MATHEMATICA Policy Research

REPORT

Medicaid Analytic Extract Person Summary (PS) Record Layout and Description 2014

August 18, 2016

Submitted to:

Centers for Medicare & Medicaid Services
7500 Security Blvd.
Mail Stop B2-29-04
Baltimore, MD 21244-1850

Project Officer: Cara Petroski

Submitted by:

Mathematica Policy Research
1100 1st Street, NE
12th Floor
Washington, DC 20002-4221

Project Director: Susan Williams

Reference Number: 50160.210

Contract Number: HHSM-500-2014-00034I
Task Order: HHSM-500-T0007

CHANGES TO THE MAX 2014 PS FILE

1. Record length increased from 3058 to 3084.

2. Added twelve monthly and the latest variables for TMSIS Eligibility Group (Data Elements 108, 109 and 110)

3. Updated the description for the MAX Uniform eligibility code variable (Data Elements 31 and 40) to include a new valid value ZZ.

MEDICAID ANALYTIC EXTRACT (MAX)

RECORD LAYOUT FOR

PERSON SUMMARY RECORD (PS)

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER:	ELEMENT NAME:	TYPE:	LENGTH:	BEG:	END:
****	MEDICAID ANALYTIC EXTRACT (MAX) PERSON SUMMARY RECORD	REC	3084	1	3084
***	MEDICAID ELIGIBILITY REGION	REGION	1175	1	1175
**	IDENTIFYING GROUP	GROUP	81	1	81
1.	MSIS IDENTIFICATION NUMBER	CHAR	20	1	20
2.	STATE ABBREVIATION CODE	CHAR	2	21	22
3.	MAX YEAR DATE	NUM	4	23	26
4.	SOCIAL SECURITY NUMBER - FROM MSIS	CHAR	9	27	35
5.	FILLER	CHAR	1	36	36
6.	SOCIAL SECURITY NUMBER FROM EXTERNAL SOURCE	CHAR	9	37	45
7.	EXTERNAL SOCIAL SECURITY NUMBER (SSN) SOURCE	CHAR	1	46	46
8.	STATE CASE NUMBER	CHAR	12	47	58
9.	MEDICARE HEALTH INSURANCE CLAIM (HIC) NUMBER - FROM MSIS	CHAR	12	59	70
10.	MEDICARE HEALTH INSURANCE CLAIM (HIC) NUMBER - FROM MEDICARE	CHAR	11	71	81
**	DEMOGRAPHIC GROUP	GROUP	53	82	134
11.	BIRTH DATE	NUM	8	82	89
12.	AGE GROUP CODE	NUM	1	90	90
13.	SEX CODE	CHAR	1	91	91
14.	RACE/ETHNICITY CODE	CHAR	1	92	92
15.	RACE - WHITE	CHAR	1	93	93
16.	RACE - BLACK/AFRICAN AMERICAN	CHAR	1	94	94
17.	RACE - AMERICAN INDIAN/ALASKAN NATIVE	CHAR	1	95	95
18.	RACE - ASIAN	CHAR	1	96	96
19.	RACE - NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER	CHAR	1	97	97
20.	ETHNICITY - HISPANIC OR LATINO	CHAR	1	98	98
21.	MEDICARE RACE/ETHNICITY CODE	CHAR	1	99	99
22.	MEDICARE LANGUAGE CODE	CHAR	1	100	100
23.	SEX-RACE CODE	NUM	1	101	101
24.	MEDICAID DEATH DATE	NUM	8	102	109
25.	MEDICARE DEATH DATE	NUM	8	110	117
26.	MEDICARE DEATH DAY SWITCH	CHAR	1	118	118
27.	DATE OF DEATH (FROM SSA DEATH MASTER FILE)	NUM	8	119	126
28.	RESIDENCE COUNTY CODE	CHAR	3	127	129
29.	RESIDENCE ZIP CODE	NUM	5	130	134

DATA ELEMENTS WITH TYPE NUM* ARE IN ZONED DECIMAL (ZD) FORMAT FOR SAS USERS.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER:	ELEMENT NAME:	TYPE:	LENGTH:	BEG:	END:
**	ANNUAL MEDICAID AND OTHER HEALTH INSURANCE GROUP	GROUP	18	135	152
30.	STATE-SPECIFIC ELIGIBILITY CODE - MOST RECENT	CHAR	6	135	140
31.	MAX UNIFORM ELIGIBILITY CODE - MOST RECENT	CHAR	2	141	142
32.	MISSING MEDICAID ELIGIBILITY DATA SWITCH	CHAR	1	143	143
33.	MONTHS OF ELIGIBILITY	NUM	2	144	145
34.	PRIVATE INSURANCE MONTHS COUNT	NUM	2	146	147
35.	MEDICARE DUAL CODE - ANNUAL	CHAR	2	148	149
36.	MEDICARE BENEFICIARY MONTHS COUNT	NUM	2	150	151
37.	MEDICARE ORIGINAL ENTITLEMENT REASON CODE	NUM	1	152	152
**	MEDICARE DUAL GROUP - MONTHLY (OCCURS 12 TIMES)	GROUP	24	153	176
38.	MEDICARE DUAL CODE - FIRST MONTH	CHAR	2	153	154
**	STATE-SPECIFIC ELIGIBILITY GROUP - MONTHLY (OCCURS 12 TIMES)	GROUP	72	177	248
39.	STATE-SPECIFIC ELIGIBILITY CODE - FIRST MONTH	CHAR	6	177	182
**	MAX UNIFORM ELIGIBILITY GROUP - MONTHLY (OCCURS 12 TIMES)	GROUP	24	249	272
40.	MAX UNIFORM ELIGIBILITY CODE - FIRST MONTH	CHAR	2	249	250
**	PRIVATE INSURANCE GROUP - MONTHLY (OCCURS 12 TIMES)	GROUP	12	273	284
41.	PRIVATE INSURANCE CODE - FIRST MONTH	NUM	1	273	273
**	MEDICARE BENEFICIARY GROUP - MONTHLY (OCCURS 12 TIMES)	GROUP	12	285	296
42.	MEDICARE BENEFICIARY CODE - FIRST MONTH	NUM	1	285	285
**	PRE-PAID PLAN MONTHS COUNT GROUP - PLAN TYPE (OCCURS 7 TIMES)	GROUP	14	297	310
43.	PRE-PAID PLAN MONTHS COUNT - FIRST PLAN TYPE	NUM	2	297	298
**	PRE-PAID PLAN ENROLLMENT GROUP - MONTHLY (OCCURS 12 TIMES)	GROUP	672	311	982
44.	PRE-PAID PLAN TYPE-1 CODE - FIRST MONTH	NUM	2	311	312
45.	PRE-PAID PLAN IDENTIFIER-1 - FIRST MONTH	CHAR	12	313	324
46.	PRE-PAID PLAN TYPE-2 CODE - FIRST MONTH	NUM	2	325	326
47.	PRE-PAID PLAN IDENTIFIER-2 - FIRST MONTH	CHAR	12	327	338
48.	PRE-PAID PLAN TYPE-3 CODE - FIRST MONTH	NUM	2	339	340
49.	PRE-PAID PLAN IDENTIFIER-3 - FIRST MONTH	CHAR	12	341	352
50.	PRE-PAID PLAN TYPE-4 CODE - FIRST MONTH	NUM	2	353	354
51.	PRE-PAID PLAN IDENTIFIER-4 - FIRST MONTH	CHAR	12	355	366
**	MEDICAID MANAGED CARE COMBINATIONS GROUP - MONTHLY (OCCURS 12 TIMES)	GROUP	24	983	1006
52.	MEDICAID MANAGED CARE COMBINATIONS - FIRST MONTH	NUM	2	983	984

DATA ELEMENTS WITH TYPE NUM* ARE IN ZONED DECIMAL (ZD) FORMAT FOR SAS USERS.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER:	ELEMENT NAME:	TYPE:	LENGTH:	BEG:	END:
**	DAYS OF ELIGIBILITY GROUP - MONTHLY (OCCURS 12 TIMES)	GROUP	24	1007	1030
53.	DAYS OF ELIGIBILITY - FIRST MONTH	NUM	2	1007	1008
**	TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) CASH FLAG GROUP - MONTHLY (OCCURS 12 TIMES)	GROUP	12	1031	1042
54.	TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) CASH FLAG - FIRST MONTH	NUM	1	1031	1031
**	RESTRICTED BENEFITS FLAG GROUP - MONTHLY (OCCURS 12 TIMES)	GROUP	12	1043	1054
55.	RESTRICTED BENEFITS FLAG - FIRST MONTH	CHAR	1	1043	1043
**	CHILD HEALTH INSURANCE PROGRAM (CHIP) CODE GROUP - MONTHLY (OCCURS 12 TIMES)	GROUP	12	1055	1066
56.	CHILD HEALTH INSURANCE PROGRAM (CHIP) CODE - FIRST MONTH	NUM	1	1055	1055
**	MEDICAID WAIVER GROUP - MONTHLY (OCCURS 12 TIMES)	GROUP	108	1067	1174
57.	MAX WAIVER TYPE CODE - 1 - FIRST MONTH	CHAR	1	1067	1067
58.	WAIVER ID - 1 - FIRST MONTH	CHAR	2	1068	1069
59.	MAX WAIVER TYPE CODE - 2 - FIRST MONTH	CHAR	1	1070	1070
60.	WAIVER ID - 2 - FIRST MONTH	CHAR	2	1071	1072
61.	MAX WAIVER TYPE CODE - 3 - FIRST MONTH	CHAR	1	1073	1073
62.	WAIVER ID - 3 - FIRST MONTH	CHAR	2	1074	1075
63.	ANNUAL 1915(C) MAX WAIVER TYPE - MOST RECENT	CHAR	1	1175	1175
***	UTILIZATION AND PAYMENT SUMMARY REGION	REGION	1720	1176	3039
64.	RECIPIENT INDICATOR	CHAR	1	1176	1176
**	INPATIENT HOSPITAL UTILIZATION SUMMARY	GROUP	18	1177	1194
65.	TOTAL INPATIENT DISCHARGE COUNT	NUM*	3	1177	1179
66.	TOTAL INPATIENT STAY COUNT	NUM*	3	1180	1182
67.	TOTAL INPATIENT LENGTH OF STAY (LOS), IN DAYS (FOR DISCHARGES)	NUM*	3	1183	1185
68.	TOTAL INPATIENT LENGTH OF STAY (LOS), IN DAYS (FOR STAYS)	NUM*	3	1186	1188
69.	TOTAL INPATIENT COVERED DAY COUNT (FOR DISCHARGES)	NUM*	3	1189	1191
70.	TOTAL INPATIENT COVERED DAY COUNT (FOR STAYS)	NUM*	3	1192	1194
**	INSTITUTIONAL LONG-TERM CARE UTILIZATION SUMMARY GROUP	GROUP	15	1195	1209
71.	LONG-TERM CARE MENTAL HOSPITAL FOR THE AGED COVERED DAY COUNT	NUM*	3	1195	1197
72.	LONG-TERM CARE INPATIENT PSYCHIATRIC FACILITY (AGE < 21) COVERED DAY COUNT	NUM*	3	1198	1200
73.	INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELLECTUAL DISABLITIES - ICF-IID COVERED DAY COUNT	NUM*	3	1201	1203
74.	NURSING FACILITY - NF - COVERED DAY COUNT	NUM*	3	1204	1206

DATA ELEMENTS WITH TYPE NUM* ARE IN ZONED DECIMAL (ZD) FORMAT FOR SAS USERS.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER:	ELEMENT NAME:	TYPE:	LENGTH:	BEG:	END:
75.	LONG-TERM CARE COVERED DAY COUNT	NUM*	3	1207	1209
**	CLAIMS PAYMENT SUMMARY GROUP	GROUP	60	1210	1269
76.	TOTAL MEDICAID RECORD COUNT	NUM*	5	1210	1214
77.	TOTAL MEDICAID FEE-FOR-SERVICE CLAIM COUNT	NUM*	5	1215	1219
78.	TOTAL MEDICAID PRE-PAID PLAN PREMIUM PAYMENT RECORD COUNT	NUM*	5	1220	1224
79.	TOTAL MEDICAID ENCOUNTER RECORD COUNT	NUM*	5	1225	1229
80.	TOTAL MEDICAID PAYMENT AMOUNT	NUM*	8	1230	1237
81.	TOTAL MEDICAID FEE-FOR-SERVICE PAYMENT AMOUNT	NUM*	8	1238	1245
82.	TOTAL MEDICAID PRE-PAID PLAN PREMIUM PAYMENT AMOUNT	NUM*	8	1246	1253
83.	TOTAL MEDICAID CHARGE AMOUNT	NUM*	8	1254	1261
84.	TOTAL THIRD PARTY PAYMENT AMOUNT	NUM*	8	1262	1269
**	PROGRAM TYPE SUMMARY GROUP - TYPE OF PROGRAM 2 - 7 (OCCURS 6 TIMES)	GROUP	330	1270	1599
85.	INPATIENT HOSPITAL RECORDS - FIRST TYPE OF PROGRAM	NUM	3	1270	1272
86.	INPATIENT HOSPITAL PAYMENTS - FIRST TYPE OF PROGRAM	NUM*	8	1273	1280
87.	INSTITUTIONAL LONG-TERM CARE RECORDS - FIRST TYPE OF PROGRAM	NUM	3	1281	1283
88.	INSTITUTIONAL LONG-TERM CARE PAYMENTS - FIRST TYPE OF PROGRAM	NUM*	8	1284	1291
89.	OTHER SERVICE RECORDS - FIRST TYPE OF PROGRAM	NUM	3	1292	1294
90.	OTHER SERVICE PAYMENTS - FIRST TYPE OF PROGRAM	NUM*	8	1295	1302
91.	PRESCRIPTION DRUG RECORDS - FIRST TYPE OF PROGRAM	NUM	3	1303	1305
92.	PRESCRIPTION DRUG PAYMENTS - FIRST TYPE OF PROGRAM	NUM*	8	1306	1313
93.	TOTAL RECORDS - FIRST TYPE OF PROGRAM	NUM	3	1314	1316
94.	TOTAL PAYMENTS - FIRST TYPE OF PROGRAM	NUM*	8	1317	1324
95.	DELIVERY CODE	NUM	1	1600	1600
**	TYPE OF SERVICE GROUP - MAX TOS (OCCURS 31 TIMES)	GROUP	1085	1601	2685
96.	RECIPIENT INDICATOR - FIRST MAX TOS	CHAR	1	1601	1601
97.	FEE-FOR-SERVICE CLAIM COUNT - FIRST MAX TOS	NUM*	5	1602	1606
98.	FEE-FOR-SERVICE MEDICAID PAYMENT AMOUNT - FIRST MAX TOS	NUM*	8	1607	1614
99.	FEE-FOR-SERVICE CHARGE AMOUNT - FIRST MAX TOS	NUM*	8	1615	1622
100.	FEE-FOR-SERVICE THIRD PARTY PAYMENT AMOUNT - FIRST MAX TOS	NUM*	8	1623	1630
101.	ENCOUNTER RECORD COUNT - FIRST MAX TOS	NUM	5	1631	1635
**	MEDICAID COMMUNITY-BASED LONG-TERM CARE (CLTC) PAYMENT SUMMARY GROUP - CLTC (OCCURS 21 TIMES BY CLTC INDICATOR FLAG)	GROUP	168	2686	2853

DATA ELEMENTS WITH TYPE NUM* ARE IN ZONED DECIMAL (ZD) FORMAT FOR SAS USERS.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER:	ELEMENT NAME:	TYPE:	LENGTH:	BEG:	END:
102.	MEDICAID PAYMENT AMOUNT - FIRST TYPE OF CLTC	NUM*	8	2686	2693
**	MEDICAID HOME AND COMMUNITY-BASED SERVICES (HCBS) PAYMENT SUMMARY GROUP - (OCCURS 18 TIMES BY FIRST TWO BYTES OF TAXONOMY CODE)	GROUP	144	2854	2997
103.	MEDICAID PAYMENT AMOUNT - FIRST TYPE OF HCBS TAXONOMY	NUM*	8	2854	2861
**	PREMIUM PAYMENT GROUP (OCCURS FOUR TIMES, ONE FOR EACH MAX TYPE OF PREMIUM TOS = 20 - 23)	GROUP	42	2998	3053
104.	PREMIUM PAYMENT INDICATOR - FIRST TYPE OF PREMIUM	NUM*	1	2998	2998
105.	PREMIUM PAYMENT RECORD COUNT - FIRST TYPE OF PREMIUM	NUM*	5	2999	3003
106.	MEDICAID PREMIUM PAYMENT AMOUNT - FIRST TYPE OF PREMIUM	NUM*	8	3004	3011
107.	ENCOUNTER RECORD COUNT - HCBS	NUM	5	3054	3058
108.	T-MSIS ELIGIBILITY GROUP - MONTHLY (OCCURS 12 TIMES)	GROUP	24	3059	3082
109.	T-MSIS ELIGIBILITY GROUP - FIRST MONTH	CHAR	2	3059	3060
110.	T-MSIS ELIGIBILITY GROUP - MOST RECENT	CHAR	2	3083	3084

DATA ELEMENTS WITH TYPE NUM* ARE IN ZONED DECIMAL (ZD) FORMAT FOR SAS USERS.

MEDICAID ANALYTIC EXTRACT (MAX)

DATA ELEMENT DICTIONARY FOR

PERSON SUMMARY RECORD (PS)

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: ****

ELEMENT NAME: **MEDICAID ANALYTIC EXTRACT (MAX) PERSON SUMMARY RECORD**

SAS VARIABLE: NONE

TYPE: REC LENGTH: 3084 BEG: 1 END: 3084

DESCRIPTION:

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 (CHIP). IF THE PERSON WAS ENROLLED IN A MEDICAID-EXPANSION CHIP PROGRAM (M-CHIP), THERE WILL BE MEDICAID ENROLLMENT DURING THE YEAR. M-CHIP ENROLLMENT WILL BE INDICATED (SEE 'ELIGIBLE STATE CHILD HEALTH INSURANCE PROGRAM (CHIP) CODE', VALUE = 2). FOR PERSONS ENROLLED IN NON-MEDICAID STAND-ALONE (SEPARATE) CHIP PROGRAMS (S-CHIP) ONLY, REPORTING IN MSIS IS OPTIONAL FOR STATES. FOR S-CHIP ENROLLEES, THERE WILL BE NO MEDICAID ENROLLMENT. S-CHIP ENROLLMENT WILL BE INDICATED (SEE 'ELIGIBLE STATE CHILD HEALTH INSURANCE PROGRAM (CHIP) CODE', VALUE = 3). THERE MAY BE NO UTILIZATION OR PAYMENT RECORDS FOR S-CHIP ENROLLEES.

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 MEDICAID ELIGIBILITY DATA SWITCH'.

MSIS RECORDS WITH TYPE OF CLAIM = 4 AND/OR THOSE WITH THE FIRST CHARACTER OF THE ELIGIBLE IDENTIFICATION NUMBER HAVING VALUE "&" (SERVICE TRACKING CLAIMS) ARE EXCLUDED FROM ALL MAX FILES.

LINK TO THE MEDICARE ENROLLMENT DATA BASE (EDB) PROCESS:

RECORDS FROM THIS FILE HAVE BEEN LINKED TO THE MEDICARE EDB TO BETTER IDENTIFY MEDICAID ENROLLEES WHO ARE ALSO ENROLLED IN MEDICARE (SO CALLED DUAL OR MEDICARE ELIGIBLES). THE PROCESS FOR LINKING A MAX RECORD TO AN EDB RECORD OCCURS IN THREE PASSES, AS FOLLOWS:

PASS 1 - THERE IS AN ATTEMPT TO LINK MAX SSN TO AN SSN IN THE EDB. IF THE MAX SSN LINKS TO AN EDB SSN, GENDER MATCHES AND DATE OF BIRTH MATCHES ON AT LEAST TWO OF THREE ELEMENTS (DAY, MONTH AND YEAR), A LINK IS ESTABLISHED. DATA USERS SHOULD NOTE THAT THIS IS A CHANGE FROM PRIOR YEARS.

PASS 2 - FOR ALL UNMATCHED MAX SSNs FROM PASS 1, THERE IS AN ATTEMPT TO LINK THESE SSNs TO A CLAIM ACCOUNT NUMBER (CAN) FROM THE HEALTH INSURANCE CLAIM (HIC) DATA ELEMENT ON THE MEDICARE EDB. IF THE MAX SSN LINKS TO AN EDB CAN, GENDER MATCHES AND DATE OF BIRTH MATCHES ON AT LEAST TWO OF THREE ELEMENTS (DAY, MONTH AND YEAR), A LINK IS ESTABLISHED. 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.

PASS 3 - FOR ALL UNMATCHED MAX RECORDS FROM PASSES 1 AND 2, THERE IS AN ATTEMPT TO LINK MEDICARE HEALTH INSURANCE CLAIM (HIC) NUMBERS REPORTED TO MEDICAID TO HIC NUMBERS IN THE MEDICARE EDB. IF THE MAX HIC LINKS TO AN EDB HIC, GENDER MATCHES AND DATE OF BIRTH MATCHES ON AT LEAST TWO OF THREE ELEMENTS (DAY, MONTH AND YEAR), A LINK IS ESTABLISHED.

FOR LINKED RECORDS, SELECTED EDB DATA ELEMENTS ARE ADDED TO THE MAX FILES:
ELIGIBLE MEDICARE HEALTH INSURANCE CLAIM (HIC) NUMBER
MEDICARE RACE/ETHNICITY
MEDICARE LANGUAGE CODE
ELIGIBLE MEDICARE DEATH DATE
ELIGIBLE MEDICARE DEATH DAY SWITCH
ELIGIBLE MEDICARE BENEFICIARY MONTHS COUNT
MEDICARE ORIGINAL ENTITLEMENT REASON CODE
ELIGIBLE MEDICARE BENEFICIARY - MONTHLY

IN ADDITION, ELIGIBLE MEDICARE DUAL CODE - ANNUAL HAS ADDITIONAL CODE VALUES TO REFLECT THE MAX/EDB LINK. BEGINNING IN MAX 2006, TWO MORE VARIABLES, ELIGIBLE MEDICARE DUAL CODE - QUARTERLY AND ELIGIBLE MEDICARE DUAL CODE - MONTHLY, CONTAIN THE ADDITIONAL CODE VALUES TO REFLECT THE MAX/EDB LINK.

MAX TYPE OF SERVICE CHANGES FOR 1999:

THE LIST OF MAX TYPES OF SERVICE (TOS) HAVE BEEN EXPANDED FOR 1999 TOPAGEBREAK2HEREINCLUDE:
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

THESE TYPES OF SERVICE HAVE BEEN ADDED TO THE EXISTING LIST AND ARE NOW REPORTED FOR THE FOLLOWING DATA ELEMENTS:
RECIPIENT INDICATOR - TYPE OF SERVICE,
RECIPIENT FEE-FOR-SERVICE CLAIM COUNT - TYPE OF SERVICE,
RECIPIENT FEE-FOR-SERVICE MEDICAID PAYMENT AMOUNT - TYPE OF SERVICE,
RECIPIENT FEE-FOR-SERVICE CHARGE AMOUNT - TYPE OF SERVICE,
RECIPIENT FEE-FOR-SERVICE THIRD PARTY PAYMENT AMOUNT - TYPE OF SERVICE, AND
RECIPIENT ENCOUNTER RECORD COUNT - TYPE OF SERVICE.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: ***

ELEMENT NAME: **MEDICAID ELIGIBILITY REGION**

SAS VARIABLE: NONE

TYPE: REGION LENGTH: 1175 BEG: 1 END: 1175

DESCRIPTION:

SUMMARIZED INFORMATION FROM MSIS AND MEDICARE ELIGIBILITY FILES.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: **

ELEMENT NAME: **IDENTIFYING GROUP**

SAS VARIABLE: NONE

TYPE: GROUP LENGTH: 81 BEG: 1 END: 81

DESCRIPTION:

DATA ELEMENTS USED TO IDENTIFY A MEDICAID ELIGIBLE.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 1.

ELEMENT NAME: **MSIS IDENTIFICATION NUMBER**

SAS VARIABLE: MSIS_ID

TYPE: CHAR LENGTH: 20 BEG: 1 END: 20

DESCRIPTION:

UNIQUE IDENTIFICATION NUMBER USED TO IDENTIFY A MEDICAID ELIGIBLE IN THE MEDICAID STATISTICAL INFORMATION SYSTEM (MSIS).

SOURCE: MSIS ELIGIBILITY FILES: 'MSIS-IDENTIFICATION-NUMBER'.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 2.

ELEMENT NAME: **STATE ABBREVIATION CODE**

SAS VARIABLE: STATE_CD

TYPE: CHAR LENGTH: 2 BEG: 21 END: 22

DESCRIPTION:

U. S. POSTAL SERVICE 2-CHARACTER ABBREVIATION FOR THE STATE MEDICAID AGENCY SUBMITTING THE DATA.

CODES:
AL = ALABAMA
AK = ALASKA
AZ = ARIZONA
AR = ARKANSAS
CA = CALIFORNIA
CO = COLORADO
CT = CONNECTICUT
DE = DELAWARE
DC = DISTRICT OF COLUMBIA
FL = FLORIDA
GA = GEORGIA
GU = GUAM/AMERICAN SAMOA
HI = HAWAII
ID = IDAHO
IL = ILLINOIS
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 FILE NAME.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 3.

ELEMENT NAME: **MAX YEAR DATE**

SAS VARIABLE: MAX_YR_DT

TYPE: NUM LENGTH: 4 BEG: 23 END: 26

DESCRIPTION:

CALENDAR YEAR COVERED BY THE MAX PERSON SUMMARY FILE.

EDIT-RULES: YYYY

USER NOTE: THIS DATA ELEMENT WAS CHANGED TO 4 CHARACTERS IN 1996.

SOURCE: MSIS ELIGIBILITY FILES.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 4.

ELEMENT NAME: **SOCIAL SECURITY NUMBER - FROM MSIS**

SAS VARIABLE: EL_SSN

TYPE: CHAR LENGTH: 9 BEG: 27 END: 35

DESCRIPTION:

SOCIAL SECURITY NUMBER OF THE MEDICAID ELIGIBLE.

USER NOTE: NOT AVAILABLE FOR SOME NEW YORK ELIGIBLES IN 1999. WHERE SOCIAL SECURITY NUMBER IS UNAVAILABLE, THIS DATA ELEMENT IS 9-FILLED.

USER NOTE: WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION, THIS DATA ELEMENT IS 9-FILLED.

SOURCE: MSIS ELIGIBILITY FILES: 'SOCIAL-SECURITY-NUMBER'.

NOTE: IN MAX 2008, A CLARIFICATION NOTE WAS ADDED ABOUT THE VALUE ASSIGNED WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 5.

ELEMENT NAME: **FILLER**

SAS VARIABLE: FILLER_1

TYPE: CHAR LENGTH: 1 BEG: 36 END: 36

DESCRIPTION:

HGT_FLAG VARIABLE DELETED IN MAX 2011. FILLER VARIABLE CREATED IN PLACE OF HGT_FLAG VARIABLE.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 6.

ELEMENT NAME: **SOCIAL SECURITY NUMBER FROM EXTERNAL SOURCE**

SAS VARIABLE: EXT_SSN

TYPE: CHAR LENGTH: 9 BEG: 37 END: 45

DESCRIPTION:

SOCIAL SECURITY NUMBER FROM EXTERNAL SOURCE.

USER NOTE: THIS FIELD IS 8-FILLED FOR RECORDS WITH NO ADDITIONAL SOURCES OF SOCIAL SECURITY NUMBER INFORMATION.

USER NOTE: WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION, THIS DATA ELEMENT IS 9-FILLED.

SOURCE: SEE MAX VARIABLE 'EXTERNAL SOCIAL SECURITY NUMBER (SSN) SOURCE'.

NOTE: IN MAX 2005, THIS VARIABLE WAS ADDED TO THE FILE.

NOTE: IN MAX 2008, A CLARIFICATION NOTE WAS ADDED ABOUT THE VALUE ASSIGNED WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 7.

ELEMENT NAME: **EXTERNAL SOCIAL SECURITY NUMBER (SSN) SOURCE**

SAS VARIABLE: EXT_SSN_SRCE

TYPE: CHAR LENGTH: 1 BEG: 46 END: 46

DESCRIPTION:

EXTERNAL SOCIAL SECURITY NUMBER INFORMATION SOURCE.

CODES:
0 = NO EXTERNAL SSN ADDED (PERSON WITH MAX ELIGIBILITY INFORMATION)
1 = SSN ADDED FROM MEDICARE ENROLLMENT DATA BASE (EDB)
2 = SSN ADDED FROM STATE-PROVIDED CROSS-REFERENCE FILE
9 = NO ELIGIBILITY INFORMATION (PERSON WITH MEDICAID CLAIMS ONLY)

NOTE: IN MAX 2005, THIS VARIABLE WAS ADDED TO THE FILE.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 8.

ELEMENT NAME: **STATE CASE NUMBER**

SAS VARIABLE: EL_STATE_CASE_NUM

TYPE: CHAR LENGTH: 12 BEG: 47 END: 58

DESCRIPTION:

STATE-ASSIGNED NUMBER WHICH UNIQUELY IDENTIFIES THE MEDICAID CASE TO WHICH THE ENROLLEE BELONGS ON THE LAST DAY OF THE FEDERAL FISCAL YEAR.

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.

USER NOTE: WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION, THIS DATA ELEMENT IS BLANK-FILLED.

SOURCE: MSIS ELIGIBILITY FILES: 'MSIS-CASE-NUMBER'.

NOTE: IN MAX 2008, A CLARIFICATION NOTE WAS ADDED ABOUT THE VALUE ASSIGNED WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 9.

ELEMENT NAME: **MEDICARE HEALTH INSURANCE CLAIM (HIC) NUMBER - FROM MSIS**

SAS VARIABLE: EL_HIC_NUM

TYPE: CHAR LENGTH: 12 BEG: 59 END: 70

DESCRIPTION:

THE ELIGIBLE'S HEALTH INSURANCE CLAIM (HIC) NUMBER FROM MEDICAID (MSIS). THIS NUMBER IS APPLICABLE ONLY TO MEDICAID ELIGIBLES WHO ARE ALSO ELIGIBLE (FROM MEDICAID) FOR MEDICARE AND IS ASSIGNED TO AN ELIGIBLE BY THE MEDICARE PROGRAM.

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.

USER NOTE: WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION, THIS DATA ELEMENT IS BLANK-FILLED.

