A DEFINITION OF "TYPE OF CLAIM". THIS MEANS THAT AMOUNTS FROM INDIVIDUAL CLAIMS ARE ADDED TO COUNTS EVEN IF THOSE AMOUNTS ARE ZERO (OR NEGATIVE AS MAY BE THE CASE WITH UNAPPLIED ADJUSTMENTS - TYPE OF CLAIM = 2). THE EFFECT OF THIS DECISION IS TO CAPTURE MEDICAID PAID AMOUNTS IN THE PAYMENT SUMMARIES, REGARDLESS OF WHETHER MEDICAID PAID THE FULL BILL OR WHETHER THERE WERE OTHER PAYMENTS WHICH REDUCED THE MEDICAID PAYMENT (E.G. THIRD PARTY COVERAGE, OUT-OF-POCKET AND/OR SPEND DOWN AMOUNTS, MEDICARE PART A OR PART B PAYMENTS, ETC.).
51. RECIPIENT INDICATOR	CHAR	1	1053 1053	INDICATOR TO SHOW IF AND HOW THE ELIGIBLE RECEIVED A MEDICAID SERVICE DURING THE CALENDAR YEAR. AND WHETHER THOSE SERVICES WERE RECEIVED UNDER A FEE-FOR-SERVICE OR PRE-PAID PLAN. 1 DIGIT CODES: 0 = THE ELIGIBLE PERSON DID NOT RECEIVED ANY SERVICES 1 = THE ELIGIBLE PERSON HAD ONLY FEE-FOR-SERVICE CLAIMS (INCLUDING CLAIMS WITH \$0 PAID AMOUNTS) FOR TYPES OF SERVICE = 1-19, 23-54 AND 99. 2 = THE ELIGIBLE PERSON HAD ONLY PREMIUM PAYMENT CLAIMS (PRE-PAID PLAN) FOR TYPES OF SERVICE = 20-22. 3 = THE ELIGIBLE PERSON HAD ONLY ENCOUNTER RECORDS (PRE-PAID PLAN) FOR TYPES OF SERVICE = 1-19, 23-54, 99. 4 = THE ELIGIBLE PERSON HAD FEE-FOR-SERVICE AND PREMIUM PAYMENT CLAIMS, BUT NO ENCOUNTER RECORDS 5 = THE ELIGIBLE PERSON HAD PREMIUM PAYMENT CLAIMS AND ENCOUNTER RECORDS, BUT NO FEE-FOR-SERVICE CLAIMS 6 = THE ELIGIBLE PERSON HAD FEE-FOR-SERVICE CLAIMD AND ENCOUNTER RECORDS, BUT NO PREMIUM PAYMENT CLAIMS 7 = THE ELIGIBLE PERSON HAD FEE-FOR-SERVICE CLAIMS, PREMIUM PAYMENT CLAIMS AND ENCOUNTER RECORDS

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	
<p>USER NOTE: SEE DATA ELEMENT #83 IN THE "TYPE OF SERVICE TABLE GROUP" WHICH IS SIMILAR TO DATA ELEMENT #51. DATA ELEMENT #83 IS DIFFERENT IN THAT IT IS CREATED BY TYPE OF SERVICE, FOR EACH OF THE LISTED TYPES OF SERVICES AND IT DOES NOT INCLUDE CODE VALUES FOR PREMIUM PAYMENTS.</p> <p>SOURCE MSIS FILES CONTAIN RECORDS WITH MEDICAID PAYMENT AMOUNT = \$0 IF THE SERVICE WAS COVERED, BUT FULL PAYMENT WAS MADE BY ANOTHER PAYER (E.G. THIRD PARTY LIABILITY). THERE ARE ALSO INSTANCES OF CLAIMS WITH MEDICAID PAYID AMOUNT < \$0. THE RECIPIENT INDICATOR IS SET VALUE >= 1 IF THE BENEFICIARY HAS AT LEAST ONE CLAIM OF ANY TYPE, REGARDLESS OF THE VALUE OF MEDICAID AMOUNT PAID (< \$0, = \$0 OR > \$0).</p> <p>SOURCE: CREATED USING MSIS CLAIMS FILES</p>				

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	
----- **** INPATIENT HOSPITAL UTILIZATION SUMMARY	GROUP	18	1054 1071	INPATIENT HOSPITAL DISCHARGE, STAY, LENGTH OF STAY AND COVERED DAYS COUNTS IN THE MAX INPATIENT HOSPITAL FILE, INTERIM CLAIM RECORDS ARE COMBINED INTO A HOSPITAL STAY RECORD IF THEY HAVE THE SAME MSIS ELIGIBLE IDENTIFICATION NUMBER, THE SAME PROVIDER IDENTIFICATION NUMBER AND ARE FOR CONTIGUOUS OR OVERLAPPING PERIODS OF TIME. CLAIMS ARE DEFINED TO BE CONTIGUOUS IF THE ENDING DATE OF SERVICE ON A PREVIOUS CLAIM IS THE SAME DAY OR THE DAY BEFORE THE BEGINNING DATE OF SERVICE FOR THE NEXT CLAIM. HOWEVER, CONTIGUOUS CLAIMS ARE NOT COMBINED INTO THE SAME STAY IF THE "PATIENT STATUS CODE" INDICATES THAT THE PATIENT WAS DISCHARGED AND WAS ADMITTED AGAIN ON THE SAME DAY (OR THE NEXT DAY). IT IS POSSIBLE THAT SOME PATIENTS ARE ACTUALLY DISCHARGED (AND SOMETIMES READMITTED) BUT THEIR RECORDS DO NOT INDICATE A STATUS OF DISCHARGED BECAUSE THE RECORDS ARE EITHER CODED INCORRECTLY OR SIMPLY MISSING THE STATUS OF DISCHARGED. IN THESE INSTANCES, SEPARATE CONTIGUOUS STAYS MAY BE COMBINED INCORRECTLY. SEPARATE HOSPITAL STAY RECORDS ARE CREATED FOR SETS OF INTERIM CLAIMS FOR MOTHERS AND INFANTS WHERE SERVICES FOR THE MOTHER ARE REPORTED ON SEPARATE CLAIMS FROM SERVICES FOR THE BABY. THIS IS TRUE EVEN IF THE MOTHER AND BABY USE THE SAME MSIS ELIGIBLE IDENTIFICATION NUMBER. IN CONTRAST, IF THE PROVIDER HAS SUBMITTED CLAIMS WHERE SERVICES FOR THE MOTHER AND BABY ARE COMBINED ON THE SAME CLAIM, ONLY ONE STAY WILL BE REPORTED HERE. IN THIS INSTANCE, IT IS NOT POSSIBLE TO SEPARATE THE SERVICES FOR THE MOTHER AND BABY. THERE ARE CIRCUMSTANCES WHERE SEPARATE STAY RECORDS MAY BE CREATED FOR THE SAME HOSPITAL STAY: (1) IF THERE ARE MULTIPLE INTERIM CLAIMS WITH THE SAME ADMISSION DATE, BUT ONE OF THE INTERIM CLAIMS DURING THE SAY IS MISSING, SEPARATE STAY RECORDS WILL BE CREATED. THIS IS BECAUSE THERE IS A GAP OF ONE OR MORE DAYS BETWEEN THE ENDING DATE OF SERVICE ON ONE RECORD AND THE BEGINNING DATE OF SERVICE ON ANOTHER. (2) SOMETIMES, A HOSPITAL WILL SUBMIT A BILL FOR THE "CROSSOVER" PORTION OF A STAY USING THEIR MEDICARE PROVIDER IDENTIFIER AND WILL SUBMIT A SECOND BILL FOR THE "NON-CROSSOVER" PORTION OF THE SAME STAY USING THEIR MEDICAID PROVIDER IDENTIFIER. IN THIS SITUATION, SEPARATE STAY RECORDS ARE CREATED, BECAUSE THE RECORDS HAVE DIFFERENT PROVIDER IDENTIFIERS.

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	
				<p>(3) IF A HOSPITAL SUBMITS SEPARATE BILLS FROM DIFFERENT COST CENTERS IN THE HOSPITAL (E.G. ANCILLARY VERSUS ACCOMMODATION SERVICES), USING DIFFERENT PROVIDER IDENTIFIERS FOR THE COST CENTERS, SEPARATE STAY RECORDS ARE CREATED.</p> <p>FOR ALL CLAIMS IN A COMBINED SET: (1) MEDICAID PAYMENTS AND COVERED DAYS ARE SUMMED, (2) DIAGNOSIS AND PROCEDURE CODES ARE PICKED UP FROM ALL OF THE INTERIM CLAIMS, AND (3) DEMOGRAPHIC INFORMATION AND THE DATE OF PAYMENT ARE TAKEN FROM THE LAST CLAIM IN THE SET.</p> <p>THE FILE FOR A GIVEN YEAR CONTAINS STAY RECORDS WHERE THE LAST DATE OF SERVICE IS IN THAT YEAR (EVEN IF THE STAY BEGAN IN A PREVIOUS YEAR).</p>
52. RECIPIENT TOTAL INPATIENT DISCHARGE COUNT	NUM	3	1054 1056	<p>TOTAL NUMBER OF INPATIENT HOSPITAL DISCHARGES, FOR THE CALENDAR YEAR.</p> <p>3 DIGITS SIGNED (SAS USERS: ZONED DECIMAL - ZD3)</p> <p>USER NOTE: THIS DATA ELEMENT COUNTS THE NUMBER OF INPATIENT HOSPITAL STAYS WITH A PATIENT STATUS CODE OTHER THAN VALUE = 09, 30 OR 99 (ONLY RECORDS FROM THE HOSPITAL FILE WHERE THE PATIENT STATUS CODE INDICATES THAT THE PATIENT WAS DISCHARGED). SINCE SOME COMPLETED STAYS MAY NOT HAVE A PATIENT STATUS OF DISCHARGED (VALUE OTHER THAN = 09, 30 OR 99), DUE TO INCOMPLETE REPORTING, THIS COUNT MAY DIFFER FROM THE COUNT IN DATA ELEMENT #53. FOR THIS REASON AND OTHER REASONS DISCUSSED ABOVE, THIS DATA ELEMENT MAY UNDERCOUNT THE ACTUAL NUMBER OF COMPLETE HOSPITAL STAYS.</p> <p>SOURCE: CREATED USING MAX INPATIENT HOSPITAL RECORDS.</p>
53. RECIPIENT TOTAL INPATIENT STAY COUNT	NUM	3	1057 1059	<p>TOTAL NUMBER OF INPATIENT HOSPITAL STAYS, FOR THE CALENDAR YEAR.</p> <p>USER NOTE: THIS DATA ELEMENT COUNTS THE NUMBER OF INPATIENT HOSPITAL STAYS (ALL RECORDS FROM THE HOSPITAL FILE), REGARDLESS OF DISCHARGE STATUS. SINCE SOME COMPLETED STAYS MAY NOT HAVE A PATIENT STATUS OF DISCHARGED (VALUE OTHER THAN = 09, 30 OR 99), DUE TO INCOMPLETE REPORTING, THIS COUNT MAY DIFFER FROM THE COUNT IN DATA ELEMENT #52. FOR REASONS DISCUSSED ABOVE, THIS DATA ELEMENT MAY OVERCOUNT THE ACTUAL NUMBER OF COMPLETE HOSPITAL STAYS.</p> <p>3 DIGITS SIGNED (SAS USERS: ZONED DECIMAL - ZD3)</p> <p>SOURCE: CREATED USING MAX INPATIENT HOSPITAL RECORDS.</p>

