

	NAME	TYPE	LENGTH	POSITIONS		CONTENTS
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****	STATE MEDICAID RESEARCH FILES PERSONAL SUMMARY RECORD	REC	1059	1	1059	<p>THE STATE MEDICAID RESEARCH FILES (SMRF) PERSONAL SUMMARY RECORD PROVIDES PERSON LEVEL INFORMATION WHICH INCLUDES SUMMARIZATIONS OF ELIGIBILITY AND PAID CLAIMS (UTILIZATION) DATA BY CALENDAR YEAR AND DATE OF SERVICE. THE FILE CONTAINS A RECORD FOR EACH UNIQUE PERSON (ELIGIBLE IDENTIFICATION NUMBER). THERE ARE A LARGE NUMBER OF ELIGIBLES WHO HAVE NO UTILIZATION IN THE YEAR. FOR THESE INDIVIDUALS, CLAIMS-BASED DATA ELEMENTS ARE BLANK. THERE ARE ALSO A SMALL NUMBER OF ELIGIBLE PERSONS FOR WHOM THERE IS UTILIZATION, BUT NO CORRESPONDING ELIGIBILITY DATA IN MSIS. THESE PERSONS ARE IDENTIFIED BY THE DATA ELEMENT "MISSING ELIGIBILITY DATA SWITCH".</p> <p>RECORDS FROM THIS FILE HAVE BEEN LINKED TO THE MEDICARE ENROLLMENT DATA BASE (EDB) TO BETTER IDENTIFY MEDICAID ENROLLEES WHO ARE ALSO ENROLLED IN MEDICARE (SO CALLED DUAL OR CROSSOVER ENROLLEES). THE PROCESS FOR LINKING A SMRF RECORD TO AN EDB RECORD OCCURS IN TWO STEPS, AS FOLLOWS:</p> <p><u>STEP 1</u></p> <p>FOR AGED ENROLLEES: THE ENROLLEE'S SOCIAL SECURITY NUMBER - SSN (DATA ELEMENT #5) AND SEX (DATA ELEMENT #10) MUST MATCH EXACTLY.</p> <p>FOR DISABLED ENROLLEES: EITHER (1) THE ENROLLEE'S SSN AND DATE OF BIRTH (DATA ELEMENT #8) MUST MATCH EXACTLY, OR (2) THE ENROLLEE'S SSN, SEX MUST MATCH EXACTLY AND TWO OF THE THREE ELEMENTS IN DATE OF BIRTH (DAY, MONTH AND YEAR) MUST MATCH EXACTLY.</p> <p><u>STEP 2</u></p> <p>FOR ALL UNMATCHED SSNs FROM STEP 1, THERE IS AN ATTEMPT TO MATCH THESE SSNs TO A CLAIM ACCOUNT NUMBER (CAN) FROM THE HEALTH INSURANCE CLAIM (HIC) DATA ELEMENT ON THE MEDICARE EDB. THIS IS DONE BECAUSE A SIGNIFICANT NUMBER OF ELIGIBLES INCORRECTLY USE THE CAN FROM AN ACCOUNT ON WHICH THEY RECEIVE AUXILIARY BENEFITS (AS A SPOUSE, WIDOW, CHILD, ETC.) AS THEIR OWN SSN. THE CHECK ON GENDER AND DATE OF BIRTH ASSURES A CORRECT MATCH IS MADE.</p> <p>FOR LINKED RECORDS, SELECTED EDB DATA ELEMENTS ARE ADDED TO SMRF FILES:</p> <p>ELIGIBLE MEDICARE HEALTH INSURANCE CLAIM (HIC) NUMBER (DATA ELEMENT #7) ELIGIBLE MEDICARE DEATH DATE (DATA ELEMENT #14) ELIGIBLE MEDICARE DEATH DAY SWITCH (DATA ELEMENT #15) ELIGIBLE MEDICARE BENEFICIARY MONTHS COUNT (DATA ELEMENT #25) ELIGIBLE MEDICARE BENEFICIARY (MONTHLY) (DATA ELEMENT #30)</p> <p>IN ADDITION, ELIGIBLE MEDICARE CROSSOVER CODE (DATA ELEMENT #20) NOW HAS ADDITIONAL CODE VALUES TO REFLECT THE RESULTS OF SMRF/EDB LINK.</p>

STATE MEDICAID RESEARCH FILES PERSON SUMMARY RECORD (1996-98)

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***	ELIGIBLE SUMMARY REGION	REGION	291	1	291	SUMMARIZED INFORMATION FROM MSIS ELIGIBILITY FILES.
**	ELIGIBLE IDENTIFYING GROUP	GROUP	78	1	78	DATA ELEMENTS USED TO IDENTIFY A MEDICAID ELIGIBLE.
1.	ELIGIBLE IDENTIFICATION NUMBER	CHAR	20	1	20	UNIQUE IDENTIFICATION NUMBER USED TO IDENTIFY A MEDICAID ELIGIBLE IN THE MEDICAID STATISTICAL INFORMATION SYSTEM (MSIS). SOURCE: MSIS ELIGIBILITY FILES
2.	STATE ABBREVIATION CODE	CHAR	2	21	22	U. S. POSTAL SERVICE 2-CHARACTER ABBREVIATION FOR THE STATE MEDICAID AGENCY SUBMITTING THE DATA. CODES: AL = ALABAMA AK = ALASKA AZ = ARIZONA AR = ARKANSAS AS = AMERICAN SAMOA CA = CALIFORNIA CO = COLORADO CT = CONNECTICUT DE = DELAWARE DC = DISTRICT OF COLUMBIA FL = FLORIDA GA = GEORGIA GU = GUAM HI = HAWAII ID = IDAHO IL = ILLINOIS

STATE MEDICAID RESEARCH FILES PERSON SUMMARY RECORD (1996-98)

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

SOURCE: MSIS ELIGIBILITY FILES

STATE MEDICAID RESEARCH FILES PERSON SUMMARY RECORD (1996-98)

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3. SMRF YEAR DATE	NUM	4	23	26	<p>CALENDAR YEAR COVERED BY THE SMRF PERSONAL SUMMARY FILE</p> <p>4 DIGITS</p> <p>EDIT-RULES: YYYY</p> <p>USER NOTE: THIS DATA ELEMENT WAS CHANGED TO 4 CHARACTERS IN 1996</p> <p>SOURCE: MSIS ELIGIBILITY FILES</p>
4. ELIGIBLE TEMPORARY IDENTIFICATION NUMBER	CHAR	20	27	46	<p>TEMPORARY PERSONAL IDENTIFICATION NUMBER ASSIGNED BY THE STATE TO AN ELIGIBLE PENDING ASSIGNMENT OF A PERMANENT IDENTIFICATION NUMBER. THIS DATA ELEMENT IS ONLY USED BY STATES THAT USE THE SOCIAL SECURITY NUMBER AS THE PERSONAL IDENTIFIER FOR MEDICAID REPORTING.</p> <p>EDIT-RULES: AS NEGOTIATED WITH EACH STATE. IF THERE IS NO TEMPORARY IDENTIFICATION NUMBER, THIS DATA ELEMENT SHOULD BE BLANK-FILLED.</p> <p>SOURCE: MSIS ELIGIBILITY FILES</p>
5. ELIGIBLE SOCIAL SECURITY NUMBER	CHAR	9	47	55	<p>SOCIAL SECURITY NUMBER OF THE MEDICAID ELIGIBLE.</p> <p>USER NOTE: NOT AVAILABLE FOR WASHINGTON. FOR IOWA, AVAILABLE FOR DUAL ENROLLEES ONLY THROUGH 6/96 AND THEN ALL ENROLLEES BEGINNING 7/96 (88% OF ENROLLEES HAD SSNs IN THE 1996 IOWA DATA).</p> <p>SOURCE: MSIS ELIGIBILITY FILES</p>
6. ELIGIBLE STATE CASE NUMBER	CHAR	12	56	67	<p>STATE-ASSIGNED NUMBER WHICH UNIQUELY IDENTIFIES THE MEDICAID CASE TO WHICH THE ENROLLEE BELONGS ON THE LAST DAY OF THE FEDERAL FISCAL YEAR.</p> <p>USER NOTE: AVAILABLE ONLY FOR 10/98 THROUGH 12/98. BLANK FILLED OTHERWISE. MAY INCLUDE ALPHA CHARACTERS. DOES NOT NECESSARILY LINK ALL FAMILY MEMBERS TOGETHER. MAY CHANGE OVER TIME. THE DEFINITION MAY 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.</p> <p>SOURCE: MSIS ELIGIBILITY FILES</p>