SOURCE: MSIS ELIGIBILITY FILES: 'HIC-NUMBER'.

NOTE: IN MAX 2008, A CLARIFICATION NOTE WAS ADDED ABOUT THE VALUE ASSIGNED WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 10.

ELEMENT NAME: **MEDICARE HEALTH INSURANCE CLAIM (HIC) NUMBER - FROM MEDICARE**

SAS VARIABLE: EDB_HIC_NUM

TYPE: CHAR LENGTH: 11 BEG: 71 END: 81

DESCRIPTION:

THE ELIGIBLE'S HEALTH INSURANCE CLAIM (HIC) NUMBER FROM THE MEDICARE ENROLLMENT DATA BASE (EDB). THIS NUMBER IS APPLICABLE ONLY TO MEDICAID ELIGIBLES WHO ARE ALSO ELIGIBLE.

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' REPORTED BY MEDICAID IS NOT FOUND IN THE EDB OR IS INVALID, THIS HIC WILL BE BLANK-FILLED.

SOURCE: MEDICARE EDB: BENEFICIARY CLAIM ACCOUNT NUMBER (CAN) AND BENEFICIARY IDENTIFICATION CODE (BIC).

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: **

ELEMENT NAME: **DEMOGRAPHIC GROUP**

SAS VARIABLE: NONE

TYPE: GROUP LENGTH: 53 BEG: 82 END: 134

DESCRIPTION:

FIELDS CONTAINING DEMOGRAPHIC DATA FOR THE ELIGIBLE.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 11.

ELEMENT NAME: **BIRTH DATE**

SAS VARIABLE: EL_DOB

TYPE: NUM LENGTH: 8 BEG: 82 END: 89

DESCRIPTION:

BIRTH DATE OF THE MEDICAID ELIGIBLE.

EDIT-RULES: YYYYMMDD

USER NOTE: WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION, THIS DATA ELEMENT IS 0-FILLED.

SOURCE: MSIS ELIGIBILITY FILES: 'DATE-OF-BIRTH'. MSIS DATES WITH 8- OR 9-FILL VALUES ARE CHANGED TO 0-FILL (ZERO-FILL).

NOTE: IN MAX 2008, A CLARIFICATION NOTE WAS ADDED ABOUT THE VALUE ASSIGNED WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 12.

ELEMENT NAME: **AGE GROUP CODE**

SAS VARIABLE: EL_AGE_GRP_CD

TYPE: NUM LENGTH: 1 BEG: 90 END: 90

DESCRIPTION:

CODE INDICATING AGE GROUP OF THE MEDICAID ELIGIBLE.

CODES:
0 = UNDER 1 YEAR
1 = AGES 1 TO 5 YEARS
2 = AGES 6 TO 14 YEARS
3 = AGES 15 TO 20 YEARS
4 = AGES 21 TO 44 YEARS
5 = AGES 45 TO 64 YEARS
6 = AGES 65 TO 74 YEARS
7 = AGES 75 TO 84 YEARS
8 = AGES 85 AND OVER
9 = UNKNOWN/ERROR

USER NOTE: WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION, THIS DATA ELEMENT IS 9-FILLED.

SOURCE: RECODED FROM MSIS ELIGIBILITY FILE USING 'ELIGIBLE-BIRTH-DATE' AND DECEMBER 31 OF THE FILE YEAR TO CALCULATE AGE GROUP.

NOTE: IN MAX 2008, A CLARIFICATION NOTE WAS ADDED ABOUT THE VALUE ASSIGNED WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 13.

ELEMENT NAME: **SEX CODE**

SAS VARIABLE: EL_SEX_CD

TYPE: CHAR LENGTH: 1 BEG: 91 END: 91

DESCRIPTION:

CODE INDICATING GENDER OF THE MEDICAID ELIGIBLE.

CODES:
F = FEMALE
M = MALE
U = UNKNOWN/ERROR

USER NOTE: THESE CODES ARE 1 (FEMALE), 2 (MALE) AND 9 (UNKNOWN) IN THE 1996-98 MSIS DATA.

USER NOTE: WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION, THIS DATA ELEMENT IS SET TO 'U'.

SOURCE: MSIS ELIGIBILITY FILES: 'SEX-CODE'.

NOTE: IN MAX 2008, A CLARIFICATION NOTE WAS ADDED ABOUT THE VALUE ASSIGNED WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 14.

ELEMENT NAME: **RACE/ETHNICITY CODE**

SAS VARIABLE: EL_RACE_ETHNCY_CD

TYPE: CHAR LENGTH: 1 BEG: 92 END: 92

DESCRIPTION:

CODE INDICATING RACE/ETHNICITY OF THE MEDICAID ELIGIBLE.

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 ALASKA 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 (HISPANIC OR LATINO NOT INDICATED) (NEW CODE BEGINNING 10/98)
9 = UNKNOWN

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.

USER NOTE: WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION, THIS DATA ELEMENT IS 9-FILLED.

SOURCE: MSIS ELIGIBILITY FILES: 'RACE-ETHNICITY-CODE'.

NOTE: IN MAX 2008, A CLARIFICATION NOTE WAS ADDED ABOUT THE VALUE ASSIGNED WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 15.

ELEMENT NAME: **RACE - WHITE**

SAS VARIABLE: RACE_CODE_1

TYPE: CHAR LENGTH: 1 BEG: 93 END: 93

DESCRIPTION:

A CODE INDICATING IF THE ELIGIBLE HAS INDICATED A RACE OF WHITE.

CODES:
0 = NON-WHITE OR RACE UNKNOWN
1 = WHITE
9 = NO ELIGIBILITY INFORMATION (PERSON WITH MEDICAID CLAIMS ONLY)

SOURCE: MSIS ELIGIBILITY FILES: 'RACE-CODE-1'.

NOTE: IN MAX 2005, THIS VARIABLE WAS ADDED TO THE FILE.

NOTE: IN MAX 2008, ADDED VALUE 9.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 16.

ELEMENT NAME: **RACE - BLACK/AFRICAN AMERICAN**

SAS VARIABLE: RACE_CODE_2

TYPE: CHAR LENGTH: 1 BEG: 94 END: 94

DESCRIPTION:

A CODE INDICATING IF THE ELIGIBLE HAS INDICATED A RACE OF BLACK OR AFRICAN AMERICAN.

CODES:
0 = NON-BLACK/AFRICAN AMERICAN OR RACE UNKNOWN
1 = BLACK OR AFRICAN AMERICAN
9 = NO ELIGIBILITY INFORMATION (PERSON WITH MEDICAID CLAIMS ONLY)

SOURCE: MSIS ELIGIBILITY FILES: 'RACE-CODE-2'.

NOTE: IN MAX 2005, THIS VARIABLE WAS ADDED TO THE FILE.

NOTE: IN MAX 2008, ADDED VALUE 9.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 17.

ELEMENT NAME: **RACE - AMERICAN INDIAN/ALASKAN NATIVE**

SAS VARIABLE: RACE_CODE_3

TYPE: CHAR LENGTH: 1 BEG: 95 END: 95

DESCRIPTION:

A CODE INDICATING IF THE ELIGIBLE HAS INDICATED A RACE OF AMERICAN INDIAN/ALASKA NATIVE.

CODES:
0 = NON-AMERICAN INDIAN/ALASKA NATIVE OR RACE UNKNOWN
1 = AMERICAN INDIAN/ALASKA NATIVE
9 = NO ELIGIBILITY INFORMATION (PERSON WITH MEDICAID CLAIMS ONLY)

SOURCE: MSIS ELIGIBILITY FILES: 'RACE-CODE-3'.

NOTE: IN MAX 2005, THIS VARIABLE WAS ADDED TO THE FILE.

NOTE: IN MAX 2008, ADDED VALUE 9.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 18.

ELEMENT NAME: **RACE - ASIAN**

SAS VARIABLE: RACE_CODE_4

TYPE: CHAR LENGTH: 1 BEG: 96 END: 96

DESCRIPTION:

A CODE INDICATING IF THE ELIGIBLE HAS INDICATED A RACE OF ASIAN.

CODES:
0 = NON-ASIAN OR RACE UNKNOWN
1 = ASIAN
9 = NO ELIGIBILITY INFORMATION (PERSON WITH MEDICAID CLAIMS ONLY)

SOURCE: MSIS ELIGIBILITY FILES: 'RACE-CODE-4'.

NOTE: IN MAX 2005, THIS VARIABLE WAS ADDED TO THE FILE.

NOTE: IN MAX 2008, ADDED VALUE 9.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 19.

ELEMENT NAME: **RACE - NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER**

SAS VARIABLE: RACE_CODE_5

TYPE: CHAR LENGTH: 1 BEG: 97 END: 97

DESCRIPTION:

A CODE INDICATING IF THE ELIGIBLE HAS INDICATED A RACE OF NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER.

CODES:
0 = NON-NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER OR RACE UNKNOWN
1 = NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER
9 = NO ELIGIBILITY INFORMATION (PERSON WITH MEDICAID CLAIMS ONLY)

SOURCE: MSIS ELIGIBILITY FILES: 'RACE-CODE-5'.

NOTE: IN MAX 2005, THIS VARIABLE WAS ADDED TO THE FILE.

NOTE: IN MAX 2008, ADDED VALUE 9.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 20.

ELEMENT NAME: **ETHNICITY - HISPANIC OR LATINO**

SAS VARIABLE: ETHNICITY_CODE

TYPE: CHAR LENGTH: 1 BEG: 98 END: 98

DESCRIPTION:

A CODE INDICATING IF THE ELIGIBLE HAS INDICATED AN ETHNICITY OF HISPANIC OR LATINO.

CODES:
0 = NON-HISPANIC OR LATINO
1 = HISPANIC OR LATINO
9 = ETHNICITY UNKNOWN

USER NOTE: WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION, THIS DATA ELEMENT IS 9-FILLED.

SOURCE: MSIS ELIGIBILITY FILES: 'ETHNICITY-CODE'.

NOTE: IN MAX 2005, THIS VARIABLE WAS ADDED TO THE FILE.

NOTE: IN MAX 2008, A CLARIFICATION NOTE WAS ADDED ABOUT THE VALUE ASSIGNED WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 21.

ELEMENT NAME: **MEDICARE RACE/ETHNICITY CODE**

SAS VARIABLE: MDCR_RACE_ETHNCY_CD

TYPE: CHAR LENGTH: 1 BEG: 99 END: 99

DESCRIPTION:

RACE/ETHNICITY OF THE MEDICARE ELIGIBLE.

CODES:
0 = UNKNOWN
1 = WHITE
2 = BLACK
3 = OTHER
4 = ASIAN
5 = HISPANIC
6 = NORTH AMERICAN NATIVE

USER NOTE: WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION, THIS DATA ELEMENT IS 0-FILLED.

SOURCE: MEDICARE ENROLLMENT DATA BASE (EDB): BENEFICIARY RACE.

NOTE: IN MAX 2005, THIS VARIABLE WAS MODIFIED FROM TYPE NUMERIC TO CHARACTER.

NOTE: IN MAX 2008, A CLARIFICATION NOTE WAS ADDED ABOUT THE VALUE ASSIGNED WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 22.

ELEMENT NAME: **MEDICARE LANGUAGE CODE**

SAS VARIABLE: MDCR_LANG_CD

TYPE: CHAR LENGTH: 1 BEG: 100 END: 100

DESCRIPTION:

CODE INDICATING 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

USER NOTE: WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION, THIS DATA ELEMENT IS BLANK.

SOURCE: MEDICARE ENROLLMENT DATA BASE (EDB): BENEFICIARY SSA LANGUAGE.

NOTE: IN MAX 2008, A CLARIFICATION NOTE WAS ADDED ABOUT THE VALUE ASSIGNED WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 23.

ELEMENT NAME: **SEX-RACE CODE**

SAS VARIABLE: EL_SEX_RACE_CD

TYPE: NUM LENGTH: 1 BEG: 101 END: 101

DESCRIPTION:

CODE INDICATING THE GENDER AND RACE OF THE MEDICAID ELIGIBLE.

CODES:
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

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.

USER NOTE: WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION, THIS DATA ELEMENT IS 9-FILLED.

SOURCE: RECODED FROM MSIS ELIGIBIITY 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 MAPS TO UNKNOWN.

NOTE: IN MAX 2008, A CLARIFICATION NOTE WAS ADDED ABOUT THE VALUE ASSIGNED WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 24.

ELEMENT NAME: **MEDICAID DEATH DATE**

SAS VARIABLE: EL_DOD

TYPE: NUM LENGTH: 8 BEG: 102 END: 109

DESCRIPTION:

DEATH DATE OF THE MEDICAID ELIGIBLE.

EDIT-RULES: YYYYMMDD

USER NOTE: THIS DATA ELEMENT SHOULD BE USED WITH CAUTION SINCE THERE MAY BE UNDERREPORTING OF DEATHS IN THE MSIS ELIGIBILITY FILES.

USER NOTE: WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION, THIS DATA ELEMENT IS 0-FILLED.

SOURCE: MSIS ELIGIBILITY FILES: 'DATE-OF-DEATH'. MSIS DATES WITH 8- OR 9-FILL VALUES ARE CHANGED TO 0-FILL (ZERO-FILL).

NOTE: IN MAX 2008, A CLARIFICATION NOTE WAS ADDED ABOUT THE VALUE ASSIGNED WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 25.

ELEMENT NAME: **MEDICARE DEATH DATE**

SAS VARIABLE: MDCR_DOD

TYPE: NUM LENGTH: 8 BEG: 110 END: 117

DESCRIPTION:

DEATH DATE OF THE MEDICARE BENEFICIARY.

EDIT-RULES: YYYYMMDD

USER NOTE: THIS DATE OF DEATH HAS BEEN ADDED TO THE MAX FILE BECAUSE THE MEDICAID DEATH DATE 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 MEDICARE DEATH DAY SWITCH. IF THE SOCIAL SECURITY NUMBER REPORTED BY MEDICAID IS NOT FOUND IN THE MEDICARE ENROLLMENT DATA BASE (EDB) OR IS INVALID, THE MEDICARE DEATH DATE IS 8-FILLED. IF THE PERSON HAS CLAIMS BUT NO ELIGIBILITY RECORD, THE MEDICARE DEATH DATE IS 0-FILLED. BEGINNING IN MAX 2007, IF THE PERSON HAS CLAIMS BUT NO ELIGIBILITY RECORD, THE MEDICARE DEATH DATE IS 8-FILLED.

SOURCE: MEDICARE EDB: BENEFICIARY DEATH DATE.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 26.

ELEMENT NAME: **MEDICARE DEATH DAY SWITCH**

SAS VARIABLE: MDCR_DEATH_DAY_SW

TYPE: CHAR LENGTH: 1 BEG: 118 END: 118

DESCRIPTION:

INDICATES WHETHER THE MEDICARE BENEFICIARY'S EXACT DAY OF DEATH HAS BEEN VERIFIED.

CODES:
N = DAY OF DEATH WAS NOT VERIFIED
Y = DAY OF DEATH WAS VERIFIED
BLANK = UNKNOWN

USER NOTE: THIS DATA ELEMENT SHOULD BE USED WITH 'ELIGIBLE MEDICARE DEATH DATE'. IF THE 'ELIGIBLE SOCIAL SECURITY NUMBER' REPORTED BY MEDICAID IS NOT FOUND IN THE MEDICARE ENROLLMENT DATA BASE (EDB) OR IS INVALID, THE SWITCH WILL BE BLANK-FILLED.

SOURCE: MEDICARE EDB: VERIFY BENEFICIARY DEATH DAY SWITCH.

NOTE: IN MAX 2008, ADDED VALUE BLANK.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 27.

ELEMENT NAME: **DATE OF DEATH (FROM SSA DEATH MASTER FILE)**

SAS VARIABLE: SSA_DOD

TYPE: NUM LENGTH: 8 BEG: 119 END: 126

DESCRIPTION:

DATE OF DEATH IN SSA DEATH MASTER FILE.

EDIT-RULES: YYYYMMDD

USER NOTE: THIS DATE OF DEATH HAS BEEN ADDED TO THE MAX FILE BECAUSE THE MEDICAID DEATH DATE MAY BE UNDERREPORTED OR UNRELIABLE. IF THE SOCIAL SECURITY NUMBER AND DATE OF BIRTH ON THE MAX RECORD EXACTLY MATCH THE SSA DEATH MASTER FILE AND 0 < SSA YEAR OF DEATH <= MAX CALENDAR YEAR, THE SSA DATE OF DEATH IS MOVED ONTO THE MAX FILE, OTHERWISE THE SSA DATE OF DEATH IS SET TO 8-FILL.

SOURCE: SOCIAL SECURITY ADMINISTRATION (SSA) DEATH MASTER FILE (DMF).

NOTE: IN MAX 2007, THIS VARIABLE WAS ADDED TO THE FILE.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 28.

ELEMENT NAME: **RESIDENCE COUNTY CODE**

SAS VARIABLE: EL_RSDNC_CNTY_CD_LTST

TYPE: CHAR LENGTH: 3 BEG: 127 END: 129

DESCRIPTION:

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
BLANK = UNKNOWN

USER NOTE: WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION, THIS DATA ELEMENT IS BLANK.

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.

NOTE: IN MAX 2008, ADDED VALUE BLANK.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 29.

ELEMENT NAME: **RESIDENCE ZIP CODE**

SAS VARIABLE: EL_RSDNC_ZIP_CD_LTST

TYPE: NUM LENGTH: 5 BEG: 130 END: 134

DESCRIPTION:

UNITED STATES POSTAL ZIP CODE OF THE MEDICAID ELIGIBLE'S RESIDENCE.

USER NOTE: MSIS VALIDATION ACTIVITIES WILL ACCEPT 0-FILLED RECORDS, SO FOR MAX, IF THE MSIS RECORD IS EITHER 0-FILLED OR BLANK-FILLED, THE MAX VALUE SHOULD BE RECODED AS 9-FILLED ('99999').

USER NOTE: WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION, THIS DATA ELEMENT IS 0-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.

NOTE: IN MAX 2005, THE LENGTH OF THIS VARIABLE WAS CHANGED FROM 9 TO 5.

NOTE: IN MAX 2008, A CLARIFICATION NOTE WAS ADDED ABOUT THE VALUE ASSIGNED WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: **

ELEMENT NAME: **ANNUAL MEDICAID AND OTHER HEALTH INSURANCE GROUP**

SAS VARIABLE: NONE

TYPE: GROUP LENGTH: 18 BEG: 135 END: 152

DESCRIPTION:

FIELDS CONTAINING MEDICAID AND OTHER HEALTH INSURANCE ELIGIBILITY DATA FOR THE ELIGIBLE.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 30.

ELEMENT NAME: **STATE-SPECIFIC ELIGIBILITY CODE - MOST RECENT**

SAS VARIABLE: EL_SS_ELGBLTY_CD_LTST

TYPE: CHAR LENGTH: 6 BEG: 135 END: 140

DESCRIPTION:

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, REQUIRES 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.

USER NOTE: WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION, THIS DATA ELEMENT IS 9-FILLED.

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.

NOTE: IN MAX 2008, A CLARIFICATION NOTE WAS ADDED ABOUT THE VALUE ASSIGNED WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 31.

ELEMENT NAME: **MAX UNIFORM ELIGIBILITY CODE - MOST RECENT**

SAS VARIABLE: EL_MAX_ELGBLTY_CD_LTST

TYPE: CHAR LENGTH: 2 BEG: 141 END: 142

DESCRIPTION:

STATE MEDICAID RESEARCH FILES (MAX) UNIFORM ELIGIBILITY CODE FOR THE MEDICAID ELIGIBLE - MOST RECENT OBSERVATION

CODES:
00 = NOT ELIGIBLE
11 = AGED, CASH
12 = BLIND/DISABLED, CASH
14 = CHILD (NOT CHILD OF UNEMPLOYED ADULT, NOT FOSTER CARE CHILD), ELIGIBLE UNDER SECTION 1931 OF THE ACT
15 = ADULT (NOT BASED ON UNEMPLOYMENT STATUS), ELIGIBLE UNDER SECTION 1931 OF THE ACT
16 = CHILD OF UNEMPLOYED ADULT, ELIGIBLE UNDER SECTION 1931 OF THE ACT
17 = UNEMPLOYED ADULT, ELIGIBLE UNDER SECTION 1931 OF THE ACT
21 = AGED, MEDICALLY NEEDY
22 = BLIND/DISABLED, MEDICALLY NEEDY
24 = CHILD, MEDICALLY NEEDY (FORMERLY AFDC CHILD, MEDICALLY NEEDY)
25 = ADULT, MEDICALLY NEEDY (FORMERLY AFDC ADULT, MEDICALLY NEEDY)
31 = AGED, POVERTY
32 = BLIND/DISABLED, POVERTY
34 = CHILD, POVERTY (INCLUDES MEDICAID EXPANSION CHIP 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
44 = OTHER CHILD
45 = OTHER ADULT
48 = FOSTER CARE CHILD
51 = AGED, SECTION 1115 DEMONSTRATION EXPANSION
52 = BLIND/DISABLED, SECTION 1115 DEMONSTRATION EXPANSION
54 = CHILD, SECTION 1115 DEMONSTRATION EXPANSION
55 = ADULT, SECTION 1115 DEMONSTRATION EXPANSION
99 = UNKNOWN ELIGIBILITY
ZZ = ASSIGNED IN RECORDS STARTING JANUARY 1, 2014, FOR MONTHS AN INDIVIDUAL WAS REPORTED IN MSIS WITH A VALID T-MSIS ELIGIBILITY GROUP, BUT NOT REPORTED WITH A MASBOE ASSIGNMENT. THIS VALUE WILL NOT BE USED ON A DUMMY RECORD.

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 MAX 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 AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC) PROGRAM, GROUPS 14-17 WERE AFDC CASH RECIPIENTS.

USER NOTE: WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION, THIS DATA ELEMENT IS 9-FILLED.

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.

NOTE: IN MAX 2008, A CLARIFICATION NOTE WAS ADDED ABOUT THE VALUE ASSIGNED WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION.

NOTE: IN MAX 2014, VALUE ZZ WAS ADDED.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 32.

ELEMENT NAME: **MISSING MEDICAID ELIGIBILITY DATA SWITCH**

SAS VARIABLE: MSNG_ELG_DATA

TYPE: CHAR LENGTH: 1 BEG: 143 END: 143

DESCRIPTION:

INDICATES PERSON FOR WHOM NO MONTHS OF ENROLLMENT IN MEDICAID WERE FOUND.

CODES:
BLANK = MEDICAID ENROLLMENT MONTHS WERE FOUND.
1 = NEITHER MEDICAID ENROLLMENT MONTHS NOR S-CHIP (CHIP CODE = 3) ENROLLMENT MONTHS WERE FOUND.
2 = S-CHIP ENROLLMENT MONTHS (CHIP CODE = 3) WERE FOUND, BUT NO MEDICAID ENROLLMENT MONTHS WERE FOUND.

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-CHIP ONLY ENROLLMENT (CHIP CODE = 3) ARE INCLUDED BECAUSE THEY DO NOT HAVE ANY MONTHS OF MEDICAID ENROLLMENT.

USER NOTE: WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION, THIS DATA ELEMENT IS SET TO 1.

SOURCE: RECODED USING MSIS ELIGIBILITY FILES.

NOTE: IN MAX 2008, A CLARIFICATION NOTE WAS ADDED ABOUT THE VALUE ASSIGNED WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 33.

ELEMENT NAME: **MONTHS OF ELIGIBILITY**

SAS VARIABLE: EL_ELGBLTY_MO_CNT

TYPE: NUM LENGTH: 2 BEG: 144 END: 145

DESCRIPTION:

TOTAL NUMBER OF MONTHS THE INDIVIDUAL WAS ELIGIBLE FOR MEDICAID DURING THE CALENDAR YEAR.

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 = 0. NOTE THAT INDIVIDUALS ENROLLED ONLY IN S-CHIP (STAND-ALONE NON-MEDICAID CHIP PROGRAMS, CHIP CODE = 3) WILL HAVE VALUE = 0 AND ARE NOT CONSIDERED TO HAVE ANY MONTHS OF MEDICAID ENROLLMENT.

USER NOTE: WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION, THIS DATA ELEMENT IS 0-FILLED.

SOURCE: RECODED USING MSIS ELIGIBILITY FILES.

NOTE: IN MAX 2008, A CLARIFICATION NOTE WAS ADDED ABOUT THE VALUE ASSIGNED WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 34.

ELEMENT NAME: **PRIVATE INSURANCE MONTHS COUNT**

SAS VARIABLE: EL_PRVT_INSRNC_MO_CNT

TYPE: NUM LENGTH: 2 BEG: 146 END: 147

DESCRIPTION:

TOTAL NUMBER OF MONTHS THE MEDICAID ELIGIBLE HAD PRIVATE INSURANCE COVERAGE DURING THE CALENDAR YEAR.

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'.

USER NOTE: WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION, THIS DATA ELEMENT IS 0-FILLED.

SOURCE: RECODED USING MSIS ELIGIBILITY FILES.

NOTE: IN MAX 2008, A CLARIFICATION NOTE WAS ADDED ABOUT THE VALUE ASSIGNED WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 35.

ELEMENT NAME: **MEDICARE DUAL CODE - ANNUAL**

SAS VARIABLE: EL_MDCR_DUAL_ANN

TYPE: CHAR LENGTH: 2 BEG: 148 END: 149

DESCRIPTION:

CODE INDICATING THAT THE ELIGIBLE IS COVERED BY MEDICARE (KNOWN AS DUAL OR MEDICARE ELIGIBILITY), ACCORDING TO MEDICAID (MSIS), MEDICARE (EDB) OR BOTH IN THE CALENDAR YEAR.

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
10 = IN MSIS, S-CHIP ELIGIBLE IS ENTITLED TO MEDICARE
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
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
60 = A RECORD WAS FOUND IN THE MEDICARE ENROLLMENT DATA BASE (EDB) FOR THE S-CHIP ELIGIBLE AND CODE 10 APPLIES
99 = IN MSIS, ELIGIBLE'S MEDICARE STATUS IS UNKNOWN

USER NOTE: THE ANNUAL DUAL CODE IS EQUAL TO THE LATEST (MOST RECENT) QUARTERLY DUAL CODE > '00' (BEGINNING WITH THE LAST QUARTER AND MOVING BACKWARDS IN TIME QUARTER BY QUARTER). IF NONE OF THE QUARTERS HAVE DUAL CODE > '00', THE ANNUAL DUAL CODE IS SET TO '00'. IF THE PERSON IS ELIGIBLE FOR MEDICAID AND ENROLLED IN THE MEDICARE ENROLLMENT DATA BASE (EDB) IN AT LEAST ONE MONTH OF THE YEAR, A '5' IS MOVED TO THE FIRST POSITION (I.E. VALUES 50-59). IF THE PERSON HAS CLAIMS BUT NO ELIGIBILITY RECORD, THE ANNUAL DUAL CODE IS SET TO '99'.

SOURCE: DERIVED FROM DATA ELEMENT 'DUAL-ELIGIBLE-CODE' IN THE MSIS ELIGIBILITY FILES AND THE EDB.

NOTE: IN MAX 2006, VALUES 50-59 WERE ADDED TO THE FILE.

NOTE: IN MAX 2009, VALUES 10 AND 60 WERE ADDED TO THE FILE.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 36.

ELEMENT NAME: **MEDICARE BENEFICIARY MONTHS COUNT**

SAS VARIABLE: EL_MDCR_BEN_MO_CNT

TYPE: NUM LENGTH: 2 BEG: 150 END: 151

DESCRIPTION:

TOTAL NUMBER OF MONTHS THE MEDICAID ELIGIBLE WAS A MEDICARE BENEFICIARY ACCORDING TO MEDICARE (EDB).

USER NOTE: THIS IS A NUMBER FROM 0 TO 12. IF THE 'ELIGIBLE SOCIAL SECURITY NUMBER' REPORTED BY MEDICAID IS NOT FOUND IN THE MEDICARE ENROLLMENT DATA BASE (EDB) OR IS INVALID, THIS COUNT WILL HAVE VALUE = 0.

USER NOTE: WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION, THIS DATA ELEMENT IS 0-FILLED.

SOURCE: MEDICARE EDB: CALCULATED USING BENEFICIARY PART A ENTITLEMENT START AND TERMINATION DATES.

NOTE: IN MAX 2008, A CLARIFICATION NOTE WAS ADDED ABOUT THE VALUE ASSIGNED WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 37.

ELEMENT NAME: **MEDICARE ORIGINAL ENTITLEMENT REASON CODE**

SAS VARIABLE: MDCR_ORIG_REAS_CD

TYPE: NUM LENGTH: 1 BEG: 152 END: 152

DESCRIPTION:

THE ORIGINAL REASON THE PERSON WAS ENTITLED TO MEDICARE BENEFITS.

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 MEDICARE ENROLLMENT DATA BASE (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 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.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: **

ELEMENT NAME: **MEDICARE DUAL GROUP - MONTHLY (OCCURS 12 TIMES)**

SAS VARIABLE: NONE

TYPE: GROUP LENGTH: 24 BEG: 153 END: 176

DESCRIPTION:

CODE INDICATING MONTHLY MEDICARE DUAL ELIGIBILITY.

USER NOTE: THIS DATA ELEMENT IS 9-FILLED IN THE 2005 MAX FILE. MONTHLY MEDICARE ENROLLMENT WILL NOT BE AVAILABLE UNTIL CALENDAR YEAR 2006.
JANUARY (POSITIONS 153 TO 154)
FEBRUARY (POSITIONS 155 TO 156)
MARCH (POSITIONS 157 TO 158)
APRIL (POSITIONS 159 TO 160)
MAY (POSITIONS 161 TO 162)
JUNE (POSITIONS 163 TO 164)
JULY (POSITIONS 165 TO 166)
AUGUST (POSITIONS 167 TO 168)
SEPTEMBER (POSITIONS 169 TO 170)
OCTOBER (POSITIONS 171 TO 172)
NOVEMBER (POSITIONS 173 TO 174)
DECEMBER (POSITIONS 175 TO 176)

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 38.

ELEMENT NAME: **MEDICARE DUAL CODE - FIRST MONTH**

SAS VARIABLE: EL_MDCR_DUAL_MO_1

TYPE: CHAR LENGTH: 2 BEG: 153 END: 154

DESCRIPTION:

CODE INDICATING THAT THE ELIGIBLE IS COVERED BY MEDICARE (KNOWN AS DUAL OR MEDICARE ELIGIBILITY), ACCORDING TO MEDICAID (MSIS), MEDICARE (EDB) OR BOTH FOR THE RESPECTIVE MONTH.