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	
54. RECIPIENT TOTAL INPATIENT LENGTH OF STAY (LOS), IN DAYS (FOR DISCHARGES)	NUM	3	1060 1062	<p>TOTAL LENGTH OF STAY, IN DAYS, FOR INPATIENT HOSPITAL DISCHARGES, FOR THE CALENDAR YEAR.</p> <p>3 DIGITS SIGNED (SAS USERS: ZONED DECIMAL - ZD3)</p> <p>USER NOTE: THIS DATA ELEMENT COUNTS THE NUMBER OF DAYS FOR INPATIENT HOSPITAL STAYS WITH A PATIENT STATUS CODE OTHER THAN VALUE = 09, 30 OR 99 (ONLY RECORDS FROM THE HOSPITAL FILE WHERE THE PATIENT STATUS CODE INDICATES THAT THE PATIENT WAS DISCHARGED). SINCE SOME COMPLETED STAYS MAY NOT HAVE A PATIENT STATUS OF DISCHARGED (VALUE OTHER THAN = 09, 30 OR 99), DUE TO INCOMPLETE REPORTING, THIS COUNT MAY DIFFER FROM THE COUNT IN DATA ELEMENT #55.</p> <p>SOURCE: CREATED USING THE NUMBER OF DAYS FROM FIRST DATE OF SERVICE TO THE LAST DATE OF SERVICE (+1 DAY IF THEY OCCUR ON THE SAME DAY) FROM MAX INPATIENT HOSPITAL RECORDS WHERE THE PATIENT STATUS CODE INDICATES THAT THE PATIENT WAS DISCHARGED. IF EITHER FIRST DATE OF SERVICE OR DATE OF DISCHARGE ARE "BAD", LOS IS ZERO-FILLED. LOS IS CALCULATED FOR BOTH CROSSOVER AND NON-CROSSOVER INPATIENT HOSPITAL RECORDS.</p>
55. RECIPIENT TOTAL INPATIENT LENGTH OF STAY (LOS), IN DAYS (FOR STAYS)	NUM	3	1063 1065	<p>TOTAL LENGTH OF STAY, IN DAYS, FOR INPATIENT HOSPITAL STAYS, FOR THE CALENDAR YEAR.</p> <p>3 DIGITS SIGNED (SAS USERS: ZONED DECIMAL - ZD3)</p> <p>USER NOTE: THIS DATA ELEMENT COUNTS THE NUMBER OF DAYS FOR INPATIENT HOSPITAL STAYS (ALL RECORDS FROM THE HOSPITAL FILE), REGARDLESS OF DISCHARGE STATUS. SINCE SOME COMPLETED STAYS MAY NOT HAVE A PATIENT STATUS OF DISCHARGED (VALUE OTHER THAN = 09, 30 OR 99), DUE TO INCOMPLETE REPORTING, THIS COUNT MAY DIFFER FROM THE COUNT IN DATA ELEMENT #54.</p> <p>SOURCE: CREATED USING THE NUMBER OF DAYS FROM FIRST DATE OF SERVICE TO THE LAST DATE OF SERVICE (+1 DAY IF THEY OCCUR ON THE SAME DAY) FROM MAX INPATIENT HOSPITAL RECORDS. IF EITHER FIRST DATE OR LAST DATE OF SERVICE ARE "BAD", LOS IS ZERO-FILLED. LOS IS CALCULATED FOR BOTH CROSSOVER AND NON-CROSSOVER INPATIENT HOSPITAL RECORDS.</p>

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
56. RECIPIENT TOTAL INPATIENT COVERED DAY COUNT (FOR DISCHARGES)	NUM	3	1066	1068	TOTAL MEDICAID COVERED DAYS OF CARE FOR INPATIENT HOSPITAL DISCHARGES, FOR THE CALENDAR YEAR. 3 DIGITS SIGNED (SAS USERS: ZONED DECIMAL - ZD3) <i>USER NOTE: THIS DATA ELEMENT COUNTS THE NUMBER OF MEDICAID COVERED INPATIENT DAYS FOR INPATIENT HOSPITAL STAYS WITH A PATIENT STATUS CODE OTHER THAN VALUE = 09, 30 OR 99 (ONLY RECORDS FROM THE HOSPITAL FILE WHERE THE PATIENT STATUS CODE INDICATES THAT THE PATIENT WAS DISCHARGED). SINCE SOME COMPLETED STAYS MAY NOT HAVE A PATIENT STATUS OF DISCHARGED (VALUE OTHER THAN = 09, 30 OR 99), DUE TO INCOMPLETE REPORTING, THIS COUNT MAY DIFFER FROM THE COUNT IN DATA ELEMENT #57.</i> SOURCE: CREATED USING MEDICAID COVERED INPATIENT DAYS FOR MAX INPATIENT HOSPITAL RECORDS. AS THIS COUNT IS BEING AGGREGATED ACROSS RECORDS, THERE ARE TWO DECISION RULES THAT APPLY: (1) IF AN INDIVIDUAL RECORD IS A MEDICARE CROSSOVER CLAIM, THEN COVERED DAYS IS SET VALUE = 0, AND (2) IF AN INDIVIDUAL CLAIM IS NOT A MEDICARE CROSSOVER CLAIM AND COVERED DAYS ARE MISSING, THEN COVERED DAYS IS SET VALUE = THE NUMBER OF DAYS FROM BEGINNING TO ENDING DATE OF SERVICE (+1 DAY IF THEY OCCUR ON THE SAME DAY).
57. RECIPIENT TOTAL INPATIENT COVERED DAY COUNT (FOR STAYS)	NUM	3	1069	1071	TOTAL MEDICAID COVERED DAYS OF CARE FOR INPATIENT HOSPITAL STAYS, FOR THE CALENDAR YEAR. 3 DIGITS SIGNED (SAS USERS: ZONED DECIMAL - ZD3) <i>USER NOTE: THIS DATA ELEMENT COUNTS THE NUMBER OF MEDICAID COVERED INPATIENT DAYS FOR INPATIENT HOSPITAL STAYS, REGARDLESS OF DISCHARGE STATUS(ALL RECORDS FROM THE HOSPITAL FILE). SINCE SOME COMPLETED STAYS MAY NOT HAVE A PATIENT STATUS OF DISCHARGED (VALUE OTHER THAN = 09, 30 OR 99), DUE TO INCOMPLETE REPORTING, THIS COUNT MAY DIFFER FROM THE COUNT IN DATA ELEMENT #56.</i> SOURCE: CREATED USING MEDICAID COVERED INPATIENT DAYS FOR MAX INPATIENT HOSPITAL RECORDS. AS THIS COUNT IS BEING AGGREGATED ACROSS RECORDS, THERE ARE TWO DECISION RULES THAT APPLY: (1) IF AN INDIVIDUAL RECORD IS A MEDICARE CROSSOVER CLAIM, THEN COVERED DAYS IS SET VALUE = 0, AND (2) IF AN INDIVIDUAL RECORD IS NOT A MEDICARE CROSSOVER CLAIM AND COVERED DAYS IS MISSING, THEN COVERED DAYS IS SET VALUE = THE NUMBER OF DAYS FROM BEGINNING TO ENDING DATE OF SERVICE (+1 DAY IF THEY OCCUR ON THE SAME DAY).

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	
**** LONG TERM CARE UTILIZATION SUMMARY	GROUP	15	1072 1086	DAY COUNTS FOR SELECTED TYPES OF LONG TERM CARE SERVICES.
58. RECIPIENT LONG TERM CARE MENTAL HOSPITAL FOR THE AGED COVERED DAY COUNT	NUM	3	1072 1074	TOTAL NUMBER OF MEDICAID COVERED DAYS FOR THE RECIPIENT IN A MENTAL HOSPITAL FOR THE AGED (NOT A HOSPITAL) FOR THE CALENDAR YEAR. 3 DIGITS SIGNED (SAS USERS: ZONED DECIMAL - ZD3) <i>USER NOTE: DAYS MAY BE > 365 IN SOME STATES AND FOR SOME LONG-TERM CARE FACILITIES. THIS CAN HAPPEN IF THE NUMBER OF COVERED DAYS FOR A GIVEN MONTH WAS REPORTED ON MULTIPLE CLAIMS (E.G. A CLAIM FOR PER DIEM PAYMENT AND A CLAIM FOR SUPPLEMENTAL SERVICES). IT IS NOT POSSIBLE TO SEPARATELY IDENTIFY PER DIEM CLAIMS VERSUS SUPPLEMENTAL CLAIMS. SO, IF DAYS ARE > 365, THIS SHOULD ALERT A DATA USER OF THE POTENTIAL OVERREPORTING OF THE NUMBER OF COVERED DAYS. WHEN DAYS ARE > 365, USERS MAY WANT TO EXAMINE RECORDS BY MONTH TO ESTIMATE THE ACTUAL NUMBER OF DAYS. DAYS ARE SET VALUE <= 998.</i> SOURCE: CREATED USING THE NUMBER OF MEDICAID COVERED INPATIENT DAYS FROM MSIS CLAIMS FOR TOS = 2 (MENTAL HOSPITAL SERVICES FOR THE AGED). AS THIS COUNT IS BEING AGGREGATED ACROSS CLAIMS, THERE IS A DECISION RULE THAT APPLIES: IF, IN AN INDIVIDUAL CLAIM, THE SUM OF COPAYMENTS AND DEDUCTIBLES IS GREATER THAN OR EQUAL TO MEDICAID PAYMENTS (E.G. IN A CROSSOVER CLAIM), THEN THESE DAYS ARE SET VALUE = 0. THIS IS BECAUSE MEDICAID WOULD BE PAYING ONLY COPAYMENT OR DEDUCTIBLE AMOUNTS, NOT FOR ACTUAL COVERED DAYS OF STAY. FOR 1995 AND EARLIER YEARS, THESE DAYS WERE NOT SET VALUE = 0 FOR CROSSOVER CLAIMS. IF THE CLAIM IS NOT A MEDICARE CROSSOVER CLAIM AND THESE DAYS ARE MISSING, THE CLAIM IS NOT EDITED. THIS IS BECAUSE IT IS NOT POSSIBLE TO DETERMINE WHETHER THE CLAIM IS FOR ACTUAL DAYS OF STAY (ROOM AND BOARD) OR ANCILLARY SERVICES (DURING THE STAY). BECAUSE OF THIS AMBIGUITY, EDITING THE CLAIM COULD INTRODUCE ERRORS AND/OR DOUBLE COUNT THESE DAYS.

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	
59. RECIPIENT LONG TERM CARE INPATIENT PSYCHIATRIC FACILITY (AGE < 21) COVERED DAY COUNT	NUM	3	1075 1077	TOTAL NUMBER OF MEDICAID COVERED DAYS FOR THE RECIPIENT IN AN INPATIENT PSYCHIATRIC FACILITY FOR INDIVIDUALS UNDER THE AGE OF 21 (NOT A HOSPITAL) FOR THE CALENDAR YEAR.

3 DIGITS SIGNED (SAS USERS: ZONED DECIMAL - ZD3)

USER NOTE: DAYS MAY BE > 365 IN SOME STATES AND FOR SOME LONG-TERM CARE FACILITIES. THIS CAN HAPPEN IF THE NUMBER OF COVERED DAYS FOR A GIVEN MONTH WAS REPORTED ON MULTIPLE CLAIMS (E.G. A CLAIM FOR PER DIEM PAYMENT AND A CLAIM FOR SUPPLEMENTAL SERVICES). IT IS NOT POSSIBLE TO SEPARATELY IDENTIFY PER DIEM CLAIMS VERSUS SUPPLEMENTAL CLAIMS. SO, IF DAYS ARE > 365, THIS SHOULD ALERT A DATA USER OF THE POTENTIAL OVERREPORTING OF THE NUMBER OF COVERED DAYS. WHEN DAYS ARE > 365, USERS MAY WANT TO EXAMINE RECORDS BY MONTH TO ESTIMATE THE ACTUAL NUMBER OF DAYS. DAYS ARE SET VALUE <= 998.