STATE MEDICAID RESEARCH FILES PERSON SUMMARY RECORD (1996-98)

NAME	TYPE	POSITIONS			CONTENTS
		LENGTH	BEG	END	
7. ELIGIBLE MEDICARE HEALTH INSURANCE CLAIM (HIC) NUMBER	CHAR	11	68	78	<p>THE MEDICARE NUMBER IDENTIFYING THE PRIMARY BENEFICIARY UNDER THE SOCIAL SECURITY ADMINISTRATION (SSA) OR RAILROAD RETIREMENT BOARD (RRB) PROGRAMS THIS IS KNOWN AS THE MEDICARE BENEFICIARY CLAIM ACCOUNT NUMBER (CAN) AND IS LOCATED IN POSITIONS 68 TO 76. THE CODE IDENTIFYING THE TYPE OF RELATIONSHIP BETWEEN THE ELIGIBLE INDIVIDUAL AND THE PRIMARY SSA OR RRB BENEFICIARY IS KNOWN AS THE BENEFICIARY IDENTIFICATION CODE (BIC) AND IS LOCATED IN POSITIONS 77 TO 78.</p> <p>USER NOTE: THE CAN (SSN OR RRB NUMBER) CONTAINED IN POSITIONS 68 TO 76 MAY MATCH THE SSN OF THE MEDICAID ENROLLEE (REPORTED IN DATA ELEMENT #5 ABOVE). FOR EXAMPLE, THIS IS LIKELY IF THE BIC HAS A VALUE OF "A" = PRIMARY CLAIMANT. CONVERSELY, THE CAN CONTAINED IN POSITIONS 68 TO 76 MAY NOT MATCH THE SSN OF THE MEDICAID ENROLLEE. IN THIS CASE, THE SSN OR RRB NUMBER WOULD BE FOR THE PRIMARY CLAIMANT, ON WHOSE ACCOUNT THE ENROLLEE RECEIVES SSA/MEDICARE BENEFITS. FOR EXAMPLE, A MAN OVER AGE 62 MIGHT BE THE PRIMARY BENEFICIARY, BUT HIS WIFE COULD RECEIVE BENEFITS BECAUSE HE IS A PRIMARY BENEFICIARY. IN THIS EXAMPLE, THE SSN WOULD BE HIS BUT THE BIC COULD HAVE VALUE OF "B" = AGED WIFE, AGE 62 AND OVER. IF THE ELIGIBLE SOCIAL SECURITY NUMBER (ELEMENT #3) REPORTED BY MEDICAID IS NOT FOUND IN THE MEDICARE ENROLLMENT DATA BASE (EDB) OR IS INVALID, THE HIC WILL BE BLANK-FILLED.</p> <p>SOURCE: MEDICARE ENROLLMENT DATA BASE (EDB), BENEFICIARY CLAIM ACCOUNT NUMBER AND BENEFICIARY IDENTIFICATION CODE.</p>
** ELIGIBLE DEMOGRAPHIC GROUP	GROUP	37	79	115	<p>DEMOGRAPHIC DATA FOR THE ELIGIBLE.</p>
8. ELIGIBLE BIRTH DATE	NUM	8	79	86	<p>BIRTH DATE OF THE MEDICAID ELIGIBLE.</p> <p>8 DIGITS</p> <p>EDIT-RULES: YYYYMMDD</p> <p>SOURCE: MSIS ELIGIBILITY FILES</p>

STATE MEDICAID RESEARCH FILES PERSON SUMMARY RECORD (1996-98)

NAME	TYPE	POSITIONS			CONTENTS
		LENGTH	BEG	END	
9. ELIGIBLE AGE GROUP CODE	NUM	1	87	87	AGE GROUP OF THE MEDICAID ELIGIBLE. 1 DIGIT CODES: 0 = UNDER 1 1 = AGES 1 TO 5 2 = AGES 6 TO 14 3 = AGES 15 TO 20 4 = AGES 21 TO 44 5 = AGES 45 TO 64 6 = AGES 65 TO 74 7 = AGES 75 TO 84 8 = AGES 85 AND OVER 9 = UNKNOWN/ERROR SOURCE: RECODED FROM MSIS ELIGIBILITY FILE USING ELIGIBLE BIRTH DATE (DATA ELEMENT #8) AND DECEMBER 31 OF THE FILE YEAR TO CALCULATE AGE GROUP.
10. ELIGIBLE SEX CODE	NUM	1	88	88	GENDER OF THE MEDICAID ELIGIBLE. 1 DIGIT CODES: 1 = FEMALE 2 = MALE 9 = UNKNOWN/ERROR USER NOTE: THESE CODES CHANGE TO F, M AND U IN THE 1999 MSIS DATA. SOURCE: MSIS ELIGIBILITY FILES

STATE MEDICAID RESEARCH FILES PERSON SUMMARY RECORD (1996-98)

NAME	TYPE	POSITIONS			CONTENTS
		LENGTH	BEG	END	
11. ELIGIBLE RACE/ETHNICITY CODE	NUM	1	89	89	<p>RACE/ETHNICITY OF THE MEDICAID ELIGIBLE.</p> <p>1 DIGIT</p> <p>CODES:</p> <p>1 = WHITE, NOT OF HISPANIC ORIGIN (CHANGED TO "WHITE" BEGINNING 10/98)</p> <p>2 = BLACK, NOT OF HISPANIC ORIGIN (CHANGED TO "BLACK OR AFRICAN AMERICAN" BEGINNING 10/98)</p> <p>3 = AMERICAN INDIAN OR ALASKAN NATIVE</p> <p>4 = ASIAN OR PACIFIC ISLANDER (CHANGED TO "ASIAN" BEGINNING 10/98)</p> <p>5 = HISPANIC (CHANGED TO "HISPANIC OR LATINO - NO RACE INFORMATION AVAILABLE" BEGINNING 10/98)</p> <p>6 = NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER (NEW CODE BEGINNING 10/98)</p> <p>7 = HISPANIC OR LATINO AND ONE OR MORE RACES (NEW CODE BEGINNING 10/98)</p> <p>8 = MORE THAN ONE RACE (NEW CODE BEGINNING 10/98)</p> <p>9 = UNKNOWN</p> <p>USER NOTE: SINCE SPECIFICATIONS FOR CODE VALUES = 7 AND 8 WERE NOT ISSUED BY HCFA 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.</p> <p>SOURCE: STATE MSIS ELIGIBILITY FILES</p>
12. ELIGIBLE SEX-RACE CODE	NUM	1	90	90	<p>GENDER AND RACE OF THE MEDICAID ELIGIBLE.</p> <p>1 DIGIT</p> <p>CODES:</p> <p>1 = WHITE, MALE</p> <p>2 = WHITE, FEMALE</p> <p>3 = NON-WHITE, MALE</p> <p>4 = NON-WHITE, FEMALE</p> <p>5 = RACE UNKNOWN, MALE</p> <p>6 = RACE UNKNOWN, FEMALE</p> <p>7 = SEX UNKNOWN, WHITE</p> <p>8 = SEX UNKNOWN, NON-WHITE</p> <p>9 = SEX AND RACE UNKNOWN</p> <p>SOURCE: RECODED FROM MSIS ELIGIBILITY FILES. CROSSWALK: MSIS RACE=1 MAPS TO WHITE, MSIS RACE=2,3,4,5,6,7 AND 8 MAPS TO NON-WHITE, MSIS RACE=9 MAPS TO UNKNOWN. MSIS SEX=2 OR M MAPS TO MALE. MSIS SEX=1 OR F MAPS TO FEMALE. MSIS SEX=9 OR U MAPS TO UNKNOWN.</p>

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STATE MEDICAID RESEARCH FILES PERSON SUMMARY RECORD (1996-98)