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
10 = IN MSIS, S-CHIP ELIGIBLE IS ENTITLED TO MEDICARE
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
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
60 = A RECORD WAS FOUND IN THE MEDICARE ENROLLMENT DATA BASE (EDB) FOR THE S-CHIP ELIGIBLE AND CODE 10 APPLIES
99 = IN MSIS, ELIGIBLE'S MEDICARE STATUS IS UNKNOWN

USER NOTE: THIS DATA ELEMENT IS EQUAL TO THE MSIS DATA ELEMENT 'DUAL-ELIGIBLE-CODE' (I.E. VALUES 00-09). IF THE PERSON IS ELIGIBLE FOR MEDICAID AND ENROLLED IN THE MEDICARE EDB IN THE SAME MONTH, A '5' IS MOVED TO THE FIRST POSITION (I.E. VALUES 50-59). IF THE PERSON HAS CLAIMS BUT NO ELIGIBILITY RECORD, THE VALUE IS SET TO 99.

SOURCE: DERIVED FROM DATA ELEMENT 'DUAL-ELIGIBLE-CODE' IN THE MSIS ELIGIBILITY FILES AND THE MEDICARE EDB.

NOTE: IN MAX 2005, THIS VARIABLE WAS ADDED TO THE FILE.

NOTE: IN MAX 2006, VALUES 50-59 WERE ADDED TO THE FILE.

NOTE: IN MAX 2009, VALUES 10 AND 60 WERE ADDED TO THE FILE.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: **

ELEMENT NAME: **STATE-SPECIFIC ELIGIBILITY GROUP - MONTHLY (OCCURS 12 TIMES)**

SAS VARIABLE: NONE

TYPE: GROUP LENGTH: 72 BEG: 177 END: 248

DESCRIPTION:

STATE-SPECIFIC ELIGIBILITY CODE CLASSIFICATION UNDER WHICH THE MEDICAID ELIGIBLE IS COVERED FROM JANUARY THROUGH DECEMBER. THE EXAMPLE IS FOR JANUARY.
JANUARY (POSITIONS 177 TO 182)
FEBRUARY (POSITIONS 183 TO 188)
MARCH (POSITIONS 189 TO 194)
APRIL (POSITIONS 195 TO 200)
MAY (POSITIONS 201 TO 206)
JUNE (POSITIONS 207 TO 212)
JULY (POSITIONS 213 TO 218)
AUGUST (POSITIONS 219 TO 224)
SEPTEMBER (POSITIONS 225 TO 230)
OCTOBER (POSITIONS 231 TO 236)
NOVEMBER (POSITIONS 237 TO 242)
DECEMBER (POSITIONS 243 TO 248)

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 39.

ELEMENT NAME: **STATE-SPECIFIC ELIGIBILITY CODE - FIRST MONTH**

SAS VARIABLE: SS_ELG_CD_MO_1

TYPE: CHAR LENGTH: 6 BEG: 177 END: 182

DESCRIPTION:

STATE-SPECIFIC ELIGIBILITY CODE CLASSIFICATION FOR THE MEDICAID ELIGIBLE AND FOR THE RESPECTIVE MONTH.

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.

USER NOTE: WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION, THIS DATA ELEMENT IS 9-FILLED.

SOURCE: MSIS ELIGIBILITY FILES: 'ELIGIBILITY-GROUP'.

NOTE: IN MAX 2008, A CLARIFICATION NOTE WAS ADDED ABOUT THE VALUE ASSIGNED WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: **

ELEMENT NAME: **MAX UNIFORM ELIGIBILITY GROUP - MONTHLY (OCCURS 12 TIMES)**

SAS VARIABLE: NONE

TYPE: GROUP LENGTH: 24 BEG: 249 END: 272

DESCRIPTION:

MEDICAID ANALYTIC EXTRACT (MAX) UNIFORM ELIGIBILITY CODE FOR THE MEDICAID ELIGIBLE FROM JANUARY THROUGH DECEMBER. THE EXAMPLE IS FOR JANUARY.
JANUARY (POSITIONS 249 TO 250)
FEBRUARY (POSITIONS 251 TO 252)
MARCH (POSITIONS 253 TO 254)
APRIL (POSITIONS 255 TO 256)
MAY (POSITIONS 257 TO 258)
JUNE (POSITIONS 259 TO 260)
JULY (POSITIONS 261 TO 262)
AUGUST (POSITIONS 263 TO 264)
SEPTEMBER (POSITIONS 265 TO 266)
OCTOBER (POSITIONS 267 TO 268)
NOVEMBER (POSITIONS 269 TO 270)
DECEMBER (POSITIONS 271 TO 272)

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 40.

ELEMENT NAME: **MAX UNIFORM ELIGIBILITY CODE - FIRST MONTH**

SAS VARIABLE: MAX_ELG_CD_MO_1

TYPE: CHAR LENGTH: 2 BEG: 249 END: 250

DESCRIPTION:

MEDICAID ANALYTIC EXTRACT (MAX) UNIFORM ELIGIBILITY CODE FOR THE MEDICAID ELIGIBLE AND FOR THE RESPECTIVE MONTH.

CODES:
00 = NOT ELIGIBLE
11 = AGED, CASH
12 = BLIND/DISABLED, CASH
14 = CHILD (NOT CHILD OF UNEMPLOYED ADULT, NOT FOSTER CARE CHILD), ELIGIBLE UNDER SECTION 1931 OF THE ACT
15 = ADULT (NOT BASED ON UNEMPLOYMENT STATUS), ELIGIBLE UNDER SECTION 1931 OF THE ACT
16 = CHILD OF UNEMPLOYED ADULT, ELIGIBLE UNDER SECTION 1931 OF THE ACT
17 = UNEMPLOYED ADULT, ELIGIBLE UNDER SECTION 1931 OF THE ACT
21 = AGED, MEDICALLY NEEDY
22 = BLIND/DISABLED, MEDICALLY NEEDY
24 = CHILD, MEDICALLY NEEDY (FORMERLY AFDC CHILD, MEDICALLY NEEDY)
25 = ADULT, MEDICALLY NEEDY (FORMERLY AFDC ADULT, MEDICALLY NEEDY)
31 = AGED, POVERTY
32 = BLIND/DISABLED, POVERTY
34 = CHILD, POVERTY (INCLUDES MEDICAID EXPANSION CHIP 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
44 = OTHER CHILD
45 = OTHER ADULT
48 = FOSTER CARE CHILD
51 = AGED, SECTION 1115 DEMONSTRATION EXPANSION
52 = BLIND/DISABLED, SECTION 1115 DEMONSTRATION EXPANSION
54 = CHILD, SECTION 1115 DEMONSTRATION EXPANSION
55 = ADULT, SECTION 1115 DEMONSTRATION EXPANSION
99 = UNKNOWN ELIGIBILITY
ZZ = ASSIGNED IN RECORDS STARTING JANUARY 1, 2014, FOR MONTHS AN INDIVIDUAL WAS REPORTED IN MSIS WITH A VALID T-MSIS ELIGIBILITY GROUP, BUT NOT REPORTED WITH A MASBOE ASSIGNMENT. THIS VALUE WILL NOT BE USED ON A DUMMY RECORD.

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 MAX 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 AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC) PROGRAM, GROUPS 14-17 WERE AFDC CASH RECIPIENTS.

USER NOTE: WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION, THIS DATA ELEMENT IS 9-FILLED.

SOURCE: RECODED USING MAINTENANCE ASSISTANCE STATUS (MAS) AND BASIS OF ELIGIBILITY (BOE) FROM MSIS ELIGIBILITY FILES.

NOTE: IN MAX 2008, A CLARIFICATION NOTE WAS ADDED ABOUT THE VALUE ASSIGNED WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION.

NOTE: IN MAX 2014, ZZ WAS ADDED.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: **

ELEMENT NAME: **PRIVATE INSURANCE GROUP - MONTHLY (OCCURS 12 TIMES)**

SAS VARIABLE: NONE

TYPE: GROUP LENGTH: 12 BEG: 273 END: 284

DESCRIPTION:

CODE INDICATING WHICH MONTHS THE MEDICAID ELIGIBLE HAD PRIVATE INSURANCE COVERAGE FROM JANUARY THROUGH DECEMBER. THE EXAMPLE IS FOR JANUARY.
JANUARY (POSITION 273)
FEBRUARY (POSITION 274)
MARCH (POSITION 275)
APRIL (POSITION 276)
MAY (POSITION 277)
JUNE (POSITION 278)
JULY (POSITION 279)
AUGUST (POSITION 280)
SEPTEMBER (POSITION 281)
OCTOBER (POSITION 282)
NOVEMBER (POSITION 283)
DECEMBER (POSITION 284)

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 41.

ELEMENT NAME: **PRIVATE INSURANCE CODE - FIRST MONTH**

SAS VARIABLE: EL_PVT_INS_CD_1

TYPE: NUM LENGTH: 1 BEG: 273 END: 273

DESCRIPTION:

CODE INDICATING IF THE ELIGIBLE HAD PRIVATE INSURANCE FOR THE RESPECTIVE MONTH.

CODES:
0 = NOT ELIGIBLE FOR MEDICAID OR CHIP DURING MONTH
1 = ELIGIBLE DID NOT HAVE PRIVATE (INDIVIDUAL OR EMPLOYER-SPONSORED) INSURANCE COVERAGE
2 = ELIGIBLE HAD PRIVATE (INDIVIDUAL OR EMPLOYER-SPONSORED) HEALTH INSURANCE COVERAGE PURCHASED WHOLE OR IN PART BY ELIGIBLE OR FAMILY MEMBER, OR PROVIDED AT NO COST TO ELIGIBLE

3 = ELIGIBLE HAD PRIVATE (INDIVIDUAL OR EMPLOYER-SPONSORED) HEALTH INSURANCE COVERAGE PURCHASED OR SUBSIDIZED, BY THE STATE
4 = BOTH 2 AND 3 APPLY
9 = STATE HAD ONLY INVALID OR MISSING INFORMATION

USER NOTE: WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION, THIS DATA ELEMENT IS 0-FILLED.

SOURCE: MSIS ELIGIBILITY FILES: 'HEALTH-INSURANCE'.

NOTE: IN MAX 2008, A CLARIFICATION NOTE WAS ADDED ABOUT THE VALUE ASSIGNED WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION.

IN MAX 2010, MODIFIED THE LABEL DESCRIPTION OF THE VALUES.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: **

ELEMENT NAME: **MEDICARE BENEFICIARY GROUP - MONTHLY (OCCURS 12 TIMES)**

SAS VARIABLE: NONE

TYPE: GROUP LENGTH: 12 BEG: 285 END: 296

DESCRIPTION:

CODE INDICATING WHICH MONTHS THE MEDICAID ELIGIBLE WAS A MEDICARE BENEFICIARY BASED ON FINDING A BENEFICIARY RECORD FOR THE ELIGIBLE IN THE MEDICARE ENROLLMENT DATA BASE. THE EXAMPLE IS FOR JANUARY.
JANUARY (POSITION 285)
FEBRUARY (POSITION 286)
MARCH (POSITION 287)
APRIL (POSITION 288)
MAY (POSITION 289)
JUNE (POSITION 290)
JULY (POSITION 291)
AUGUST (POSITION 292)
SEPTEMBER (POSITION 293)
OCTOBER (POSITION 294)
NOVEMBER (POSITION 295)
DECEMBER (POSITION 296)

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 42.

ELEMENT NAME: **MEDICARE BENEFICIARY CODE - FIRST MONTH**

SAS VARIABLE: EL_MDCR_BEN_MO_1

TYPE: NUM LENGTH: 1 BEG: 285 END: 285

DESCRIPTION:

CODE INDICATING WHETHER THE MEDICAID ELIGIBLE WAS COVERED BY MEDICARE FOR THE RESPECTIVE MONTH (BASED ON FINDING A BENEFICIARY RECORD FOR THE ELIGIBLE IN THE MEDICARE ENROLLMENT DATA BASE (EDB) FOR THE MONTH).

CODES:
0 = THERE WAS NO RECORD OF ELIGIBILITY FOR THE MONTH FOUND IN THE MEDICARE ENROLLMENT DATA BASE (EDB).
1 = THERE WAS A RECORD OF ELIGIBILITY FOR THE MONTH FOUND IN THE MEDICARE ENROLLMENT DATA BASE (EDB), FOR MEDICARE PART A (HOSPITAL INSURANCE).
2 = THERE WAS A RECORD OF ELIGIBILITY FOR THE MONTH FOUND IN THE MEDICARE ENROLLMENT DATA BASE (EDB), FOR MEDICARE PART B (SUPPLEMENTARY MEDICAL INSURANCE).
3 = THERE WAS A RECORD OF ELIGIBILITY FOR THE MONTH FOUND IN THE MEDICARE ENROLLMENT DATA BASE (EDB), FOR BOTH MEDICARE PART A AND PART B (BOTH HOSPITAL AND SUPPLEMENTARY MEDICAL INSURANCE).

USER NOTE: IF THE 'ELIGIBLE SOCIAL SECURITY NUMBER' REPORTED BY MEDICAID IS NOT FOUND IN THE MEDICARE EDB OR IS INVALID, THIS DATA ELEMENT WILL HAVE VALUE = 0.

USER NOTE: WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION, THIS DATA ELEMENT IS 0-FILLED.

SOURCE: MEDICARE EDB, CALCULATED USING BENEFICIARY ENTITLEMENT START AND TERMINATION DATES.

NOTE: IN MAX 2008, A CLARIFICATION NOTE WAS ADDED ABOUT THE VALUE ASSIGNED WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: **

ELEMENT NAME: **PRE-PAID PLAN MONTHS COUNT GROUP - PLAN TYPE (OCCURS 7 TIMES)**

SAS VARIABLE: NONE

TYPE: GROUP LENGTH: 14 BEG: 297 END: 310

DESCRIPTION:

FIELDS INDICATING THE 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 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.

COMPREHENSIVE MANAGED CARE PLANS - E.G. HMOs (POSITIONS 297 TO 298)
DENTAL MANAGED CARE PLANS (POSITIONS 299 T0 300)
BEHAVIORAL MANAGED CARE PLANS (POSITIONS 301 TO 302)
PRENATAL/DELIVERY MANAGED CARE PLANS (POSITIONS 303 TO 304)
LONG-TERM CARE MANAGED CARE PLANS (POSITIONS 305 TO 306)
ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) PLANS (POSITION 307 TO 308)
PRIMARY CARE CASE MANAGEMENT PLANS (PCCMs) (POSITIONS 309 TO 310)

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 43.

ELEMENT NAME: **PRE-PAID PLAN MONTHS COUNT - FIRST PLAN TYPE**

SAS VARIABLE: EL_PPH_PLN_MO_CNT_CMCP

TYPE: NUM LENGTH: 2 BEG: 297 END: 298

DESCRIPTION:

TOTAL NUMBER OF MONTHS THE MEDICAID ELIGIBLE WAS ENROLLED IN THE PARTICULAR TYPE OF PLAN DURING THE CALENDAR YEAR.

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 PRE-PAID PLAN TYPE CODES' THAT CONTAIN A CODE VALUE = 99 (ELIGIBLE'S MANAGED CARE PLAN STATUS IS UNKNOWN THIS MONTH).

USER NOTE: WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION, THIS DATA ELEMENT IS 0-FILLED.

SOURCE: CREATED USING MSIS ELIGIBILITY FILES.

NOTE: IN MAX 2008, A CLARIFICATION NOTE WAS ADDED ABOUT THE VALUE ASSIGNED WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: **

ELEMENT NAME: **PRE-PAID PLAN ENROLLMENT GROUP - MONTHLY (OCCURS 12 TIMES)**

SAS VARIABLE: NONE

TYPE: GROUP LENGTH: 672 BEG: 311 END: 982

DESCRIPTION:

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 311 TO 366)
- ELIGIBLE PRE-PAID PLAN TYPE-1 CODE (POSITIONS 311 TO 312)
- ELIGIBLE PRE-PAID PLAN IDENTIFIER-1 (POSITIONS 313 TO 324)
- ELIGIBLE PRE-PAID PLAN TYPE-2 CODE (POSITIONS 325 TO 326)
- ELIGIBLE PRE-PAID PLAN IDENTIFIER-2 (POSITIONS 327 TO 338)
- ELIGIBLE PRE-PAID PLAN TYPE-3 CODE (POSITIONS 339 TO 340)
- ELIGIBLE PRE-PAID PLAN IDENTIFIER-3 (POSITIONS 341 TO 352)
- ELIGIBLE PRE-PAID PLAN TYPE-4 CODE (POSITIONS 353 TO 354)
- ELIGIBLE PRE-PAID PLAN IDENTIFIER-4 (POSITIONS 355 TO 366)

FEBRUARY (POSITIONS 367 TO 422)
- ELIGIBLE PRE-PAID PLAN TYPE-1 CODE (POSITIONS 367 TO 368)
- ELIGIBLE PRE-PAID PLAN IDENTIFIER-1 (POSITIONS 369 TO 380)
- ELIGIBLE PRE-PAID PLAN TYPE-2 CODE (POSITIONS 381 TO 382)
- ELIGIBLE PRE-PAID PLAN IDENTIFIER-2 (POSITIONS 383 TO 394)
- ELIGIBLE PRE-PAID PLAN TYPE-3 CODE (POSITIONS 395 TO 396)
- ELIGIBLE PRE-PAID PLAN IDENTIFIER-3 (POSITIONS 397 TO 408)
- ELIGIBLE PRE-PAID PLAN TYPE-4 CODE (POSITIONS 409 TO 410)
- ELIGIBLE PRE-PAID PLAN IDENTIFIER-4 (POSITIONS 411 TO 422)

MARCH (POSITIONS 423 TO 478)
- ELIGIBLE PRE-PAID PLAN TYPE-1 CODE (POSITIONS 423 TO 424)
- ELIGIBLE PRE-PAID PLAN IDENTIFIER-1 (POSITIONS 425 TO 436)
- ELIGIBLE PRE-PAID PLAN TYPE-2 CODE (POSITIONS 437 TO 438)
- ELIGIBLE PRE-PAID PLAN IDENTIFIER-2 (POSITIONS 439 TO 450)
- ELIGIBLE PRE-PAID PLAN TYPE-3 CODE (POSITIONS 451 TO 452)
- ELIGIBLE PRE-PAID PLAN IDENTIFIER-3 (POSITIONS 453 TO 464)
- ELIGIBLE PRE-PAID PLAN TYPE-4 CODE (POSITIONS 465 TO 466)
- ELIGIBLE PRE-PAID PLAN IDENTIFIER-4 (POSITIONS 467 TO 478)

APRIL (POSITIONS 479 TO 534)
- ELIGIBLE PRE-PAID PLAN TYPE-1 CODE (POSITIONS 479 TO 480)
- ELIGIBLE PRE-PAID PLAN IDENTIFIER-1 (POSITIONS 481 TO 492)
- ELIGIBLE PRE-PAID PLAN TYPE-2 CODE (POSITIONS 493 TO 494)
- ELIGIBLE PRE-PAID PLAN IDENTIFIER-2 (POSITIONS 495 TO 506)
- ELIGIBLE PRE-PAID PLAN TYPE-3 CODE (POSITIONS 507 TO 508)
- ELIGIBLE PRE-PAID PLAN IDENTIFIER-3 (POSITIONS 509 TO 520)
- ELIGIBLE PRE-PAID PLAN TYPE-4 CODE (POSITIONS 521 TO 522)
- ELIGIBLE PRE-PAID PLAN IDENTIFIER-4 (POSITIONS 523 TO 534)

MAY (POSITIONS 535 TO 590)
- ELIGIBLE PRE-PAID PLAN TYPE-1 CODE (POSITIONS 535 TO 536)
- ELIGIBLE PRE-PAID PLAN IDENTIFIER-1 (POSITIONS 537 TO 548)
- ELIGIBLE PRE-PAID PLAN TYPE-2 CODE (POSITIONS 549 TO 550)
- ELIGIBLE PRE-PAID PLAN IDENTIFIER-2 (POSITIONS 551 TO 562)
- ELIGIBLE PRE-PAID PLAN TYPE-3 CODE (POSITIONS 563 TO 564)
- ELIGIBLE PRE-PAID PLAN IDENTIFIER-3 (POSITIONS 565 TO 576)
- ELIGIBLE PRE-PAID PLAN TYPE-4 CODE (POSITIONS 577 TO 578)
- ELIGIBLE PRE-PAID PLAN IDENTIFIER-4 (POSITIONS 579 TO 590)

JUNE (POSITIONS 591 TO 646)
- ELIGIBLE PRE-PAID PLAN TYPE-1 CODE (POSITIONS 591 TO 592)
- ELIGIBLE PRE-PAID PLAN IDENTIFIER-1 (POSITIONS 593 TO 604)
- ELIGIBLE PRE-PAID PLAN TYPE-2 CODE (POSITIONS 605 TO 606)
- ELIGIBLE PRE-PAID PLAN IDENTIFIER-2 (POSITIONS 607 TO 618)
- ELIGIBLE PRE-PAID PLAN TYPE-3 CODE (POSITIONS 619 TO 620)
- ELIGIBLE PRE-PAID PLAN IDENTIFIER-3 (POSITIONS 621 TO 632)
- ELIGIBLE PRE-PAID PLAN TYPE-4 CODE (POSITIONS 633 TO 634)
- ELIGIBLE PRE-PAID PLAN IDENTIFIER-4 (POSITIONS 635 TO 646)

JULY (POSITIONS 647 TO 702)
- ELIGIBLE PRE-PAID PLAN TYPE-1 CODE (POSITIONS 647 TO 648)
- ELIGIBLE PRE-PAID PLAN IDENTIFIER-1 (POSITIONS 649 TO 660)
- ELIGIBLE PRE-PAID PLAN TYPE-2 CODE (POSITIONS 661 TO 662)
- ELIGIBLE PRE-PAID PLAN IDENTIFIER-2 (POSITIONS 663 TO 674)

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELIGIBLE PRE-PAID PLAN TYPE-3 CODE (POSITIONS 675 TO 676)
ELIGIBLE PRE-PAID PLAN IDENTIFIER-3 (POSITIONS 677 TO 688)
ELIGIBLE PRE-PAID PLAN TYPE-4 CODE (POSITIONS 689 TO 690)
ELIGIBLE PRE-PAID PLAN IDENTIFIER-4 (POSITIONS 691 TO 702)
AUGUST (POSITIONS 703 TO 758)
ELIGIBLE PRE-PAID PLAN TYPE-1 CODE (POSITIONS 703 TO 704)
ELIGIBLE PRE-PAID PLAN IDENTIFIER-1 (POSITIONS 705 TO 716)
ELIGIBLE PRE-PAID PLAN TYPE-2 CODE (POSITIONS 717 TO 718)
ELIGIBLE PRE-PAID PLAN IDENTIFIER-2 (POSITIONS 719 TO 730)
ELIGIBLE PRE-PAID PLAN TYPE-3 CODE (POSITIONS 731 TO 732)
ELIGIBLE PRE-PAID PLAN IDENTIFIER-3 (POSITIONS 733 TO 744)
ELIGIBLE PRE-PAID PLAN TYPE-4 CODE (POSITIONS 745 TO 746)
ELIGIBLE PRE-PAID PLAN IDENTIFIER-4 (POSITIONS 747 TO 758)
SEPTEMBER (POSITIONS 759 TO 814)
ELIGIBLE PRE-PAID PLAN TYPE-1 CODE (POSITIONS 759 TO 760)
ELIGIBLE PRE-PAID PLAN IDENTIFIER-1 (POSITIONS 761 TO 772)
ELIGIBLE PRE-PAID PLAN TYPE-2 CODE (POSITIONS 773 TO 774)
ELIGIBLE PRE-PAID PLAN IDENTIFIER-2 (POSITIONS 775 TO 786)
ELIGIBLE PRE-PAID PLAN TYPE-3 CODE (POSITIONS 787 TO 788)
ELIGIBLE PRE-PAID PLAN IDENTIFIER-3 (POSITIONS 789 TO 800)
ELIGIBLE PRE-PAID PLAN TYPE-4 CODE (POSITIONS 801 TO 802)
ELIGIBLE PRE-PAID PLAN IDENTIFIER-4 (POSITIONS 803 TO 814)
OCTOBER (POSITIONS 815 TO 870)
ELIGIBLE PRE-PAID PLAN TYPE-1 CODE (POSITIONS 815 TO 816)
ELIGIBLE PRE-PAID PLAN IDENTIFIER-1 (POSITIONS 817 TO 828)
ELIGIBLE PRE-PAID PLAN TYPE-2 CODE (POSITIONS 829 TO 830)
ELIGIBLE PRE-PAID PLAN IDENTIFIER-2 (POSITIONS 831 TO 842)
ELIGIBLE PRE-PAID PLAN TYPE-3 CODE (POSITIONS 843 TO 844)
ELIGIBLE PRE-PAID PLAN IDENTIFIER-3 (POSITIONS 845 TO 856)
ELIGIBLE PRE-PAID PLAN TYPE-4 CODE (POSITIONS 857 TO 858)
ELIGIBLE PRE-PAID PLAN IDENTIFIER-4 (POSITIONS 859 TO 870)
NOVEMBER (POSITIONS 871 TO 926)
ELIGIBLE PRE-PAID PLAN TYPE-1 CODE (POSITIONS 871 TO 872)
ELIGIBLE PRE-PAID PLAN IDENTIFIER-1 (POSITIONS 873 TO 884)
ELIGIBLE PRE-PAID PLAN TYPE-2 CODE (POSITIONS 885 TO 886)
ELIGIBLE PRE-PAID PLAN IDENTIFIER-2 (POSITIONS 887 TO 898)
ELIGIBLE PRE-PAID PLAN TYPE-3 CODE (POSITIONS 899 TO 900)
ELIGIBLE PRE-PAID PLAN IDENTIFIER-3 (POSITIONS 901 TO 912)
ELIGIBLE PRE-PAID PLAN TYPE-4 CODE (POSITIONS 913 TO 914)
ELIGIBLE PRE-PAID PLAN IDENTIFIER-4 (POSITIONS 915 TO 926)
DECEMBER (POSITIONS 927 TO 982)
ELIGIBLE PRE-PAID PLAN TYPE-1 CODE (POSITIONS 927 TO 928)
ELIGIBLE PRE-PAID PLAN IDENTIFIER-1 (POSITIONS 929 TO 940)
ELIGIBLE PRE-PAID PLAN TYPE-2 CODE (POSITIONS 941 TO 942)
ELIGIBLE PRE-PAID PLAN IDENTIFIER-2 (POSITIONS 943 TO 954)
ELIGIBLE PRE-PAID PLAN TYPE-3 CODE (POSITIONS 955 TO 956)
ELIGIBLE PRE-PAID PLAN IDENTIFIER-3 (POSITIONS 957 TO 968)
ELIGIBLE PRE-PAID PLAN TYPE-4 CODE (POSITIONS 969 TO 970)
ELIGIBLE PRE-PAID PLAN IDENTIFIER-4 (POSITIONS 971 TO 982)

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 44.

ELEMENT NAME: **PRE-PAID PLAN TYPE-1 CODE - FIRST MONTH**

SAS VARIABLE: EL_PHP_TYPE_1_1

TYPE: NUM LENGTH: 2 BEG: 311 END: 312

DESCRIPTION:

CODE INDICATING THE TYPE OF THE FIRST OF UP TO FOUR MANAGED CARE PLAN TYPES IN WHICH THE ELIGIBLE WAS ENROLLED FOR THE RESPECTIVE MONTH.

CODES:
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.

USER NOTE: WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION, THIS DATA ELEMENT IS 9-FILLED.

SOURCE: MSIS ELIGIBILITY FILES: 'PLAN-TYPE-1'.

NOTE: IN MAX 2008, A CLARIFICATION NOTE WAS ADDED ABOUT THE VALUE ASSIGNED WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 45.

ELEMENT NAME: **PRE-PAID PLAN IDENTIFIER-1 - FIRST MONTH**

SAS VARIABLE: EL_PHP_ID_1_1

TYPE: CHAR LENGTH: 12 BEG: 313 END: 324

DESCRIPTION:

THE STATE ASSIGNED MANAGED CARE PLAN IDENTIFICATION NUMBER ASSOCIATED WITH PLAN TYPE-1 IN WHICH THE ELIGIBLE WAS ENROLLED FOR THE RESPECTIVE MONTH.

USER NOTE: WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION, THIS DATA ELEMENT IS BLANK-FILLED.

SOURCE: MSIS ELIGIBILITY FILES: 'PLAN-ID-1'.

NOTE: IN MAX 2008, A CLARIFICATION NOTE WAS ADDED ABOUT THE VALUE ASSIGNED WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 46.

ELEMENT NAME: **PRE-PAID PLAN TYPE-2 CODE - FIRST MONTH**

SAS VARIABLE: EL_PHP_TYPE_2_1

TYPE: NUM LENGTH: 2 BEG: 325 END: 326

DESCRIPTION:

CODE INDICATING THE TYPE OF THE SECOND OF UP TO FOUR MANAGED CARE PLAN TYPES IN WHICH THE ELIGIBLE WAS ENROLLED FOR THE RESPECTIVE MONTH.

CODES:
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.

USER NOTE: WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION, THIS DATA ELEMENT IS 9-FILLED.

SOURCE: MSIS ELIGIBILITY FILES: 'PLAN-TYPE-2'.

NOTE: IN MAX 2008, A CLARIFICATION NOTE WAS ADDED ABOUT THE VALUE ASSIGNED WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 47.

ELEMENT NAME: **PRE-PAID PLAN IDENTIFIER-2 - FIRST MONTH**

SAS VARIABLE: EL_PHP_ID_2_1

TYPE: CHAR LENGTH: 12 BEG: 327 END: 338

DESCRIPTION:

THE STATE ASSIGNED MANAGED CARE PLAN IDENTIFICATION NUMBER ASSOCIATED WITH PLAN TYPE-2 IN WHICH THE ELIGIBLE WAS ENROLLED FOR THE RESPECTIVE MONTH.

USER NOTE: WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION, THIS DATA ELEMENT IS BLANK-FILLED.

SOURCE: MSIS ELIGIBILITY FILES: 'PLAN-ID-2'.

NOTE: IN MAX 2008, A CLARIFICATION NOTE WAS ADDED ABOUT THE VALUE ASSIGNED WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 48.