SOURCE: CREATED USING THE NUMBER OF MEDICAID COVERED INPATIENT DAYS FROM MSIS CLAIMS FOR THE TOS = 4 (INPATIENT PSYCHIATRIC FACILITY FOR INDIVIDUALS UNDER THE AGE OF 21). AS THIS COUNT IS BEING AGGREGATED ACROSS CLAIMS, THERE IS A DECISION RULE THAT APPLIES: IF, IN AN INDIVIDUAL CLAIM, THE SUM OF COPAYMENTS AND DEDUCTIBLES IS GREATER THAN OR EQUAL TO MEDICAID PAYMENTS (E.G. IN A CROSSOVER CLAIM), THEN THESE DAYS ARE SET VALUE = 0. THIS IS BECAUSE MEDICAID WOULD BE PAYING ONLY COPAYMENT OR DEDUCTIBLE AMOUNTS, NOT FOR ACTUAL COVERED DAYS OF STAY. FOR 1995 AND EARLIER YEARS, THESE DAYS WERE NOT SET VALUE = 0 FOR CROSSOVER CLAIMS. IF THE CLAIM IS NOT A MEDICARE CROSSOVER CLAIM AND THESE DAYS ARE MISSING, THE CLAIM IS NOT EDITED. THIS IS BECAUSE IT IS NOT POSSIBLE TO DETERMINE WHETHER THE CLAIM IS FOR ACTUAL DAYS OF STAY (ROOM AND BOARD) OR ANCILLARY SERVICES (DURING THE STAY). BECAUSE OF THIS AMBIGUITY, EDITING THE CLAIM COULD INTRODUCE ERRORS AND/OR DOUBLE COUNT THESE DAYS.

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS			CONTENTS
		LENGTH	BEG	END	
60. RECIPIENT INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED - ICF-MR - COVERED DAY COUNT	NUM	3	1078	1080	<p>TOTAL NUMBER OF MEDICAID COVERED DAYS FOR THE RECIPIENT IN AN INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED - ICF-MR - FOR THE CALENDAR YEAR.</p> <p>3 DIGITS SIGNED (SAS USERS: ZONED DECIMAL - ZD3)</p> <p>USER NOTE: THIS COUNT EXCLUDES LEAVE DAYS. IF MEDICAID PAYMENTS WERE MADE FOR LEAVE DAYS, PAYMENTS PER DAY (USING THESE DAY COUNTS) MAY BE OVERSTATED. CONVERSELY, IF MEDICAID DID NOT PAY FOR LEAVE DAYS AND LEAVE DAYS WERE ADDED TO COVERED DAY COUNTS, PAYMENTS PER DAY MAY BE UNDERSTATED. STATES MAY PAY LOWER AMOUNTS THAN STANDARD DAY RATES OR MAY NOT PAY AT ALL FOR LEAVE DAYS. SINCE IT IS NOT POSSIBLE TO DETERMINE WHEN TO ADD (AND WHEN NOT TO ADD) LEAVE DAYS TO COVERED DAY COUNTS, THEY ARE EXCLUDED.</p> <p>DAYS MAY BE > 365 IN SOME STATES AND FOR SOME LONG-TERM CARE FACILITIES. THIS CAN HAPPEN IF THE NUMBER OF COVERED DAYS FOR A GIVEN MONTH WAS REPORTED ON MULTIPLE CLAIMS (E.G. A CLAIM FOR PER DIEM PAYMENT AND A CLAIM FOR SUPPLEMENTAL SERVICES). IT IS NOT POSSIBLE TO SEPARATELY IDENTIFY PER DIEM CLAIMS VERSUS SUPPLEMENTAL CLAIMS. SO, IF DAYS ARE > 365, THIS SHOULD ALERT A DATA USER OF THE POTENTIAL OVERREPORTING OF THE NUMBER OF COVERED DAYS. WHEN DAYS ARE > 365, USERS MAY WANT TO EXAMINE RECORDS BY MONTH TO ESTIMATE THE ACTUAL NUMBER OF DAYS. DAYS ARE SET VALUE <= 998.</p> <p>SOURCE: CREATED USING THE NUMBER OF MEDICAID NURSING FACILITY DAYS FROM MSIS CLAIMS FOR THE TOS = 5 (INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED - ICF-MR). AS THIS COUNT IS BEING AGGREGATED ACROSS CLAIMS, THERE IS A DECISION RULE THAT APPLIES: IF, IN AN INDIVIDUAL CLAIM, THE SUM OF COPAYMENTS AND DEDUCTIBLES IS GREATER THAN OR EQUAL TO MEDICAID PAYMENTS (E.G. IN A CROSSOVER CLAIM), THEN THESE DAYS ARE SET VALUE = 0. THIS IS BECAUSE MEDICAID WOULD BE PAYING ONLY COPAYMENT OR DEDUCTIBLE AMOUNTS, NOT FOR ACTUAL COVERED DAYS OF STAY. FOR 1995 AND EARLIER YEARS, THESE DAYS WERE NOT SET VALUE = 0 FOR CROSSOVER CLAIMS. IF THE CLAIM IS NOT A MEDICARE CROSSOVER CLAIM AND THESE DAYS ARE MISSING, THE CLAIM IS NOT EDITED. THIS IS BECAUSE IT IS NOT POSSIBLE TO DETERMINE WHETHER THE CLAIM IS FOR ACTUAL DAYS OF STAY (ROOM AND BOARD) OR ANCILLARY SERVICES (DURING THE STAY). BECAUSE OF THIS AMBIGUITY, EDITING THE CLAIM COULD INTRODUCE ERRORS AND/OR DOUBLE COUNT THESE DAYS.</p>

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	
61. RECIPIENT NURSING FACILITY - NF - COVERED DAY COUNT	NUM	3	1081 1083	TOTAL NUMBER OF MEDICAID COVERED DAYS FOR THE RECIPIENT IN AN NURSING FACILITY FOR THE CALENDAR YEAR. 3 DIGITS SIGNED (SAS USERS: ZONED DECIMAL - ZD3) USER NOTE: THIS COUNT EXCLUDE LEAVE DAYS. IF MEDICAID PAYMENTS WERE MADE FOR LEAVE DAYS, PAYMENTS PER DAY (USING THESE DAY COUNTS) MAY BE OVERSTATED. CONVERSELY, IF MEDICAID DID NOT PAY FOR LEAVE DAYS AND LEAVE DAYS WERE ADDED TO COVERED DAY COUNTS, PAYMENTS PER DAY MAY BE UNDERSTATED. STATES MAY PAY LOWER AMOUNTS THAN STANDARD DAY RATES OR MAY NOT PAY AT ALL FOR LEAVE DAYS. SINCE IT IS NOT POSSIBLE TO DETERMINE WHEN TO ADD (AND WHEN NOT TO ADD) LEAVE DAYS TO COVERED DAY COUNTS. DAYS MAY BE > 365 IN SOME STATES AND FOR SOME LONG-TERM CARE FACILITIES. THIS CAN HAPPEN IF THE NUMBER OF COVERED DAYS FOR A GIVEN MONTH WAS REPORTED ON MULTIPLE CLAIMS (E.G. A CLAIM FOR PER DIEM PAYMENT AND A CLAIM FOR SUPPLEMENTAL SERVICES). IT IS NOT POSSIBLE TO SEPARATELY IDENTIFY PER DIEM CLAIMS VERSUS SUPPLEMENTAL CLAIMS. SO, IF DAYS ARE > 365, THIS SHOULD ALERT A DATA USER OF THE POTENTIAL OVERREPORTING OF THE NUMBER OF COVERED DAYS. WHEN DAYS ARE > 365, USERS MAY WANT TO EXAMINE RECORDS BY MONTH TO ESTIMATE THE ACTUAL NUMBER OF DAYS. DAYS ARE SET VALUE <= 998. SOURCE: CREATED USING THE NUMBER OF MEDICAID NURSING FACILITY DAYS FROM MSIS CLAIMS FOR THE TOS = 7 (NURSING FACILITY SERVICES - NFS - ALL OTHER). AS THIS COUNT IS BEING AGGREGATED ACROSS CLAIMS, THERE IS A DECISION RULE THAT APPLIES: IF, IN AN INDIVIDUAL CLAIM, THE SUM OF COPAYMENTS AND DEDUCTIBLES IS GREATER THAN OR EQUAL TO MEDICAID PAYMENTS (E.G. IN A CROSSOVER CLAIM), THEN THESE DAYS ARE SET VALUE = 0. THIS IS BECAUSE MEDICAID WOULD BE PAYING ONLY COPAYMENT OR DEDUCTIBLE AMOUNTS, NOT FOR ACTUAL COVERED DAYS OF STAY. FOR 1995 AND EARLIER YEARS, THESE DAYS WERE NOT SET VALUE = 0 FOR CROSSOVER CLAIMS. IF THE CLAIM IS NOT A MEDICARE CROSSOVER CLAIM AND THESE DAYS ARE MISSING, THE CLAIM IS NOT EDITED. THIS IS BECAUSE IT IS NOT POSSIBLE TO DETERMINE WHETHER THE CLAIM IS FOR ACTUAL DAYS OF STAY (ROOM AND BOARD) OR ANCILLARY SERVICES (DURING THE STAY). BECAUSE OF THIS AMBIGUITY, EDITING THE CLAIM COULD INTRODUCE ERRORS AND/OR DOUBLE COUNT THESE DAYS.

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	
62. RECIPIENT LONG TERM CARE COVERED DAY COUNT	NUM	3	1084 1086	TOTAL NUMBER OF MEDICAID COVERED DAYS FOR THE RECIPIENT IN A LONG TERM CARE FACILITY (NOT A HOSPITAL), FOR THE CALENDAR YEAR. 3 DIGITS SIGNED (SAS USERS: ZONED DECIMAL - ZD3) <i>USER NOTE: DAYS MAY BE > 365 IN SOME STATES AND FOR SOME LONG-TERM CARE FACILITIES. THIS CAN HAPPEN IF THE NUMBER OF COVERED DAYS FOR A GIVEN MONTH WAS REPORTED ON MULTIPLE CLAIMS (E.G. A CLAIM FOR PER DIEM PAYMENT AND A CLAIM FOR SUPPLEMENTAL SERVICES). IT IS NOT POSSIBLE TO SEPARATELY IDENTIFY PER DIEM CLAIMS VERSUS SUPPLEMENTAL CLAIMS. SO, IF DAYS ARE > 365, THIS SHOULD ALERT A DATA USER OF THE POTENTIAL OVERREPORTING OF THE NUMBER OF COVERED DAYS. WHEN DAYS ARE > 365, USERS MAY WANT TO EXAMINE RECORDS BY MONTH TO ESTIMATE THE ACTUAL NUMBER OF DAYS. DAYS ARE SET VALUE <= 998.</i> SOURCE: CREATED BY SUMMING THE COVERED DAY COUNTS FROM DATA ELEMENT #58 (RECIPIENT MENTAL HOSPITAL FOR THE AGED COVERED DAY COUNT), DATA ELEMENT #59 (RECIPIENT INPATIENT PSYCHIATRIC FACILITY (AGE < 21) COVERED DAY COUNT), DATA ELEMENT #60 (RECIPIENT INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED - ICF-MR - COVERED DAY COUNT) AND DATA ELEMENT #61 (RECIPIENT NURSING FACILITY - NF - COVERED DAY COUNT).