NAME	TYPE	LENGTH	POSITIONS BEG END	CONTENTS
13. ELIGIBLE DEATH DATE	NUM	8	91 98	DEATH DATE OF THE MEDICAID ELIGIBLE. 8 DIGITS EDIT-RULES: YYYYMMDD USER NOTE: THIS DATA ELEMENT SHOULD BE USED WITH CAUTION SINCE THERE MAY BE UNDERREPORTING OF DEATHS OR DEATH DATES MAY BE UNRELIABLE IN THE MSIS ELIGIBILITY FILES. SOURCE: MSIS ELIGIBILITY FILES
14. ELIGIBLE MEDICARE DEATH DATE	NUM	8	99 106	DEATH DATE OF THE MEDICARE BENEFICIARY. 8 DIGITS EDIT-RULES YYYYMMDD USER NOTE: THIS DATE OF DEATH HAS BEEN ADDED TO THE SMRF FILE BECAUSE THE ELIGIBLE DEATH DATE (DATA ELEMENT #13) MAY BE UNDERREPORTED OR UNRELIABLE. IT MAY CONTAIN ONLY A VALID YEAR AND MONTH. IN THESE CASES, THE PERSON'S DAY OF DEATH IS SET OT THE END OF THE MONTH. IT IS POSSIBLE TO DETERMINE WHETHER THE DAY OF DEATH IS ACTUALLY THE END OF THE MONTH OR THE DAY OF DEATH WAS NOT VALID (AND WAS SET TO THE END OF THE MONTH) BY CHECKING THE ELIGIBLE MEDICARE DEATH DAY SWITCH (DATA ELEMENT #15). IF THE ELIGIBLE SOCIAL SECURITY NUMBER (ELEMENT #3) REPORTED BY MEDICAID IS NOT FOUND IN THE MEDICARE ENROLLMENT DATA BASE (EDB) OR IS INVALID, THE ELIGIBLE MEDICARE DEATH DATE WILL BE 8-FILLED. SOURCE: MEDICARE ENROLLMENT DATA BASE (EDB), BENEFICIARY DEATH DATE.

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STATE MEDICAID RESEARCH FILES PERSON SUMMARY RECORD (1996-98)

NAME	TYPE	POSITIONS			CONTENTS
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15. ELIGIBLE MEDICARE DEATH DAY SWITCH	CHAR	1	107	107	<p>INDICATES WHETHER THE MEDICARE BENEFICIARY'S EXACT DAY OF DEATH HAS BEEN VERIFIED.</p> <p>1 CHARACTER</p> <p>CODES:</p> <p>N = DAY OF DEATH WAS NOT VERIFIED Y = DAY OF DEATH WAS VERIFIED</p> <p>USER NOTE: THIS DATA ELEMENT SHOULD BE USED WITH THE ELIGIBLE MEDICARE DEATH DATE (DATA ELEMENT #14). IF THE ELIGIBLE SOCIAL SECURITY NUMBER (ELEMENT #3) REPORTED BY MEDICAID IS NOT FOUND IN THE MEDICARE ENROLLMENT DATA BASE (EDB) OR IS INVALID, THE SWITCH WILL BE BLANK-FILLED.</p> <p>SOURCE: MEDICARE ENROLLMENT DATA BASE (EDB), VERIFY BENEFICIARY DEATH DAY SWITCH.</p>
16. ELIGIBLE RESIDENCE COUNTY CODE	CHAR	3	108	110	<p>FEDERAL INFORMATION PROCESSING STANDARD (FIPS) CODE INDICATING THE ELIGIBLE'S COUNTY OF RESIDENCE.</p> <p>CODES: FIPS NUMERIC COUNTY CODES, OR 000 = ELIGIBLE RESIDES OUT OF STATE 999 = UNKNOWN/ERROR</p> <p>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 DECEMBER AND MOVING BACKWARDS IN TIME MONTH BY MONTH.</p>
17. ELIGIBLE RESIDENCE ZIP CODE	NUM	5	111	115	<p>UNITED STATES POSTAL ZIP CODE OF THE MEDICAID ELIGIBLE'S RESIDENCE.</p> <p>5 DIGITS</p> <p>USER NOTE: MSIS VALIDATION ACTIVITIES WILL ACCEPT ZERO-FILLED RECORDS, SO FOR SMRF, IF THE MSIS RECORD IS EITHER ZERO-FILLED OR BLANK-FILLED, THE SMRF VALUE SHOULD BE RECODED AS 9-FILLED ('99999')</p> <p>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 DECEMBER AND MOVING BACKWARD IN TIME MONTH BY MONTH.</p>

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**	ANNUAL ELIGIBLE MEDICAID AND OTHER HEALTH INSURANCE GROUP		20	116	135	MEDICAID, CROSSOVER (MEDICAID AND MEDICARE) AND OTHER HEALTH INSURANCE ELIGIBILITY DATA FOR THE ELIGIBLE.
18.	STATE SPECIFIC ELIGIBILITY CODE - MOST RECENT	CHAR	6	116	121	<p>STATE SPECIFIC ELIGIBILITY CODE CLASSIFICATION UNDER WHICH THE MEDICAID ELIGIBLE IS COVERED - MOST RECENT OBSERVATION.</p> <p>USER NOTES: THESE SOURCE CODES ARE GENERALLY NOT APPLICABLE FOR MOST RESEARCH ACTIVITIES. THE DATA ELEMENT CHANGES OVER TIME, VARIES 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 SMRF UNIFORM ELIGIBILITY CODES. THEREFORE, MOST USERS WILL WANT TO USE SMRF 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 SMRF 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 SMRF PERSON SUMMARY FILE.</p> <p>SOURCE: THIS CODE WAS DERIVED BY USING MONTHLY OBSERVATIONS OF STATE SPECIFIC ELIGIBILITY 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.</p>

STATE MEDICAID RESEARCH FILES PERSON SUMMARY RECORD (1996-98)

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19. SMRF UNIFORM ELIGIBILITY CODE - MOST RECENT	NUM	2	122	123	STATE MEDICAID RESEARCH FILES (SMRF) UNIFORM ELIGIBILITY CODE FOR THE MEDICAID ELIGIBLE - MOST RECENT OBSERVATION

2 DIGITS

CODES:

00 = NOT ELIGIBLE
 11 = AGED, CASH
 12 = BLIND/DISABLED, CASH
 14 = AFDC CHILD, CASH
 16 = AFDC-U CHILD, CASH
 15 = AFDC ADULT, CASH
 17 = AFDC-U ADULT, CASH
 21 = AGED, MEDICALLY NEEDY (MN)
 22 = BLIND/DISABLED, MN
 24 = AFDC CHILD, MN
 25 = AFDC ADULT, MN
 31 = AGED, POVERTY
 32 = BLIND/DISABLED, POVERTY
 34 = CHILD, POVERTY
 35 = ADULT, POVERTY
 41 = OTHER AGED
 42 = OTHER BLIND/DISABLED
 48 = FOSTER CARE CHILD
 44 = OTHER CHILD
 45 = OTHER ADULT
 99 = UNKNOWN ELIGIBILITY

USER NOTE: THIS CODE LIST IS NEARLY THE SAME AS THE LIST FOR THE 1999
 SMRF FILE, EXCEPT THAT CODES ARE ADDED FOR 1999 TO IDENTIFY SECTION 1115
 DEMONSTRATION EXPANSION ELIGIBLES. FOR 1999, IT IS NOT NECESSARY TO MAP
 SMRF UNIFORM ELIGIBILITY INTO THESE CODES. CHANGES IN THE 1999 MSIS
 SPECIFICATIONS TO STATES RESULTED IN MSIS MAINTENANCE ASSISTANCE STATUS
 (MAS) AND BASIS OF ELIGIBILITY (BOE) CODES THAT DIRECTLY CORRESPOND.

SOURCE: THIS CODE WAS DERIVED BY USING MONTHLY OBSERVATIONS OF SMRF
 UNIFORM ELIGIBILITY GROUP (FOR ALL GROUPS INCLUDING 1115 DEMONSTRATION
 EXPANSION ELIGIBLES) AND SELECTING THE FIRST MEANINGFUL CODE (NOT 0- OR 9-
 FILLED) BEGINNING WITH DECEMBER AND MOVING BACKWARDS IN TIME MONTH BY
 MONTH.