ELEMENT NAME: **PRE-PAID PLAN TYPE-3 CODE - FIRST MONTH**

SAS VARIABLE: EL_PHP_TYPE_3_1

TYPE: NUM LENGTH: 2 BEG: 339 END: 340

DESCRIPTION:

CODE INDICATING THE TYPE OF THE THIRD OF UP TO FOUR MANAGED CARE PLAN TYPES IN WHICH THE ELIGIBLE WAS ENROLLED FOR THE RESPECTIVE MONTH.

CODES:
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.

USER NOTE: WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION, THIS DATA ELEMENT IS 9-FILLED.

SOURCE: MSIS ELIGIBILITY FILES: 'PLAN-TYPE-3'.

NOTE: IN MAX 2008, A CLARIFICATION NOTE WAS ADDED ABOUT THE VALUE ASSIGNED WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 49.

ELEMENT NAME: **PRE-PAID PLAN IDENTIFIER-3 - FIRST MONTH**

SAS VARIABLE: EL_PHP_ID_3_1

TYPE: CHAR LENGTH: 12 BEG: 341 END: 352

DESCRIPTION:

THE STATE ASSIGNED MANAGED CARE PLAN IDENTIFICATION NUMBER ASSOCIATED WITH PLAN TYPE-3 IN WHICH THE ELIGIBLE WAS ENROLLED FOR THE RESPECTIVE MONTH.

USER NOTE: WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION, THIS DATA ELEMENT IS BLANK-FILLED.

SOURCE: MSIS ELIGIBILITY FILES: 'PLAN-ID-3'.

NOTE: IN MAX 2008, A CLARIFICATION NOTE WAS ADDED ABOUT THE VALUE ASSIGNED WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 50.

ELEMENT NAME: **PRE-PAID PLAN TYPE-4 CODE - FIRST MONTH**

SAS VARIABLE: EL_PHP_TYPE_4_1

TYPE: NUM LENGTH: 2 BEG: 353 END: 354

DESCRIPTION:

CODE INDICATING THE TYPE OF THE FOURTH OF UP TO FOUR MANAGED CARE PLAN TYPES IN WHICH THE ELIGIBLE WAS ENROLLED FOR THE RESPECTIVE MONTH.

CODES:
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.

USER NOTE: WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION, THIS DATA ELEMENT IS 9-FILLED.

SOURCE: MSIS ELIGIBILITY FILES: 'PLAN-TYPE-4'.

NOTE: IN MAX 2008, A CLARIFICATION NOTE WAS ADDED ABOUT THE VALUE ASSIGNED WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 51.

ELEMENT NAME: **PRE-PAID PLAN IDENTIFIER-4 - FIRST MONTH**

SAS VARIABLE: EL_PHP_ID_4_1

TYPE: CHAR LENGTH: 12 BEG: 355 END: 366

DESCRIPTION:

THE STATE ASSIGNED MANAGED CARE PLAN IDENTIFICATION NUMBER ASSOCIATED WITH PLAN TYPE-4 IN WHICH THE ELIGIBLE WAS ENROLLED FOR THE RESPECTIVE MONTH.

USER NOTE: WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION, THIS DATA ELEMENT IS BLANK-FILLED.

SOURCE: MSIS ELIGIBILITY FILES: 'PLAN-ID-4'.

NOTE: IN MAX 2008, A CLARIFICATION NOTE WAS ADDED ABOUT THE VALUE ASSIGNED WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: **

ELEMENT NAME: **MEDICAID MANAGED CARE COMBINATIONS GROUP - MONTHLY (OCCURS 12 TIMES)**

SAS VARIABLE: NONE

TYPE: GROUP LENGTH: 24 BEG: 983 END: 1006

DESCRIPTION:

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 (POSITIONS 983 TO 984)
FEBRUARY (POSITIONS 985 TO 986)
MARCH (POSITIONS 987 TO 988)
APRIL (POSITIONS 989 TO 990)
MAY (POSITIONS 991 TO 992)
JUNE (POSITIONS 993 TO 994)
JULY (POSITIONS 995 TO 996)
AUGUST (POSITIONS 997 TO 998)
SEPTEMBER (POSITIONS 999 TO 1000)
OCTOBER (POSITIONS 1001 TO 1002)
NOVEMBER (POSITIONS 1003 TO 1004)
DECEMBER (POSITIONS 1005 TO 1006)

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 52.

ELEMENT NAME: **MEDICAID MANAGED CARE COMBINATIONS - FIRST MONTH**

SAS VARIABLE: MC_COMBO_MO_1

TYPE: NUM LENGTH: 2 BEG: 983 END: 984

DESCRIPTION:

CODE INDICATING THE TYPES OF MANAGED CARE THE ELIGIBLE WAS ENROLLED IN FOR THE RESPECTIVE MONTH.

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

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 CODE		MSIS 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 (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

USER NOTE: WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION, THIS DATA ELEMENT IS 0-FILLED.

SOURCE: CREATED FROM MSIS ELIGIBILITY FILES USING 'PLAN-TYPE-1 TO -4'.

NOTE: IN MAX 2008, A CLARIFICATION NOTE WAS ADDED ABOUT THE VALUE ASSIGNED WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: **

ELEMENT NAME: **DAYS OF ELIGIBILITY GROUP - MONTHLY (OCCURS 12 TIMES)**

SAS VARIABLE: NONE

TYPE: GROUP LENGTH: 24 BEG: 1007 END: 1030

DESCRIPTION:

INDICATES THE NUMBER OF DAYS THE MEDICAID ELIGIBLE WAS ENROLLED IN MEDICAID FROM JANUARY THROUGH DECEMBER. THE EXAMPLE IS FOR JANUARY.
JANUARY (POSITIONS 1007 TO 1008)
FEBRUARY (POSITIONS 1009 TO 1010)
MARCH (POSITIONS 1011 TO 1012)
APRIL (POSITIONS 1013 TO 1014)
MAY (POSITIONS 1015 TO 1016)
JUNE (POSITIONS 1017 TO 1018)
JULY (POSITIONS 1019 TO 1020)
AUGUST (POSITIONS 1021 TO 1022)
SEPTEMBER (POSITIONS 1023 TO 1024)
OCTOBER (POSITIONS 1025 TO 1026)
NOVEMBER (POSITIONS 1027 TO 1028)
DECEMBER (POSITIONS 1029 TO 1030)

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 53.

ELEMENT NAME: **DAYS OF ELIGIBILITY - FIRST MONTH**

SAS VARIABLE: EL_DAYS_EL_CNT_1

TYPE: NUM LENGTH: 2 BEG: 1007 END: 1008

DESCRIPTION:

THE NUMBER OF DAYS THE ELIGIBLE WAS ENROLLED IN MEDICAID FOR THE RESPECTIVE MONTH.

USER NOTE: WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION, THIS DATA ELEMENT IS 0-FILLED.

SOURCE: MSIS ELIGIBILITY FILES: 'DAYS-OF-ELIGIBILITY'.

NOTE: IN MAX 2008, A CLARIFICATION NOTE WAS ADDED ABOUT THE VALUE ASSIGNED WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: **

ELEMENT NAME: **TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) CASH FLAG GROUP - MONTHLY (OCCURS 12 TIMES)**

SAS VARIABLE: NONE

TYPE: GROUP LENGTH: 12 BEG: 1031 END: 1042

DESCRIPTION:

INDICATES WHETHER THE ELIGIBLE RECEIVED TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) BENEFITS FROM JANUARY THROUGH DECEMBER. THE EXAMPLE IS FOR JANUARY.
JANUARY (POSITION 1031)
FEBRUARY (POSITION 1032)
MARCH (POSITION 1033)
APRIL (POSITION 1034)
MAY (POSITION 1035)
JUNE (POSITION 1036)
JULY (POSITION 1037)
AUGUST (POSITION 1038)
SEPTEMBER (POSITION 1039)
OCTOBER (POSITION 1040)
NOVEMBER (POSITION 1041)
DECEMBER (POSITION 1042)

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 54.

ELEMENT NAME: **TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) CASH FLAG - FIRST MONTH**

SAS VARIABLE: EL_TANF_CASH_FLG_1

TYPE: NUM LENGTH: 1 BEG: 1031 END: 1031

DESCRIPTION:

CODE INDICATING WHETHER THE ELIGIBLE RECEIVED TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) BENEFITS FOR THE RESPECTIVE MONTH.

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.

USER NOTE: WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION, THIS DATA ELEMENT IS 9-FILLED.

SOURCE: MSIS ELIGIBILITY FILES: 'TANF-CASH-FLAG'.

NOTE: IN MAX 2008, A CLARIFICATION NOTE WAS ADDED ABOUT THE VALUE ASSIGNED WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: **

ELEMENT NAME: **RESTRICTED BENEFITS FLAG GROUP - MONTHLY (OCCURS 12 TIMES)**

SAS VARIABLE: NONE

TYPE: GROUP LENGTH: 12 BEG: 1043 END: 1054

DESCRIPTION:

INDICATES THE SCOPE OF MEDICAID BENEFITS TO WHICH AN ELIGIBLE IS ENTITLED FROM JANUARY THROUGH DECEMBER. THE EXAMPLE IS FOR JANUARY.
JANUARY (POSITION 1043)
FEBRUARY (POSITION 1044)
MARCH (POSITION 1045)
APRIL (POSITION 1046)
MAY (POSITION 1047)
JUNE (POSITION 1048)
JULY (POSITION 1049)
AUGUST (POSITION 1050)
SEPTEMBER (POSITION 1051)
OCTOBER (POSITION 1052)
NOVEMBER (POSITION 1053)
DECEMBER (POSITION 1054)

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 55.

ELEMENT NAME: **RESTRICTED BENEFITS FLAG - FIRST MONTH**

SAS VARIABLE: EL_RSTRCT_BNFT_FLG_1

TYPE: CHAR LENGTH: 1 BEG: 1043 END: 1043

DESCRIPTION:

CODE INDICATING THE SCOPE OF MEDICAID BENEFITS TO WHICH AN ELIGIBLE IS ENTITLED FOR THE RESPECTIVE MONTH.

CODES:
0 = INDIVIDUAL IS NOT ELIGIBLE FOR MEDICAID OR CHIP DURING THE MONTH.
1 = INDIVIDUAL IS ELIGIBLE FOR MEDICAID OR CHIP DURING THE MONTH AND IS ENTITLED TO THE FULL SCOPE OF MEDICAID BENEFITS.
2 = INDIVIDUAL IS ELIGIBLE FOR MEDICAID OR M-CHIP 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 OR CHIP DURING THE MONTH BUT ONLY ENTITLED TO RESTRICTED BENEFITS FOR PREGNANCY-RELATED SERVICES.
5 = INDIVIDUAL IS ELIGIBLE FOR MEDICAID OR M-CHP 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 NEEDY OR OTHER CRITERIA).
6 = INDIVIDUAL IS ELIGIBLE FOR MEDICAID OR M-CHIP BUT ONLY ENTITLED TO RECEIVE FAMILY PLANNING SERVICES (BEGINNING IN 2001).
7 = INDIVIDUAL IS ELIGIBLE FOR MEDICAID AND ENTITLED TO MEDICAID BENEFITS UNDER AN ALTERNATIVE PACKAGE OF BENCHMARK-EQUIVALENT COVERAGE, AS ENACTED BY THE DEFICIT REDUCTION ACT OF 2005.
8 = INDIVIDUAL IS ELIGIBLE FOR MEDICAID AND ENTITLED TO BENEFITS UNDER A "MONEY FOLLOWS THE PERSON" (MFP) REBALANCING DEMONSTRATION, AS ENACTED BY THE DEFICIT REDUCTION ACT OF 2005, TO ALLOW STATES TO DEVELOP COMMUNITY-BASED LONG-TERM CARE OPPORTUNITIES.
9 = INDIVIDUAL'S BENEFIT RESTRICTIONS ARE UNKNOWN.
A = INDIVIDUAL IS ELIGIBLE FOR MEDICAID AND ENTITLED TO BENEFITS UNDER THE PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES DEMONSTRATION GRANT PROGRAM (PRTF), AS ENACTED BY THE DEFICIT REDUCTION ACT OF 2005. PRTF GRANTS ASSIST STATES TO HELP PROVIDE COMMUNITY ALTERNATIVES TO PSYCHIATRIC RESIDENT TREATMENT FACILITIES FOR CHILDREN.
B = INDIVIDUAL IS ELIGIBLE FOR MEDICAID AND ENTITLED TO MEDICAID BENEFITS USING A HEALTH OPPORTUNITY ACCOUNT (HOA).
C = INDIVIDUAL IS ELIGIBLE FOR SEPARATE CHIP DENTAL COVERAGE (SUPPLEMENTAL DENTAL WRAPAROUND BENEFIT TO EMPLOYER-SPONSORED INSURANCE).
W = INDIVIDUAL IS ONLY ELIGIBLE FOR MEDICAID HEALTH INSURANCE PREMIUM PAYMENT ASSISTANCE (NO ADDITIONAL TITLE XIX or XXI FFS OR MANAGED CARE WRAPAROUND SERVICES) IN MASSACHUSETTS, NEW JERSEY, OKLAHOMA, OR VERMONT.
X = INDIVIDUAL IS ELIGIBLE FOR MEDICAID DURING THE MONTH BUT ONLY ENTITLED TO RECEIVE PRESCRIPTION DRUG BENEFITS (BEGINNING IN 2003).
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)
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)

USER NOTE: 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 MONTHLY MEDICARE DUAL CODE = 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 MONTHLY MEDICARE DUAL CODE IS NOT = 51, 53, OR 56.

USER NOTE: WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION, THIS DATA ELEMENT IS 9-FILLED.

SOURCE: MSIS ELIGIBILITY FILES: 'RESTRICTED-BENEFITS-FLAG'.

NOTE: IN MAX 2006, VALUES 7, 8, A, AND B WERE ADDED TO THE FILE.

NOTE: IN MAX 2008, VALUE W WAS ADDED TO THE FILE AND A CLARIFICATION NOTE WAS ADDED ABOUT THE VALUE ASSIGNED WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION.

NOTE: IN MAX 2009, ENROLLMENT IN PREMIUM ASSISTANCE PROGRAMS (VALUE W) WAS EXPANDED TO INCLUDE ADDITIONAL STATES BUT ONLY WHEN THE ENROLLEES WERE CLEARLY IDENTIFIABLE.

NOTE: IN MAX 2010, NEW JERSEY WAS ADDED TO THE LIST OF STATES WITH ENROLLMENT IN PREMIUM ASSISTANCE PROGRAMS (VALUE W).

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: **

ELEMENT NAME: **CHILD HEALTH INSURANCE PROGRAM (CHIP) CODE GROUP - MONTHLY (OCCURS 12 TIMES)**

SAS VARIABLE: NONE

TYPE: GROUP LENGTH: 12 BEG: 1055 END: 1066

DESCRIPTION:

INDICATES WHETHER THE INDIVIDUAL WAS ELIGIBLE FOR THE CHILD HEALTH INSURANCE PROGRAM (CHIP) FROM JANUARY THROUGH DECEMBER. THE EXAMPLE IS FOR JANUARY.
JANUARY (POSITION 1055)
FEBRUARY (POSITION 1056)
MARCH (POSITION 1057)
APRIL (POSITION 1058)
MAY (POSITION 1059)
JUNE (POSITION 1060)
JULY (POSITION 1061)
AUGUST (POSITION 1062)
SEPTEMBER (POSITION 1063)
OCTOBER (POSITION 1064)
NOVEMBER (POSITION 1065)
DECEMBER (POSITION 1066)

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 56.

ELEMENT NAME: **CHILD HEALTH INSURANCE PROGRAM (CHIP) CODE - FIRST MONTH**

SAS VARIABLE: EL_CHIP_FLAG_1

TYPE: NUM LENGTH: 1 BEG: 1055 END: 1055

DESCRIPTION:

CODE INDICATING WHETHER THE INDIVIDUAL WAS ELIGIBLE FOR THE CHILD HEALTH INSURANCE PROGRAM (CHIP) FOR THE RESPECTIVE MONTH.

CODES:
0 = INDIVIDUAL WAS NOT A MEDICAID ELIGIBLE (INCLUDING M-CHIP) AND NOT ELIGIBLE FOR SEPARATE CHIP DURING THE MONTH.
1 = INDIVIDUAL WAS A MEDICAID ELIGIBLE, BUT WAS NOT INCLUDED IN EITHER A MEDICAID EXPANSION CHIP OR A SEPARATE TITLE XXI CHIP PROGRAM DURING THE MONTH.
2 = INDIVIDUAL WAS ENROLLED IN THE MEDICAID EXPANSION CHIP PROGRAM (M-CHIP) AND SUBJECT TO ENHANCED FEDERAL MATCHING FUNDS DURING THE MONTH.
3 = INDIVIDUAL WAS NOT A MEDICAID ELIGIBLE (INCLUDING M-CHIP), BUT WAS INCLUDED IN A NON MEDICAID EXPANSION TITLE XXI CHIP PROGRAM DURING THE MONTH (S-CHIP). REPORTING OF MSIS ELIGIBILITY RECORDS FOR THESE NON-MEDICAID CHIP INDIVIDUALS IS OPTIONAL FOR STATES.
9 = CHIP STATUS IS UNKNOWN.

USER NOTE: WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION, THIS DATA ELEMENT IS 9-FILLED.

SOURCE: MSIS ELIGIBILITY FILES: 'CHIP-CODE'.

NOTE: IN MAX 2008, A CLARIFICATION NOTE WAS ADDED ABOUT THE VALUE ASSIGNED WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: **

ELEMENT NAME: **MEDICAID WAIVER GROUP - MONTHLY (OCCURS 12 TIMES)**

SAS VARIABLE: NONE

TYPE: GROUP LENGTH: 108 BEG: 1067 END: 1174

DESCRIPTION:

THE MONTHLY MEDICAID WAIVER GROUP FIELD IS A SET OF DATA ELEMENTS CONSISTING OF THREE WAIVER TYPE CODES, AND THREE WAIVER ID FIELDS, OCCURRING 12 TIMES. THE EXAMPLE IS FOR JANUARY.
JANUARY (POSITIONS 1067 TO 1075)
FEBRUARY (POSITIONS 1076 TO 1084)
MARCH (POSITIONS 1085 TO 1093)
APRIL (POSITIONS 1094 TO 1102)
MAY (POSITIONS 1103 TO 1111)
JUNE (POSITIONS 1112 TO 1120)
JULY (POSITIONS 1121 TO 1129)
AUGUST (POSITIONS 1130 TO 1138)
SEPTEMBER (POSITIONS 1139 TO 1147)
OCTOBER (POSITIONS 1148 TO 1156)
NOVEMBER (POSITIONS 1157 TO 1165)
DECEMBER (POSITIONS 1166 TO 1174)

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 57.

ELEMENT NAME: **MAX WAIVER TYPE CODE - 1 - FIRST MONTH**

SAS VARIABLE: MAX_WAIVER_TYPE_1_MO_1

TYPE: CHAR LENGTH: 1 BEG: 1067 END: 1067

DESCRIPTION:

CODE INDICATING WAIVER TYPE.
BLANK = INDIVIDUAL'S WAIVER ENROLLMENT IS UNKNOWN (PERSON WITH MISSING ELIGIBILITY INFORMATION)
0 = INDIVIDUAL WAS NOT ELIGIBLE FOR MEDICAID OR CHIP THIS MONTH
1 = ENROLLED IN SECTION 1115 WAIVER THIS MONTH
2 = ENROLLED IN SECTION 1915(B) WAIVER THIS MONTH
4 = ENROLLED IN COMBINED SECTION 1915(B)(C) WAIVER THIS MONTH
5 = ENROLLED IN SECTION 1115 HIFA (HEALTH INSURANCE AND FLEXIBILITY AND ACCOUNTABILITY) WAIVER THIS MONTH
6 = SECTION 1115 PHARMACY WAIVER COVERAGE THIS MONTH
7 = ENROLLED IN OTHER TYPE OF WAIVER THIS MONTH
8 = NOT APPLICABLE (NOT ENROLLED IN A WAIVER THIS MONTH)
9 = ENROLLED IN UNKNOWN TYPE OF WAIVER THIS MONTH
A = ENROLLED IN SECTION 1115 DISASTER-RELATED WAIVER THAT ALLOWS FOR COVERAGE RELATED TO A HURRICANE OR OTHER DISASTER THIS MONTH
F = ENROLLED IN SECTION 1115 FAMILY PLANNING-ONLY WAIVER THIS MONTH
G = ENROLLED IN SECTION 1915(C) WAIVER FOR AGED AND DISABLED (A/D) THIS MONTH
H = ENROLLED IN SECTION 1915(C) WAIVER FOR AGED THIS MONTH
I = ENROLLED IN SECTION 1915(C) WAIVER FOR PHYSICALLY DISABLED (PD) THIS MONTH
J = ENROLLED IN SECTION 1915(C) WAIVER FOR PEOPLE WITH BRAIN INJURIES (BI) THIS MONTH
K = ENROLLED IN SECTION 1915(C) WAIVER FOR PEOPLE WITH HIV/AIDS THIS MONTH
L = ENROLLED IN SECTION 1915(C) WAIVER FOR INTELLECTUALLY DISABLED/DEVELOPMENTALLY DISABLED/ (ID/DD) THIS MONTH
M = ENROLLED IN SECTION 1915(C) WAIVER FOR PEOPLE WITH MENTAL ILLNESS/SERIOUS EMOTIONAL DISTURBANCE (MI/SED) THIS MONTH
N = ENROLLED IN SECTION 1915(C) WAIVER FOR TECHNOLOGY DEPENDENT/MEDICALLY FRAGILE THIS MONTH
O = ENROLLED IN SECTION 1915(C) WAIVER FOR UNSPECIFIED OR UNKNOWN POPULATIONS
P = ENROLLED IN SECTION 1915(C) WAIVER FOR AUTISM/AUTISM SPECTRUM DISORDER THIS MONTH

USER NOTE: MAX WAIVER TYPE CODES DIFFER FROM MSIS WAIVER TYPE CODES IN THAT MSIS WAIVER TYPE CODE VALUE = 3 DOES NOT APPEAR IN THE MAX CODES. THE MSIS DEFINITION FOR WAIVER TYPE CODE VALUE = 3 IS "THE ASSOCIATED WAIVER-ID-NUMBER IS FOR A 1915(C) WAIVER THIS MONTH. MAY ALSO BE CALLED 2176, HOME AND COMMUNITY-BASED CARE, HCBS, HCB, AND WILL OFTEN MENTION SPECIFIC POPULATIONS SUCH AS ID/DD, AGED, DISABLED/PHYSICALLY DISABLED, AGED/DISABLED, AIDS/ARC, MENTAL HEALTH, TBI/HEAD INJURY, SPECIAL CARE CHILDREN/TECHNOLOGY DEPENDENT CHILDREN". FOR MAX WAIVER TYPE CODE, MSIS WAIVER TYPE CODE VALUE = 3 HAS BEEN EXPANDED INTO THE GROUP OF CODE VALUES = G THROUGH P.

SOURCE: MSIS ELIGIBILITY FILES: WAIVER-TYPE-1 AND THE MAX WAIVER CROSSWALK, WHICH MAPS THE 1915(C) WAIVER TYPE INTO MORE DETAILED CATEGORIES.

NOTES: IN MAX 2005, THIS VARIABLE WAS ADDED TO THE FILE. IN MAX 2006, THE VALUE P WAS ADDED TO THE FILE.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 58.

ELEMENT NAME: **WAIVER ID - 1 - FIRST MONTH**

SAS VARIABLE: MAX_WAIVER_ID_1_MO_1

TYPE: CHAR LENGTH: 2 BEG: 1068 END: 1069

DESCRIPTION:

STATE-ASSIGNED WAIVER IDENTIFICATION NUMBER.

USER NOTE: THIS DATA ELEMENT IS 0-FILLED FOR INDIVIDUALS NOT ELIGIBLE FOR MEDICAID DURING THE MONTH, 8-FILLED FOR INDIVIDUALS ENROLLED IN MEDICAID BUT NOT ENROLLED IN A WAIVER DURING THE MONTH, AND 9-FILLED FOR INDIVIDUALS WITH UNKNOWN WAIVER ENROLLMENT FOR THE RESPECTIVE MONTH.

USER NOTE: WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION, THIS DATA ELEMENT IS 9-FILLED.

SOURCE: MSIS ELIGIBILITY FILES: WAIVER-ID-1.

NOTE: IN MAX 2005, THIS VARIABLE WAS ADDED TO THE FILE.

NOTE: IN MAX 2008, A CLARIFICATION NOTE WAS ADDED ABOUT THE VALUE ASSIGNED WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 59.

ELEMENT NAME: **MAX WAIVER TYPE CODE - 2 - FIRST MONTH**

SAS VARIABLE: MAX_WAIVER_TYPE_2_MO_1

TYPE: CHAR LENGTH: 1 BEG: 1070 END: 1070

DESCRIPTION:

CODE INDICATING WAIVER TYPE.

CODES:
BLANK = INDIVIDUAL'S WAIVER ENROLLMENT IS UNKNOWN (PERSON WITH MISSING ELIGIBILITY INFORMATION)
0 = INDIVIDUAL WAS NOT ELIGIBLE FOR MEDICAID OR CHIP THIS MONTH
1 = ENROLLED IN SECTION 1115 WAIVER THIS MONTH
2 = ENROLLED IN SECTION 1915(B) WAIVER THIS MONTH
4 = ENROLLED IN COMBINED SECTION 1915(B)(C) WAIVER THIS MONTH
5 = ENROLLED IN SECTION 1115 HIFA (HEALTH INSURANCE AND FLEXIBILITY AND ACCOUNTABILITY) WAIVER THIS MONTH
6 = SECTION 1115 PHARMACY WAIVER COVERAGE THIS MONTH
7 = ENROLLED IN OTHER TYPE OF WAIVER THIS MONTH
8 = NOT APPLICABLE (NOT ENROLLED IN A WAIVER THIS MONTH)
9 = ENROLLED IN UNKNOWN TYPE OF WAIVER THIS MONTH
A = ENROLLED IN SECTION 1115 DISASTER-RELATED WAIVER THAT ALLOWS FOR COVERAGE RELATED TO A HURRICANE OR OTHER DISASTER THIS MONTH
F = ENROLLED IN SECTION 1115 FAMILY PLANNING-ONLY WAIVER THIS MONTH
G = ENROLLED IN SECTION 1915(C) WAIVER FOR AGED AND DISABLED (A/D) THIS MONTH
H = ENROLLED IN SECTION 1915(C) WAIVER FOR AGED THIS MONTH
I = ENROLLED IN SECTION 1915(C) WAIVER FOR PHYSICALLY DISABLED (PD) THIS MONTH
J = ENROLLED IN SECTION 1915(C) WAIVER FOR PEOPLE WITH BRAIN INJURIES (BI) THIS MONTH
K = ENROLLED IN SECTION 1915(C) WAIVER FOR PEOPLE WITH HIV/AIDS THIS MONTH
L = ENROLLED IN SECTION 1915(C) WAIVER FOR INTELLECTUALLY DISABLED/DEVELOPMENTALLY DISABLED/ (ID/DD) THIS MONTH
M = ENROLLED IN SECTION 1915(C) WAIVER FOR PEOPLE WITH MENTAL ILLNESS/SERIOUS EMOTIONAL DISTURBANCE (MI/SED) THIS MONTH
N = ENROLLED IN SECTION 1915(C) WAIVER FOR TECHNOLOGY DEPENDENT/MEDICALLY FRAGILE THIS MONTH
O = ENROLLED IN SECTION 1915(C) WAIVER FOR UNSPECIFIED OR UNKNOWN POPULATIONS
P = ENROLLED IN SECTION 1915(C) WAIVER FOR AUTISM/AUTISM SPECTRUM DISORDER THIS MONTH

USER NOTE: MAX WAIVER TYPE CODES DIFFER FROM MSIS WAIVER TYPE CODES IN THAT MSIS WAIVER TYPE CODE VALUE = 3 DOES NOT APPEAR IN THE MAX CODES. THE MSIS DEFINITION FOR WAIVER TYPE CODE VALUE = 3 IS "THE ASSOCIATED WAIVER-ID-NUMBER IS FOR A 1915(C) WAIVER THIS MONTH. MAY ALSO BE CALLED 2176, HOME AND COMMUNITY-BASED CARE, HCBS, HCB, AND WILL OFTEN MENTION SPECIFIC POPULATIONS SUCH AS ID/DD, AGED, DISABLED/PHYSICALLY DISABLED, AGED/DISABLED, AIDS/ARC, MENTAL HEALTH, TBI/HEAD INJURY, SPECIAL CARE CHILDREN/TECHNOLOGY DEPENDENT CHILDREN". FOR MAX WAIVER TYPE CODE, MSIS WAIVER TYPE CODE VALUE = 3 HAS BEEN EXPANDED INTO THE GROUP OF CODE VALUES = G THROUGH P.

SOURCE: MSIS ELIGIBILITY FILES: WAIVER-TYPE-2 AND THE MAX WAIVER CROSSWALK, WHICH MAPS THE 1915(C) WAIVER TYPE INTO MORE DETAILED CATEGORIES.

NOTES: IN MAX 2005, THIS VARIABLE WAS ADDED TO THE FILE. IN MAX 2006, THE VALUE P WAS ADDED TO THE FILE.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 60.

ELEMENT NAME: **WAIVER ID - 2 - FIRST MONTH**

SAS VARIABLE: MAX_WAIVER_ID_2_MO_1

TYPE: CHAR LENGTH: 2 BEG: 1071 END: 1072

DESCRIPTION:

STATE-ASSIGNED WAIVER IDENTIFICATION NUMBER.

USER NOTE: THIS DATA ELEMENT IS 0-FILLED FOR INDIVIDUALS NOT ELIGIBLE FOR MEDICAID DURING THE MONTH, 8-FILLED FOR INDIVIDUALS ENROLLED IN MEDICAID BUT NOT ENROLLED IN A WAIVER DURING THE MONTH, AND 9-FILLED FOR INDIVIDUALS WITH UNKNOWN WAIVER ENROLLMENT FOR THE RESPECTIVE MONTH.

USER NOTE: WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION, THIS DATA ELEMENT IS 9-FILLED.

SOURCE: MSIS ELIGIBILITY FILES: WAIVER-ID-2.

NOTE: IN MAX 2005, THIS VARIABLE WAS ADDED TO THE FILE.

NOTE: IN MAX 2008, A CLARIFICATION NOTE WAS ADDED ABOUT THE VALUE ASSIGNED WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 61.