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS			CONTENTS
		LENGTH	BEG	END	
**** CLAIMS PAYMENT SUMMARY	GROUP	60	1087	1146	THE DATA ELEMENTS IN THIS GROUP SUMMARIZE CLAIMS COUNTS AND PAYMENT AMOUNTS.
63. RECIPIENT TOTAL MEDICAID RECORD COUNT	NUM	5	1087	1091	<p>RECIPIENT'S TOTAL NUMBER OF FEE-FOR-SERVICE CLAIMS, PREMIUM PAYMENT CLAIMS AND ENCOUNTER RECORDS FOR THE CALENDAR YEAR, FOR ALL TYPES OF SERVICE AND ANY TYPE OF CLAIM.</p> <p>5 DIGITS SIGNED (SAS USERS: ZONED DECIMAL - ZD5)</p> <p><i>USER NOTES: THIS IS A SUM OF THE COUNTS IN DATA ELEMENTS #64-66. MSIS RECORDS WITH TYPE OF CLAIM = 4 (SERVICE TRACKING CLAIM) ARE EXCLUDED FROM ALL MAX FILES.</i></p> <p>SOURCE: MSIS CLAIMS FILES.</p>
64. RECIPIENT TOTAL MEDICAID FEE-FOR-SERVICE CLAIM COUNT	NUM	5	1092	1096	<p>RECIPIENT'S TOTAL NUMBER OF FEE-FOR-SERVICE CLAIMS FOR THE CALENDAR YEAR, FOR TYPES OF SERVICE = 1-19, 23-54 AND 99 AND TYPE OF CLAIM = 1 (FEE-FOR-SERVICE) OR TYPE OF CLAIM = 5 (SUPPLEMENTAL PAYMENT).</p> <p>5 DIGITS SIGNED (SAS USERS: ZONED DECIMAL - ZD5)</p> <p>SOURCE: MSIS CLAIMS FILES.</p>
65. RECIPIENT TOTAL MEDICAID PRE-PAID PLAN PREMIUM PAYMENT RECORD COUNT	NUM	5	1097	1101	<p>RECIPIENT'S TOTAL NUMBER OF PREMIUM PAYMENT CLAIMS FOR THE CALENDAR YEAR, FOR TYPES OF SERVICE = 20-22.</p> <p>5 DIGITS SIGNED (SAS USERS: ZONED DECIMAL - ZD5)</p> <p><i>USER NOTE: RECORDS WITH TYPES OF SERVICE = 20-22 SHOULD HAVE TYPE OF CLAIM = 2 (CAPITATED PAYMENT). IF NOT, IT IS MORE LIKELY THAT TYPE OF SERVICE IS CORRECT. SO, WE COUNT RECORDS HERE WITH TYPES OF SERVICE = 20-22 AND ANY VALUE FOR TYPE OF CLAIM.</i></p> <p>SOURCE: MSIS CLAIMS FILES.</p>
66. RECIPIENT TOTAL MEDICAID ENCOUNTER RECORD COUNT	NUM	5	1102	1106	<p>RECIPIENT'S TOTAL NUMBER OF ENCOUNTER RECORDS FOR THE CALENDAR YEAR. FOR TYPES OF SERVICE = 1-19, 23-54 AND 99 AND TYPE OF CLAIM = 3 (ENCOUNTER RECORD).</p> <p>5 DIGITS SIGNED (SAS USERS: ZONED DECIMAL - ZD5)</p> <p>SOURCE: MSIS CLAIMS FILES.</p>

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	
67. RECIPIENT TOTAL MEDICAID PAYMENT AMOUNT	NUM	8	1107 1114	TOTAL AMOUNT OF MONEY PAID BY MEDICAID FOR THE RECIPIENT DURING THE CALENDAR YEAR (FEE-FOR-SERVICE AND PREMIUM PAYMENTS), FOR ALL TYPES OF SERVICE AND ANY TYPE OF CLAIM. 8 DIGITS SIGNED (SAS USERS: ZONED DECIMAL - ZD8) <i>USER NOTES: THIS IS A SUM OF THE AMOUNTS IN DATA ELEMENTS #68-69. ENCOUNTER RECORDS (TYPE OF CLAIM = 3) HAVE \$0 PAYMENT AMOUNTS. MSIS RECORDS WITH TYPE OF CLAIM = 4 (SERVICE TRACKING CLAIM) ARE EXCLUDED FROM ALL MAX FILES.</i> SOURCE: MSIS CLAIMS FILES
68. RECIPIENT TOTAL MEDICAID FEE-FOR-SERVICE PAYMENT AMOUNT	NUM	8	1115 1122	AMOUNT OF MONEY PAID BY MEDICAID (UNDER FEE-FOR-SERVICE) FOR THE RECIPIENT DURING THE CALENDAR YEAR, FOR TYPES OF SERVICE = 1-19, 23-54 AND 99 AND TYPE OF CLAIM = 1 (FEE-FOR-SERVICE) OR TYPE OF CLAIM = 5 (SUPPLEMENTAL PAYMENT). 8 DIGITS SIGNED (SAS USERS: ZONED DECIMAL - ZD8) <i>USER NOTE: ENCOUNTER RECORDS (TYPE OF CLAIM = 3) HAVE \$0 PAYMENT AMOUNTS.</i> SOURCE: MSIS CLAIMS FILES
69. RECIPIENT TOTAL MEDICAID PRE-PAID PLAN PREMIUM PAYMENT AMOUNT	NUM	8	1123 1130	AMOUNT OF MONEY PAID BY MEDICAID (PREMIUM PAYMENTS TO PREPAID PLANS) FOR THE RECIPIENT DURING THE CALENDAR YEAR, FOR TYPES OF SERVICE = 20-22. 8 DIGITS SIGNED (SAS USERS: ZONED DECIMAL - ZD8) <i>USER NOTE: RECORDS WITH TYPES OF SERVICE = 20-22 SHOULD HAVE TYPE OF CLAIM = 2 (CAPITATED PAYMENT). IF NOT, IT IS MORE LIKELY THAT TYPE OF SERVICE IS CORRECT. SO, WE COUNT RECORDS HERE WITH TYPES OF SERVICE = 20-22 AND ANY VALUE FOR TYPE OF CLAIM. ALSO, ENCOUNTER RECORDS (TYPE OF CLAIM = 3) HAVE \$0 PAYMENT AMOUNTS.</i> SOURCE: MSIS CLAIMS FILES

1

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS			CONTENTS
		LENGTH	BEG	END	
70. RECIPIENT TOTAL MEDICAID CHARGE AMOUNT	NUM	8	1131	1138	TOTAL AMOUNT OF CHARGES BY PROVIDERS TO MEDICAID FOR THE RECIPIENT DURING THE CALENDAR YEAR. 8 DIGITS SIGNED (SAS USERS: ZONED DECIMAL - ZD8) <i>USER NOTE: THIS AMOUNT IS NOT APPLICABLE FOR ENCOUNTER OR PREMIUM PAYMENT RECORDS.</i> SOURCE: MSIS CLAIMS FILES
71. RECIPIENT TOTAL THIRD PARTY PAYMENT AMOUNT	NUM	8	1139	1146	TOTAL NON-MEDICAID PAYMENTS FOR SERVICES FOR THE RECIPIENT DURING THE CALENDAR YEAR. 8 DIGITS SIGNED (SAS USERS: ZONED DECIMAL - ZD8) <i>USER NOTE: THIS AMOUNT IS NOT APPLICABLE FOR ENCOUNTER OR PREMIUM PAYMENT RECORDS.</i> SOURCE: MSIS CLAIMS FILES

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	
**** PROGRAM TYPE SUMMARY	GROUP	330	1147 1476	<p>THE DATA ELEMENTS IN THIS GROUP SUMMARIZE CLAIMS COUNTS AND PAYMENT AMOUNTS, BY TYPE OF SPECIAL PROGRAM UNDER WHICH THE SERVICE WAS PROVIDED. ENCOUNTER RECORDS (TYPE OF CLAIM = 3) ARE EXCLUDED FROM THESE COUNTS. THERE ARE SIX OCCURRENCES OF THIS GROUP, ONE FOR EACH OF THE MSIS PROGRAM TYPE CODE VALUES, EXCLUDING EPSDT. [ALTHOUGH EPSDT MAY BE VIEWED AS A PROGRAM BY SOME, IT CAN BE MORE ACCURATELY DESCRIBED AS A GROUP OF SERVICES, WITH A STRONG EMPHASIS ON PREVENTIVE CARE. HOWEVER, THERE IS NO STANDARD DEFINITION OF EPSDT SERVICES AND THERE ARE NO STANDARD REPORTING REQUIREMENTS FOR EPSDT SERVICES IN MEDICAID DATA SYSTEMS. THEREFORE, THERE IS SUBSTANTIAL VARIATION IN REPORTING FOR EPSDT ACROSS STATES. FOR THESE REASONS, USE OF TYPE OF PROGRAM = 1 (EPSDT) IS UNRELIABLE FOR CROSS-STATE COMPARISONS OR DEVELOPMENT OF NATIONAL STATISTICS.].</p> <p>FOR EACH PROGRAM TYPE CODE, THERE ARE TEN DATA ELEMENTS. THERE ARE COUNTS OF RECORDS AND SUMMED PAYMENT AMOUNTS FROM EACH OF THE FOUR MAX CLAIMS FILES (INPATIENT HOSPITAL, LONG TERM CARE, OTHER SERVICES AND PRESCRIPTION DRUG). IN ADDITION, THERE ARE TOTALS THAT ARE SUMS ACROSS THE FOUR CLAIMS FILES. USERS ARE REMINDED THAT SELECTED MAX TYPE OF SERVICE CODE VALUES CAN BE FOUND IN MORE THAN ONE OF THE SRMF CLAIMS FILES (E.G. DURABLE MEDICAL EQUIPMENT AND SUPPLIES CAN BE FOUND IN BOTH THE OTHER SERVICES FILE AND THE PRESCRIPTION DRUG FILE).</p> <p>PROGRAM TYPE 6 IS USED TO REPORT SERVICES PROVIDED TO RECIPIENTS OF HOME AND COMMUNITY-BASED SERVICES FOR INDIVIDUALS AGE 65 AND OLDER UNDER SECTION 1915(d). PROGRAM TYPE 7 IS USED TO REPORT SERVICES PROVIDED UNDER A SECTION 1915(c) WAIVER. SEE THE "MEDICAID STATISTICAL INFORMATION SYSTEM (MSIS) - TAPE SPECIFICATIONS AND DATA DICTIONARY", ATTACHMENT 5 FOR ADDITIONAL INFORMATION ON PROGRAM TYPES.</p> <p>THE EXAMPLES ARE FOR PROGRAM TYPE 2 - FAMILY PLANNING.</p> <p>PROGRAM TYPE 2 - FAMILY PLANNING (POSITIONS 1147 TO 1201) NUMBER OF INPATIENT HOSPITAL RECORDS (POSITIONS 1147 TO 1149) PAYMENTS FOR INPATIENT HOSPITAL SERVICES (POSITIONS 1150 TO 1157) NUMBER OF LONG TERM CARE RECORDS (POSITIONS 1158 TO 1160) PAYMENTS FOR LONG TERM CARE SERVICES (POSITIONS 1161 TO 1168) NUMBER OF OTHER SERVICE RECORDS (POSITIONS 1169 TO 1171) PAYMENTS FOR OTHER SERVICES (POSITIONS 1172 TO 1179) NUMBER OF PRESCRIPTION DRUG RECORDS (POSITIONS 1180 TO 1182) PAYMENTS FOR PRESCRIPTION DRUGS (POSITIONS 1183 TO 1190) NUMBER OF TOTAL RECORDS (POSITIONS 1191 TO 1193) TOTAL PAYMENTS (POSITIONS 1194 TO 1201)</p>