STATE MEDICAID RESEARCH FILES PERSON SUMMARY RECORD (1996-98)

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20. MISSING ELIGIBILITY DATA SWITCH	CHAR	1	124	124	<p>INDICATES NO ELIGIBILITY DATA WERE FOUND FOR THIS CALENDAR YEAR</p> <p>CODES:</p> <p>BLANK = ELIGIBILITY DATA WERE FOUND</p> <p>1 = NO ELIGIBILITY DATA WERE FOUND</p> <p>SOURCE: CODED AT HCFA USING MSIS ELIGIBILITY FILES</p>
21. ELIGIBLE MONTHS COUNT	NUM	2	125	126	<p>TOTAL NUMBER OF MONTHS THE INDIVIDUAL WAS ELIGIBLE FOR MEDICAID DURING THE CALENDAR YEAR.</p> <p>2 DIGITS</p> <p>USER NOTE: THIS IS A NUMBER FROM 0 TO 12. IT IS GIVEN VALUE > 0 BASED ON EITHER (1) THE NUMBER OF MONTHS WITH CODES IN DATA ELEMENT #27 (STATE SPECIFIC ELIGIBILITY CODE), OR (2) IF THERE ARE NO MONTHS WITH CODES IN DATA ELEMENT #27, THEN THE NUMBER OF MONTHS WITH VALID CODES IN EITHER OF TWO MSIS DATA ELEMENTS "MAINTENANCE ASSISTANCE STATUS" (MAS) OR "BASIS OF ELIGIBILITY" (BOE). IF THERE IS NOT AN ELIGIBILITY RECORD, IT IS CODED WITH VALUE = 99 (UNKNOWN).</p> <p>SOURCE: CODED AT HCFA USING MSIS ELIGIBILITY FILES</p>
22. ELIGIBLE PRIVATE INSURANCE MONTHS COUNT	NUM	2	127	128	<p>TOTAL NUMBER OF MONTHS THE MEDICAID ELIGIBLE HAD PRIVATE INSURANCE COVERAGE DURING THE CALENDAR YEAR.</p> <p>2 DIGITS</p> <p>USER NOTE: THIS IS A NUMBER FROM 0 TO 12. IT IS GIVEN VALUE > 0 BASED ON THE NUMBER OF MONTHS 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"</p> <p>SOURCE: CODED AT HCFA USING MSIS ELIGIBILITY FILES</p>

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23. ELIGIBLE MEDICARE CROSSOVER CODE	NUM	1	129	129	<p>INDICATES THAT THE ELIGIBLE IS OR HAS BEEN COVERED BY MEDICARE (KNOWN AS CROSSOVER, DUAL OR MEDICARE ELIGIBILITY)</p> <p>1 DIGIT</p> <p>CODES:</p> <p>0 = NO CROSSOVER</p> <p>1 = DUAL ELIGIBILITY FLAG HAS A VALUE OF 1 (MEANING THAT THE PERSON IS OR HAS BEEN COVERED BY MEDICARE)</p> <p>2 = MEDICARE DEDUCTIBLE OR COINSURANCE PAID BY MEDICAID ON AT LEAST ONE CLAIM DURING THE YEAR.</p> <p>3 = BOTH 1 AND 2 APPLY.</p> <p>4 = A RECORD WAS FOUND IN THE MEDICARE ENROLLMENT DATA BASE (EDB) FOR THE ELIGIBLE, AND NEITHER 1 NOR 2 APPLY.</p> <p>5 = A RECORD WAS FOUND IN THE MEDICARE ENROLLMENT DATA BASE (EDB) FOR THE ELIGIBLE, AND 1 APPLIES.</p> <p>6 = A RECORD WAS FOUND IN THE MEDICARE ENROLLMENT DATA BASE (EDB) FOR THE ELIGIBLE, AND 2 APPLIES.</p> <p>7 = A RECORD WAS FOUND IN THE MEDICARE ENROLLMENT DATA BASE (EDB) FOR THE ELIGIBLE, AND BOTH 1 AND 2 APPLY.</p> <p>9 = ELIGIBLE'S MEDICARE STATUS IS UNKNOWN</p> <p>USER NOTE: BEGINNING IN 10/98, MSIS CAPTURES GREATER DETAIL ON DUAL ELIGIBILITY. GIVEN THE IMPORTANCE OF CROSSOVER STATUS FOR SOME DATA USERS, THE EXPANDED DETAIL APPEARS AS DATA ELEMENT #24 IN THIS FILE. TO PROVIDE CONSISTENCY WITH EARLIER CODES FOR OTHER DATA USERS, THESE 2 CHARACTER CODES, AVAILABLE ONLY FOR 10/98 THROUGH 12/98, HAVE BEEN MAPPED INTO THE CODES LISTED ABOVE, AS FOLLOWS:</p> <p>TO FROM</p> <p>SMRF MSIS FY99</p> <p>CODE CODE (DUAL-ELIGIBLE-FLAG)</p> <p>0 = 00 ELIGIBLE IS NOT A MEDICARE BENEFICIARY.</p> <p>1 = 01 ELIGIBLE IS ENTITLED TO MEDICARE - QMB ONLY</p> <p>1 = 02 ELIGIBLE IS ENTITLED TO MEDICARE - QMB AND FULL MEDICAID COVERAGE</p> <p>1 = 03 ELIGIBLE IS ENTITLED TO MEDICARE - SLMB ONLY</p> <p>1 = 04 ELIGIBLE IS ENTITLED TO MEDICARE - SLMB AND FULL MEDICAID COVERAGE</p> <p>1 = 05 ELIGIBLE IS ENTITLED TO MEDICARE - QDWI</p> <p>1 = 06 ELIGIBLE IS ENTITLED TO MEDICARE - QUALIFYING INDIVIDUAL (1)</p> <p>1 = 07 ELIGIBLE IS ENTITLED TO MEDICARE - QUALIFYING INDIVIDUAL (2)</p> <p>1 = 08 ELIGIBLE IS ENTITLED TO MEDICARE - OTHER DUAL ELIGIBLE</p> <p>1 = 09 ELIGIBLE IS ENTITLED TO MEDICARE - DUAL ELIGIBILITY CATEGORY UNK.</p> <p>9 = 99 ELIGIBLE'S MEDICARE STATUS IS UNKNOWN</p>

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		LENGTH	BEG END	
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				ONCE THIS MAPPING IS COMPLETED, VALUE = 0 IS CHANGED TO VALUE = 2 AND VALUE = 1 IS CHANGED TO VALUE = 3 IF THERE WAS MEDICARE DEDUCTIBLE OR COINSURANCE PAID BY MEDICAID FOR AT LEAST ONE CLAIM DURING THE YEAR. IF THE ELIGIBLE SOCIAL SECURITY NUMBER (ELEMENT #3) REPORTED BY MEDICAID IS NOT FOUND IN THE MEDICARE ENROLLMENT DATA BASE (EDB) OR IS INVALID, ONLY CODE VALUES = 0-3 AND 9 WILL APPLY.
				SOURCE: THE DUAL ELIGIBILITY FLAG IS OBTAINED FROM MSIS ELIGIBILITY FILES AND DEDUCTIBLE OR COINSURANCE PAID AMOUNTS ARE OBTAINED FROM SMRF CLAIMS. MEDICARE INFORMATION FOR VALUES = 4 TO 7 IS OBTAINED FROM THE MEDICARE ENROLLMENT DATA BASE (EDB).
24. ELIGIBLE MEDICARE CROSSOVER CODE - NEW VALUES IN 1999	CHAR	2	130 131	INDICATES THAT THE ELIGIBLE IS OR HAS BEEN COVERED BY MEDICARE (KNOWN AS CROSSOVER, DUAL OR MEDICARE ELIGIBILITY)
				2 CHARACTERS
				CODES:
				00 = ELIGIBLE IS NOT A MEDICARE BENEFICIARY
				01 = ELIGIBLE IS ENTITLED TO MEDICARE - QMB ONLY
				02 = ELIGIBLE IS ENTITLED TO MEDICARE - QMB AND FULL MEDICARE COVERAGE
				03 = ELIGIBLE IS ENTITLED TO MEDICARE - SLMB ONLY
				04 = ELIGIBLE IS ENTITLED TO MEDICARE - SLMB AND FULL MEDICARE COVERAGE
				05 = ELIGIBLE IS ENTITLED TO MEDICARE - QDWI
				06 = ELIGIBLE IS ENTITLED TO MEDICARE - QUALIFYING INDIVIDUALS (1)
				07 = ELIGIBLE IS ENTITLED TO MEDICARE - QUALIFYING INDIVIDUALS (2)
				08 = ELIGIBLE IS ENTITLED TO MEDICARE - OTHER DUAL ELIGIBLES
				09 = ELIGIBLE IS ENTITLED TO MEDICARE - DUAL ELIGIBILITY CATEGORY UNKNOWN
				99 = ELIGIBLE'S MEDICARE STATUS IS UNKNOWN
				USER NOTE: THIS DATA ELEMENT WILL BE BLANK-FILLED FOR 1996 AND 1997. IT IS TAKEN DIRECTLY FROM THE MSIS DATA ELEMENT "DUAL ELIGIBLE FLAG". THERE IS ONE OBSERVATION IN MSIS FOR 10/98 THROUGH 12/98. IF THERE IS NO ELIGIBLE RECORD FOR THE ENROLLEE FROM 10/98 THROUGH 12/98, IT IS BLANK-FILLED.
				SOURCE: MSIS ELIGIBILITY FILES