ELEMENT NAME: **MAX WAIVER TYPE CODE - 3 - FIRST MONTH**

SAS VARIABLE: MAX_WAIVER_TYPE_3_MO_1

TYPE: CHAR LENGTH: 1 BEG: 1073 END: 1073

DESCRIPTION:

CODE INDICATING WAIVER TYPE.

CODES:
BLANK = INDIVIDUAL'S WAIVER ENROLLMENT IS UNKNOWN (PERSON WITH MISSING ELIGIBILITY INFORMATION)
0 = INDIVIDUAL WAS NOT ELIGIBLE FOR MEDICAID OR CHIP THIS MONTH
1 = ENROLLED IN SECTION 1115 WAIVER THIS MONTH
2 = ENROLLED IN SECTION 1915(B) WAIVER THIS MONTH
4 = ENROLLED IN COMBINED SECTION 1915(B)(C) WAIVER THIS MONTH
5 = ENROLLED IN SECTION 1115 HIFA (HEALTH INSURANCE AND FLEXIBILITY AND ACCOUNTABILITY) WAIVER THIS MONTH
6 = SECTION 1115 PHARMACY WAIVER COVERAGE THIS MONTH
7 = ENROLLED IN OTHER TYPE OF WAIVER THIS MONTH
8 = NOT APPLICABLE (NOT ENROLLED IN A WAIVER THIS MONTH)
9 = ENROLLED IN UNKNOWN TYPE OF WAIVER THIS MONTH
A = ENROLLED IN SECTION 1115 DISASTER-RELATED WAIVER THAT ALLOWS FOR COVERAGE RELATED TO A HURRICANE OR OTHER DISASTER THIS MONTH
F = ENROLLED IN SECTION 1115 FAMILY PLANNING-ONLY WAIVER THIS MONTH
G = ENROLLED IN SECTION 1915(C) WAIVER FOR AGED AND DISABLED (A/D) THIS MONTH
H = ENROLLED IN SECTION 1915(C) WAIVER FOR AGED THIS MONTH
I = ENROLLED IN SECTION 1915(C) WAIVER FOR PHYSICALLY DISABLED (PD) THIS MONTH
J = ENROLLED IN SECTION 1915(C) WAIVER FOR PEOPLE WITH BRAIN INJURIES (BI) THIS MONTH
K = ENROLLED IN SECTION 1915(C) WAIVER FOR PEOPLE WITH HIV/AIDS THIS MONTH
L = ENROLLED IN SECTION 1915(C) WAIVER FOR INTELLECTUALLY DISABLED/DEVELOPMENTALLY DISABLED/ (ID/DD) THIS MONTH
M = ENROLLED IN SECTION 1915(C) WAIVER FOR PEOPLE WITH MENTAL ILLNESS/SERIOUS EMOTIONAL DISTURBANCE (MI/SED) THIS MONTH
N = ENROLLED IN SECTION 1915(C) WAIVER FOR TECHNOLOGY DEPENDENT/MEDICALLY FRAGILE THIS MONTH
O = ENROLLED IN SECTION 1915(C) WAIVER FOR UNSPECIFIED OR UNKNOWN POPULATIONS
P = ENROLLED IN SECTION 1915(C) WAIVER FOR AUTISM/AUTISM SPECTRUM DISORDER THIS MONTH

USER NOTE: MAX WAIVER TYPE CODES DIFFER FROM MSIS WAIVER TYPE CODES IN THAT MSIS WAIVER TYPE CODE VALUE = 3 DOES NOT APPEAR IN THE MAX CODES. THE MSIS DEFINITION FOR WAIVER TYPE CODE VALUE = 3 IS "THE ASSOCIATED WAIVER-ID-NUMBER IS FOR A 1915(C) WAIVER THIS MONTH. MAY ALSO BE CALLED 2176, HOME AND COMMUNITY-BASED CARE, HCBS, HCB, AND WILL OFTEN MENTION SPECIFIC POPULATIONS SUCH AS ID/DD, AGED, DISABLED/PHYSICALLY DISABLED, AGED/DISABLED, AIDS/ARC, MENTAL HEALTH, TBI/HEAD INJURY, SPECIAL CARE CHILDREN/TECHNOLOGY DEPENDENT CHILDREN". FOR MAX WAIVER TYPE CODE, MSIS WAIVER TYPE CODE VALUE = 3 HAS BEEN EXPANDED INTO THE GROUP OF CODE VALUES = G THROUGH P.

SOURCE: MSIS ELIGIBILITY FILES: WAIVER-TYPE-3 AND THE MAX WAIVER CROSSWALK, WHICH MAPS THE 1915(C) WAIVER TYPE INTO MORE DETAILED CATEGORIES.

NOTES: IN MAX 2005, THIS VARIABLE WAS ADDED TO THE FILE. IN MAX 2006, THE VALUE P WAS ADDED TO THE FILE.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 62.

ELEMENT NAME: **WAIVER ID - 3 - FIRST MONTH**

SAS VARIABLE: MAX_WAIVER_ID_3_MO_1

TYPE: CHAR LENGTH: 2 BEG: 1074 END: 1075

DESCRIPTION:

STATE-ASSIGNED WAIVER IDENTIFICATION NUMBER.

USER NOTE: THIS DATA ELEMENT IS 0-FILLED FOR INDIVIDUALS NOT ELIGIBLE FOR MEDICAID DURING THE MONTH, 8-FILLED FOR INDIVIDUALS ENROLLED IN MEDICAID BUT NOT ENROLLED IN A WAIVER DURING THE MONTH, AND 9-FILLED FOR INDIVIDUALS WITH UNKNOWN WAIVER ENROLLMENT FOR THE RESPECTIVE MONTH.

USER NOTE: WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION, THIS DATA ELEMENT IS 9-FILLED.

SOURCE: MSIS ELIGIBILITY FILES: WAIVER-ID-3.

NOTE: IN MAX 2005, THIS VARIABLE WAS ADDED TO THE FILE.

NOTE: IN MAX 2008, A CLARIFICATION NOTE WAS ADDED ABOUT THE VALUE ASSIGNED WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 63.

ELEMENT NAME: **ANNUAL 1915(C) MAX WAIVER TYPE - MOST RECENT**

SAS VARIABLE: MAX_1915C_WAIVER_TYPE_LTST

TYPE: CHAR LENGTH: 1 BEG: 1175 END: 1175

DESCRIPTION:

CODE CONTAINS THE TARGET POPULATION FOR THE ENROLLEE'S MOST RECENT SECTION 1915(C) WAIVER. THE TARGET POPULATION CODES ARE DERIVED FROM THE STATES' WAIVER IDS.

CODES:
G = INDIVIDUAL WAS ENROLLED IN A 1915(C) WAIVER WITH A TARGET POPULATION OF AGED AND DISABLED
H = INDIVIDUAL WAS ENROLLED IN A 1915(C) WAIVER WITH A TARGET POPULATION OF AGED
I = INDIVIDUAL WAS ENROLLED IN A 1915(C) WAIVER WITH A TARGET POPULATION OF PHYSICALLY DISABLED
J = INDIVIDUAL WAS ENROLLED IN A 1915(C) WAIVER WITH A TARGET POPULATION OF BRAIN INJURED
K = INDIVIDUAL WAS ENROLLED IN A 1915(C) WAIVER WITH A TARGET POPULATION OF HIV/AIDS
L = INDIVIDUAL WAS ENROLLED IN A 1915(C) WAIVER WITH A TARGET POPULATION OF ID/DD
M = INDIVIDUAL WAS ENROLLED IN A 1915(C) WAIVER WITH A TARGET POPULATION OF MENTALLY ILL/SEVERELY EMOTIONALLY DISTURBED
N = INDIVIDUAL WAS ENROLLED IN A 1915(C) WAIVER WITH A TARGET POPULATION OF TECHNOLOGY-DEPENDENT/MEDICALLY FRAGILE
O = INDIVIDUAL WAS ENROLLED IN A 1915(C) WAIVER WITH A TARGET POPULATION OF OTHER OR UNKNOWN
P = ENROLLED IN SECTION 1915(C) WAIVER FOR AUTISM/AUTISM SPECTRUM DISORDER
0 = INDIVIDUAL WAS NEVER ENROLLED IN A 1915(C) WAIVER DURING THE YEAR
BLANK = INDIVIDUAL'S WAIVER ENROLLMENT IS UNKNOWN (PERSON WITH MISSING ELIGIBILITY INFORMATION)

USER NOTE: THESE CODE VALUES ARE DERIVED FROM MAX WAIVER TYPE CODE VALUES G THROUGH P. THE ANNUAL VALUE IS DETERMINED USING THE THREE MONTHLY WAIVER TYPE CODE VALUES FOR EACH OF THE 12 MONTHS OF THE YEAR. IF AN INDIVIDUAL WAS ENROLLED IN MORE THAN ONE 1915(C) WAIVER DURING THE MOST RECENT MONTH WITH ANY 1915(C) ENROLLMENT, THE HIERARCHY FOR THIS CODE IS AS FOLLOWS, WITH THE EARLIEST WAIVER TYPE LISTED HERE AS THE ONE THAT WILL BE CAPTURED:
P = ENROLLED IN SECTION 1915(C) WAIVER FOR AUTISM/AUTISM SPECTRUM DISORDER
L = INDIVIDUAL WAS ENROLLED IN A 1915(C) WAIVER WITH A TARGET POPULATION OF ID/DD
M = INDIVIDUAL WAS ENROLLED IN A 1915(C) WAIVER WITH A TARGET POPULATION OF MENTALLY ILL/SEVERELY EMOTIONALLY DISTURBED
J = INDIVIDUAL WAS ENROLLED IN A 1915(C) WAIVER WITH A TARGET POPULATION OF BRAIN INJURED
K = INDIVIDUAL WAS ENROLLED IN A 1915(C) WAIVER WITH A TARGET POPULATION OF HIV/AIDS
N = INDIVIDUAL WAS ENROLLED IN A 1915(C) WAIVER WITH A TARGET POPULATION OF TECHNOLOGY-DEPENDENT/MEDICALLY FRAGILE
G = INDIVIDUAL WAS ENROLLED IN A 1915(C) WAIVER WITH A TARGET POPULATION OF AGED AND DISABLED
I = INDIVIDUAL WAS ENROLLED IN A 1915(C) WAIVER WITH A TARGET POPULATION OF PHYSICALLY DISABLED
H = INDIVIDUAL WAS ENROLLED IN A 1915(C) WAIVER WITH A TARGET POPULATION OF AGED
O = INDIVIDUAL WAS ENROLLED IN A 1915(C) WAIVER WITH A TARGET POPULATION OF OTHER OR UNKNOWN

NOTES: IN MAX 2005, THIS VARIABLE WAS ADDED TO THE FILE. IN MAX 2006, THE VALUE P WAS ADDED TO THE FILE.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: ***

ELEMENT NAME: **UTILIZATION AND PAYMENT SUMMARY REGION**

SAS VARIABLE: NONE

TYPE: REGION LENGTH: 1720 BEG: 1176 END: 3039

DESCRIPTION:

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 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.).

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 64.

ELEMENT NAME: **RECIPIENT INDICATOR**

SAS VARIABLE: RCPNT_IND

TYPE: CHAR LENGTH: 1 BEG: 1176 END: 1176

DESCRIPTION:

CODE INDICATING 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.

CODES:
0 = THE ELIGIBLE PERSON DID NOT RECEIVE ANY SERVICES.
1 = THE ELIGIBLE PERSON HAD ONLY FEE-FOR-SERVICE CLAIMS FOR TYPES OF SERVICE = 1-19, 24-54 AND 99.
2 = THE ELIGIBLE PERSON HAD ONLY PREMIUM PAYMENT CLAIMS (PRE-PAID PLAN) FOR TYPES OF SERVICE = 20-23.
3 = THE ELIGIBLE PERSON HAD ONLY ENCOUNTER RECORDS (PRE-PAID PLAN) FOR TYPES OF SERVICE = 1-19, 24-54, 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 CLAIMS AND ENCOUNTER RECORDS, BUT NO PREMIUM PAYMENT CLAIMS.
7 = THE ELIGIBLE PERSON HAD FEE-FOR-SERVICE CLAIMS, PREMIUM PAYMENT CLAIMS AND ENCOUNTER RECORDS.
8 = S-CHIP ENROLLMENT MONTHS WERE FOUND BUT NO MEDICAID ENROLLMENT MONTHS WERE FOUND.
9 = NEITHER S-CHIP ENROLLMENT MONTHS NOR MEDICAID ENROLLMENT MONTHS WERE FOUND.

USER NOTE: SEE 'TYPE OF SERVICE RECIPIENT INDICATOR' WHICH IS SIMILAR TO 'RECIPIENT INDICATOR'. THE FIELD 'TYPE OF SERVICE RECIPIENT INDICATOR' IS DIFFERENT. 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.

USER NOTE: WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION, THIS DATA ELEMENT IS 9-FILLED.

USER NOTE: 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 PAID AMOUNT < $0. IN MAX ALL NON-ENCOUNTER CLAIMS WITH MEDICAID PAYMENT AMOUNT LESS THAN OR EQUAL TO ZERO ARE DELETED. THE RECIPIENT INDICATOR IS SET TO 1 THROUGH 7 IF THE BENEFICIARY HAS AT LEAST ONE CLAIM OF ANY TYPE.

SOURCE: CREATED USING MSIS CLAIMS FILES.

NOTE: IN MAX 2006, VALUES 8 AND 9 WERE ADDED TO THE FILE.

NOTE: IN MAX 2008, A CLARIFICATION NOTE WAS ADDED ABOUT THE VALUE ASSIGNED WHEN SOMEONE HAS CLAIMS BUT NO ELIGIBILITY INFORMATION.

NOTE: IN MAX 2010, USER NOTE WAS UPDATED TO CLARIFY THAT IN MAX ALL NON-ENCOUNTER CLAIMS WITH MEDICAID PAYMENT AMOUNT LESS THAN OR EQUAL TO ZERO ARE DELETED.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: **

ELEMENT NAME: **INPATIENT HOSPITAL UTILIZATION SUMMARY**

SAS VARIABLE: NONE

TYPE: GROUP LENGTH: 18 BEG: 1177 END: 1194

DESCRIPTION:

FIELDS CONTAINING 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 STAY 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 MEDICARE "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.

(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.

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.

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).

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 65.

ELEMENT NAME: **TOTAL INPATIENT DISCHARGE COUNT**

SAS VARIABLE: TOT_IP_DSCHRG_CNT

TYPE: NUM* LENGTH: 3 BEG: 1177 END: 1179

DESCRIPTION:

TOTAL NUMBER OF INPATIENT HOSPITAL DISCHARGES, FOR THE CALENDAR YEAR.

(SAS USERS: ZONED DECIMAL - ZD3)

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 'RECIPIENT TOTAL INPATIENT STAY COUNT'. FOR THIS REASON AND OTHER REASONS DISCUSSED ABOVE, THIS DATA ELEMENT MAY UNDERCOUNT THE ACTUAL NUMBER OF COMPLETE HOSPITAL STAYS.

SOURCE: CREATED USING MAX INPATIENT HOSPITAL RECORDS.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 66.

ELEMENT NAME: **TOTAL INPATIENT STAY COUNT**

SAS VARIABLE: TOT_IP_STAY_CNT

TYPE: NUM* LENGTH: 3 BEG: 1180 END: 1182

DESCRIPTION:

TOTAL NUMBER OF INPATIENT HOSPITAL STAYS, FOR THE CALENDAR YEAR.

(SAS USERS: ZONED DECIMAL - ZD3)

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 'RECIPIENT TOTAL INPATIENT DISCHARGE COUNT'. FOR REASONS DISCUSSED ABOVE, THIS DATA ELEMENT MAY OVERCOUNT THE ACTUAL NUMBER OF COMPLETE HOSPITAL STAYS.

SOURCE: CREATED USING MAX INPATIENT HOSPITAL RECORDS.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 67.

ELEMENT NAME: **TOTAL INPATIENT LENGTH OF STAY (LOS), IN DAYS (FOR DISCHARGES)**

SAS VARIABLE: TOT_IP_DAY_CNT_DSCHRG

TYPE: NUM* LENGTH: 3 BEG: 1183 END: 1185

DESCRIPTION:

TOTAL LENGTH OF STAY, IN DAYS, FOR INPATIENT HOSPITAL DISCHARGES, FOR THE CALENDAR YEAR.

(SAS USERS: ZONED DECIMAL - ZD3)

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 'RECIPIENT TOTAL INPATIENT LENGTH OF STAY (LOS), IN DAYS (FOR STAYS)'.

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 0-FILLED. LOS IS CALCULATED FOR BOTH MEDICARE CROSSOVER AND NON-CROSSOVER INPATIENT HOSPITAL RECORDS.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 68.

ELEMENT NAME: **TOTAL INPATIENT LENGTH OF STAY (LOS), IN DAYS (FOR STAYS)**

SAS VARIABLE: TOT_IP_DAY_CNT_STAYS

TYPE: NUM* LENGTH: 3 BEG: 1186 END: 1188

DESCRIPTION:

TOTAL LENGTH OF STAY, IN DAYS, FOR INPATIENT HOSPITAL STAYS, FOR THE CALENDAR YEAR.

(SAS USERS: ZONED DECIMAL - ZD3)

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 'RECIPIENT TOTAL INPATIENT LENGTH OF STAY (LOS), IN DAYS (FOR DISCHARGES)'.

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 0-FILLED. LOS IS CALCULATED FOR BOTH MEDICARE CROSSOVER AND NON-CROSSOVER INPATIENT HOSPITAL RECORDS.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 69.

ELEMENT NAME: **TOTAL INPATIENT COVERED DAY COUNT (FOR DISCHARGES)**

SAS VARIABLE: TOT_IP_CVR_DAY_CNT_DSCHRG

TYPE: NUM* LENGTH: 3 BEG: 1189 END: 1191

DESCRIPTION:

TOTAL MEDICAID-COVERED DAYS OF CARE FOR INPATIENT HOSPITAL DISCHARGES, FOR THE CALENDAR YEAR.

(SAS USERS: ZONED DECIMAL - ZD3)

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 'RECIPIENT TOTAL INPATIENT COVERED DAY COUNT (FOR STAYS)'.

SOURCE: CREATED USING MEDICAID-COVERED INPATIENT DAYS FROM MAX INPATIENT HOSPITAL RECORDS. AS THIS COUNT IS BEING AGGREGATED ACROSS THE IP CLAIM RECORDS, IF THE CLAIM IS A MEDICARE CROSSOVER CLAIM OR THE CLAIM IS PART OF A HOSPITAL STAY THAT HAS A MEDICARE CROSSOVER CLAIM, THE MEDICAID-COVERED INPATIENT DAYS IS RECODED TO 0 ON THE CLAIM(S) IN THAT STAY.

NOTE: IN MAX 2006, THIS SPECIFICATION WAS UPDATED.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 70.

ELEMENT NAME: **TOTAL INPATIENT COVERED DAY COUNT (FOR STAYS)**

SAS VARIABLE: TOT_IP_CVR_DAY_CNT_STAYS

TYPE: NUM* LENGTH: 3 BEG: 1192 END: 1194

DESCRIPTION:

TOTAL MEDICAID-COVERED DAYS OF CARE FOR INPATIENT HOSPITAL STAYS, FOR THE CALENDAR YEAR.

(SAS USERS: ZONED DECIMAL - ZD3)

USER NOTE: THIS DATA ELEMENT COUNTS THE NUMBER OF MEDICAID-COVERED INPATIENT DAYS FOR INPATIENT HOSPITAL STAYS, REGARDLESS OF DISCHARGE STATUS.

SOURCE: CREATED USING MEDICAID-COVERED INPATIENT DAYS FROM MAX INPATIENT HOSPITAL RECORDS. AS THIS COUNT IS BEING AGGREGATED ACROSS THE IP CLAIM RECORDS, IF THE CLAIM IS A MEDICARE CROSSOVER CLAIM OR THE CLAIM IS PART OF A HOSPITAL STAY THAT HAS A MEDICARE CROSSOVER CLAIM, THE MEDICAID-COVERED INPATIENT DAYS IS RECODED TO 0 ON THE CLAIM(S) IN THAT STAY.

NOTE: IN MAX 2006, THIS SPECIFICATION WAS UPDATED.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: **

ELEMENT NAME: **INSTITUTIONAL LONG-TERM CARE UTILIZATION SUMMARY GROUP**

SAS VARIABLE: NONE

TYPE: GROUP LENGTH: 15 BEG: 1195 END: 1209

DESCRIPTION:

FIELDS CONTAINING DAY COUNTS FOR SELECTED TYPES OF LONG-TERM CARE SERVICES.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 71.

ELEMENT NAME: **LONG-TERM CARE MENTAL HOSPITAL FOR THE AGED COVERED DAY COUNT**

SAS VARIABLE: TOT_LTC_CVR_DAY_CNT_AGED

TYPE: NUM* LENGTH: 3 BEG: 1195 END: 1197

DESCRIPTION:

TOTAL NUMBER OF MEDICAID-COVERED DAYS FOR THE RECIPIENT IN A MENTAL HOSPITAL FOR THE AGED (NOT A HOSPITAL) FOR THE CALENDAR YEAR.

(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 TOS = 02 (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 MEDICARE 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 MEDICARE 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 DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 72.

ELEMENT NAME: **LONG-TERM CARE INPATIENT PSYCHIATRIC FACILITY (AGE < 21) COVERED DAY COUNT**

SAS VARIABLE: TOT_LTC_CVR_DAY_CNT_PSYCH

TYPE: NUM* LENGTH: 3 BEG: 1198 END: 1200

DESCRIPTION:

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.

(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 TOS = 04 (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 MEDICARE 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 MEDICARE 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 DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 73.

ELEMENT NAME: **INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELLECTUAL DISABLITIES - ICF-IID COVERED DAY COUNT**

SAS VARIABLE: TOT_LTC_CVR_DAY_CNT_ICFMR

TYPE: NUM* LENGTH: 3 BEG: 1201 END: 1203

DESCRIPTION:

TOTAL NUMBER OF MEDICAID-COVERED DAYS FOR THE RECIPIENT IN AN INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELLECTUAL DISABLITIES - ICF-IID - FOR THE CALENDAR YEAR. (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 NURSING FACILITY DAYS FROM MSIS CLAIMS FOR TOS = 05 (INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELLECTUAL DISABLITIES - ICF-IID). 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 MEDICARE 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 MEDICARE 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 DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 74.

ELEMENT NAME: **NURSING FACILITY - NF - COVERED DAY COUNT**

SAS VARIABLE: TOT_LTC_CVR_DAY_CNT_NF

TYPE: NUM* LENGTH: 3 BEG: 1204 END: 1206

DESCRIPTION:

TOTAL NUMBER OF MEDICAID-COVERED DAYS FOR THE RECIPIENT IN A NURSING FACILITY FOR THE CALENDAR YEAR.

(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 NURSING FACILITY DAYS FROM MSIS CLAIMS FOR TOS = 07 (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 MEDICARE 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 MEDICARE 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 DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 75.

ELEMENT NAME: **LONG-TERM CARE COVERED DAY COUNT**

SAS VARIABLE: TOT_LTC_CVR_DAY_CNT

TYPE: NUM* LENGTH: 3 BEG: 1207 END: 1209

DESCRIPTION:

TOTAL NUMBER OF MEDICAID-COVERED DAYS FOR THE RECIPIENT IN A LONG-TERM CARE FACILITY (NOT A HOSPITAL), FOR THE CALENDAR YEAR.

(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 BY SUMMING THE COVERED DAY COUNTS FROM 'RECIPIENT LONG-TERM CARE MENTAL HOSPITAL FOR THE AGED COVERED DAY COUNT' , 'RECIPIENT LONG-TERM CARE INPATIENT PSYCHIATRIC FACILITY (AGE < 21) COVERED DAY ', 'RECIPIENT INTERMEDIATE CARE CARE FACILITY FOR INDIVIDUALS WITH INTELLECTUAL DISABLITIES - ICF-IID COVERED DAY ' AND 'RECIPIENT NURSING FACILITY - NF - COVERED DAY COUNT'.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: **

ELEMENT NAME: **CLAIMS PAYMENT SUMMARY GROUP**

SAS VARIABLE: NONE

TYPE: GROUP LENGTH: 60 BEG: 1210 END: 1269

DESCRIPTION:

THE DATA ELEMENTS IN THIS GROUP SUMMARIZE CLAIMS COUNTS AND PAYMENT AMOUNTS.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 76.

ELEMENT NAME: **TOTAL MEDICAID RECORD COUNT**

SAS VARIABLE: TOT_MDCD_CLM_CNT

TYPE: NUM* LENGTH: 5 BEG: 1210 END: 1214

DESCRIPTION:

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.

(SAS USERS: ZONED DECIMAL - ZD5)

USER NOTES: THIS IS A SUM OF THE COUNTS IN 'RECIPIENT TOTAL MEDICAID FEE-FOR-SERVICE CLAIM COUNT', 'RECIPIENT TOTAL MEDICAID PRE-PAID PLAN PREMIUM PAYMENT RECORD COUNT' AND 'RECIPIENT TOTAL MEDICAID ECOUNTER RECORD COUNT'. MSIS RECORDS WITH TYPE OF CLAIM = 4 (SERVICE TRACKING CLAIM) ARE EXCLUDED FROM ALL MAX FILES.

SOURCE: MSIS CLAIMS FILES.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 77.

ELEMENT NAME: **TOTAL MEDICAID FEE-FOR-SERVICE CLAIM COUNT**

SAS VARIABLE: TOT_MDCD_FFS_CLM_CNT

TYPE: NUM* LENGTH: 5 BEG: 1215 END: 1219

DESCRIPTION:

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).

(SAS USERS: ZONED DECIMAL - ZD5)

SOURCE: MSIS CLAIMS FILES.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 78.

ELEMENT NAME: **TOTAL MEDICAID PRE-PAID PLAN PREMIUM PAYMENT RECORD COUNT**

SAS VARIABLE: TOT_MDCD_PREM_CLM_CNT

TYPE: NUM* LENGTH: 5 BEG: 1220 END: 1224

DESCRIPTION:

RECIPIENT'S TOTAL NUMBER OF PREMIUM PAYMENT CLAIMS FOR THE CALENDAR YEAR, FOR TYPES OF SERVICE = 20-23.

(SAS USERS: ZONED DECIMAL - ZD5)

USER NOTE: RECORDS WITH TYPES OF SERVICE = 20-23 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 = 20-23 AND ANY VALUE FOR TYPE OF CLAIM.

SOURCE: MSIS CLAIMS FILES.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 79.

ELEMENT NAME: **TOTAL MEDICAID ENCOUNTER RECORD COUNT**

SAS VARIABLE: TOT_MDCD_ENCT_CLM_CNT

TYPE: NUM* LENGTH: 5 BEG: 1225 END: 1229

DESCRIPTION:

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).

(SAS USERS: ZONED DECIMAL - ZD5)

SOURCE: MSIS CLAIMS FILES.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 80.

ELEMENT NAME: **TOTAL MEDICAID PAYMENT AMOUNT**

SAS VARIABLE: TOT_MDCD_PYMT_AMT

TYPE: NUM* LENGTH: 8 BEG: 1230 END: 1237

DESCRIPTION:

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.

(SAS USERS: ZONED DECIMAL - ZD8)

USER NOTES: THIS IS A SUM OF THE AMOUNTS IN 'RECIPIENT TOTAL MEDICAID FEE-FOR-SERVICE PAYMENT AMOUNT' AND 'RECIPIENT TOTAL MEDICAID PRE-PAID PLAN PREMIUM PAYMENT AMOUNT'. 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.

SOURCE: MSIS CLAIMS FILES.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 81.

ELEMENT NAME: **TOTAL MEDICAID FEE-FOR-SERVICE PAYMENT AMOUNT**

SAS VARIABLE: TOT_MDCD_FFS_PYMT_AMT

TYPE: NUM* LENGTH: 8 BEG: 1238 END: 1245

DESCRIPTION:

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).

(SAS USERS: ZONED DECIMAL - ZD8)

USER NOTE: ENCOUNTER RECORDS (TYPE OF CLAIM = 3) HAVE $0 PAYMENT AMOUNTS.

SOURCE: MSIS CLAIMS FILES.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 82.

ELEMENT NAME: **TOTAL MEDICAID PRE-PAID PLAN PREMIUM PAYMENT AMOUNT**

SAS VARIABLE: TOT_MDCD_PREM_PYMT_AMT

TYPE: NUM* LENGTH: 8 BEG: 1246 END: 1253

DESCRIPTION:

AMOUNT OF MONEY PAID BY MEDICAID (PREMIUM PAYMENTS TO PREPAID PLANS) FOR THE RECIPIENT DURING THE CALENDAR YEAR, FOR TYPES OF SERVICE = 20-23.

(SAS USERS: ZONED DECIMAL - ZD8)

USER NOTE: RECORDS WITH TYPES OF SERVICE = 20-23 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 = 20-23 AND ANY VALUE FOR TYPE OF CLAIM. ALSO, ENCOUNTER RECORDS (TYPE OF CLAIM = 3) HAVE $0 PAYMENT AMOUNTS.

SOURCE: MSIS CLAIMS FILES.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 83.

ELEMENT NAME: **TOTAL MEDICAID CHARGE AMOUNT**

SAS VARIABLE: TOT_MDCD_CHRG_AMT

TYPE: NUM* LENGTH: 8 BEG: 1254 END: 1261

DESCRIPTION:

TOTAL AMOUNT OF CHARGES BY PROVIDERS TO MEDICAID FOR THE RECIPIENT DURING THE CALENDAR YEAR.

(SAS USERS: ZONED DECIMAL - ZD8)

USER NOTE: THIS AMOUNT IS NOT APPLICABLE FOR ENCOUNTER OR PREMIUM PAYMENT RECORDS.

SOURCE: MSIS CLAIMS FILES.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 84.

ELEMENT NAME: **TOTAL THIRD PARTY PAYMENT AMOUNT**

SAS VARIABLE: TOT_MDCD_TP_PYMT_AMT

TYPE: NUM* LENGTH: 8 BEG: 1262 END: 1269

DESCRIPTION:

TOTAL NON-MEDICAID PAYMENTS FOR SERVICES FOR THE RECIPIENT DURING THE CALENDAR YEAR.

(SAS USERS: ZONED DECIMAL - ZD8)

USER NOTE: THIS AMOUNT IS NOT APPLICABLE FOR ENCOUNTER OR PREMIUM PAYMENT RECORDS.