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	
				PROGRAM TYPE 3 - RURAL HEALTH CLINIC (POSITIONS 1202 TO 1256)
				NUMBER OF INPATIENT HOSPITAL RECORDS (POSITIONS 1202 TO 1204)
				PAYMENTS FOR INPATIENT HOSPITAL SERVICES (POSITIONS 1205 TO 1212)
				NUMBER OF LONG TERM CARE RECORDS (POSITIONS 1213 TO 1215)
				PAYMENTS FOR LONG TERM CARE SERVICES (POSITIONS 1216 TO 1223)
				NUMBER OF OTHER SERVICE RECORDS (POSITIONS 1224 TO 1226)
				PAYMENTS FOR OTHER SERVICES (POSITIONS 1227 TO 1234)
				NUMBER OF PRESCRIPTION DRUG RECORDS (POSITIONS 1235 TO 1237)
				PAYMENTS FOR PRESCRIPTION DRUGS (POSITIONS 1238 TO 1245)
				NUMBER OF TOTAL RECORDS (POSITIONS 1246 TO 1248)
				TOTAL PAYMENTS (POSITIONS 1249 TO 1256)
				PROGRAM TYPE 4 - FEDERALLY QUALIFIED HEALTH CENTERS - FQHCs
				(POSITIONS 1257 TO 1311)
				NUMBER OF INPATIENT HOSPITAL RECORDS (POSITIONS 1257 TO 1259)
				PAYMENTS FOR INPATIENT HOSPITAL SERVICES (POSITIONS 1260 TO 1267)
				NUMBER OF LONG TERM CARE RECORDS (POSITIONS 1268 TO 1270)
				PAYMENTS FOR LONG TERM CARE SERVICES (POSITIONS 1271 TO 1278)
				NUMBER OF OTHER SERVICE RECORDS (POSITIONS 1279 TO 1281)
				PAYMENTS FOR OTHER SERVICES (POSITIONS 1282 TO 1289)
				NUMBER OF PRESCRIPTION DRUG RECORDS (POSITIONS 1290 TO 1292)
				PAYMENTS FOR PRESCRIPTION DRUGS (POSITIONS 1293 TO 1300)
				NUMBER OF TOTAL RECORDS (POSITIONS 1301 TO 1303)
				TOTAL PAYMENTS (POSITIONS 1304 TO 1311)
				PROGRAM TYPE 5 - INDIAN HEALTH SERVICES (POSITIONS 1312 TO 1366)
				NUMBER OF INPATIENT HOSPITAL RECORDS (POSITIONS 1312 TO 1314)
				PAYMENTS FOR INPATIENT HOSPITAL SERVICES (POSITIONS 1315 TO 1322)
				NUMBER OF LONG TERM CARE RECORDS (POSITIONS 1323 TO 1325)
				PAYMENTS FOR LONG TERM CARE SERVICES (POSITIONS 1326 TO 1333)
				NUMBER OF OTHER SERVICE RECORDS (POSITIONS 1334 TO 1336)
				PAYMENTS FOR OTHER SERVICES (POSITIONS 1337 TO 1344)
				NUMBER OF PRESCRIPTION DRUG RECORDS (POSITIONS 1345 TO 1347)
				PAYMENTS FOR PRESCRIPTION DRUGS (POSITIONS 1348 TO 1355)
				NUMBER OF TOTAL RECORDS (POSITIONS 1356 TO 1358)
				TOTAL PAYMENTS (POSITIONS 1359 TO 1366)

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	
				PROGRAM TYPE 6 - HOME AND COMMUNITY BASED CARE FOR DISABLED ELDERLY AND INDIVIDUALS AGE 65 AND OLDER (POSITIONS 1367 TO 1421) NUMBER OF INPATIENT HOSPITAL RECORDS (POSITIONS 1367 TO 1369) PAYMENTS FOR INPATIENT HOSPITAL SERVICES (POSITIONS 1370 TO 1377) NUMBER OF LONG TERM CARE RECORDS (POSITIONS 1378 TO 1380) PAYMENTS FOR LONG TERM CARE SERVICES (POSITIONS 1381 TO 1388) NUMBER OF OTHER SERVICE RECORDS (POSITIONS 1389 TO 1391) PAYMENTS FOR OTHER SERVICES (POSITIONS 1392 TO 1399) NUMBER OF PRESCRIPTION DRUG RECORDS (POSITIONS 1400 TO 1402) PAYMENTS FOR PRESCRIPTION DRUGS (POSITIONS 1403 TO 1410) NUMBER OF TOTAL RECORDS (POSITIONS 1411 TO 1413) TOTAL PAYMENTS (POSITIONS 1414 TO 1421) PROGRAM TYPE 7 - HOME AND COMMUNITY BASED CARE WAIVER SERVICES (POSITIONS 1422 TO 1476) NUMBER OF INPATIENT HOSPITAL RECORDS (POSITIONS 1422 TO 1424) PAYMENTS FOR INPATIENT HOSPITAL SERVICES (POSITIONS 1425 TO 1432) NUMBER OF LONG TERM CARE RECORDS (POSITIONS 1433 TO 1435) PAYMENTS FOR LONG TERM CARE SERVICES (POSITIONS 1436 TO 1443) NUMBER OF OTHER SERVICE RECORDS (POSITIONS 1444 TO 1446) PAYMENTS FOR OTHER SERVICES (POSITIONS 1447 TO 1454) NUMBER OF PRESCRIPTION DRUG RECORDS (POSITIONS 1455 TO 1457) PAYMENTS FOR PRESCRIPTION DRUGS (POSITIONS 1458 TO 1465) NUMBER OF TOTAL RECORDS (POSITIONS 1466 TO 1468) TOTAL PAYMENTS (POSITIONS 1469 TO 1476)
72. INPATIENT HOSPITAL RECORDS - FAMILY PLANNING	NUM	3	1147 1149	NUMBER OF INPATIENT HOSPITAL RECORDS CONTAINING MSIS PROGRAM TYPE = 2 (FAMILY PLANNING). 3 DIGITS SOURCE: CREATED USING THE MSIS INPATIENT HOSPITAL CLAIMS FILE
73. INPATIENT HOSPITAL PAYMENTS - FAMILY PLANNING	NUM	8	1150 1157	MEDICAID PAYMENT AMOUNT FOR ALL INPATIENT HOSPITAL RECORDS CONTAINING MSIS PROGRAM TYPE = 2 (FAMILY PLANNING) 8 DIGITS SIGNED (SAS USERS: ZONED DECIMAL - ZD8) SOURCE: CREATED USING THE MSIS INPATIENT HOSPITAL CLAIMS FILE

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	
74. LONG TERM CARE RECORDS - FAMILY PLANNING	NUM	3	1158 1160	NUMBER OF LONG TERM CARE RECORDS CONTAINING MSIS PROGRAM TYPE = 2 (FAMILY PLANNING). 3 DIGITS SOURCE: CREATED USING THE MSIS LONG TERM CARE CLAIMS FILE
75. LONG TERM CARE PAYMENTS - FAMILY PLANNING	NUM	8	1161 1168	MEDICAID PAYMENT AMOUNT FOR ALL LONG TERM CARE RECORDS CONTAINING MSIS PROGRAM TYPE = 2 (FAMILY PLANNING) 8 DIGITS SIGNED (SAS USERS: ZONED DECIMAL - ZD8) SOURCE: CREATED USING THE MSIS LONG TERM CARE CLAIMS FILE
76. OTHER SERVICE RECORDS - FAMILY PLANNING	NUM	3	1169 1171	NUMBER OF OTHER SERVICE RECORDS CONTAINING MSIS PROGRAM TYPE = 2 (FAMILY PLANNING). 3 DIGITS SOURCE: CREATED USING THE MSIS OTHER SERVICE CLAIMS FILE
77. OTHER SERVICE PAYMENTS - FAMILY PLANNING	NUM	8	1172 1179	MEDICAID PAYMENT AMOUNT FOR ALL OTHER SERVICE RECORDS CONTAINING MSIS PROGRAM TYPE = 2 (FAMILY PLANNING) 8 DIGITS SIGNED (SAS USERS: ZONED DECIMAL - ZD8) SOURCE: CREATED USING THE MSIS OTHER SERVICE CLAIMS FILE
78. PRESCRIPTION DRUG RECORDS - FAMILY PLANNING	NUM	3	1180 1182	NUMBER OF PRESCRIPTION DRUG RECORDS CONTAINING MSIS PROGRAM TYPE = 2 (FAMILY PLANNING). 3 DIGITS SOURCE: CREATED USING THE MSIS PRESCRIPTION DRUG CLAIMS FILE
79. PRESCRIPTION DRUG PAYMENTS - FAMILY PLANNING	NUM	8	1183 1190	MEDICAID PAYMENT AMOUNT FOR ALL PRESCRIPTION DRUG RECORDS CONTAINING MSIS PROGRAM TYPE = 2 (FAMILY PLANNING) 8 DIGITS SIGNED (SAS USERS: ZONED DECIMAL - ZD8) SOURCE: CREATED USING THE MSIS PRESCRIPTION DRUG CLAIMS FILE

1

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
80. TOTAL RECORDS - FAMILY PLANNING	NUM	3	1191	1193	TOTAL NUMBER OF RECORDS CONTAINING MSIS PROGRAM TYPE =2 (FAMILY PLANNING) 3 DIGITS SOURCE: CREATED USING ALL OF THE MSIS CLAIMS FILES, ALTHOUGH FAMILY PLANNING SERVICES PROVIDED TO A PERSON RECEIVING LONG-TERM CARE SERVICES WILL APPEAR IN THE "OTHER SERVICES" FILE.
81. TOTAL PAYMENTS - FAMILY PLANNING	NUM	8	1194	1201	MEDICAID PAYMENT AMOUNT FOR ALL RECORDS CONTAINING MSIS PROGRAM TYPE = 2 (FAMILY PLANNING) 8 DIGITS SIGNED (SAS USERS: ZONED DECIMAL - ZD8) SOURCE: CREATED USING ALL OF THE MSIS CLAIMS FILES, ALTHOUGH FAMILY PLANNING SERVICES PROVIDED TO A PERSON RECEIVING LONG-TERM CARE SERVICES WILL APPEAR IN THE "OTHER SERVICES" FILE.
82. RECIPIENT MATERNAL DELIVERY CODE	NUM	1	1477	1477	CODE INDICATING WHETHER OR NOT THE ELIGIBLE HAD AT LEAST ONE INPATIENT HOSPITAL STAY IN THE YEAR WITH A MATERNAL DELIVERY DIAGNOSIS CODE. 1 DIGIT CODES: 0 = NO MAX/MAX INPATIENT STAY DURING THE YEAR WITH A MATERNAL DELIVERY DIAGNOSIS CODE. 1 = AT LEAST ONE MAX/MAX INPATIENT STAY DURING THE YEAR WITH A MATERNAL DELIVERY DIAGNOSIS CODE. USER NOTES: DIAGNOSIS CODES 650, 640.0-676.9 (WITH A 5 TH DIGIT OF '1' OR '2') OR V27.1-V27.9 ON MAX IP CLAIMS ARE USED TO IDENTIFY MATERNAL DELIVERIES. SOME INPATIENT HOSPITAL DELIVERY CLAIMS ARE FOR THE MOTHER ONLY, SOME FOR THE INFANTS SEPARATELY AND SOME ARE COMBINED MOTHER/INFANT CLAIMS. THE MAX DELIVERY CODE IS SET TO 1 FOR MOTHER ONLY AND COMBINED MOTHER/INFANT CLAIMS AS LONG AS THE CLAIM HAS A MATERNAL DELIVERY DIAGNOSIS CODE. INPATIENT HOSPITAL PROCEDURE CODES WERE NOT USED AS THEY ARE NOT AS RELIABLE AS DIAGNOSIS CODES (SOMETIMES THEY ARE USED FOR FALSE LABOR OR OTHER NON-DELIVERY PRE-NATAL CONDITIONS).