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
25. ELIGIBLE MEDICARE BENEFICIARY MONTHS COUNT	NUM	2	132	133	<p>TOTAL NUMBER OF MONTHS THE MEDICAID ELIGIBLE WAS A MEDICARE BENEFICIARY.</p> <p>2 DIGITS</p> <p>USER NOTE: THIS IS A NUMBER FROM 0 TO 12. IF THE ELIGIBLE SOCIAL SECURITY NUMBER (ELEMENT #3) REPORTED BY MEDICAID IS NOT FOUND IN THE MEDICARE ENROLLMENT DATA BASE (EDB) OR IS INVALID, THIS COUNT WILL HAVE VALUE = 0.</p> <p>SOURCE: MEDICARE ENROLLMENT DATA BASE (EDB), CALCULATED USING BENEFICIARY PART A ENTITLEMENT START AND TERMINATION DATES.</p>
26. ELIGIBLE PRE-PAID PLAN MONTHS COUNT	NUM	2	134	135	<p>TOTAL NUMBER OF MONTHS THE MEDICAID ELIGIBLE WAS ENROLLED IN AN HMO OR OTHER PRE-PAID PLAN DURING THE CALENDAR YEAR.</p> <p>2 DIGITS</p> <p>USER NOTE: THIS IS A NUMBER FROM 0 TO 12. MONTHS OF ENROLLMENT IN PRIMARY CARE CASE MANAGEMENT (PCCM) ARE NOT COUNTED AS PRE-PAID PLAN MONTHS BECAUSE SERVICES RENDERED TO PERSONS IN A PCCM ARE USUALLY PAID ON A FEE-FOR-SERVICE BASIS. EVERY MONTH WHICH HAS ONE OF THE FOLLOWING SMRF ELIGIBLE PRE-PAID PLAN CODES IS COUNTED:</p> <p>010 = ENROLLED IN A PREPAID HEALTH PLAN (PHP) ONLY</p> <p>011 = ENROLLED IN PCCM AND A PHP</p> <p>100 = ENROLLED IN AN HMO/HEALTH INSURING ORGANIZATION (HIO) ONLY</p> <p>110 = ENROLLED IN AN HMO/HIO AND PHP</p> <p>777 = ENROLLED IN AN OTHER MANAGED CARE OR CAPITATION PLAN</p> <p>SOURCE: CODED AT HCFA USING MSIS ELIGIBILITY FILES</p>

STATE MEDICAID RESEARCH FILES PERSON SUMMARY RECORD (1996-98)

	NAME	TYPE	POSITIONS			CONTENTS
			LENGTH	BEG	END	
**	MONTHLY STATE SPECIFIC ELIGIBILITY GROUP	GROUP	72	136	207	STATE SPECIFIC ELIGIBILITY CODE CLASSIFICATION UNDER WHICH THE MEDICAID ELIGIBLE IS COVERED FROM JANUARY THROUGH DECEMBER. THE EXAMPLE IS FOR JANUARY. JANUARY (POSITIONS 136 TO 141) FEBRUARY (POSITIONS 142 TO 147) MARCH (POSITIONS 148 TO 153) APRIL (POSITIONS 154 TO 159) MAY (POSITIONS 160 TO 165) JUNE (POSITIONS 166 TO 171) JULY (POSITIONS 172 TO 177) AUGUST (POSITIONS 178 TO 183) SEPTEMBER (POSITIONS 184 TO 189) OCTOBER (POSITIONS 190 TO 195) NOVEMBER (POSITIONS 196 TO 201) DECEMBER (POSITIONS 202 TO 207)
27.	STATE SPECIFIC ELIGIBILITY CODE	CHAR	6	136	141	STATE SPECIFIC ELIGIBILITY CODE CLASSIFICATION FOR THE MEDICAID ELIGIBLE AND FOR THE MONTH 6 CHARACTERS USER NOTES: THESE SOURCE CODES ARE GENERALLY NOT APPLICABLE FOR MOST RESEARCH ACTIVITIES. THE DATA ELEMENT CHANGES OVER TIME, VARIES ACROSS STATES IN TERMS OF THE LEVEL AND TYPE OF ELIGIBILITY DESCRIBED, REQUIRES A DETAILED KNOWLEDGE OF MEDICAID ELIGIBILITY AND REQUIRES AN UNDERSTANDING OF THE IDIOSYNCRACIES OF INDIVIDUAL STATE ELIGIBILITY SYSTEMS. THESE CODES HAVE BEEN MAPPED INTO SMRF UNIFORM ELIGIBILITY CODES. THEREFORE, MOST USERS WILL WANT TO USE SMRF 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. SOURCE: MSIS ELIGIBILITY FILES

STATE MEDICAID RESEARCH FILES PERSON SUMMARY RECORD (1996-98)

	NAME	TYPE	LENGTH	BEG	END	POSITIONS	CONTENTS
**	MONTHLY SMRF UNIFORM ELIGIBILITY GROUP	GROUP	24	208	231		<p>STATE MEDICAID RESEARCH FILES (SMRF) UNIFORM ELIGIBILITY CODE FOR THE MEDICAID ELIGIBLE FROM JANUARY THROUGH DECEMBER. THE EXAMPLE IS FOR JANUARY.</p> <p>JANUARY (POSITIONS 208 TO 209) FEBRUARY (POSITIONS 210 TO 211) MARCH (POSITIONS 212 TO 213) APRIL (POSITIONS 214 TO 215) MAY (POSITIONS 216 TO 217) JUNE (POSITIONS 218 TO 219) JULY (POSITIONS 220 TO 221) AUGUST (POSITIONS 222 TO 223) SEPTEMBER (POSITIONS 224 TO 225) OCTOBER (POSITIONS 226 TO 227) NOVEMBER (POSITIONS 228 TO 229) DECEMBER (POSITIONS 230 TO 231)</p>
28.	SMRF UNIFORM ELIGIBILITY CODE	NUM	2	208	209		<p>STATE MEDICAID RESEARCH FILES (SMRF) UNIFORM ELIGIBILITY CODE FOR THE MEDICAID ELIGIBLE AND FOR THE MONTH</p> <p>2 DIGITS</p> <p>CODES:</p> <p>00 = NOT ELIGIBLE 11 = AGED, CASH 12 = BLIND/DISABLED, CASH 14 = AFDC CHILD, CASH 16 = AFDC-U CHILD, CASH 15 = AFDC ADULT, CASH 17 = AFDC-U ADULT, CASH 21 = AGED, MEDICALLY NEEDY (MN) 22 = BLIND/DISABLED, MN 24 = AFDC CHILD, MN 25 = AFDC ADULT, MN 31 = AGED, POVERTY 32 = BLIND/DISABLED, POVERTY 34 = CHILD, POVERTY 35 = ADULT, POVERTY 41 = OTHER AGED 42 = OTHER BLIND/DISABLED</p>