SOURCE: MSIS CLAIMS FILES.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: **

ELEMENT NAME: **PROGRAM TYPE SUMMARY GROUP - TYPE OF PROGRAM 2 - 7 (OCCURS 6 TIMES)**

SAS VARIABLE: NONE

TYPE: GROUP LENGTH: 330 BEG: 1270 END: 1599

DESCRIPTION:

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 EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT (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.]

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 MAX CLAIMS FILES (E.G. DURABLE MEDICAL EQUIPMENT AND SUPPLIES CAN BE FOUND IN BOTH THE OTHER SERVICES FILE AND THE PRESCRIPTION DRUG FILE).

PROGRAM TYPE 6 IS USED TO REPORT SERVICES PROVIDED TO RECIPIENTS OF HOME AND COMMUNITY-BASED SERVICES FOR INDIVIDUALS AGE 65 AND OLDER. PROGRAM TYPE 7 IS USED TO REPORT SERVICES PROVIDED UNDER A SECTION 1915(C) WAIVER.

THE EXAMPLES ARE FOR PROGRAM TYPE 2 - FAMILY PLANNING.

PROGRAM TYPE 2 - FAMILY PLANNING (POSITIONS 1270 TO 1324)
- NUMBER OF INPATIENT HOSPITAL RECORDS (POSITIONS 1270 TO 1272)
- PAYMENTS FOR INPATIENT HOSPITAL SERVICES (POSITIONS 1273 TO 1280)
- NUMBER OF LONG-TERM CARE RECORDS (POSITIONS 1281 TO 1283)
- PAYMENTS FOR LONG-TERM CARE SERVICES (POSITIONS 1284 TO 1291)
- NUMBER OF OTHER SERVICE RECORDS (POSITIONS 1292 TO 1294)
- PAYMENTS FOR OTHER SERVICES (POSITIONS 1295 TO 1302)
- NUMBER OF PRESCRIPTION DRUG RECORDS (POSITIONS 1303 TO 1305)
- PAYMENTS FOR PRESCRIPTION DRUGS (POSITIONS 1306 TO 1313)
- NUMBER OF TOTAL RECORDS (POSITIONS 1314 TO 1316)
- TOTAL PAYMENTS (POSITIONS 1317 TO 1324)

PROGRAM TYPE 3 - RURAL HEALTH CLINIC (POSITIONS 1325 TO 1379)
- NUMBER OF INPATIENT HOSPITAL RECORDS (POSITIONS 1325 TO 1327)
- PAYMENTS FOR INPATIENT HOSPITAL SERVICES (POSITIONS 1328 T0 1335)
- NUMBER OF LONG-TERM CARE RECORDS (POSITIONS 1336 TO 1338)
- PAYMENTS FOR LONG-TERM CARE SERVICES (POSITIONS 1339 TO 1346)
- NUMBER OF OTHER SERVICE RECORDS (POSITIONS 1347 TO 1349)
- PAYMENTS FOR OTHER SERVICES (POSITIONS 1350 TO 1357)
- NUMBER OF PRESCRIPTION DRUG RECORDS (POSITIONS 1358 TO 1360)
- PAYMENTS FOR PRESCRIPTION DRUGS (POSITIONS 1361 TO 1368)
- NUMBER OF TOTAL RECORDS (POSITIONS 1369 TO 1371)
- TOTAL PAYMENTS (POSITIONS 1372 TO 1379)

PROGRAM TYPE 4 - FEDERALLY QUALIFIED HEALTH CENTERS - FQHCs (POSITIONS 1380 TO 1434)
- NUMBER OF INPATIENT HOSPITAL RECORDS (POSITIONS 1380 TO 1382)
- PAYMENTS FOR INPATIENT HOSPITAL SERVICES (POSITIONS 1383 TO 1390)
- NUMBER OF LONG-TERM CARE RECORDS (POSITIONS 1391 TO 1393)
- PAYMENTS FOR LONG-TERM CARE SERVICES (POSITIONS 1394 TO 1401)
- NUMBER OF OTHER SERVICE RECORDS (POSITIONS 1402 TO 1404)
- PAYMENTS FOR OTHER SERVICES (POSITIONS 1405 TO 1412)
- NUMBER OF PRESCRIPTION DRUG RECORDS (POSITIONS 1413 TO 1415)
- PAYMENTS FOR PRESCRIPTION DRUGS (POSITIONS 1416 TO 1423)
- NUMBER OF TOTAL RECORDS (POSITIONS 1424 TO 1426)
- TOTAL PAYMENTS (POSITIONS 1427 TO 1434)

PROGRAM TYPE 5 - INDIAN HEALTH SERVICES (POSITIONS 1435 TO 1489)
- NUMBER OF INPATIENT HOSPITAL RECORDS (POSITIONS 1435 TO 1437)

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

PAYMENTS FOR INPATIENT HOSPITAL SERVICES (POSITIONS 1438 TO 1445)
NUMBER OF LONG-TERM CARE RECORDS (POSITIONS 1446 TO 1448)
PAYMENTS FOR LONG-TERM CARE SERVICES (POSITIONS 1449 TO 1456)
NUMBER OF OTHER SERVICE RECORDS (POSITIONS 1457 TO 1459)
PAYMENTS FOR OTHER SERVICES (POSITIONS 1460 TO 1467)
NUMBER OF PRESCRIPTION DRUG RECORDS (POSITIONS 1468 TO 1470)
PAYMENTS FOR PRESCRIPTION DRUGS (POSITIONS 1471 TO 1478)
NUMBER OF TOTAL RECORDS (POSITIONS 1479 TO 1481)
TOTAL PAYMENTS (POSITIONS 1482 TO 1489)
PROGRAM TYPE 6 - HOME AND COMMUNITY-BASED CARE FOR DISABLED ELDERLY AND INDIVIDUALS AGE 65 AND OLDER (POSITIONS 1490 TO 1544)
NUMBER OF INPATIENT HOSPITAL RECORDS (POSITIONS 1490 TO 1492)
PAYMENTS FOR INPATIENT HOSPITAL SERVICES (POSITIONS 1493 TO 1500)
NUMBER OF LONG-TERM CARE RECORDS (POSITIONS 1501 TO 1503)
PAYMENTS FOR LONG-TERM CARE SERVICES (POSITIONS 1504 TO 1511)
NUMBER OF OTHER SERVICE RECORDS (POSITIONS 1512 TO 1514)
PAYMENTS FOR OTHER SERVICES (POSITIONS 1515 TO 1522)
NUMBER OF PRESCRIPTION DRUG RECORDS (POSITIONS 1523 TO 1525)
PAYMENTS FOR PRESCRIPTION DRUGS (POSITIONS 1526 TO 1533)
NUMBER OF TOTAL RECORDS (POSITIONS 1534 TO 1536)
TOTAL PAYMENTS (POSITIONS 1537 TO 1544)
PROGRAM TYPE 7 - HOME AND COMMUNITY-BASED CARE WAIVER SERVICES (POSITIONS 1545 TO 1599)
NUMBER OF INPATIENT HOSPITAL RECORDS (POSITIONS 1545 TO 1547)
PAYMENTS FOR INPATIENT HOSPITAL SERVICES (POSITIONS 1548 TO 1555)
NUMBER OF LONG-TERM CARE RECORDS (POSITIONS 1556 TO 1558)
PAYMENTS FOR LONG-TERM CARE SERVICES (POSITIONS 1559 TO 1566)
NUMBER OF OTHER SERVICE RECORDS (POSITIONS 1567 TO 1569)
PAYMENTS FOR OTHER SERVICES (POSITIONS 1570 TO 1577)
NUMBER OF PRESCRIPTION DRUG RECORDS (POSITIONS 1578 TO 1580)
PAYMENTS FOR PRESCRIPTION DRUGS (POSITIONS 1581 TO 1588)
NUMBER OF TOTAL RECORDS (POSITIONS 1589 TO 1591)
TOTAL PAYMENTS (POSITIONS 1592 TO 1599)

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 85.

ELEMENT NAME: **INPATIENT HOSPITAL RECORDS - FIRST TYPE OF PROGRAM**

SAS VARIABLE: IP_HOSP_REC_FP

TYPE: NUM LENGTH: 3 BEG: 1270 END: 1272

DESCRIPTION:

NUMBER OF INPATIENT HOSPITAL RECORDS CONTAINING MSIS PROGRAM TYPE = 2 (FAMILY PLANNING).

SOURCE: CREATED USING THE MSIS INPATIENT HOSPITAL CLAIMS FILE.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 86.

ELEMENT NAME: **INPATIENT HOSPITAL PAYMENTS - FIRST TYPE OF PROGRAM**

SAS VARIABLE: IP_HOSP_PYMT_FP

TYPE: NUM* LENGTH: 8 BEG: 1273 END: 1280

DESCRIPTION:

MEDICAID PAYMENT AMOUNT FOR ALL INPATIENT HOSPITAL RECORDS CONTAINING MSIS PROGRAM TYPE = 2 (FAMILY PLANNING).

(SAS USERS: ZONED DECIMAL - ZD8)

SOURCE: CREATED USING THE MSIS INPATIENT HOSPITAL CLAIMS FILE.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 87.

ELEMENT NAME: **INSTITUTIONAL LONG-TERM CARE RECORDS - FIRST TYPE OF PROGRAM**

SAS VARIABLE: LT_REC_CNT_FP

TYPE: NUM LENGTH: 3 BEG: 1281 END: 1283

DESCRIPTION:

NUMBER OF LONG-TERM CARE RECORDS CONTAINING MSIS PROGRAM TYPE = 2 (FAMILY PLANNING).

SOURCE: CREATED USING THE MSIS LONG-TERM CARE CLAIMS FILE.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 88.

ELEMENT NAME: **INSTITUTIONAL LONG-TERM CARE PAYMENTS - FIRST TYPE OF PROGRAM**

SAS VARIABLE: LT_PYMT_AMT_FP

TYPE: NUM* LENGTH: 8 BEG: 1284 END: 1291

DESCRIPTION:

MEDICAID PAYMENT AMOUNT FOR ALL LONG-TERM CARE RECORDS CONTAINING MSIS PROGRAM TYPE = 2 (FAMILY PLANNING).

(SAS USERS: ZONED DECIMAL - ZD8)

SOURCE: CREATED USING THE MSIS LONG-TERM CARE CLAIMS FILE.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 89.

ELEMENT NAME: **OTHER SERVICE RECORDS - FIRST TYPE OF PROGRAM**

SAS VARIABLE: OT_REC_CNT_FP

TYPE: NUM LENGTH: 3 BEG: 1292 END: 1294

DESCRIPTION:

NUMBER OF OTHER SERVICE RECORDS CONTAINING MSIS PROGRAM TYPE = 2 (FAMILY PLANNING).

SOURCE: CREATED USING THE MSIS OTHER SERVICE CLAIMS FILE.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 90.

ELEMENT NAME: **OTHER SERVICE PAYMENTS - FIRST TYPE OF PROGRAM**

SAS VARIABLE: OT_PYMT_AMT_FP

TYPE: NUM* LENGTH: 8 BEG: 1295 END: 1302

DESCRIPTION:

MEDICAID PAYMENT AMOUNT FOR ALL OTHER SERVICE RECORDS CONTAINING MSIS PROGRAM TYPE = 2 (FAMILY PLANNING).

(SAS USERS: ZONED DECIMAL - ZD8)

SOURCE: CREATED USING THE MSIS OTHER SERVICE CLAIMS FILE.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 91.

ELEMENT NAME: **PRESCRIPTION DRUG RECORDS - FIRST TYPE OF PROGRAM**

SAS VARIABLE: RX_REC_CNT_FP

TYPE: NUM LENGTH: 3 BEG: 1303 END: 1305

DESCRIPTION:

NUMBER OF PRESCRIPTION DRUG RECORDS CONTAINING MSIS PROGRAM TYPE = 2 (FAMILY PLANNING).

SOURCE: CREATED USING THE MSIS PRESCRIPTION DRUG CLAIMS FILE.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 92.

ELEMENT NAME: **PRESCRIPTION DRUG PAYMENTS - FIRST TYPE OF PROGRAM**

SAS VARIABLE: RX_PYMT_AMT_FP

TYPE: NUM* LENGTH: 8 BEG: 1306 END: 1313

DESCRIPTION:

MEDICAID PAYMENT AMOUNT FOR ALL PRESCRIPTION DRUG RECORDS CONTAINING MSIS PROGRAM TYPE = 2 (FAMILY PLANNING).

(SAS USERS: ZONED DECIMAL - ZD8)

SOURCE: CREATED USING THE MSIS PRESCRIPTION DRUG CLAIMS FILE.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 93.

ELEMENT NAME: **TOTAL RECORDS - FIRST TYPE OF PROGRAM**

SAS VARIABLE: TOT_REC_CNT_FP

TYPE: NUM LENGTH: 3 BEG: 1314 END: 1316

DESCRIPTION:

TOTAL NUMBER OF RECORDS CONTAINING MSIS PROGRAM TYPE = 2 (FAMILY PLANNING).

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.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 94.

ELEMENT NAME: **TOTAL PAYMENTS - FIRST TYPE OF PROGRAM**

SAS VARIABLE: TOT_PYMT_AMT_FP

TYPE: NUM* LENGTH: 8 BEG: 1317 END: 1324

DESCRIPTION:

MEDICAID PAYMENT AMOUNT FOR ALL RECORDS CONTAINING MSIS PROGRAM TYPE = 2 (FAMILY PLANNING).

(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.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 95.

ELEMENT NAME: **DELIVERY CODE**

SAS VARIABLE: RCPNT_DLVRY_CD

TYPE: NUM LENGTH: 1 BEG: 1600 END: 1600

DESCRIPTION:

CODE INDICATING WHETHER OR NOT THE ELIGIBLE HAD AT LEAST ONE INPATIENT HOSPITAL STAY IN THE YEAR WITH A MATERNAL DELIVERY DIAGNOSIS CODE.

CODES:
0 = NO MAX INPATIENT CLAIM DURING THE YEAR WITH A MATERNAL DELIVERY DIAGNOSIS CODE.
1 = AT LEAST ONE MAX INPATIENT CLAIM DURING THE YEAR WITH A MATERNAL DELIVERY DIAGNOSIS CODE.

USER NOTES:

REFER TO THE DELIVERY CODE ON THE IP RECORD FOR THE LIST OF DELIVERY DIAGNOSIS CODES.

SOME INPATIENT HOSPITAL DELIVERY CLAIMS ARE ONLY FOR THE MOTHER, SOME ARE ONLY FOR THE NEWBORN, AND SOME ARE COMBINED MOTHER/NEWBORN CLAIMS.

INPATIENT HOSPITAL PROCEDURE CODES WERE NOT USED TO IDENTIFY DELIVERIES BECAUSE THEY ARE NOT AS RELIABLE AS DIAGNOSIS CODES.

A SMALL PERCENTAGE OF MEDICAID DELIVERIES OCCUR IN PLACES OF SERVICE OTHER THAN THE INPATIENT HOSPITAL.

IN MAX 1999-2005 THE DELIVERY INDICATOR ON THE PS FILE INCORRECTLY INCLUDED BOTH MOTHERS AND NEWBORNS INSTEAD OF JUST MOTHERS. STARTING WITH MAX 2006 IT INCLUDES ONLY MATERNAL DELIVERIES. THE DELIVERY INDICATOR ON THE IP FILE CAN BE USED TO PROPERLY IDENTIFY EITHER MATERNAL AND/OR NEWBORN DELIVERIES DURING 1999-2005.

IN MAX 1992-1995 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 BECAUSE IT MAY MISREPRESENT DELIVERY EXPENDITURES FOR A NUMBER OF REASONS, INCLUDING:

- BOTH THE NEWBORN AND MOTHER'S EXPENDITURES ARE INCLUDED ON COMBINED OTHER/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.

SOURCE: CREATED FROM MSIS IP CLAIMS.

NOTE: IN MAX 2006, THIS SPECIFICATION WAS UPDATED.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: **

ELEMENT NAME: **TYPE OF SERVICE GROUP - MAX TOS (OCCURS 31 TIMES)**

SAS VARIABLE: NONE

TYPE: GROUP LENGTH: 1085 BEG: 1601 END: 2685

DESCRIPTION:

THERE ARE 31 OCCURRENCES, ONE FOR EACH OF THE MAX TYPES OF SERVICE (TOS) EXCEPT TOS=20, 21, 22 AND 23. 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.

IN MAX 1999-2005, THE SUMMARY EXPENDITURE AND SERVICE MEASURES FOR CLAIMS WITH A TYPE OF SERVICE OF DRUGS (CODE 16) ONLY INCLUDE THOSE DRUG CLAIMS WITH PROPER NDC CODES. THERE CAN BE ADDITIONAL DRUG CLAIMS REPORTED WITH AN IMPROPER NDC, WHICH WERE MOVED TO THE OTHER SERVICES (OT) FILE WITH A TYPE OF SERVICE 16 (DRUGS). THESE NON-NDC DRUG CLAIMS ARE REPORTED IN THE PERSON SUMMARY (PS) TYPE OF SERVICE DATA SECTION WITH TYPE OF SERVICE 99 (UNKNOWN). IN MAX 2006, THEY ARE REPORTED IN THE PS TYPE OF SERVICE DATA SECTION WITH TYPE OF SERVICE 16 (DRUGS).

FOR TYPES OF SERVICE THAT RELATE TO PREMIUM PAYMENTS: TOS = 20 (CAPITATED PAYMENTS TO HMO, HIO, OR PACE PLANS), TOS = 21 (CAPITATED PAYMENTS TO PREPAID HEALTH PLANS - PHPs), TOS = 22 (CAPITATED PAYMENTS FOR PRIMARY CARE CASE MANAGEMENT - PCCM), AND TOS=23 (CAPITATED PAYMENTS TO PRIVATE HEALTH INSURANCE - PHI), SEE THE 'PREMIUM PAYMENT DATA' GROUP.

SERVICES AND MEDICAID PAYMENT AMOUNTS REPORTED IN THE 31 TYPE OF SERVICE CATEGORIES MAY ALSO BE REPORTED IN THE 21 COMMUNITY-BASED LONG-TERM CARE CATEGORIES.

THE OCCURRENCES ARE AS FOLLOWS:

CODES
01 = INPATIENT HOSPITAL (POSITION 1601 TO 1635)
RECIPIENT INDICATOR (POSITION 1601) RECIPIENT FEE-FOR-SERVICE CLAIM COUNT (POSITIONS 1602 TO 1606)
RECIPIENT FEE-FOR-SERVICE MEDICAID PAYMENT AMOUNT (POSITIONS 1607 TO 1614)
RECIPIENT FEE-FOR-SERVICE CHARGE AMOUNT (POSITIONS 1615 TO 1622)
RECIPIENT FEE-FOR-SERVICE THIRD PARTY PAYMENT AMOUNT (POSITIONS 1623 TO 1630)
RECIPIENT ENCOUNTER RECORD COUNT (POSITIONS 1631 TO 1635)
02 = MENTAL HOSPITAL SERVICES FOR THE AGED (POSITIONS 1636 TO 1670)
RECIPIENT INDICATOR (POSITION 1636) RECIPIENT FEE-FOR-SERVICE CLAIM COUNT (POSITIONS 1637 TO 1641)
RECIPIENT FEE-FOR-SERVICE MEDICAID PAYMENT AMOUNT (POSITIONS 1642 TO 1649)
RECIPIENT FEE-FOR-SERVICE CHARGE AMOUNT (POSITIONS 1650 TO 1657)
RECIPIENT FEE-FOR-SERVICE THIRD PARTY PAYMENT AMOUNT (POSITIONS 1658 TO 1665)
RECIPIENT ENCOUNTER RECORD COUNT (POSITIONS 1666 TO 1670)
04 = INPATIENT PSYCHIATRIC FACILITY FOR INDIVIDUALS UNDER THE AGE OF 21 (POSITIONS 1671 TO 1705)
RECIPIENT INDICATOR (POSITION 1671) RECIPIENT FEE-FOR-SERVICE CLAIM COUNT (POSITIONS
1672 TO 1676)
RECIPIENT FEE-FOR-SERVICE MEDICAID PAYMENT AMOUNT (POSITIONS 1677 TO 1684)
RECIPIENT FEE-FOR-SERVICE CHARGE AMOUNT (POSITIONS 1685 TO 1692)
RECIPIENT FEE-FOR-SERVICE THIRD PARTY PAYMENT AMOUNT (POSITIONS 1693 TO 1700)
RECIPIENT ENCOUNTER RECORD COUNT (POSITIONS 1701 TO 1705)
05 = INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELLECTUAL DISABLITIES (POSTIONS 1706 TO 1740)
RECIPIENT INDICATOR (POSITION 1706) RECIPIENT FEE-FOR-SERVICE CLAIM COUNT (POSITIONS
1707 TO 1711)
RECIPIENT FEE-FOR-SERVICE MEDICAID PAYMENT AMOUNT (POSITIONS 1712 TO 1719)
RECIPIENT FEE-FOR-SERVICE CHARGE AMOUNT (POSITIONS 1720 TO 1727)
RECIPIENT FEE-FOR-SERVICE THIRD PARTY PAYMENT AMOUNT (POSITIONS 1728 TO 1735)
RECIPIENT ENCOUNTER RECORD COUNT (POSITIONS 1736 TO 1740)
07 = NURSING FACILITY SERVICES - ALL OTHER (POSITIONS 1741 TO 1775)
RECIPIENT INDICATOR (POSITION 1741) RECIPIENT FEE-FOR-SERVICE CLAIM COUNT (POSITIONS 1742 TO 1746)
RECIPIENT FEE-FOR-SERVICE MEDICAID PAYMENT AMOUNT (POSITIONS 1747 TO 1754)
RECIPIENT FEE-FOR-SERVICE CHARGE AMOUNT (POSITIONS 1755 TO 1762)
RECIPIENT FEE-FOR-SERVICE THIRD PARTY PAYMENT AMOUNT (POSITIONS 1763 TO 1770)
RECIPIENT ENCOUNTER RECORD COUNT (POSITIONS 1771 TO 1775)
08 = PHYSICIANS (POSITIONS 1776 TO 1810)
RECIPIENT INDICATOR (POSITION 1776) RECIPIENT FEE-FOR-SERVICE CLAIM COUNT (POSITIONS 1777 TO 1781)
RECIPIENT FEE-FOR-SERVICE MEDICAID PAYMENT AMOUNT (POSITIONS 1782 TO 1789)
RECIPIENT FEE-FOR-SERVICE CHARGE AMOUNT (POSITIONS 1790 TO 1797)
RECIPIENT FEE-FOR-SERVICE THIRD PARTY PAYMENT AMOUNT (POSITIONS 1798 TO 1805)
RECIPIENT ENCOUNTER RECORD COUNT (POSITIONS 1806 TO 1810)
09 = DENTAL (POSITIONS 1811 TO 1845)
RECIPIENT INDICATOR (POSITION 1811) RECIPIENT FEE-FOR-SERVICE CLAIM COUNT (POSITIONS 1812 TO 1816)
RECIPIENT FEE-FOR-SERVICE MEDICAID PAYMENT AMOUNT (POSITIONS 1817 TO 1824)
RECIPIENT FEE-FOR-SERVICE CHARGE AMOUNT (POSITIONS 1825 TO 1832)
RECIPIENT FEE-FOR-SERVICE THIRD PARTY PAYMENT AMOUNT (POSITIONS 1833 TO 1840)
RECIPIENT ENCOUNTER RECORD COUNT (POSITIONS 1841 TO 1845)
10 = OTHER PRACTITIONERS (POSITIONS 1846 TO 1880)
RECIPIENT INDICATOR (POSITION 1846) RECIPIENT FEE-FOR-SERVICE CLAIM COUNT (POSITIONS 1847 TO 1851)
RECIPIENT FEE-FOR-SERVICE MEDICAID PAYMENT AMOUNT (POSITIONS 1852 TO 1859)
RECIPIENT FEE-FOR-SERVICE CHARGE AMOUNT (POSITIONS 1860 TO 1867)
RECIPIENT FEE-FOR-SERVICE THIRD PARTY PAYMENT AMOUNT (POSITIONS 1868 TO 1875)

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

RECIPIENT ENCOUNTER RECORD COUNT (POSITIONS 1876 TO 1880)
11 = OUTPATIENT HOSPITAL (POSITIONS 1881 TO 1915)
RECIPIENT INDICATOR (POSITION 1881) RECIPIENT FEE-FOR-SERVICE CLAIM COUNT (POSITIONS 1882 TO 1886)
RECIPIENT FEE-FOR-SERVICE MEDICAID PAYMENT AMOUNT (POSITIONS 1887 TO 1894)
RECIPIENT FEE-FOR-SERVICE CHARGE AMOUNT (POSITIONS 1895 TO 1902)
RECIPIENT FEE-FOR-SERVICE THIRD PARTY PAYMENT AMOUNT (POSITIONS 1903 TO 1910)
RECIPIENT ENCOUNTER RECORD COUNT (POSITIONS 1911 TO 1915)
12 = CLINIC (POSITIONS 1916 TO 1950)
RECIPIENT INDICATOR (POSITION 1916) RECIPIENT FEE-FOR-SERVICE CLAIM COUNT (POSITIONS 1917 TO 1921)
RECIPIENT FEE-FOR-SERVICE MEDICAID PAYMENT AMOUNT (POSITIONS 1922 TO 1929)
RECIPIENT FEE-FOR-SERVICE CHARGE AMOUNT (POSITIONS 1930 TO 1937)
RECIPIENT FEE-FOR-SERVICE THIRD PARTY PAYMENT AMOUNT (POSITIONS 1938 TO 1945)
RECIPIENT ENCOUNTER RECORD COUNT (POSITIONS 1946 TO 1950)
13 = HOME HEALTH (POSITIONS 1951 TO 1985)
RECIPIENT INDICATOR (POSITION 1951) RECIPIENT FEE-FOR-SERVICE CLAIM COUNT (POSITIONS 1952 TO 1956)
RECIPIENT FEE-FOR-SERVICE MEDICAID PAYMENT AMOUNT (POSITIONS 1957 TO 1964)
RECIPIENT FEE-FOR-SERVICE CHARGE AMOUNT (POSITIONS 1965 TO 1972)
RECIPIENT FEE-FOR-SERVICE THIRD PARTY PAYMENT AMOUNT (POSITIONS 1973 TO 1980)
RECIPIENT ENCOUNTER RECORD COUNT (POSITIONS 1981 TO 1985)
15 = LAB AND X-RAY (POSITIONS 1986 TO 2020)
RECIPIENT INDICATOR (POSITION 1986) RECIPIENT FEE-FOR-SERVICE CLAIM COUNT (POSITIONS 1987 TO 1991)
RECIPIENT FEE-FOR-SERVICE MEDICAID PAYMENT AMOUNT (POSITIONS 1992 TO 1999)
RECIPIENT FEE-FOR-SERVICE CHARGE AMOUNT (POSITIONS 2000 TO 2007)
RECIPIENT FEE-FOR-SERVICE THIRD PARTY PAYMENT AMOUNT (POSITIONS 2008 TO 2015)
RECIPIENT ENCOUNTER RECORD COUNT (POSITIONS 2016 TO 2020)
16 = DRUG (POSITIONS 2021 TO 2055)
RECIPIENT INDICATOR (POSITION 2021) RECIPIENT FEE-FOR-SERVICE CLAIM COUNT (POSITIONS 2022 TO 2026)
RECIPIENT FEE-FOR-SERVICE MEDICAID PAYMENT AMOUNT (POSITIONS 2027 TO 2034)
RECIPIENT FEE-FOR-SERVICE CHARGE AMOUNT (POSITIONS 2035 TO 2042)
RECIPIENT FEE-FOR-SERVICE THIRD PARTY PAYMENT AMOUNT (POSITIONS 2043 TO 2050)
RECIPIENT ENCOUNTER RECORD COUNT (POSITIONS 2051 TO 2055)
19 = OTHER SERVICES (POSITIONS 2056 TO 2090)
RECIPIENT INDICATOR (POSITION 2056) RECIPIENT FEE-FOR-SERVICE CLAIM COUNT (POSITIONS 2057 TO 2061)
RECIPIENT FEE-FOR-SERVICE MEDICAID PAYMENT AMOUNT (POSITIONS 2062 TO 2069)
RECIPIENT FEE-FOR-SERVICE CHARGE AMOUNT (POSITIONS 2070 TO 2077)
RECIPIENT FEE-FOR-SERVICE THIRD PARTY PAYMENT AMOUNT (POSITIONS 2078 TO 2085)
RECIPIENT ENCOUNTER RECORD COUNT (POSITIONS 2086 TO 2090)
24 = STERILIZATIONS (POSITIONS 2091 TO 2125)
RECIPIENT INDICATOR (POSITION 2091) RECIPIENT FEE-FOR-SERVICE CLAIM COUNT (POSITIONS 2092 TO 2096)
RECIPIENT FEE-FOR-SERVICE MEDICAID PAYMENT AMOUNT (POSITIONS 2097 TO 2104)
RECIPIENT FEE-FOR-SERVICE CHARGE AMOUNT (POSITIONS 2105 TO 2112)
RECIPIENT FEE-FOR-SERVICE THIRD PARTY PAYMENT AMOUNT (POSITIONS 2113 TO 2120)
RECIPIENT ENCOUNTER RECORD COUNT (POSITIONS 2121 TO 2125)
25 = ABORTIONS (POSITIONS 2126 TO 2160)
RECIPIENT INDICATOR (POSITION 2126) RECIPIENT FEE-FOR-SERVICE CLAIM COUNT (POSITIONS 2127 TO 2131)
RECIPIENT FEE-FOR-SERVICE MEDICAID PAYMENT AMOUNT (POSITIONS 2132 TO 2139)
RECIPIENT FEE-FOR-SERVICE CHARGE AMOUNT (POSITIONS 2140 TO 2147)
RECIPIENT FEE-FOR-SERVICE THIRD PARTY PAYMENT AMOUNT (POSITIONS 2148 TO 2155)
RECIPIENT ENCOUNTER RECORD COUNT (POSITIONS 2156 TO 2160)
26 = TRANSPORTATION SERVICES (POSITIONS 2161 TO 2195)
RECIPIENT INDICATOR (POSITION 2161) RECIPIENT FEE-FOR-SERVICE CLAIM COUNT (POSITIONS 2162 TO 2166)
RECIPIENT FEE-FOR-SERVICE MEDICAID PAYMENT AMOUNT (POSITIONS 2167 TO 2174)
RECIPIENT FEE-FOR-SERVICE CHARGE AMOUNT (POSITIONS 2175 TO 2182)
RECIPIENT FEE-FOR-SERVICE THIRD PARTY PAYMENT AMOUNT (POSITIONS 2183 TO 2190)
RECIPIENT ENCOUNTER RECORD COUNT (POSITIONS 2191 TO 2195)
30 = PERSONAL CARE SERVICES (POSITIONS 2196 TO 2230)
RECIPIENT INDICATOR (POSITION 2196) RECIPIENT FEE-FOR-SERVICE CLAIM COUNT (POSITIONS 2197 TO 2201)
RECIPIENT FEE-FOR-SERVICE MEDICAID PAYMENT AMOUNT (POSITIONS 2202 TO 2209)
RECIPIENT FEE-FOR-SERVICE CHARGE AMOUNT (POSITIONS 2210 TO 2217)
RECIPIENT FEE-FOR-SERVICE THIRD PARTY PAYMENT AMOUNT (POSITIONS 2218 TO 2225)