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	
<p>ONLY A VERY SMALL PERCENTAGE OF DELIVERIES OCCUR IN PLACES OF SERVICE OTHER THAN THE INPATIENT HOSPITAL.</p> <p>IN THE 1992-95 SMRF FILES THERE WAS ALSO A FIELD CONTAINING A SUMMARY OF THE MEDICAID AMOUNT PAID FOR ALL DELIVERY CLAIMS. THAT DATA ELEMENT HAS BEEN ELIMINATED IN LATER MAX FILES SINCE IT MAY MISREPRESENT DELIVERY EXPENDITURES FOR A NUMBER OF REASONS, INCLUDING:</p> <ul style="list-style-type: none"> - BOTH THE NEWBORN AND MOTHER'S EXPENDITURES ARE INCLUDED ON COMBINED MOTHER/NEWBORN CLAIMS. - ONLY THE MOTHER'S EXPENDITURES ARE INCLUDED WHEN THERE ARE SEPARATE CLAIMS FOR MOTHERS AND NEWBORNS. - THERE ARE SOMETIMES MULTIPLE INPATIENT HOSPITAL DELIVERY CLAIMS FOR ONE DELIVERY (E.G. FALSE LABOR OR COMPLICATIONS AFTER DELIVERY) DUE TO MISCODING ON THE CLAIMS. IN THESE INSTANCES, ALL OF THESE EXPENDITURES ARE INCLUDED. <p>SOURCE: CREATED USING MSIS CLAIMS DATA ELEMENTS FROM THE INPATIENT HOSPITAL FILE ONLY, SINCE ONLY A SMALL PERCENTAGE OF DELIVERIES OCCUR IN OTHER PLACES OF SERVICE.</p>				

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS			CONTENTS
		LENGTH	BEG	END	
**** TYPE OF SERVICE DATA	GROUP	1085	1478	2562	<p>THERE ARE 31 OCCURRENCES, ONE FOR EACH OF THE MAX TYPES OF SERVICE (TOS) EXCEPT TOS=20, 21 AND 22. THERE ARE SIX DATA ELEMENTS FOR EACH LISTED TOS. AMONG THE SIX DATA ELEMENTS, THE FIRST FIVE ARE FOR FEE-FOR-SERVICE (FFS) RECORDS: RECIPIENT INDICATOR, CLAIM COUNT, MEDICAID PAYMENT AMOUNT, CHARGE AMOUNT AND THIRD PARTY PAYMENT AMOUNT. THE LAST IS A COUNT OF THE ENROLLEE'S ENCOUNTER RECORDS FOR CARE RECEIVED FROM PREPAID PLANS, IF ANY, FOR THAT TOS.</p> <p>FOR TYPES OF SERVICE THAT RELATE TO PREMIUM PAYMENTS: TOS=20 (CAPITATED PAYMENTS TO HMO OR HIO PLAN), TOS=21 (CAPITATED PAYMENTS TO PREPAID HEALTH PLANS - PHPs) AND TOS=22 (CAPITATED PAYMENTS FOR PRIMARY CARE CASE MANAGEMENT - PCCM), SEE THE "PREMIUM PAYMENT DATA" GROUP.</p> <p>THE OCCURRENCES ARE AS FOLLOWS:</p> <p>CODES</p> <p>01 = INPATIENT HOSPITAL (POSITION 1478 TO 1512) FEE-FOR-SERVICE (FFS) RECIPIENT INDICATOR (POSITION 1478) FFS CLAIM COUNT (POSITIONS 1479 TO 1483) FFS MEDICAID PAYMENT AMOUNT (POSITIONS 1484 TO 1491) FFS CHARGE AMOUNT (POSITIONS 1492 TO 1499) FFS THIRD PARTY PAYMENT AMOUNT (POSITIONS 1500 TO 1507) ENCOUNTER RECORD COUNT (POSITIONS 1508 TO 1512)</p> <p>02 = MENTAL HOSPITAL SERVICES FOR THE AGED (POSITIONS 1513 TO 1547) FEE-FOR-SERVICE (FFS) RECIPIENT INDICATOR (POSITION 1513) FFS CLAIM COUNT (POSITIONS 1514 TO 1518) FFS MEDICAID PAYMENT AMOUNT (POSITIONS 1519 TO 1526) FFS CHARGE AMOUNT (POSITIONS 1527 TO 1534) FFS THIRD PARTY PAYMENT AMOUNT (POSITIONS 1535 TO 1542) ENCOUNTER RECORD COUNT (POSITIONS 1543 TO 1547)</p> <p>04 = INPATIENT PSYCHIATRIC FACILITY FOR INDIVIDUALS UNDER THE AGE OF 21 (POSITIONS 1548 TO 1582) FEE-FOR-SERVICE (FFS) RECIPIENT INDICATOR (POSITION 1548) FFS CLAIM COUNT (POSITIONS 1549 TO 1553) FFS MEDICAID PAYMENT AMOUNT (POSITIONS 1554 TO 1561) FFS CHARGE AMOUNT (POSITIONS 1562 TO 1569) FFS THIRD PARTY PAYMENT AMOUNT (POSITIONS 1570 TO 1577) ENCOUNTER RECORD COUNT (POSITIONS 1578 TO 1582)</p>

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	
				05 = INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED (POSITIONS 1583 TO 1617) FEE-FOR-SERVICE (FFS) RECIPIENT INDICATOR (POSITION 1583) FFS CLAIM COUNT (POSITIONS 1584 TO 1588) FFS MEDICAID PAYMENT AMOUNT (POSITIONS 1589 TO 1596) FFS CHARGE AMOUNT (POSITIONS 1597 TO 1604) FFS THIRD PARTY PAYMENT AMOUNT (POSITIONS 1605 TO 1612) ENCOUNTER RECORD COUNT (POSITIONS 1613 TO 1617)
				07 = NURSING FACILITY SERVICES - ALL OTHER (POSITIONS 1618 TO 1652) FEE-FOR-SERVICE (FFS) RECIPIENT INDICATOR (POSITION 1618) FFS CLAIM COUNT (POSITIONS 1619 TO 1623) FFS MEDICAID PAYMENT AMOUNT (POSITIONS 1624 TO 1631) FFS CHARGE AMOUNT (POSITIONS 1632 TO 1639) FFS THIRD PARTY PAYMENT AMOUNT (POSITIONS 1640 TO 1647) ENCOUNTER RECORD COUNT (POSITIONS 1648 TO 1652)
				08 = PHYSICIANS (POSITIONS 1653 TO 1687) FEE-FOR-SERVICE (FFS) RECIPIENT INDICATOR (POSITION 1653) FFS CLAIM COUNT (POSITIONS 1654 TO 1658) FFS MEDICAID PAYMENT AMOUNT (POSITIONS 1659 TO 1666) FFS CHARGE AMOUNT (POSITIONS 1667 TO 1674) FFS THIRD PARTY PAYMENT AMOUNT (POSITIONS 1675 TO 1682) ENCOUNTER RECORD COUNT (POSITIONS 1683 TO 1687)
				09 = DENTAL (POSITIONS 1688 TO 1722) FEE-FOR-SERVICE (FFS) RECIPIENT INDICATOR (POSITION 1688) FFS CLAIM COUNT (POSITIONS 1689 TO 1693) FFS MEDICAID PAYMENT AMOUNT (POSITIONS 1694 TO 1701) FFS CHARGE AMOUNT (POSITIONS 1702 TO 1709) FFS THIRD PARTY PAYMENT AMOUNT (POSITIONS 1710 TO 1717) ENCOUNTER RECORD COUNT (POSITIONS 1718 TO 1722)
				10 = OTHER PRACTITIONERS (POSITIONS 1723 TO 1757) FEE-FOR-SERVICE (FFS) RECIPIENT INDICATOR (POSITION 1723) FFS CLAIM COUNT (POSITIONS 1724 TO 1728) FFS MEDICAID PAYMENT AMOUNT (POSITIONS 1729 TO 1736) FFS CHARGE AMOUNT (POSITIONS 1737 TO 1744) FFS THIRD PARTY PAYMENT AMOUNT (POSITIONS 1745 TO 1752) ENCOUNTER RECORD COUNT (POSITIONS 1753 TO 1757)

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	
				11 = OUTPATIENT HOSPITAL (POSITIONS 1758 TO 1792) FEE-FOR-SERVICE (FFS) RECIPIENT INDICATOR (POSITION 1758) FFS CLAIM COUNT (POSITIONS 1759 TO 1763) FFS MEDICAID PAYMENT AMOUNT (POSITIONS 1764 TO 1771) FFS CHARGE AMOUNT (POSITIONS 1772 TO 1779) FFS THIRD PARTY PAYMENT AMOUNT (POSITIONS 1780 TO 1787) ENCOUNTER RECORD COUNT (POSITIONS 1788 TO 1792)
				12 = CLINIC (POSITIONS 1793 TO 1827) FEE-FOR-SERVICE (FFS) RECIPIENT INDICATOR (POSITION 1793) FFS CLAIM COUNT (POSITIONS 1794 TO 1798) FFS MEDICAID PAYMENT AMOUNT (POSITIONS 1799 TO 1806) FFS CHARGE AMOUNT (POSITIONS 1807 TO 1814) FFS THIRD PARTY PAYMENT AMOUNT (POSITIONS 1815 TO 1822) ENCOUNTER RECORD COUNT (POSITIONS 1823 TO 1827)
				13 = HOME HEALTH (POSITIONS 1828 TO 1862) FEE-FOR-SERVICE (FFS) RECIPIENT INDICATOR (POSITION 1828) FFS CLAIM COUNT (POSITIONS 1829 TO 1833) FFS MEDICAID PAYMENT AMOUNT (POSITIONS 1834 TO 1841) FFS CHARGE AMOUNT (POSITIONS 1842 TO 1849) FFS THIRD PARTY PAYMENT AMOUNT (POSITIONS 1850 TO 1857) ENCOUNTER RECORD COUNT (POSITIONS 1858 TO 1862)
				15 = LAB AND X-RAY (POSITIONS 1863 TO 1897) FEE-FOR-SERVICE (FFS) RECIPIENT INDICATOR (POSITION 1863) FFS CLAIM COUNT (POSITIONS 1864 TO 1868) FFS MEDICAID PAYMENT AMOUNT (POSITIONS 1869 TO 1876) FFS CHARGE AMOUNT (POSITIONS 1877 TO 1884) FFS THIRD PARTY PAYMENT AMOUNT (POSITIONS 1885 TO 1892) ENCOUNTER RECORD COUNT (POSITIONS 1893 TO 1897)
				16 = PRESCRIBED DRUG (POSITIONS 1898 TO 1932) FEE-FOR-SERVICE (FFS) RECIPIENT INDICATOR (POSITION 1898) FFS CLAIM COUNT (POSITIONS 1899 TO 1903) FFS MEDICAID PAYMENT AMOUNT (POSITIONS 1904 TO 1911) FFS CHARGE AMOUNT (POSITIONS 1912 TO 1919) FFS THIRD PARTY PAYMENT AMOUNT (POSITIONS 1920 TO 1927) ENCOUNTER RECORD COUNT (POSITIONS 1928 TO 1932)