STATE MEDICAID RESEARCH FILES PERSON SUMMARY RECORD (1996-98)

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
					48 = FOSTER CARE CHILD
					44 = OTHER CHILD
					45 = OTHER ADULT
					99 = UNKNOWN ELIGIBILITY
					USER NOTE: THIS CODE LIST IS NEARLY THE SAME AS THE LIST FOR THE 1999 SMRF FILE, EXCEPT THAT CODES ARE ADDED FOR 1999 TO IDENTIFY SECTION 1115 DEMONSTRATION EXPANSION ELIGIBLES. FOR 1999, IT IS NOT NECESSARY TO MAP SMRF UNIFORM ELIGIBILITY INTO THESE CODES. CHANGES IN THE 1999 MSIS SPECIFICATIONS TO STATES RESULTED IN MSIS MAINTENANCE ASSISTANCE STATUS (MAS) AND BASIS OF ELIGIBILITY (BOE) CODES THAT DIRECTLY CORRESPOND.
					SOURCE: CODED AT HCFA USING MSIS STATE SPECIFIC ELIGIBILITY CODES AND OTHER ELIGIBILITY DATA ELEMENTS, AS NECESSARY (FOR ALL GROUPS INCLUDING 1115 DEMONSTRATION EXPANSION ELIGIBLES).

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STATE MEDICAID RESEARCH FILES PERSON SUMMARY RECORD (1996-98)

	NAME	TYPE	LENGTH	POSITIONS		CONTENTS
				BEG	END	
**	MONTHLY ELIGIBLE PRIVATE INSURANCE GROUP	GROUP	12	232	243	<p>INDICATES WHICH MONTHS THE MEDICAID ELIGIBLE HAD PRIVATE INSURANCE COVERAGE FROM JANUARY THROUGH DECEMBER. THE EXAMPLE IS FOR JANUARY.</p> <p>JANUARY (POSITION 232) FEBRUARY (POSITION 233) MARCH (POSITION 234) APRIL (POSITION 235) MAY (POSITION 236) JUNE (POSITION 237) JULY (POSITION 238) AUGUST (POSITION 239) SEPTEMBER (POSITION 240) OCTOBER (POSITION 241) NOVEMBER (POSITION 242) DECEMBER (POSITION 243)</p>
29.	ELIGIBLE PRIVATE INSURANCE CODE	NUM	1	232	232	<p>CODE INDICATING IF THE ELIGIBLE HAD PRIVATE INSURANCE DURING THE MONTH 1 DIGIT</p> <p>CODES:</p> <p>0 = NOT ELIGIBLE FOR MEDICAID 1 = NO PRIVATE INSURANCE COVERAGE 2 = PRIVATE INSURANCE PURCHASED BY THIRD PARTY 3 = PRIVATE INSURANCE PURCHASED BY STATE 4 = BOTH 2 AND 3 APPLY (1/96 THROUGH 9/98) EITHER (1) BOTH 2 AND 3 APPLY OR (2) 2 AND 3 APPLY AND FUNDING SOURCE UNKNOWN (10/98 THROUGH 12/98) 9 = INVALID OR MISSING DATA</p> <p>SOURCE: MSIS ELIGIBILITY FILES</p>

STATE MEDICAID RESEARCH FILES PERSON SUMMARY RECORD (1996-98)

	NAME	TYPE	LENGTH	POSITIONS		CONTENTS
				BEG	END	
**	ELIGIBLE MONTHLY MEDICARE BENEFICIARY GROUP	GROUP	12	244	255	<p>INDICATES WHICH MONTHS THE MEDICAID ELIGIBLE WAS A MEDICARE BENEFICIARY BASED ON FINDING A BENEFICIARY RECORD FOR THE ELIGIBLE ON THE MEDICARE ENROLLMENT DATA BASE. THE EXAMPLE IS FOR JANUARY.</p> <p>JANUARY (POSITIONS 244) FEBRUARY (POSITIONS 245) MARCH (POSITIONS 246) APRIL (POSITIONS 247) MAY (POSITIONS 248) JUNE (POSITIONS 249) JULY (POSITIONS 250) AUGUST (POSITIONS 251) SEPTEMBER (POSITIONS 252) OCTOBER (POSITIONS 253) NOVEMBER (POSITIONS 254) DECEMBER (POSITIONS 255)</p>
30.	ELIGIBLE MEDICARE BENEFICIARY	NUM	1	244	244	<p>CODE INDICATING WHETHER THE MEDICAID ELIGIBLE WAS A MEDICARE BENEFICIARY DURING THE MONTH (BASE ON FINDING A BENEFICIARY RECORD FOR THE ELIGIBLE ON THE MEDICARE ENROLLMENT DATA BASE FOR THE MONTH)</p> <p>1 DIGIT</p> <p>CODES:</p> <p>0 = THERE WAS NO RECORD OF ELIGIBILITY FOR THE MONTH FOUND ON THE MEDICARE ENROLLMENT DATA BASE. 1 = THERE WAS A RECORD OF ELIGIBILITY FOR THE MONTH FOUND ON THE MEDICARE ENROLLMENT DATA BASE, FOR MEDICARE PART A (HOSPITAL INSURANCE). 2 = THERE WAS A RECORD OF ELIGIBILITY FOR THE MONTH FOUND ON THE MEDICARE ENROLLMENT DATA BASE, FOR MEDICARE PART B (SUPPLEMENTARY MEDICAL INSURANCE). 3 = THERE WAS A RECORD OF ELIGIBILITY FOR THE MONTH FOUND ON THE MEDICARE ENROLLMENT DATA BASE, FOR BOTH MEDICARE PART A AND PART B (BOTH HOSPITAL AND SUPPLEMENTARY MEDICAL INSURANCE).</p> <p>USER NOTE: IF THE ELIGIBLE SOCIAL SECURITY NUMBER (ELEMENT #3) REPORTED BY MEDICAID IS NOT FOUND IN THE MEDICARE ENROLLMENT DATA BASE (EDB) OR IS INVALID, THIS DATA ELEMENT WILL HAVE VALUE = 0.</p> <p>SOURCE: MEDICARE ENROLLMENT DATA BASE (EDB), CALCULATED USING BENEFICIARY ENTITLEMENT START AND TERMINATION DATES.</p>

STATE MEDICAID RESEARCH FILES PERSON SUMMARY RECORD (1996-98)

	NAME	TYPE	POSITIONS			CONTENTS
			LENGTH	BEG	END	
**	MONTHLY ELIGIBLE PRE-PAID PLAN GROUP	GROUP	36	256	291	<p>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.</p> <p>JANUARY (POSITIONS 256 TO 258) FEBRUARY (POSITIONS 259 TO 261) MARCH (POSITIONS 262 TO 264) APRIL (POSITIONS 265 TO 267) MAY (POSITIONS 268 TO 270) JUNE (POSITIONS 271 TO 273) JULY (POSITIONS 274 TO 276) AUGUST (POSITIONS 277 TO 279) SEPTEMBER (POSITIONS 280 TO 282) OCTOBER (POSITIONS 283 TO 285) NOVEMBER (POSITIONS 286 TO 288) DECEMBER (POSITIONS 289 TO 291)</p>
31.	ELIGIBLE PRE-PAID PLAN CODE	NUM	3	256	258	<p>CODE INDICATING WHETHER AN ELIGIBLE WAS ENROLLED IN AN HMO OR OTHER PREPAID HEALTH PLAN DURING THE MONTH. FOR THE PURPOSE OF THIS DATA ELEMENT, AN HMO OR PREPAID HEALTH PLAN (PHP) IS DEFINED AS A LICENSED PROVIDER OF MEDICAL CARE THAT DELIVERS SERVICES BASED ON PREMIUM PAYMENTS.</p> <p>3 DIGITS</p> <p>CODES</p> <p>000 = NOT ELIGIBLE FOR MEDICAID 001 = ENROLLED IN PRIMARY CARE CASE MANAGEMENT (PCCM) ONLY 010 = ENROLLED IN A PREPAID HEALTH PLAN (PHP) ONLY 011 = ENROLLED IN PCCM AND A PHP 100 = ENROLLED IN AN HMO/HEALTH INSURING ORGANIZATION (HIO) ONLY 110 = ENROLLED IN AN HMO/HIO AND PHP 777 = ENROLLED IN AN OTHER MANAGED CARE OR CAPITATION PLAN 888 = NOT ENROLLED IN AN HMO/HIO, PHP OR PCCM 999 = INVALID OR MISSING DATA</p> <p>USER NOTE: CODE VALUES 011 AND 110 ARE NECESSARY BECAUSE MSIS COLLECTS INFORMATION ON SIMULTANEOUS ENROLLMENT IN AS MANY AS TO 4 PLANS BEGINNING IN 10/98. IT IS NOT NECESSARY TO DEFINE CODE VALUES FOR PERSONS ENROLLED</p>