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

RECIPIENT ENCOUNTER RECORD COUNT (POSITIONS 2226 TO 2230)
31 = TARGETED CASE MANAGEMENT (POSITIONS 2231 TO 2265)
RECIPIENT INDICATOR (POSITION 2231) RECIPIENT FEE-FOR-SERVICE CLAIM COUNT (POSITIONS 2232 TO 2236)
RECIPIENT FEE-FOR-SERVICE MEDICAID PAYMENT AMOUNT (POSITIONS 2237 TO 2244)
RECIPIENT FEE-FOR-SERVICE CHARGE AMOUNT (POSITIONS 2245 TO 2252)
RECIPIENT FEE-FOR-SERVICE THIRD PARTY PAYMENT AMOUNT (POSITIONS 2253 TO 2260)
RECIPIENT ENCOUNTER RECORD COUNT (POSITIONS 2261 TO 2265)
33 = REHABILITATION SERVICES (POSITIONS 2266 TO 2300)
RECIPIENT INDICATOR (POSITION 2266) RECIPIENT FEE-FOR-SERVICE CLAIM COUNT (POSITIONS 2267 TO 2271)
RECIPIENT FEE-FOR-SERVICE MEDICAID PAYMENT AMOUNT (POSITIONS 2272 TO 2279)
RECIPIENT FEE-FOR-SERVICE CHARGE AMOUNT (POSITIONS 2280 TO 2287)
RECIPIENT FEE-FOR-SERVICE THIRD PARTY PAYMENT AMOUNT (POSITIONS 2288 TO 2295)
RECIPIENT ENCOUNTER RECORD COUNT (POSITIONS 2296 TO 2300)
34 = PT, OT, SPEECH, HEARING SERVICES (POSITIONS 2301 TO 2335)
RECIPIENT INDICATOR (POSITION 2301) RECIPIENT FEE-FOR-SERVICE CLAIM COUNT (POSITIONS 2302 TO 2306)
RECIPIENT FEE-FOR-SERVICE MEDICAID PAYMENT AMOUNT (POSITIONS 2307 TO 2314)
RECIPIENT FEE-FOR-SERVICE CHARGE AMOUNT (POSITIONS 2315 TO 2322)
RECIPIENT FEE-FOR-SERVICE THIRD PARTY PAYMENT AMOUNT (POSITIONS 2323 TO 2330)
RECIPIENT ENCOUNTER RECORD COUNT (POSITIONS 2331 TO 2335)
35 = HOSPICE BENEFITS (POSITIONS 2336 TO 2370)
RECIPIENT INDICATOR (POSITION 2336) RECIPIENT FEE-FOR-SERVICE CLAIM COUNT (POSITIONS 2337 TO 2341)
RECIPIENT FEE-FOR-SERVICE MEDICAID PAYMENT AMOUNT (POSITIONS 2342 TO 2349)
RECIPIENT FEE-FOR-SERVICE CHARGE AMOUNT (POSITIONS 2350 TO 2357)
RECIPIENT FEE-FOR-SERVICE THIRD PARTY PAYMENT AMOUNT (POSITIONS 2358 TO 2365)
RECIPIENT ENCOUNTER RECORD COUNT (POSITIONS 2366 TO 2370)
36 = NURSE MIDWIFE SERVICES (POSITIONS 2371 TO 2405)
RECIPIENT INDICATOR (POSITION 2371) RECIPIENT FEE-FOR-SERVICE CLAIM COUNT (POSITIONS 2372 TO 2376)
RECIPIENT FEE-FOR-SERVICE MEDICAID PAYMENT AMOUNT (POSITIONS 2377 TO 2384)
RECIPIENT FEE-FOR-SERVICE CHARGE AMOUNT (POSITIONS 2385 TO 2392)
RECIPIENT FEE-FOR-SERVICE THIRD PARTY PAYMENT AMOUNT (POSITIONS 2393 TO 2400)
RECIPIENT ENCOUNTER RECORD COUNT (POSITIONS 2401 TO 2405)
37 = NURSE PRACTITIONER SERVICES (POSITIONS 2406 TO 2440)
RECIPIENT INDICATOR (POSITION 2406) RECIPIENT FEE-FOR-SERVICE CLAIM COUNT (POSITIONS 2407 TO 2411)
RECIPIENT FEE-FOR-SERVICE MEDICAID PAYMENT AMOUNT (POSITIONS 2412 TO 2419)
RECIPIENT FEE-FOR-SERVICE CHARGE AMOUNT (POSITIONS 2420 TO 2427)
RECIPIENT FEE-FOR-SERVICE THIRD PARTY PAYMENT AMOUNT (POSITIONS 2428 TO 2435)
RECIPIENT ENCOUNTER RECORD COUNT (POSITIONS 2436 TO 2440)
38 = PRIVATE DUTY NURSING (POSITIONS 2441 TO 2475)
RECIPIENT INDICATOR (POSITION 2441) RECIPIENT FEE-FOR-SERVICE CLAIM COUNT (POSITIONS 2442 TO 2446)
RECIPIENT FEE-FOR-SERVICE MEDICAID PAYMENT AMOUNT (POSITIONS 2447 TO 2454)
RECIPIENT FEE-FOR-SERVICE CHARGE AMOUNT (POSITIONS 2455 TO 2462)
RECIPIENT FEE-FOR-SERVICE THIRD PARTY PAYMENT AMOUNT (POSITIONS 2463 TO 2470)
RECIPIENT ENCOUNTER RECORD COUNT (POSITIONS 2471 TO 2475)
39 = RELIGIOUS NON-MEDICAL HEALTH CARE INSTITUTIONS (POSITIONS 2476 TO 2510)
RECIPIENT INDICATOR (POSITION 2476) RECIPIENT FEE-FOR-SERVICE CLAIM COUNT (POSITIONS 2477 TO 2481)
RECIPIENT FEE-FOR-SERVICE MEDICAID PAYMENT AMOUNT (POSITIONS 2482 TO 2489)
RECIPIENT FEE-FOR-SERVICE CHARGE AMOUNT (POSITIONS 2490 TO 2497)
RECIPIENT FEE-FOR-SERVICE THIRD PARTY PAYMENT AMOUNT (POSITIONS 2498 TO 2505)
RECIPIENT ENCOUNTER RECORD COUNT (POSITIONS 2506 TO 2510)
51 = DURABLE MEDICAL EQUIPMENT (DME) AND SUPPLIES (INCLUDES EMERGENCY RESPONSE SYSTEMS AND HOME MODIFICATIONS) (POSITIONS 2511 TO 2545)
RECIPIENT INDICATOR (POSITION 2511) RECIPIENT FEE-FOR-SERVICE CLAIM COUNT (POSITIONS 2512 TO 2516)
RECIPIENT FEE-FOR-SERVICE MEDICAID PAYMENT AMOUNT (POSITIONS 2517 TO 2524)
RECIPIENT FEE-FOR-SERVICE CHARGE AMOUNT (POSITIONS 2525 TO 2532)
RECIPIENT FEE-FOR-SERVICE THIRD PARTY PAYMENT AMOUNT (POSITIONS 2533 TO 2540)
RECIPIENT ENCOUNTER RECORD COUNT (POSITIONS 2541 TO 2545)
52 = RESIDENTIAL CARE (DEFINITION CHANGED FOR 2003 AND LATER YEARS - ADDITIONAL INFORMATION IS AVAILABLE ON REQUEST) (POSITIONS 2546 TO 2580)
RECIPIENT INDICATOR (POSITION 2546) RECIPIENT FEE-FOR-SERVICE CLAIM COUNT (POSITIONS 2547 TO 2551)
RECIPIENT FEE-FOR-SERVICE MEDICAID PAYMENT AMOUNT (POSITIONS 2552 TO 2559)
RECIPIENT FEE-FOR-SERVICE CHARGE AMOUNT (POSITIONS 2560 TO 2567)
RECIPIENT FEE-FOR-SERVICE THIRD PARTY PAYMENT AMOUNT (POSITIONS 2568 TO 2575)

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

RECIPIENT ENCOUNTER RECORD COUNT (POSITIONS 2576 TO 2580)
53 = PSYCHIATRIC SERVICES (EXCLUDING ADULT DAY CARE) (POSITIONS 2581 TO 2615)
RECIPIENT INDICATOR (POSITION 2581) RECIPIENT FEE-FOR-SERVICE CLAIM COUNT (POSITIONS 2582 TO 2586)
RECIPIENT FEE-FOR-SERVICE MEDICAID PAYMENT AMOUNT (POSITIONS 2587 TO 2594)
RECIPIENT FEE-FOR-SERVICE CHARGE AMOUNT (POSITIONS 2595 TO 2602)
RECIPIENT FEE-FOR-SERVICE THIRD PARTY PAYMENT AMOUNT (POSITIONS 2603 TO 2610)
RECIPIENT ENCOUNTER RECORD COUNT (POSITIONS 2611 TO 2615)
54 = ADULT DAY CARE (POSITIONS 2616 TO 2650)
RECIPIENT INDICATOR (POSITION 2616) RECIPIENT FEE-FOR-SERVICE CLAIM COUNT (POSITIONS 2617 TO 2621)
RECIPIENT FEE-FOR-SERVICE MEDICAID PAYMENT AMOUNT (POSITIONS 2622 TO 2629)
RECIPIENT FEE-FOR-SERVICE CHARGE AMOUNT (POSITIONS 2630 TO 2637)
RECIPIENT FEE-FOR-SERVICE THIRD PARTY PAYMENT AMOUNT (POSITIONS 2638 TO 2645)
RECIPIENT ENCOUNTER RECORD COUNT (POSITIONS 2646 TO 2650)
99 = UNKNOWN (POSITIONS 2651 TO 2685)
RECIPIENT INDICATOR (POSITION 2651) RECIPIENT FEE-FOR-SERVICE CLAIM COUNT (POSITIONS 2652 TO 2656)
RECIPIENT FEE-FOR-SERVICE MEDICAID PAYMENT AMOUNT (POSITIONS 2657 TO 2664)
RECIPIENT FEE-FOR-SERVICE CHARGE AMOUNT (POSITIONS 2665 TO 2672)
RECIPIENT FEE-FOR-SERVICE THIRD PARTY PAYMENT AMOUNT (POSITIONS 2673 TO 2680)
RECIPIENT ENCOUNTER RECORD COUNT (POSITIONS 2681 TO 2685)

USER NOTE: THE FOLLOWING CODES ARE INVALID: 03, 06, 14, 17, 18, 27, 28, 29, 32 AND 40-50. BEGINNING IN 10/98, MSIS IDENTIFIED EARLY PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (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.

NOTE: IN MAX 2006, THIS SPECIFICATION WAS UPDATED.

NOTE: IN MAX 2008, THIS SPECIFICATION WAS UPDATED.

NOTE: IN MAX 2008, A TYPOGRAPHICAL ERROR WAS CORRECTED -- TYPE OF SERVICE = 20 NOW INCLUDES PACE.

NOTE: IN MAX 2008, A CLARIFICATION NOTE WAS ADDED TO EXPLAIN HOW THE 31 TYPE OF SERVICE CATEGORIES RELATE TO THE 21 COMMUNITY-BASED LONG-TERM CARE CATEGORIES.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 96.

ELEMENT NAME: **RECIPIENT INDICATOR - FIRST MAX TOS**

SAS VARIABLE: FEE_FOR_SRVC_IND_01

TYPE: CHAR LENGTH: 1 BEG: 1601 END: 1601

DESCRIPTION:

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. THIS DATA ELEMENT IS REPORTED FOR ALL TYPES OF SERVICE, EXCEPT TOS = 20, 21, 22, AND 23.

CODES:
0 = THE ELIGIBLE PERSON DID NOT RECEIVE ANY SERVICES
1 = THE ELIGIBLE PERSON HAD ONLY FEE-FOR-SERVICE CLAIMS
2 = THE ELIGIBLE PERSON HAD ONLY ENCOUNTER RECORDS (PRE-PAID PLAN)
3 = THE ELIGIBLE PERSON HAD BOTH FEE-FOR-SERVICE CLAIMS AND ENCOUNTER RECORDS

USER NOTE: SEE 'RECIPIENT INDICATOR' WHICH IS SIMILAR TO 'TYPE OF SERVICE RECIPIENT INDICATOR'. THIS ELEMENT 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 PAID AMOUNT < $0. IN MAX ALL NON-ENCOUNTER CLAIMS WITH MEDICAID PAYMENT AMOUNT LESS THAN OR EQUAL TO ZERO ARE DELETED. THE RECIPIENT INDICATOR IS SET VALUE >= 1 IF THE BENEFICIARY HAS AT LEAST ONE CLAIM FOR THIS TYPE OF SERVICE.

SOURCE: CREATED FOR EACH OF 31 MAX TYPES OF SERVICE, USING MSIS CLAIMS FILES, AS NOTED ABOVE.

NOTE: IN MAX 2010, USER NOTE WAS UPDATED TO CLARIFY THAT IN MAX ALL NON-ENCOUNTER CLAIMS WITH MEDICAID PAYMENT AMOUNT LESS THAN OR EQUAL TO ZERO ARE DELETED.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 97.

ELEMENT NAME: **FEE-FOR-SERVICE CLAIM COUNT - FIRST MAX TOS**

SAS VARIABLE: FFS_CLM_CNT_01

TYPE: NUM* LENGTH: 5 BEG: 1602 END: 1606

DESCRIPTION:

TOTAL NUMBER OF FEE-FOR-SERVICE CLAIMS FOR THE RECIPIENT DURING THE CALENDAR YEAR FOR THIS TYPE OF SERVICE. THIS DATA ELEMENT IS REPORTED FOR ALL TYPES OF SERVICE, EXCEPT TOS = 20, 21, 22, AND 23.

(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 DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 98.

ELEMENT NAME: **FEE-FOR-SERVICE MEDICAID PAYMENT AMOUNT - FIRST MAX TOS**

SAS VARIABLE: FFS_PYMT_AMT_01

TYPE: NUM* LENGTH: 8 BEG: 1607 END: 1614

DESCRIPTION:

TOTAL FEE-FOR-SERVICE MEDICAID PAYMENTS FOR THE RECIPIENT DURING THE CALENDAR YEAR FOR THIS TYPE OF SERVICE. THIS DATA ELEMENT IS REPORTED FOR ALL TYPES OF SERVICE EXCEPT TOS = 20, 21, 22, AND 23.

(SAS USERS: ZONED DECIMAL - ZD8)

SOURCE: CREATED FOR EACH OF 31 MAX TYPES OF SERVICE, USING MSIS CLAIMS FILES, AS NOTED ABOVE.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 99.

ELEMENT NAME: **FEE-FOR-SERVICE CHARGE AMOUNT - FIRST MAX TOS**

SAS VARIABLE: FFS_CHRG_AMT_01

TYPE: NUM* LENGTH: 8 BEG: 1615 END: 1622

DESCRIPTION:

TOTAL AMOUNT OF FEE-FOR-SERVICE CHARGES FOR THE RECIPIENT DURING THE CALENDAR YEAR FOR THIS TYPE OF SERVICE. THIS DATA ELEMENT IS REPORTED FOR ALL TYPES OF SERVICE EXCEPT TOS = 20, 21, 22, AND 23.

(SAS USERS: ZONED DECIMAL - ZD8)

SOURCE: CREATED FOR EACH OF 31 MAX TYPES OF SERVICE, USING MSIS CLAIMS FILES, AS NOTED ABOVE.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 100.

ELEMENT NAME: **FEE-FOR-SERVICE THIRD PARTY PAYMENT AMOUNT - FIRST MAX TOS**

SAS VARIABLE: FFS_TP_AMT_01

TYPE: NUM* LENGTH: 8 BEG: 1623 END: 1630

DESCRIPTION:

TOTAL NON-MEDICAID PAYMENTS, RELATED TO FEE-FOR-SERVICE CARE FOR THE RECIPIENT DURING THE CALENDAR YEAR FOR THIS TYPE OF SERVICE. THIS DATA ELEMENT IS REPORTED FOR ALL TYPES OF SERVICE EXCEPT TOS = 20, 21, 22, AND 23.

(SAS USERS: ZONED DECIMAL - ZD8)

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.

SOURCE: CREATED FOR EACH OF 31 MAX TYPES OF SERVICE, USING MSIS CLAIMS FILES, AS NOTED ABOVE.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 101.

ELEMENT NAME: **ENCOUNTER RECORD COUNT - FIRST MAX TOS**

SAS VARIABLE: ENCTR_REC_CNT_01

TYPE: NUM LENGTH: 5 BEG: 1631 END: 1635

DESCRIPTION:

TOTAL NUMBER OF ENCOUNTER RECORDS (TYPE OF CLAIM = 3), RELATED TO CARE PROVIDED BY A CAPITATED (PREPAID) PLAN FOR THE RECIPIENT DURING THE CALENDAR YEAR FOR THIS TYPE OF SERVICE. THIS DATA ELEMENT IS REPORTED FOR ALL TYPES OF SERVICE EXCEPT TOS = 20, 21, 22, AND 23.

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'.

SOURCE: CREATED FOR EACH OF 31 MAX TYPES OF SERVICE, USING MSIS CLAIMS FILES, AS NOTED ABOVE.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: **

ELEMENT NAME: **MEDICAID COMMUNITY-BASED LONG-TERM CARE (CLTC) PAYMENT SUMMARY GROUP - CLTC (OCCURS 21 TIMES BY CLTC INDICATOR FLAG)**

SAS VARIABLE: NONE

TYPE: GROUP LENGTH: 168 BEG: 2686 END: 2853

DESCRIPTION:

THERE ARE 21 OCCURRENCES, ONE FOR EACH MAX COMMUNITY-BASED LONG-TERM CARE INDICATOR CODE.

SERVICES AND MEDICAID PAYMENT AMOUNTS REPORTED IN THE 21 COMMUNITY-BASED LONG-TERM CARE CATEGORIES MAY ALSO BE REPORTED IN THE 31 TYPE OF SERVICE CATEGORIES.

CODES
11 = NON-WAIVER PERSONAL CARE (POSITIONS 2686 TO 2693)
12 = NON-WAIVER PRIVATE DUTY NURSING (POSITIONS 2694 TO 2701)
13 = NON-WAIVER ADULT DAY (POSITIONS 2702 TO 2709)
14 = NON-WAIVER HOME HEALTH (POSITIONS 2710 TO 2717)
15 = NON-WAIVER RESIDENTIAL CARE (POSITIONS 2718 TO 2725)
16 = NON-WAIVER REHABILITATION FOR AGED OR DISABLED ENROLLEE (POSITIONS 2726 TO 2733)
17 = NON-WAIVER TARGETED CASE MANAGEMENT FOR AGED OR DISABLED ENROLLEE (POSITIONS 2734 TO 2741)
18 = NON-WAIVER TRANSPORTATION FOR AGED OR DISABLED ENROLLEE (POSITIONS 2742 TO 2749)
19 = NON-WAIVER HOSPICE CARE FOR AGED OR DISABLED ENROLLEE (POSITIONS 2750 TO 2757)
20 = NON-WAIVER DURABLE MEDICAL EQUIPMENT FOR AGED OR DISABLED ENROLLEE (POSITIONS 2758 TO 2765)
30 = WAIVER SERVICE IN ANY OTHER TYPE OF SERVICE NOT LISTED BELOW (POSITIONS 2766 TO 2773)
31 = WAIVER PERSONAL CARE (POSITIONS 2774 TO 2781)
32 = WAIVER PRIVATE DUTY NURSING (POSITIONS 2782 TO 2789)
33 = WAIVER ADULT DAY (POSITIONS 2790 TO 2797)
34 = WAIVER HOME HEALTH (POSITIONS 2798 TO 2805)
35 = WAIVER RESIDENTIAL CARE (POSITIONS 2806 TO 2813)
36 = WAIVER REHABILITATION (POSITIONS 2814 TO 2821)
37 = WAIVER TARGETED CASE MANAGEMENT (POSITIONS 2822 TO 2829)
38 = WAIVER TRANSPORTATION (POSITIONS 2830 TO 2837)
39 = WAIVER HOSPICE CARE (POSITIONS 2838 TO 2845)
40 = WAIVER DURABLE MEDICAL EQUIPMENT (POSITIONS 2846 TO 2853)

NOTE: IN MAX 2008, THIS SPECIFICATION WAS UPDATED.

NOTE: IN MAX 2008, A CLARIFICATION NOTE WAS ADDED TO EXPLAIN HOW THE 31 TYPE OF SERVICE CATEGORIES RELATE TO THE 21 COMMUNITY-BASED LONG-TERM CARE CATEGORIES.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 102.

ELEMENT NAME: **MEDICAID PAYMENT AMOUNT - FIRST TYPE OF CLTC**

SAS VARIABLE: CLTC_FFS_PYMT_AMT_11

TYPE: NUM* LENGTH: 8 BEG: 2686 END: 2693

DESCRIPTION:

FIELD CONTAINING THE FIRST OF 21 MEDICAID PAYMENT AMOUNTS EXISTING FOR EACH MAX COMMUNITY-BASED LONG-TERM CARE INDICATOR CODE. THERE IS ONE DATA ELEMENT FOR EACH LISTED CODE REFLECTING TOTAL FEE-FOR-SERVICE MEDICAID PAYMENT AMOUNT DURING THE YEAR. WAIVER SERVICES INCLUDE SERVICES COVERED UNDER 1915(C) WAIVERS THAT ARE IDENTIFIED IN PROGRAM TYPE CODES 6 OR 7.

(SAS USERS: ZONED DECIMAL - ZD8)

CODES:
11 = NON-WAIVER PERSONAL CARE PROGRAM TYPE NOT = (6 OR 7) AND MAX TOS = 30
12 = NON-WAIVER PRIVATE DUTY NURSING PROGRAM TYPE NOT = (6 OR 7) AND MAX TOS = 38
13 = NON-WAIVER ADULT DAY PROGRAM TYPE NOT = (6 OR 7) AND MAX TOS = 54
14 = NON-WAIVER HOME HEALTH PROGRAM TYPE NOT = (6 OR 7) AND MAX TOS = 13
15 = NON-WAIVER RESIDENTIAL CARE PROGRAM TYPE NOT = (6 OR 7) AND MAX TOS = 52
16 = NON-WAIVER REHABILITATION FOR AGED OR DISABLED ENROLLEE PROGRAM TYPE NOT = (6 OR 7) AND MAX TOS = 33 AND BOE = (1 OR 2)
17 = NON-WAIVER TARGETED CASE MANAGEMENT FOR AGED OR DISABLED ENROLLEE PROGRAM TYPE NOT = (6 OR 7) AND MAX TOS = 31 AND BOE = (1 OR 2)
18 = NON-WAIVER TRANSPORTATION FOR AGED OR DISABLED ENROLLEE PROGRAM TYPE NOT = (6 OR 7) AND MAX TOS = 26 AND BOE = (1 OR 2)
19 = NON-WAIVER HOSPICE CARE FOR AGED OR DISABLED ENROLLEE PROGRAM TYPE NOT = (6 OR 7) AND MAX TOS = 35 AND BOE = (1 OR 2)
20 = NON-WAIVER DURABLE MEDICAL EQUIPMENT FOR AGED OR DISABLED ENROLLEE PROGRAM TYPE NOT = (6 OR 7) AND MAX TOS = 51 AND BOE = (1 OR 2)
30 = WAIVER SERVICE IN ANY OTHER TYPE OF SERVICE NOT LISTED BELOW PROGRAM TYPE = (6 OR 7) AND MAX TOS NOT = (30, 38, 54, 13, 52, 33, 31, 26, 35, 51)
31 = WAIVER PERSONAL CARE PROGRAM TYPE = (6 OR 7) AND MAX TOS = 30
32 = WAIVER PRIVATE DUTY NURSING PROGRAM TYPE = (6 OR 7) AND MAX TOS = 38
33 = WAIVER ADULT DAY PROGRAM TYPE = (6 OR 7) AND MAX TOS = 54
34 = WAIVER HOME HEALTH PROGRAM TYPE = (6 OR 7) AND MAX TOS = 13
35 = WAIVER RESIDENTIAL CARE PROGRAM TYPE = (6 OR 7) AND MAX TOS = 52
36 = WAIVER REHABILITATION PROGRAM TYPE = (6 OR 7) AND MAX TOS = 33
37 = WAIVER TARGETED CASE MANAGEMENT PROGRAM TYPE = (6 OR 7) AND MAX TOS = 31
38 = WAIVER TRANSPORTATION PROGRAM TYPE = (6 OR 7) AND MAX TOS = 26
39 = WAIVER HOSPICE CARE PROGRAM TYPE = (6 OR 7) AND MAX TOS = 35
40 = WAIVER DURABLE MEDICAL EQUIPMENT PROGRAM TYPE = (6 OR 7) AND MAX TOS = 51

USER NOTE: BECAUSE THERE IS AMBIGUITY REGARDING WHAT SERVICES ARE FOR COMMUNITY-BASED LONG-TERM CARE (CLTC), A BROAD SET OF CLAIMS IS IDENTIFIED IN THE CLTC INDICATOR. RESEARCHERS SHOULD USE CAUTION WHEN DETERMINING WHICH CODES TO UTILIZE IN CLTC ANALYSES.

NOTE: IN MAX 2005, THIS VARIABLE WAS ADDED TO THE FILE.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: **

ELEMENT NAME: **MEDICAID HOME AND COMMUNITY-BASED SERVICES (HCBS) PAYMENT SUMMARY GROUP - (OCCURS 18 TIMES BY FIRST TWO BYTES OF TAXONOMY CODE)**

SAS VARIABLE: NONE

TYPE: GROUP LENGTH: 144 BEG: 2854 END: 2997

DESCRIPTION:

THERE ARE 18 OCCURRENCES, ONE FOR EACH HOME AND COMMUNITY-BASED SERVICES (HCBS) IDENTIFIED BY THE FIRST TWO BYTES OF THE TAXONOMY CODE.

WAIVER SERVICES AND MEDICAID PAYMENT AMOUNTS REPORTED IN THE 18 HOME AND COMMUNITY-BASED SERVICES IDENTIFIED BY THE FIRST TWO BYTES OF THE TAXONOMY CODE.

CODES
01 = CASE MANAGEMENT (POSITIONS 2854 TO 2861)
02 = ROUND-THE-CLOCK SERVICES (POSITIONS 2862 TO 2869)
03 = SUPPORTED EMPLOYMENT (POSITIONS 2870 TO 2877)
04 = DAY SERVICES (POSITIONS 2878 TO 2885)
05 = NURSING SERVICES (POSITIONS 2886 TO 2893)
06 = HOME DELIVERED MEALS (POSITIONS 2894 TO 2901)
07 = RENT AND FOOD EXPENSES FOR LIVE-IN CAREGIVER (POSITIONS 2902 TO 2909)
08 = HOME-BASED SERVICES (POSITIONS 2910 TO 2917)
09 = CAREGIVER SUPPORT (POSITIONS 2918 TO 2925)
10 = OTHER MENTAL HEALTH AND BHS (POSITIONS 2926 TO 2933)
11 = OTHER HEALTH AND THERAPEUTIC SERVICES (POSITIONS 2934 TO 2941)
12 = SERICES SUPPORTING PARTICIPANT DIRECTION (POSITIONS 2942 TO 2949)
13 = PARTICIPANT TRAINING (POSITIONS 2950 TO 2957)
14 = EQUIPMENT, TECNOLOGY, AND MODIFICATIONS (POSITIONS 2958 TO 2965)
15 = NON-MEDICAL TRANSPORTATION (POSITIONS 2966 TO 2973)
16 = COMMUNITY TRANSITION SERVICES (POSITIONS 2974 TO 2981)
17 = OTHER SERVICES (POSITIONS 2982 TO 2989)
99 = UNKNOWN (POSITIONS 2990 TO 2997)

NOTE: IN MAX 2010, THIS GROUP WAS ADDED.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 103.

ELEMENT NAME: **MEDICAID PAYMENT AMOUNT - FIRST TYPE OF HCBS TAXONOMY**

SAS VARIABLE: HCBS_FFS_PYMT_AMT_01

TYPE: NUM* LENGTH: 8 BEG: 2854 END: 2861

DESCRIPTION:

FIELD CONTAINING THE FIRST OF 18 MEDICAID PAYMENT AMOUNTS EXISTING FOR EACH HOME AND COMMUNITY-BASED SERVICES IDENTIFIED BY THE FIRST TWO BYTES OF THE TAXONOMY CODE. THERE IS ONE DATA ELEMENT FOR EACH LISTED CODE REFLECTING TOTAL FEE-FOR-SERVICE MEDICAID PAYMENT AMOUNT DURING THE YEAR. IT INCLUDES ONLY WAIVER SERVICES IDENTIFIED IN PROGRAM TYPE CODES 6 OR 7. CODES:
01 = CASE MANAGEMENT
02 = ROUND-THE-CLOCK SERVICES
03 = SUPPORTED EMPLOYMENT
04 = DAY SERVICES
05 = NURSING SERVICES
06 = HOME DELIVERED MEALS
07 = RENT AND FOOD EXPENSES FOR LIVE-IN CAREGIVER
08 = HOME-BASED SERVICES
09 = CAREGIVER SUPPORT
10 = OTHER MENTAL HEALTH AND BEHAVIORAL SERVICES
11 = OTHER HEALTH AND THERAPEUTIC SERVICES
12 = SERVICES SUPPORTING PARTICIPANT DIRECTION
13 = PARTICIPANT TRAINING
14 = EQUIPMENT, TECHNOLOGY, AND MODIFICATIONS
15 = NON-MEDICAL TRANSPORTATION
16 = COMMUNITY TRANSITION SERVICES
17 = OTHER SERVICES
99 = UNKNOWN

NOTE: IN MAX 2010, THIS VARIABLE WAS ADDED TO THE FILE.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: **

ELEMENT NAME: **PREMIUM PAYMENT GROUP (OCCURS FOUR TIMES, ONE FOR EACH MAX TYPE OF PREMIUM TOS = 20 - 23)**

SAS VARIABLE: NONE

TYPE: GROUP LENGTH: 42 BEG: 2998 END: 3053

DESCRIPTION:

THERE ARE FOUR OCCURRENCES, ONE FOR EACH OF THE MAX TYPES OF SERVICE (TOS). FOR CAPITATED PAYMENT CLAIMS (TOS = 20, 21, 22, AND 23), 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 FEE-FOR-SERVICE 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, 22 OR 23).