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	
				19 = OTHER SERVICES (POSITIONS 1933 TO 1967) FEE-FOR-SERVICE (FFS) RECIPIENT INDICATOR (POSITION 1933) FFS CLAIM COUNT (POSITIONS 1934 TO 1938) FFS MEDICAID PAYMENT AMOUNT (POSITIONS 1939 TO 1946) FFS CHARGE AMOUNT (POSITIONS 1947 TO 1954) FFS THIRD PARTY PAYMENT AMOUNT (POSITIONS 1955 TO 1962) ENCOUNTER RECORD COUNT (POSITIONS 1963 TO 1967)
				24 = STERILIZATIONS (POSITIONS 1968 TO 2002) FEE-FOR-SERVICE (FFS) RECIPIENT INDICATOR (POSITION 1968) FFS CLAIM COUNT (POSITIONS 1969 TO 1973) FFS MEDICAID PAYMENT AMOUNT (POSITIONS 1974 TO 1981) FFS CHARGE AMOUNT (POSITIONS 1982 TO 1989) RECIPIENT THIRD PARTY PAYMENT AMOUNT (POSITIONS 1990 TO 1997) RECIPIENT ENCOUNTER RECORD COUNT (POSITIONS 1998 TO 2002)
				25 = ABORTIONS (POSITIONS 2003 TO 2037) FEE-FOR-SERVICE (FFS) RECIPIENT INDICATOR (POSITION 2003) FFS CLAIM COUNT (POSITIONS 2004 TO 2008) FFS MEDICAID PAYMENT AMOUNT (POSITIONS 2009 TO 2016) FFS CHARGE AMOUNT (POSITIONS 2017 TO 2024) FFS THIRD PARTY PAYMENT AMOUNT (POSITIONS 2025 TO 2032) ENCOUNTER RECORD COUNT (POSITIONS 2033 TO 2037)
				26 = TRANSPORTATION SERVICES (POSITIONS 2038 TO 2072) FEE-FOR-SERVICE (FFS) RECIPIENT INDICATOR (POSITION 2038) FFS CLAIM COUNT (POSITIONS 2039 TO 2043) FFS MEDICAID PAYMENT AMOUNT (POSITIONS 2044 TO 2051) FFS CHARGE AMOUNT (POSITIONS 2052 TO 2059) FFS THIRD PARTY PAYMENT AMOUNT (POSITIONS 2060 TO 2067) ENCOUNTER RECORD COUNT (POSITIONS 2068 TO 2072)
				30 = PERSONAL CARE SERVICES (POSITIONS 2073 TO 2107) FEE-FOR-SERVICE (FFS) RECIPIENT INDICATOR (POSITION 2073) FFS CLAIM COUNT (POSITIONS 2074 TO 2078) FFS MEDICAID PAYMENT AMOUNT (POSITIONS 2079 TO 2086) FFS CHARGE AMOUNT (POSITIONS 2087 TO 2094) FFS THIRD PARTY PAYMENT AMOUNT (POSITIONS 2095 TO 2102) ENCOUNTER RECORD COUNT (POSITIONS 2103 TO 2107)

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	
				31 = TARGETED CASE MANAGEMENT (POSITIONS 2108 TO 2142) FEE-FOR-SERVICE (FFS) RECIPIENT INDICATOR (POSITION 2108) FFS CLAIM COUNT (POSITIONS 2109 TO 2113) FFS MEDICAID PAYMENT AMOUNT (POSITIONS 2114 TO 2121) FFS CHARGE AMOUNT (POSITIONS 2122 TO 2129) FFS THIRD PARTY PAYMENT AMOUNT (POSITIONS 2130 TO 2137) ENCOUNTER RECORD COUNT (POSITIONS 2138 TO 2142)
				33 = REHABILITATION SERVICES (POSITIONS 2143 TO 2177) FEE-FOR-SERVICE (FFS) RECIPIENT INDICATOR (POSITION 2143) FFS CLAIM COUNT (POSITIONS 2144 TO 2148) FFS MEDICAID PAYMENT AMOUNT (POSITIONS 2149 TO 2156) FFS CHARGE AMOUNT (POSITIONS 2157 TO 2164) FFS THIRD PARTY PAYMENT AMOUNT (POSITIONS 2165 TO 2172) ENCOUNTER RECORD COUNT (POSITIONS 2173 TO 2177)
				34 = PT, OT, SPEECH, HEARING SERVICES (POSITIONS 2178 TO 2212) FEE-FOR-SERVICE (FFS) RECIPIENT INDICATOR (POSITION 2178) FFS CLAIM COUNT (POSITIONS 2179 TO 2183) FFS MEDICAID PAYMENT AMOUNT (POSITIONS 2184 TO 2191) FFS CHARGE AMOUNT (POSITIONS 2192 TO 2199) FFS THIRD PARTY PAYMENT AMOUNT (POSITIONS 2200 TO 2207) ENCOUNTER RECORD COUNT (POSITIONS 2208 TO 2212)
				35 = HOSPICE BENEFITS (POSITIONS 2213 TO 2247) FEE-FOR-SERVICE (FFS) RECIPIENT INDICATOR (POSITION 2213) FFS CLAIM COUNT (POSITIONS 2214 TO 2218) FFS MEDICAID PAYMENT AMOUNT (POSITIONS 2219 TO 2226) FFS CHARGE AMOUNT (POSITIONS 2227 TO 2234) FFS THIRD PARTY PAYMENT AMOUNT (POSITIONS 2235 TO 2242) ENCOUNTER RECORD COUNT (POSITIONS 2243 TO 2247)
				36 = NURSE MIDWIFE SERVICES (POSITIONS 2248 TO 2282) FEE-FOR-SERVICE (FFS) RECIPIENT INDICATOR (POSITION 2248) FFS CLAIM COUNT (POSITIONS 2249 TO 2253) FFS MEDICAID PAYMENT AMOUNT (POSITIONS 2254 TO 2261) FFS CHARGE AMOUNT (POSITIONS 2262 TO 2269) FFS THIRD PARTY PAYMENT AMOUNT (POSITIONS 2270 TO 2277) ENCOUNTER RECORD COUNT (POSITIONS 2278 TO 2282)

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	
				37 = NURSE PRACTITIONER SERVICES (POSITIONS 2283 TO 2317) FEE-FOR-SERVICE (FFS) RECIPIENT INDICATOR (POSITION 2283) FFS CLAIM COUNT (POSITIONS 2284 TO 2288) FFS MEDICAID PAYMENT AMOUNT (POSITIONS 2289 TO 2296) FFS CHARGE AMOUNT (POSITIONS 2297 TO 2304) FFS THIRD PARTY PAYMENT AMOUNT (POSITIONS 2305 TO 2312) ENCOUNTER RECORD COUNT (POSITIONS 2313 TO 2317)
				38 = PRIVATE DUTY NURSING (POSITIONS 2318 TO 2352) FEE-FOR-SERVICE (FFS) RECIPIENT INDICATOR (POSITION 2318) FFS CLAIM COUNT (POSITIONS 2319 TO 2323) FFS MEDICAID PAYMENT AMOUNT (POSITIONS 2324 TO 2331) FFS CHARGE AMOUNT (POSITIONS 2332 TO 2339) FFS THIRD PARTY PAYMENT AMOUNT (POSITIONS 2340 TO 2347) ENCOUNTER RECORD COUNT (POSITIONS 2348 TO 2352)
				39 = RELIGIOUS NON-MEDICAL HEALTH CARE INSTITUTIONS (POSITIONS 2353 TO 2387) FEE-FOR-SERVICE (FFS) RECIPIENT INDICATOR (POSITION 2353) FFS CLAIM COUNT (POSITIONS 2354 TO 2358) FFS MEDICAID PAYMENT AMOUNT (POSITIONS 2359 TO 2366) FFS CHARGE AMOUNT (POSITIONS 2367 TO 2374) FFS THIRD PARTY PAYMENT AMOUNT (POSITIONS 2375 TO 2382) ENCOUNTER RECORD COUNT (POSITIONS 2383 TO 2387)
				51 = DURABLE MEDICAL EQUIPMENT (DME) AND SUPPLIES (INCLUDES EMERGENCY RESPONSE SYSTEMS AND HOME MODIFICATIONS) (POSITIONS 2388 TO 2422) FEE-FOR-SERVICE (FFS) RECIPIENT INDICATOR (POSITION 2388) FFS CLAIM COUNT (POSITIONS 2389 TO 2393) FFS MEDICAID PAYMENT AMOUNT (POSITIONS 2394 TO 2401) FFS CHARGE AMOUNT (POSITIONS 2402 TO 2409) FFS THIRD PARTY PAYMENT AMOUNT (POSITIONS 2410 TO 2417) ENCOUNTER RECORD COUNT (POSITIONS 2418 TO 2422)
				52 = RESIDENTIAL CARE (POSITIONS 2423 TO 2457) (DEFINITION CHANGED FOR 2003 AND LATER YEARS - ADDITIONAL INFORMATION IS AVAILABLE ON REQUEST) FEE-FOR-SERVICE (FFS) RECIPIENT INDICATOR (POSITION 2423) FFS CLAIM COUNT (POSITIONS 2424 TO 2428) FFS MEDICAID PAYMENT AMOUNT (POSITIONS 2429 TO 2436) FFS CHARGE AMOUNT (POSITIONS 2437 TO 2444) FFS THIRD PARTY PAYMENT AMOUNT (POSITIONS 2445 TO 2452) ENCOUNTER RECORD COUNT (POSITIONS 2453 TO 2457)

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	
				53 = PSYCHIATRIC SERVICES (EXCLUDING ADULT DAY CARE) (POSITIONS 2458 TO 2492) FEE-FOR-SERVICE (FFS) RECIPIENT INDICATOR (POSITION 2458) FFS CLAIM COUNT (POSITIONS 2459 TO 2463) FFS MEDICAID PAYMENT AMOUNT (POSITIONS 2464 TO 2471) FFS CHARGE AMOUNT (POSITIONS 2472 TO 2479) FFS THIRD PARTY PAYMENT AMOUNT (POSITIONS 2480 TO 2487) ENCOUNTER RECORD COUNT (POSITIONS 2488 TO 2492)
				54 = ADULT DAY CARE (POSITIONS 2493 TO 2527) FEE-FOR-SERVICE (FFS) RECIPIENT INDICATOR (POSITION 2493) FFS CLAIM COUNT (POSITIONS 2494 TO 2498) FFS MEDICAID PAYMENT AMOUNT (POSITIONS 2499 TO 2506) FFS CHARGE AMOUNT (POSITIONS 2507 TO 2514) FFS THIRD PARTY PAYMENT AMOUNT (POSITIONS 2515 TO 2522) ENCOUNTER RECORD COUNT (POSITIONS 2523 TO 2527)
				99 = UNKNOWN (POSITIONS 2528 TO 2562) FEE-FOR-SERVICE (FFS) RECIPIENT INDICATOR (POSITION 2528) FFS CLAIM COUNT (POSITIONS 2529 TO 2533) FFS MEDICAID PAYMENT AMOUNT (POSITIONS 2534 TO 2541) FFS CHARGE AMOUNT (POSITIONS 2542 TO 2549) FFS THIRD PARTY PAYMENT AMOUNT (POSITIONS 2550 TO 2557) ENCOUNTER RECORD COUNT (POSITIONS 2558 TO 2562)

USER NOTE: THE FOLLOWING CODES ARE INVALID: 03, 06, 14, 17, 18, 23, 27, 28, 29, 32 AND 40-50. BEGINNING IN 10/98, MSIS IDENTIFIED EPSDT; FAMILY PLANNING; RURAL HEALTH CLINIC; FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs); INDIAN HEALTH; HOME AND COMMUNITY BASED CARE FOR DISABLED, ELDERLY AND INDIVIDUALS AGE 65 AND OLDER; AND HOME AND COMMUNITY BASED CARE WAIVER SERVICES USING A NEW DATA ELEMENT, "PROGRAM TYPE". A SUBSTANTIAL NUMBER OF NEW MSIS TYPE OF SERVICE CODES WERE ADDED IN FISCAL YEAR 1998.