STATE MEDICAID RESEARCH FILES PERSON SUMMARY RECORD (1996-98)

NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	
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				<p>SIMULTANEOUSLY IN HMO/HIO AND PCCM PLANS (OR HMO/HIO AND PCCM AND PHP) BECAUSE IT IS UNLIKELY THAT A PERSON WOULD BE ENROLLED SIMULTANEOUSLY IN AN HMO AND A PCCM PLAN. MSIS CODES 500 (ELIGIBLE WAS ENROLLED IN AN OTHER CAPITATION PLAN WITH COVERAGE PURCHASED BY THE STATE) AND 800 (ELIGIBLE WAS ENROLLED IN AN OTHER CAPITATION PLAN WITH COVERAGE PURCHASED BY A THIRD PARTY), REPORTED IN MSIS FROM 1/96 TO 9/97, WERE NOT USED TO CREATE THESE CODE VALUES. THIS IS BECAUSE THESE CODES WERE USED BY ONLY NINE STATES, AND IT IS NOT CLEAR WHAT TYPES OF PLANS WERE BEING REPORTED FOR THESE CODE VALUES.</p> <p>FOR THIS DATA ELEMENT, CODE MAPPINGS ARE AS FOLLOWS:</p> <p>TO FROM</p> <p>SMRF MSIS FY97 (10/96 THROUGH 9/97)</p> <p>CODE CODE (HMO-ENROLLMENT)</p> <p>000 = 000 NOT ELIGIBLE FOR MEDICAID</p> <p>001 = N/A NO CODING FOR ENROLLMENT IN PCCM (1/96 THROUGH 9/97)</p> <p>010 = 200 ELIGIBLE WAS ENROLLED IN A PREPAID HEALTH PLAN WITH COVERAGE PURCHASED BY THE STATE</p> <p>010 = 700 ELIGIBLE WAS ENROLLED IN A PREPAID HEALTH PLAN WITH COVERAGE PURCHASED BY A THIRD PARTY</p> <p>011 = N/A NO CODING FOR ENROLLMENT IN MORE THAN ONE TYPE OF PLAN (1/96 THROUGH 9/97)</p> <p>100 = 100 ELIGIBLE WAS ENROLLED IN A PRIVATE HMO WITH COVERAGE PURCHASED BY THE STATE</p> <p>100 = 600 ELIGIBLE WAS ENROLLED IN A PRIVATE HMO WITH COVERAGE PURCHASED BY A THIRD PARTY</p> <p>110 = N/A NO CODING FOR ENROLLMENT IN MORE THAN ONE TYPE OF PLAN</p> <p>777 = 500 ELIGIBLE WAS ENROLLED IN AN OTHER CAPITATION PLAN WITH COVERAGE PURCHASED BY THE STATE.</p> <p>777 = 800 ELIGIBLE WAS ENROLLED IN AN OTHER CAPITATION PLAN WITH COVERAGE PURCHASED BY A THIRD PARTY</p> <p>888 = 001 ELIGIBLE WAS NOT ENROLLED IN A PRIVATE HMO, PHP OR OTHER CAPITATION PLAN</p> <p>999 = 999 THE STATE HAD ONLY INVALID OR MISSING INFORMATION</p>

STATE MEDICAID RESEARCH FILES PERSON SUMMARY RECORD (1996-98)

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
					<p>TO FROM</p> <p>SMRF MSIS FY98 (10/97 THROUGH 9/98)</p> <p>CODE CODE (HMO-ENROLLMENT)</p> <p>000 = 00 NOT ELIGIBLE (DATA ELEMENT #24 SMRF UNIFORM ELIGIBILITY CODE).</p> <p>001 = 001 ELIGIBLE WAS ENROLLED IN A PCCM PLAN ONLY</p> <p>010 = 010 ELIGIBLE WAS ENROLLED IN A PREPAID HEALTH PLAN (PHP) ONLY</p> <p>011 = 011 ELIGIBLE WAS ENROLLED IN BOTH A PCCM AND A PHP</p> <p>100 = 100 ELIGIBLE WAS ENROLLED IN AN HMO/HEALTH INSURING ORGANIZATION (HIO) ONLY</p> <p>100 = 101 ELIGIBLE WAS ENROLLED IN AN HMO/HEALTH INSURING ORGANIZATION (HIO) AND A PCCM</p> <p>110 = 110 ELIGIBLE WAS ENROLLED IN AN HMO/HEALTH INSURING ORGANIZATION (HIO) AND A PHP</p> <p>110 = 111 ELIGIBLE WAS ENROLLED IN AN HMO/HEALTH INSURING ORGANIZATION (HIO) AND A PHP AND A PCCM</p> <p>777 = N/A NO CODING FOR ENROLLMENT IN OTHER CAPITATION (10/97 THROUGH 9/98)</p> <p>888 = 000 NOT ENROLLED IN ANY MANAGED CARE PLAN TYPE FOR THE MONTH</p> <p>999 = 999 THE STATE HAD ONLY INVALID OR MISSING INFORMATION</p> <p>FOR MSIS FY99 (10/98 THROUGH 12/98), PLAN-TYPE CODES CAN BE CATEGORIZED AS FOLLOWS:</p> <p>COMPREHENSIVE PLANS:</p> <p>01 = ELIGIBLE IS ENROLLED IN A MEDICAL OR COMPREHENSIVE MANAGED CARE PLAN THIS MONTH (E.G. HMO)</p> <p>06 = ELIGIBLE IS ENROLLED IN A PROGRAM FOR ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)</p> <p>PREPAID HEALTH PLANS (PHPs):</p> <p>02 = ELIGIBLE IS ENROLLED IN A DENTAL MANAGED CARE PLAN THIS MONTH.</p> <p>03 = ELIGIBLE IS ENROLLED IN A BEHAVIORAL HEALTH MANAGED CARE PLAN THIS MONTH.</p> <p>04 = ELIGIBLE IS ENROLLED IN A PRENATAL/DELIVERY MANAGED CARE PLAN THIS MONTH.</p> <p>05 = ELIGIBLE IS ENROLLED IN A LONG-TERM CARE MANAGED CARE PLAN THIS MONTH.</p> <p>PRIMARY CARE CASE MANAGEMENT (PCCMs):</p> <p>07 = ELIGIBLE IS ENROLLED IN A PRIMARY CARE CASE MANAGEMENT MANAGED CARE PLAN THIS MONTH</p> <p>OTHER PLANS:</p> <p>08 = ELIGIBLE IS ENROLLED IN AN OTHER MANAGED CARE PLAN THIS MONTH</p>

STATE MEDICAID RESEARCH FILES PERSON SUMMARY RECORD (1996-98)