FOR ALL OTHER TYPES OF SERVICE, SEE THE 'TYPE OF SERVICE DATA' GROUP.

THE OCCURRENCES ARE AS FOLLOWS:

CODES:
20 = CAPITATED PAYMENTS TO HMO, HIO, OR PACE PLANS (POSITIONS 2998 TO 3011)
PREMIUM PAYMENT INDICATOR (POSITION 2998)
PREMIUM PAYMENT RECORD COUNT (POSITIONS 2999 TO 3003)
MEDICAID PREMIUM PAYMENT AMOUNT (POSITIONS 3004 TO 3011)
21 = CAPITATED PAYMENTS TO PREPAID HEALTH PLANS - PHPs (POSITIONS 3012 TO 3025)
PREMIUM PAYMENT INDICATOR (POSITION 3012)
PREMIUM PAYMENT RECORD COUNT (POSITIONS 3013 TO 3017)
MEDICAID PREMIUM PAYMENT AMOUNT (POSITIONS 3018 TO 3025)
22 = CAPITATED PAYMENTS FOR PRIMARY CARE CASE MANAGEMENT - PCCM (POSITIONS 3026 TO 3039)
PREMIUM PAYMENT INDICATOR (POSITION 3026)
PREMIUM PAYMENT RECORD COUNT (POSITIONS 3027 TO 3031)
MEDICAID PREMIUM PAYMENT AMOUNT (POSITIONS 3032 TO 3039)
23 = CAPITATED PAYMENTS TO PRIVATE HEALTH INSURANCE - PHI (POSITIONS 3040 TO 3053)
PREMIUM PAYMENT INDICATOR (POSITION 3040)
PREMIUM PAYMENT RECORD COUNT (POSITIONS 3041 TO 3045)
MEDICAID PREMIUM PAYMENT AMOUNT (POSITIONS 3046 TO 3053)

NOTE: IN MAX 2008, A TYPOGRAPHICAL ERROR WAS CORRECTED -- TYPE OF SERVICE = 20 NOW INCLUDES PACE.

NOTE: VARIABLES FOR TOS= 23 ADDED IN MAX 2011.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 104.

ELEMENT NAME: **PREMIUM PAYMENT INDICATOR - FIRST TYPE OF PREMIUM**

SAS VARIABLE: PREM_PYMT_IND_HMO

TYPE: NUM* LENGTH: 1 BEG: 2998 END: 2998

DESCRIPTION:

INDICATOR TO SHOW IF ANY PREMIUM PAYMENTS WERE MADE TO A CAPITATED (PREPAID) PLAN FOR THIS ELIGIBLE DURING THE CALENDAR YEAR. THIS DATA ELEMENT IS REPORTED ONLY FOR TOS = 20, 21, 22, AND 23.

CODES:
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 FOUR MAX TYPES OF SERVICE FOR PREMIUM PAYMENTS, USING MSIS CLAIMS FILES, AS NOTED ABOVE.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 105.

ELEMENT NAME: **PREMIUM PAYMENT RECORD COUNT - FIRST TYPE OF PREMIUM**

SAS VARIABLE: PREM_PYMT_REC_CNT_HMO

TYPE: NUM* LENGTH: 5 BEG: 2999 END: 3003

DESCRIPTION:

TOTAL NUMBER OF PREMIUM PAYMENTS THAT WERE MADE TO A CAPITATED (PREPAID) PLAN FOR THIS ELIGIBLE DURING THE CALENDAR YEAR. THIS DATA ELEMENT IS REPORTED ONLY FOR TOS = 20, 21, 22, AND 23.

(SAS USERS: ZONED DECIMAL - ZD5)

SOURCE: CREATED FOR EACH OF THE FOUR MAX TYPES OF SERVICE FOR PREMIUM PAYMENTS, USING MSIS CLAIMS FILES, AS NOTED ABOVE.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 106.

ELEMENT NAME: **MEDICAID PREMIUM PAYMENT AMOUNT - FIRST TYPE OF PREMIUM**

SAS VARIABLE: PREM_MDCD_PYMT_AMT_HMO

TYPE: NUM* LENGTH: 8 BEG: 3004 END: 3011

DESCRIPTION:

TOTAL DOLLAR AMOUNT OF PREMIUM PAYMENTS THAT WERE MADE TO A CAPITATED (PREPAID) PLAN FOR THIS ELIGIBLE DURING THE CALENDAR YEAR. THIS DATA ELEMENT IS REPORTED ONLY FOR TOS = 20, 21, 22, AND 23.

(SAS USERS: ZONED DECIMAL - ZD8)

SOURCE: CREATED FOR EACH OF THE FOUR MAX TYPES OF SERVICE FOR PREMIUM PAYMENTS, USING MSIS CLAIMS FILES, AS NOTED ABOVE.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 107.

ELEMENT NAME: **ENCOUNTER RECORD COUNT - HCBS**

SAS VARIABLE: ENCTR_REC_CNT_HCBS

TYPE: NUM LENGTH: 5 BEG: 3054 END: 3058

DESCRIPTION:

TOTAL NUMBER OF ENCOUNTER RECORDS (TYPE OF CLAIM = 3), RELATED TO HOME AND COMMUNITY-BASED SERVICES FOR THE RECIPIENT DURING THE CALENDAR YEAR.

NOTE: IN MAX 2011, THIS VARIABLE WAS ADDED TO THE FILE.

SOURCE: CREATED USING MSIS CLAIMS FILES.

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 108.

ELEMENT NAME: **T-MSIS ELIGIBILITY GROUP - MONTHLY (OCCURS 12 TIMES)**

SAS VARIABLE: NONE

TYPE: GROUP LENGTH: 24 BEG: 3059 END: 3082

DESCRIPTION:

T-MSIS ELIGIBILITY GROUP UNDER WHICH THE MEDICAID ELIGIBLE IS COVERED FROM JANUARY THROUGH DECEMBER. THE EXAMPLE IS FOR JANUARY.
JANUARY (POSITIONS 3059 TO 3060)
FEBRUARY (POSITIONS 3061 TO 3062)
MARCH (POSITIONS 3063 TO 3064)
APRIL (POSITIONS 3065 TO 3066)
MAY (POSITIONS 3067 TO 3068)
JUNE (POSITIONS 3069 TO 3070)
JULY (POSITIONS 3071 TO 3072)
AUGUST (POSITIONS 3073 TO 3074)
SEPTEMBER (POSITIONS 3075 TO 3076)
OCTOBER (POSITIONS 3077 TO 3078)
NOVEMBER (POSITIONS 3079 TO 3080)
DECEMBER (POSITIONS 3081 TO 3082)

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 109.

ELEMENT NAME: **T-MSIS ELIGIBILITY GROUP - FIRST MONTH**

SAS VARIABLE: TMSIS_ELG_GRP_MO_1

TYPE: CHAR LENGTH: 2 BEG: 3059 END: 3060

DESCRIPTION:

CODE INDICATING MONTHLY T-MSIS ELIGIBILTY GROUP.

NOTE: THIS DATA ELEMENT IS NEW FOR MAX 2014.

CODES:
01 = PARENTS AND OTHER CARETAKER RELATIVES (FAMILY/ADULT, MANDATORY COVERAGE)
02 = TRANSITIONAL MEDICAL ASSISTANCE (FAMILY/ADULT, MANDATORY COVERAGE)
03 = EXTENDED MEDICAID DUE TO EARNINGS (FAMILY/ADULT, MANDATORY COVERAGE)
04 = EXTENDED MEDICAID DUE TO SPOUSAL SUPPORT COLLECTIONS (FAMILY/ADULT, MANDATORY COVERAGE)
05 = PREGNANT WOMEN (FAMILY/ADULT, MANDATORY COVERAGE)
06 = DEEMED NEWBORNS (FAMILY/ADULT, MANDATORY COVERAGE)
07 = INFANTS AND CHILDREN UNDER AGE 19 (FAMILY/ADULT, MANDATORY COVERAGE)
08 = CHILDREN WITH TITLE IV-E ADOPTION ASSISTANCE, FOSTER CARE OR GUARDIANSHIP CARE (FAMILY/ADULT, MANDATORY COVERAGE)
09 = FORMER FOSTER CARE CHILDREN (FAMILY/ADULT, MANDATORY COVERAGE)
10 = NOT USED (REPLACED BY 72-75)11= INDIVIDUALS RECEIVING SSI (AGED, BLIND, DISABLED [ABD], MANDATORY COVERAGE)
12 = AGED, BLIND, DISABLED INDIVIDUALS IN 209(B) STATES (ABD, MANDATORY COVERAGE)
13 = INDIVIDUALS RECEIVING MANDATORY STATE SUPPLEMENTS (ABD, MANDATORY COVERAGE)
14 = INDIVIDUALS WHO ARE ESSENTIAL SPOUSES (ABD, MANDATORY COVERAGE)
15 = INSTITUTIONALIZED INDIVIDUALS COUNTINUOSLY ELIGIBLE SINCE 1973 (ABD, MANDATORY COVERAGE)
16 = BLIND OR DISABLED INDIVIDUALS ELIGIBLE IN 1973 (ABD, MANDATORY COVERAGE)
17 = INDIVIDUALS WHO LOST ELIGIBILITY FOR SSI/SSP DUE TO INCREASE IN OASDI BENEFITS IN 1972 (ABD, MANDATORY COVERAGE)
18 = INDIVIDUALS WHO WOULD BE ELIGIBLE FOR SSI/SSP BUT FOR OASDI COLA INCREASES SINCE APRIL 1977 (ABD, MANDATORY COVERAGE)
19 = DISABLED WIDOWS AND WIDOWERS INELIGIBLE FOR SSI DUE TO INCREASE IN OASDI (ABD, MANDATORY COVERAGE)
20 = DISABLED WIDOWS AND WIDOWERS INELIGIBLE FOR SSI DUE TO EARLY RECEIPT OF SOCIAL SECURITY (ABD, MANDATORY COVERAGE)
21 = WORKING DISABLED UNDER 1619(B) (ABD, MANDATORY COVERAGE)
22 = DISABLED ADULT CHILDREN (ABD, MANDATORY COVERAGE)
23 = QUALIFIED MEDICARE BENEFICIARIES (ABD, MANDATORY COVERAGE)
24 = QUALIFIED DISABLED AND WORKING INDIVIDUALS (ABD, MANDATORY COVERAGE)
25 = SPECIFIED LOW INCOME MEDICARE BENEFICIARIES (ABD, MANDATORY COVERAGE)
26 = QUALIFYING INDIVIDUALS (ABD, MANDATORY COVERAGE)
27 = OPTIONAL COVERAGE OF PARENTS AND OTHER CARETAKER RELATIVES (FAMILY/ADULT, OPTIONS FOR COVERAGE)
28 = REASONABLE CLASSIFICATIONS OF INDIVIDUALS UNDER AGE 21 (FAMILY/ADULT, OPTIONS FOR COVERAGE)
29 = CHILDREN WITH NON-IV-E ADOPTION ASSISTANCE (FAMILY/ADULT, OPTIONS FOR COVERAGE)
30 = INDEPENDENT FOSTER CARE ADOLESCENTS (FAMILY/ADULT, OPTIONS FOR COVERAGE)
31 = OPTIONAL TARGETED LOW INCOME CHILDREN (FAMILY/ADULT, OPTIONS FOR COVERAGE)
32 = INDIVIDUALS ELECTING COBRA CONTINUATION COVERAGE (FAMILY/ADULT, OPTIONS FOR COVERAGE)
33 = INDIVIDUALS ABOVE 133% FPL UNDER AGE 65 (FAMILY/ADULT, OPTIONS FOR COVERAGE)
34 = CERTAIN INDIVIDUALS NEEDING TREATMENT FOR BREAST OR CERVICAL CANCER (FAMILY/ADULT, OPTIONS FOR COVERAGE)
35 = INDIVIDUALS ELIGIBLE FOR FAMILY PLANNING SERVICES (FAMILY/ADULT, OPTIONS FOR COVERAGE)
36 = INDIVIDUALS WITH TUBERCULOSIS (FAMILY/ADULT, OPTIONS FOR COVERAGE)
37 = AGED, BLIND OR DISABLED INDIVIDUALS ELIGIBLE FOR BUT NOT RECEIVING CASH ASSISTANCE (ABD, OPTIONS FOR COVERAGE)
38 = INDIVIDUALS ELIGIBLE FOR CASH ASSISTANCE EXCEPT FOR INSTITUTIONALIZATION (ABD, OPTIONS FOR COVERAGE)
39 = INDIVIDUALS RECEIVING HCBS UNDER INSTITUTIONAL RULES (ABD, OPTIONS FOR COVERAGE)
40 = OPTIONAL STATE SUPPLEMENT RECIPIENTS - 1634 STATES, AND SSI CRITERIA STATES WITH 1616 AGREEMENTS (ABD, OPTIONS FOR COVERAGE)
41 = OPTIONAL STATE SUPPLEMENT RECIPIENTS - 209(B) STATES, AND SSI CRITERIA STATES WITHOUT 1616 AGREEMENTS (ABD, OPTIONS FOR COVERAGE)
42 = INSTITUTIONALIZED INDIVIDUALS ELIGIBLE UNDER A SPECIAL INCOME LEVEL (ABD, OPTIONS FOR COVERAGE)
43 = INDIVIDUALS PARTICIPATING IN A PACE PROGRAM UNDER INSTITUTIONAL RULES (ABD, OPTIONS FOR COVERAGE)
44 = INDIVIDUALS RECEIVING HOSPICE CARE (ABD, OPTIONS FOR COVERAGE)

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

45 = QUALIFIED DISABLED CHILDREN UNDER AGE 19 (ABD, OPTIONS FOR COVERAGE)
46 = POVERTY LEVEL AGED OR DISABLED (ABD, OPTIONS FOR COVERAGE)
47 = WORK INCENTIVES ELIGIBIITY GROUP (ABD, OPTIONS FOR COVERAGE)
48 = TICKET TO WORK BASIC GROUP (ABD, OPTIONS FOR COVERAGE)
49 = TICKET TO WORK MEDICAL IMPROVEMENTS GROUP (ABD, OPTIONS FOR COVERAGE)
50 = FAMILY OPPORTUNITY ACT CHILDREN WITH DISABILITIES (ABD, OPTIONS FOR COVERAGE)
51 = INDIVIDUALS ELIGIBLE FOR HCBS (ABD, OPTIONS FOR COVERAGE)
52 = INDIVIDUALS ELIGIBLE FOR HCBS - SPECIAL INCOME LEVEL (ABD, OPTIONS FOR COVERAGE)
53 = MEDICALLY NEEDY PREGNANT WOMEN (FAMILY/ADULT, MEDICALLY NEEDY)
54 = MEDICALLY NEEDY CHILDREN UNDER AGE 18 (FAMILY/ADULT, MEDICALLY NEEDY)
55 = MEDICALLY NEEDY AGE 18 THROUGH 20 (FAMILY/ADULT, MEDICALLY NEEDY)
56 = MEDICALLY NEEDY PARENTS AND OTHER CARETAKERS (FAMILY/ADULT, MEDICALLY NEEDY)
57 = REMOVED - DO NOT USE
58 = REMOVED - DO NOT USE
59 = MEDICALLY NEEDY AGED, BLIND OR DISABLED (ABD, MEDICALLY NEEDY)
60 = MEDICALLY NEEDY BLIND OR DISABLED INDIVIDUALS ELIGIBLE IN 1973 (ABD, MEDICALLY NEEDY)
61 = TARGETED LOW-INCOME CHILDREN (CHILDREN, OPTIONAL)
62 = DEEMED NEWBORN (CHILDREN, OPTIONAL)
63 = CHILDREN INELIGIBLE FOR MEDICAID DUE TO LOSS OF INCOME DISREGARDS (CHILDREN, MANDATORY)
64 = COVERAGE FROM CONCEPTION TO BIRTH (CHILDREN, OPTIONS FOR COVERAGE)
65 = CHILDREN WITH ACCESS TO PUBLIC EMPLOYEE COVERAGE (CHILDREN, OPTIONS FOR COVERAGE)
66 = CHILDREN ELIGIBLE FOR DENTAL ONLY SUPPLEMENTAL COVERAGE (CHILDREN, OPTIONS FOR COVERAGE)
67 = TARGETED LOW-INCOME PREGNANT WOMEN (PREGNANT WOMEN,OPTIONS FOR COVERAGE)
68 = PREGNANT WOMEN WITH ACCESS TO PUBLIC EMPLOYEE COVERAGE (PREGNANT WOMEN, OPTIONS FOR COVERAGE)
69 = INDIVIDUALS WITH MENTAL HEALTH CONDITIONS (EXPANSION GROUP) (1115 EXPANSION)
70 = FAMILY PLANNING PARTICIPANTS (EXPANSION GROUP) (1115 EXPANSION)
71 = OTHER EXPANSION GROUP (1115 EXPANSION)
72 = ADULT GROUP - INDIVIDUALS AT OR BELOW 133% FPL, AGE 19-64, NEWLY ELIGIBLE FOR ALL STATES (FAMILY/ADULT, MANDATORY COVERAGE)
73 = ADULT GROUP - INDIVIDUALS AT OR BELOW 133% FPL, AGE 19-64, NOT NEWLY ELIGIBLE FOR NON 1905Z(3) STATES (FAMILY/ADULT, MANDATORY COVERAGE)
74 = ADULT GROUP - INDIVIDUALS AT OR BELOW 133% FPL, AGE 19-64, NOT NEWLY ELIGIBLE PARENT/CARETAKER-RELATIVE IN 1905Z(3) STATES (FAMILY/ADULT, MANDATORY COVERAGE)
75 = ADULT GROUP - INDIVIDUALS AT OR BELOW 133% FPL, AGE 19-64, NOT NEWLY ELIGIBLE NON-PARENT/CARETAKER-RELATIVE IN 1905Z(3) STATES (FAMILY/ADULT, MANDATORY COVERAGE)
99 = DEFAULT VALUE IN A DUMMY MAX PS RECORD

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

ELEMENT NUMBER: 110.

ELEMENT NAME: **T-MSIS ELIGIBILITY GROUP - MOST RECENT**

SAS VARIABLE: TMSIS_ELG_GRP_LTST

TYPE: CHAR LENGTH: 2 BEG: 3083 END: 3084

DESCRIPTION:

T-MSIS ELIGIBILITY GROUP CODE UNDER WHICH THE MEDICAID ELIGIBLE IS COVERED - MOST RECENT OBSERVATION.

NOTE: THIS DATA ELEMENT IS NEW FOR MAX 2014.

CODES:
01 = PARENTS AND OTHER CARETAKER RELATIVES (FAMILY/ADULT, MANDATORY COVERAGE)
02 = TRANSITIONAL MEDICAL ASSISTANCE (FAMILY/ADULT, MANDATORY COVERAGE)
03 = EXTENDED MEDICAID DUE TO EARNINGS (FAMILY/ADULT, MANDATORY COVERAGE)
04 = EXTENDED MEDICAID DUE TO SPOUSAL SUPPORT COLLECTIONS (FAMILY/ADULT, MANDATORY COVERAGE)
05 = PREGNANT WOMEN (FAMILY/ADULT, MANDATORY COVERAGE)
06 = DEEMED NEWBORNS (FAMILY/ADULT, MANDATORY COVERAGE)
07 = INFANTS AND CHILDREN UNDER AGE 19 (FAMILY/ADULT, MANDATORY COVERAGE)
08 = CHILDREN WITH TITLE IV-E ADOPTION ASSISTANCE, FOSTER CARE OR GUARDIANSHIP CARE (FAMILY/ADULT, MANDATORY COVERAGE)
09 = FORMER FOSTER CARE CHILDREN (FAMILY/ADULT, MANDATORY COVERAGE)
10 = NOT USED (REPLACED BY 72-75)11= INDIVIDUALS RECEIVING SSI (AGED, BLIND, DISABLED [ABD], MANDATORY COVERAGE)
12 = AGED, BLIND, DISABLED INDIVIDUALS IN 209(B) STATES (ABD, MANDATORY COVERAGE)
13 = INDIVIDUALS RECEIVING MANDATORY STATE SUPPLEMENTS (ABD, MANDATORY COVERAGE)
14 = INDIVIDUALS WHO ARE ESSENTIAL SPOUSES (ABD, MANDATORY COVERAGE)
15 = INSTITUTIONALIZED INDIVIDUALS COUNTINUOSLY ELIGIBLE SINCE 1973 (ABD, MANDATORY COVERAGE)
16 = BLIND OR DISABLED INDIVIDUALS ELIGIBLE IN 1973 (ABD, MANDATORY COVERAGE)
17 = INDIVIDUALS WHO LOST ELIGIBILITY FOR SSI/SSP DUE TO INCREASE IN OASDI BENEFITS IN 1972 (ABD, MANDATORY COVERAGE)
18 = INDIVIDUALS WHO WOULD BE ELIGIBLE FOR SSI/SSP BUT FOR OASDI COLA INCREASES SINCE APRIL 1977 (ABD, MANDATORY COVERAGE)
19 = DISABLED WIDOWS AND WIDOWERS INELIGIBLE FOR SSI DUE TO INCREASE IN OASDI (ABD, MANDATORY COVERAGE)
20 = DISABLED WIDOWS AND WIDOWERS INELIGIBLE FOR SSI DUE TO EARLY RECEIPT OF SOCIAL SECURITY (ABD, MANDATORY COVERAGE)
21 = WORKING DISABLED UNDER 1619(B) (ABD, MANDATORY COVERAGE)
22 = DISABLED ADULT CHILDREN (ABD, MANDATORY COVERAGE)
23 = QUALIFIED MEDICARE BENEFICIARIES (ABD, MANDATORY COVERAGE)
24 = QUALIFIED DISABLED AND WORKING INDIVIDUALS (ABD, MANDATORY COVERAGE)
25 = SPECIFIED LOW INCOME MEDICARE BENEFICIARIES (ABD, MANDATORY COVERAGE)
26 = QUALIFYING INDIVIDUALS (ABD, MANDATORY COVERAGE)
27 = OPTIONAL COVERAGE OF PARENTS AND OTHER CARETAKER RELATIVES (FAMILY/ADULT, OPTIONS FOR COVERAGE)
28 = REASONABLE CLASSIFICATIONS OF INDIVIDUALS UNDER AGE 21 (FAMILY/ADULT, OPTIONS FOR COVERAGE)
29 = CHILDREN WITH NON-IV-E ADOPTION ASSISTANCE (FAMILY/ADULT, OPTIONS FOR COVERAGE)
30 = INDEPENDENT FOSTER CARE ADOLESCENTS (FAMILY/ADULT, OPTIONS FOR COVERAGE)
31 = OPTIONAL TARGETED LOW INCOME CHILDREN (FAMILY/ADULT, OPTIONS FOR COVERAGE)
32 = INDIVIDUALS ELECTING COBRA CONTINUATION COVERAGE (FAMILY/ADULT, OPTIONS FOR COVERAGE)
33 = INDIVIDUALS ABOVE 133% FPL UNDER AGE 65 (FAMILY/ADULT, OPTIONS FOR COVERAGE)
34 = CERTAIN INDIVIDUALS NEEDING TREATMENT FOR BREAST OR CERVICAL CANCER (FAMILY/ADULT, OPTIONS FOR COVERAGE)
35 = INDIVIDUALS ELIGIBLE FOR FAMILY PLANNING SERVICES (FAMILY/ADULT, OPTIONS FOR COVERAGE)
36 = INDIVIDUALS WITH TUBERCULOSIS (FAMILY/ADULT, OPTIONS FOR COVERAGE)
37 = AGED, BLIND OR DISABLED INDIVIDUALS ELIGIBLE FOR BUT NOT RECEIVING CASH ASSISTANCE (ABD, OPTIONS FOR COVERAGE)
38 = INDIVIDUALS ELIGIBLE FOR CASH ASSISTANCE EXCEPT FOR INSTITUTIONALIZATION (ABD, OPTIONS FOR COVERAGE)
39 = INDIVIDUALS RECEIVING HCBS UNDER INSTITUTIONAL RULES (ABD, OPTIONS FOR COVERAGE)
40 = OPTIONAL STATE SUPPLEMENT RECIPIENTS - 1634 STATES, AND SSI CRITERIA STATES WITH 1616 AGREEMENTS (ABD, OPTIONS FOR COVERAGE)
41 = OPTIONAL STATE SUPPLEMENT RECIPIENTS - 209(B) STATES, AND SSI CRITERIA STATES WITHOUT 1616 AGREEMENTS (ABD, OPTIONS FOR COVERAGE)
42 = INSTITUTIONALIZED INDIVIDUALS ELIGIBLE UNDER A SPECIAL INCOME LEVEL (ABD, OPTIONS FOR COVERAGE)
43 = INDIVIDUALS PARTICIPATING IN A PACE PROGRAM UNDER INSTITUTIONAL RULES (ABD, OPTIONS FOR COVERAGE)
44 = INDIVIDUALS RECEIVING HOSPICE CARE (ABD, OPTIONS FOR COVERAGE)

MEDICAID ANALYTIC EXTRACT DATA ELEMENT DICTIONARY (2014)
PERSON SUMMARY (PS) RECORD

45 = QUALIFIED DISABLED CHILDREN UNDER AGE 19 (ABD, OPTIONS FOR COVERAGE)
46 = POVERTY LEVEL AGED OR DISABLED (ABD, OPTIONS FOR COVERAGE)
47 = WORK INCENTIVES ELIGIBIITY GROUP (ABD, OPTIONS FOR COVERAGE)
48 = TICKET TO WORK BASIC GROUP (ABD, OPTIONS FOR COVERAGE)
49 = TICKET TO WORK MEDICAL IMPROVEMENTS GROUP (ABD, OPTIONS FOR COVERAGE)
50 = FAMILY OPPORTUNITY ACT CHILDREN WITH DISABILITIES (ABD, OPTIONS FOR COVERAGE)
51 = INDIVIDUALS ELIGIBLE FOR HCBS (ABD, OPTIONS FOR COVERAGE)
52 = INDIVIDUALS ELIGIBLE FOR HCBS - SPECIAL INCOME LEVEL (ABD, OPTIONS FOR COVERAGE)
53 = MEDICALLY NEEDY PREGNANT WOMEN (FAMILY/ADULT, MEDICALLY NEEDY)
54 = MEDICALLY NEEDY CHILDREN UNDER AGE 18 (FAMILY/ADULT, MEDICALLY NEEDY)
55 = MEDICALLY NEEDY AGE 18 THROUGH 20 (FAMILY/ADULT, MEDICALLY NEEDY)
56 = MEDICALLY NEEDY PARENTS AND OTHER CARETAKERS (FAMILY/ADULT, MEDICALLY NEEDY)
57 = REMOVED - DO NOT USE
58 = REMOVED - DO NOT USE
59 = MEDICALLY NEEDY AGED, BLIND OR DISABLED (ABD, MEDICALLY NEEDY)
60 = MEDICALLY NEEDY BLIND OR DISABLED INDIVIDUALS ELIGIBLE IN 1973 (ABD, MEDICALLY NEEDY)
61 = TARGETED LOW-INCOME CHILDREN (CHILDREN, OPTIONAL)
62 = DEEMED NEWBORN (CHILDREN, OPTIONAL)
63 = CHILDREN INELIGIBLE FOR MEDICAID DUE TO LOSS OF INCOME DISREGARDS (CHILDREN, MANDATORY)
64 = COVERAGE FROM CONCEPTION TO BIRTH (CHILDREN, OPTIONS FOR COVERAGE)
65 = CHILDREN WITH ACCESS TO PUBLIC EMPLOYEE COVERAGE (CHILDREN, OPTIONS FOR COVERAGE)
66 = CHILDREN ELIGIBLE FOR DENTAL ONLY SUPPLEMENTAL COVERAGE (CHILDREN, OPTIONS FOR COVERAGE)
67 = TARGETED LOW-INCOME PREGNANT WOMEN (PREGNANT WOMEN,OPTIONS FOR COVERAGE)
68 = PREGNANT WOMEN WITH ACCESS TO PUBLIC EMPLOYEE COVERAGE (PREGNANT WOMEN, OPTIONS FOR COVERAGE)
69 = INDIVIDUALS WITH MENTAL HEALTH CONDITIONS (EXPANSION GROUP) (1115 EXPANSION)
70 = FAMILY PLANNING PARTICIPANTS (EXPANSION GROUP) (1115 EXPANSION)
71 = OTHER EXPANSION GROUP (1115 EXPANSION)
72 = ADULT GROUP - INDIVIDUALS AT OR BELOW 133% FPL, AGE 19-64, NEWLY ELIGIBLE FOR ALL STATES (FAMILY/ADULT, MANDATORY COVERAGE)
73 = ADULT GROUP - INDIVIDUALS AT OR BELOW 133% FPL, AGE 19-64, NOT NEWLY ELIGIBLE FOR NON 1905Z(3) STATES (FAMILY/ADULT, MANDATORY COVERAGE)
74 = ADULT GROUP - INDIVIDUALS AT OR BELOW 133% FPL, AGE 19-64, NOT NEWLY ELIGIBLE PARENT/CARETAKER-RELATIVE IN 1905Z(3) STATES (FAMILY/ADULT, MANDATORY COVERAGE)
75 = ADULT GROUP - INDIVIDUALS AT OR BELOW 133% FPL, AGE 19-64, NOT NEWLY ELIGIBLE NON-PARENT/CARETAKER-RELATIVE IN 1905Z(3) STATES (FAMILY/ADULT, MANDATORY COVERAGE)
99 = DEFAULT VALUE IN A DUMMY MAX PS RECORD

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

www.mathematica-mpr.com

Improving public well-being by conducting high quality, objective research and surveys

PRINCETON, NJ ■ ANN ARBOR, MI ■ CAMBRIDGE, MA ■ CHICAGO, IL ■ OAKLAND, CA ■ WASHINGTON, DC

MATHEMATICA
Policy Research