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
*** TYPE OF SERVICE TABLE	GROUP	35	1478	1512	OCCURS: 31 TIMES, ONCE FOR EACH MAX TYPE OF SERVICE LISTED ABOVE. THE EXAMPLES (DATA ELEMENTS #89 TO #94) ARE FOR THE FIRST TYPE OF SERVICE, TOS = 1 (INPATIENT HOSPITAL).
83. TYPE OF SERVICE RECIPIENT INDICATOR	CHAR	1	1478	1478	INDICATOR TO SHOW IF AND HOW THE ELIGIBLE RECEIVED A MEDICAID SERVICE (UNDER FEE-FOR-SERVICE) DURING THE CALENDAR YEAR, FOR THIS TYPE OF SERVICE. <u>THIS DATA ELEMENT IS REPORTED FOR ALL TYPES OF SERVICE, EXCEPT TOS = 20, 21 AND 22.</u> 1 DIGIT 0 = THE ELIGIBLE PERSON DID NOT RECEIVED ANY SERVICES 1 = THE ELIGIBLE PERSON HAD ONLY FEE-FOR-SERVICE CLAIMS (INCLUDING CLAIMS WITH \$0 PAID AMOUNTS) 2 = THE ELIGIBLE PERSON HAD ONLY ENCOUNTER RECORDS (PRE-PAID PLAN) 3 = THE ELIGIBLE PERSON HAD BOTH FEE-FOR-SERVICE CLAIMS AND ENCOUNTER RECORDS <i>USER NOTE: SEE DATA ELEMENT #51 WHICH IS SIMILAR TO DATA ELEMENT #78. DATA ELEMENT #83 IS DIFFERENT IN THAT IT IS CREATED BY TYPE OF SERVICE, FOR EACH OF THE LISTED TYPES OF SERVICES AND IT DOES NOT INCLUDE CODE VALUES FOR PREMIUM PAYMENTS. SOURCE MSIS FILES CONTAIN RECORDS WITH MEDICAID PAYMENT AMOUNT = \$0 IF THE SERVICE WAS COVERED, BUT FULL PAYMENT WAS MADE BY ANOTHER PAYER (E.G. THIRD PARTY LIABILITY). THERE ARE ALSO INSTANCES OF CLAIMS WITH MEDICAID PAYID AMOUNT < \$0. THE RECIPIENT INDICATOR IS SET VALUE >= 1 IF THE BENEFICIARY HAS AT LEAST ONE CLAIM FOR THIS TYPE OF SERVICE, REGARDLESS OF THE VALUE OF MEDICAID AMOUNT PAID (< \$0, = \$0 OR > \$0).</i> SOURCE: CREATED FOR EACH OF 31 MAX TYPES OF SERVICE, USING MSIS CLAIMS FILES, AS NOTED ABOVE.
84. FEE-FOR SERVICE CLAIM COUNT	NUM	5	1479	1483	TOTAL NUMBER OF CLAIMS FOR THE RECIPIENT (UNDER FEE-FOR-SERVICE) FOR A SPECIFIED TYPE OF SERVICE. <u>THIS DATA ELEMENT IS REPORTED FOR ALL TYPES OF SERVICE, EXCEPT TOS = 20, 21 AND 22.</u> 5 DIGITS SIGNED (SAS USERS: ZONED DECIMAL - ZD5) SOURCE: CREATED FOR EACH OF 31 MAX TYPES OF SERVICE, USING MSIS CLAIMS FILES, AS NOTED ABOVE.

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	
85. FEE-FOR-SERVICE MEDICAID PAYMENT AMOUNT	NUM	8	1484 1491	TOTAL FEE-FOR-SERVICE MEDICAID PAYMENTS UNDER THIS TYPE OF SERVICE FOR THE FOR THE RECIPIENT DURING THE CALENDAR YEAR. <u>THIS DATA ELEMENT IS REPORTED FOR ALL TYPES OF SERVICE EXCEPT TOS = 20, 21 AND 22.</u> 8 DIGITS SIGNED (SAS USERS: ZONED DECIMAL - ZD8) SOURCE: CREATED FOR EACH OF 31 MAX TYPES OF SERVICE, USING MSIS CLAIMS FILES, AS NOTED ABOVE.
86. FEE-FOR-SERVICE CHARGE AMOUNT	NUM	8	1492 1499	TOTAL AMOUNT OF FEE-FOR-SERVICE CHARGES UNDER THIS TYPE OF SERVICE FOR THE RECIPIENT DURING THE CALENDAR YEAR. <u>THIS DATA ELEMENT IS REPORTED FOR ALL TYPES OF SERVICE EXCEPT TOS = 20, 21 AND 22.</u> 8 DIGITS SIGNED (SAS USERS: ZONED DECIMAL - ZD8) SOURCE: CREATED FOR EACH OF 31 MAX TYPES OF SERVICE, USING MSIS CLAIMS FILES, AS NOTED ABOVE.
87. FEE-FOR-SERVICE THIRD PARTY PAYMENT AMOUNT	NUM	8	1500 1507	TOTAL NON-MEDICAID PAYMENTS, RELATED TO FEE-FOR-SERVICE CARE, FOR THIS TYPE OF SERVICE FOR THE RECIPIENT DURING THE CALENDAR YEAR. <u>THIS DATA ELEMENT IS REPORTED FOR ALL TYPE OF SERVICE EXCEPT TOS = 20, 21 AND 22.</u> 8 DIGITS SIGNED (SAS USERS: ZONED DECIMAL - ZD8) <i>USER NOTE: THERE MAY BE SUBSTANTIAL VARIATION IN THE REPORTING OF THIRD PARTY LIABILITY (TPL) AMOUNTS ACROSS STATES. THIS IS BECAUSE STATES USE DIFFERENT METHODS OF COLLECTING TPL PAYMENTS. SOME STATES MAY REQUIRE PROVIDERS TO THOROUGHLY PURSUE COLLECTION OF TPL PAYMENTS BEFORE CLAIMS ARE ADJUDICATED FOR MEDICAID PAYMENT. OTHER STATES MAY DESIRE TO PAY PROVIDERS PROMPTLY AND THEN RECOVER TPL PAYMENTS FROM OTHER PAYERS. FOR THESE REASONS, THE EXTENT TO WHICH TPL COLLECTIONS ARE ACCURATELY REPORTED IN MSIS IS UNKNOWN.</i> SOURCE: CREATED FOR EACH OF 31 MAX TYPES OF SERVICE, USING MSIS CLAIMS FILES, AS NOTED ABOVE.

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS			CONTENTS
		LENGTH	BEG	END	
88. ENCOUNTER RECORD COUNT	NUM	5	1508	1512	<p>RECIPIENT'S TOTAL NUMBER OF ENCOUNTER RECORDS (TYPE OF CLAIM = 3), RELATED TO CARE PROVIDED BY A CAPITATED (PREPAID) PLAN FOR THE SPECIFIED TYPE OF SERVICE DURING THE CALENDAR YEAR. <u>THIS DATA ELEMENT IS REPORTED FOR ALL TYPES OF SERVICE EXCEPT TOS = 20, 21 AND 22.</u></p> <p>USER NOTE: THIS DATA ELEMENT IS THE ONLY EXCEPTION TO THE RULE OF EXCLUDING ENCOUNTER RECORDS FROM SUMMARY COUNTS. THE RULE IS DISCUSSED AT THE BEGINNING OF THE "RECIPIENT CLAIMS SUMMARY REGION".</p> <p>SOURCE: CREATED FOR EACH OF 31 MAX TYPES OF SERVICE, USING MSIS CLAIMS FILES, AS NOTED ABOVE.</p>
**** PREMIUM PAYMENT DATA	GROUP	42	2563	2604	<p>THERE ARE 3 OCCURRENCES, ONE FOR EACH OF THE MAX TYPES OF SERVICE (TOS). FOR CAPITATED PAYMENT CLAIMS (TOS=20, 21, AND 22), THERE ARE THREE DATA ELEMENTS (PREMIUM PAYMENT INDICATOR, PREMIUM PAYMENT RECORD COUNT AND MEDICAID PREMIUM AMOUNT). THIS IS BECAUSE THE DATA ELEMENTS THAT ARE TYPICAL FOR FFS CLAIMS, DO NOT APPLY TO PREMIUM PAYMENT CLAIMS. IN PARTICULAR, THERE ARE NO ASSOCIATED ENCOUNTER RECORDS, SINCE THESE TOSs ARE FOR PREMIUM PAYMENTS ONLY. ENCOUNTER RECORDS FOR THE ENROLLEE ARE REPORTED ACCORDING TO THEIR TYPE OF SERVICE (OTHER THAN 20, 21 OR 22).</p> <p>FOR ALL OTHER TYPES OF SERVICE, SEE THE "TYPE OF SERVICE DATA" GROUP.</p> <p>THE OCCURRENCES ARE AS FOLLOWS:</p> <p>CODES</p> <p>20 = CAPITATED PAYMENTS TO HMO OR HIO PLAN (POSITIONS 2563 TO 2576) PREMIUM PAYMENT INDICATOR (POSITION 2563) PREMIUM PAYMENT RECORD COUNT (POSITIONS 2564 TO 2568) MEDICAID PREMIUM PAYMENT AMOUNT (POSITIONS 2569 TO 2576)</p> <p>21 = CAPITATED PAYMENTS TO PREPAID HEALTH PLANS - PHPs (POSITIONS 2577 TO 2590) PREMIUM PAYMENT INDICATOR (POSITION 2577) PREMIUM PAYMENT RECORD COUNT (POSITIONS 2578 TO 2582) MEDICAID PREMIUM PAYMENT AMOUNT (POSITIONS 2583 TO 2590)</p> <p>22 = CAPITATED PAYMENTS FOR PRIMARY CARE CASE MANAGEMENT - PCCM (POSITIONS 2591 TO 2604) PREMIUM PAYMENT INDICATOR (POSITION 2591) PREMIUM PAYMENT RECORD COUNT (POSITIONS 2592 TO 2596) MEDICAID PREMIUM PAYMENT AMOUNT (POSITIONS 2597 TO 2604)</p>

MEDICAID ANALYTIC EXTRACT PERSONAL SUMMARY RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	
*** PREMIUM PAYMENT TABLE	GROUP	14	2563 2576	OCCURS: 3 TIMES, ONCE FOR EACH TYPE OF SERVICE LISTED ABOVE. THE THE EXAMPLES (DATA ELEMENTS #84 TO #86) ARE FOR TOS = 20 (CAPITATED PAYMENTS TO HMO OR HIO PLAN).
89. PREMIUM PAYMENT INDICATOR	NUM	1	2563 2563	INDICATOR TO SHOW IF ANY PREMIUM PAYMENTS WERE MADE TO A CAPITATED (PREPAID) PLAN FOR THIS ELIGIBLE DURING THE CALENDAR YEAR. <u>THIS DATA ELEMENT IS REPORTED ONLY FOR TOS = 20, 21 AND 22.</u> 1 DIGIT 0 = NO PREMIUM PAYMENTS WERE MADE FOR THIS ELIGIBLE BY MEDICAID 1 = PREMIUM PAYMENTS WERE MADE FOR THIS ELIGIBLE BY MEDICAID SOURCE: CREATED FOR EACH OF THE 3 MAX TYPES OF SERVICE FOR PREMIUM PAYMENTS, USING MSIS CLAIMS FILES, AS NOTED ABOVE.
90. PREMIUM PAYMENT RECORD COUNT	NUM	5	2564 2568	TOTAL NUMBER OF PREMIUM PAYMENTS THAT WERE MADE TO A CAPITATED (PREPAID) PLAN FOR THIS ELIGIBLE DURING THE CALENDAR YEAR. <u>THIS DATA ELEMENT IS REPORTED ONLY FOR TOS = 20, 21 AND 22.</u> 5 DIGITS SIGNED (SAS USERS: ZONED DECIMAL - ZD5) SOURCE: CREATED FOR EACH OF THE 3 MAX TYPES OF SERVICE FOR PREMIUM PAYMENTS, USING MSIS CLAIMS FILES, AS NOTED ABOVE.
91. MEDICAID PREMIUM PAYMENT AMOUNT	NUM	8	2569 2576	TOTAL DOLLAR AMOUNT OF PREMIUM PAYMENTS THAT WERE MADE TO A CAPITATED (PREPAID) PLAN FOR THIS ELIGIBLE DURING THE CALENDAR YEAR. <u>THIS DATA ELEMENT IS REPORTED ONLY FOR TOS = 20, 21 AND 22.</u> 8 DIGITS SIGNED (SAS USERS: ZONED DECIMAL - ZD8) SOURCE: CREATED FOR EACH OF THE 3 MAX TYPES OF SERVICE FOR PREMIUM PAYMENTS, USING MSIS CLAIMS FILES, AS NOTED ABOVE.