		POSITIONS			
NAME	TYPE	LENGTH	BEG	END	CONTENTS

GIVEN THIS CHARACTERIZATION, THE CODE MAPS, FROM FY99 MSIS (PLAN-TYPE) TO SMRF ARE AS FOLLOWS:					
000 = 00 NOT ELIGIBLE (DATA ELEMENT #24 SMRF UNIFORM ELIGIBILITY CODE).					
001 = ELIGIBLE WAS ENROLLED IN A PCCM (07), ONLY					
010 = ELIGIBLE WAS ENROLLED IN A PHP (02, 03, 04 AND/OR 05), ONLY					
010 = ELIGIBLE WAS ENROLLED IN A PHP (02, 03, 04 AND/OR 05), AND					
AN OTHER PLAN (08)					
011 = ELIGIBLE WAS ENROLLED IN A PHP (02, 03, 04 AND/OR 05), AND					
A PCCM (07)					
011 = ELIGIBLE WAS ENROLLED IN A PHP (02, 03, 04 AND/OR 05), AND					
A PCCM (07) AND AN OTHER PLAN (08)					
011 = ELIGIBLE WAS ENROLLED IN A PCCM (07) AND AN OTHER PLAN (08)					
100 = ELIGIBLE WAS ENROLLED IN A COMPREHENSIVE PLAN (01 AND/OR 06), ONLY					
110 = ELIGIBLE WAS ENROLLED IN A COMPREHENSIVE PLAN (01 AND/OR 06), AND					
A PHP (02, 03, 04 AND/OR 05)					
110 = ELIGIBLE WAS ENROLLED IN A COMPREHENSIVE PLAN (01 AND/OR 06), AND					
AN OTHER PLAN (08)					
110 = ELIGIBLE WAS ENROLLED IN A COMPREHENSIVE PLAN (01 AND/OR 06), AND					
A PNP (02, 03, 04 AND/OR 05), AND A PCCM (07)					
110 = ELIGIBLE WAS ENROLLED IN A COMPREHENSIVE PLAN (01 AND/OR 06), AND					
A PHP (02, 03, 04 AND/OR 05), AND AN OTHER PLAN (08)					
110 = ELIGIBLE WAS ENROLLED IN A COMPREHENSIVE PLAN (01 AND/OR 06), AND					
A PCCM (07) AND AN OTHER PLAN (08)					
110 = ELIGIBLE WAS ENROLLED IN A COMPREHENSIVE PLAN (01 AND/OR 06), AND					
A PHP (02, 03, 04 AND/OR 05), AND A PCCM (07), AND AN OTHER					
PLAN (08)					
777 = ELIGIBLE WAS ENROLLED IN AN OTHER PLAN (08), ONLY					
888 = 88 NOT APPLICABLE, INDIVIDUAL IS ELIGIBLE FOR MEDICAID, BUT IS NOT					
ENROLLED IN A MANAGED CARE PLAN THIS MONTH					
999 = 99 ELIGIBLE'S MANAGED CARE PLAN STATUS IS UNKNOWN					
NOTE THAT THE VALUE OF SMRF CODE = 000 (NOT ELIGIBLE) VALUES FOR 10/97 TO					
9/98 AND 10/98 TO 12/98 ARE DETERMINED BY THE SMRF UNIFORM ELIGIBILITY					
CODE (DATA ELEMENT #28). THIS IS BECAUSE A STATE MAY IDENTIFY A PERSON					
WITH A PARTICULAR MANAGED CARE PLAN EVEN IF THAT PERSON IS NOT ENROLLED IN					
MEDICAID DURING THE MONTH. THIS IS SO THAT MEDICAID ENROLLS THAT PERSON					
IN THE CORRECT MANAGED CARE PLAN WHEN THEY ARE RE-ENROLLED IN MEDICAID.					
SOURCE: MSIS ELIGIBILITY FILES					

STATE MEDICAID RESEARCH FILES PERSON SUMMARY RECORD (1996-98)

	NAME	TYPE	POSITIONS			CONTENTS
			LENGTH	BEG	END	
***	RECIPIENT CLAIMS SUMMARY REGION	REGION	768	292	1059	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. 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.). AN IMPORTANT EXCEPTION OCCURS IN DATA ELEMENTS #54-57 WHICH ARE COUNTS OF ENCOUNTER RECORDS (TYPE OF CLAIM = 3).
32.	RECIPIENT INDICATOR	NUM	1	292	292	<p>INDICATOR TO SHOW IF AND HOW THE ELIGIBLE RECEIVED A MEDICAID SERVICE DURING THE CALENDAR YEAR.</p> <p>1 DIGIT</p> <p>CODES:</p> <p>0 = NO MEDICAID PAYMENT OR SERVICE USE FOR THIS ELIGIBLE 1 = ELIGIBLE HAD ONE OR MORE MEDICAID COVERED SERVICE(S), WHERE MEDICAID PAYMENT WAS > \$0 IN AT LEAST ONE OF THOSE SERVICE(S). 2 = ELIGIBLE HAD ONE OR MORE MEDICAID COVERED SERVICE(S), BUT MEDICAID PAYMENT WAS NEVER > \$0 FOR ANY OF THOSE SERVICE(S).</p> <p>USER NOTE: SEE DATA ELEMENT #49 IN THE "TYPE OF SERVICE TABLE GROUP" WHICH IS SIMILAR TO DATA ELEMENT #32, EXCEPT THAT DATA ELEMENT #49 IS CREATED BY TYPE OF SERVICE, FOR EACH OF THE LISTED TYPES OF SERVICES.</p> <p>SOURCE MSIS FILES CONTAIN RECORDS WITH MEDICAID PAYMENT AMOUNT = \$0 IF THE SERVICE WAS COVERED, BUT FULL PAYMENT WAS MADE BY ANOTHER PAYER (E.G. THIRD PARTY LIABILITY).</p> <p>SOURCE: CREATED USING MSIS CLAIMS FILES</p>

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	NAME	TYPE	POSITIONS			CONTENTS
			LENGTH	BEG	END	
**	INPATIENT HOSPITAL UTILIZATION SUMMARY	GROUP	18	293	310	<p>INPATIENT HOSPITAL DISCHARGE, STAY, LENGTH OF STAY AND COVERED DAYS COUNTS</p> <p>IN THE SMRF 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).</p> <p>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.</p> <p>SEPARATE HOSPITAL STAY RECORDS ARE CREATED FOR SETS OF INTERIM CLAIMS FOR MOTHERS AND INFANTS WHO USE THE SAME MSIS ELIGIBLE IDENTIFICATION NUMBER, BUT HAVE SEPARATE CLAIMS. IN CONTRAST, SOME STAYS FOR THE MOTHER'S DELIVERY AND INFANT'S NEWBORN WILL BE COMBINED. THIS IS BECAUSE THE PROVIDER HAS SUBMITTED CLAIMS WHICH INCLUDE SERVICES FOR THE MOTHER AND INFANT SO THAT IT IS NOT POSSIBLE TO GENERATE SEPARATE STAY RECORDS.</p> <p>THERE ARE CIRCUMSTANCES WHERE SEPARATE STAY RECORDS MAY BE CREATED FOR THE SAME HOSPITAL STAY:</p> <p>(1) IF THERE ARE MULTIPLE INTERIM CLAIMS WITH THE SAME ADMISSION DATE, BUT ONE OF THE INTERIM CLAIMS DURING THE SAY IS MISSING, SEPARATE STAY RECORDS WILL BE CREATED. THIS IS BECAUSE THERE IS A GAP OF ONE OR MORE DAYS BETWEEN THE ENDING DATE OF SERVICE ON ONE RECORD AND THE BEGINNING DATE OF SERVICE ON ANOTHER.</p> <p>(2) SOMETIMES, A HOSPITAL WILL SUBMIT A BILL FOR THE "CROSSOVER" PORTION OF A STAY USING THEIR MEDICARE PROVIDER IDENTIFIER AND WILL SUBMIT A SECOND BILL FOR THE "NON-CROSSOVER" PORTION OF THE SAME STAY USING THEIR MEDICAID PROVIDER IDENTIFIER. IN THIS SITUATION, SEPARATE STAY RECORDS ARE CREATED, BECAUSE THE RECORDS HAVE DIFFERENT PROVIDER IDENTIFIERS.</p>

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NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
<hr/>					
					<p>(3) IF A HOSPITAL SUBMITS SEPARATE BILLS FROM DIFFERENT COST CENTERS IN THE HOSPITAL (E.G. ANCILLARY VERSUS ACCOMMODATION SERVICES), USING DIFFERENT PROVIDER IDENTIFIERS FOR THE COST CENTERS, SEPARATE STAY RECORDS ARE CREATED.</p> <p>FOR ALL CLAIMS IN A COMBINED SET: (1) MEDICAID PAYMENTS AND COVERED DAYS ARE SUMMED, (2) ALL DIAGNOSIS AND PROCEDURE CODES ARE PICKED UP FROM THE INTERIM CLAIMS, AND (3) DEMOGRAPHIC INFORMATION AND THE DATE OF PAYMENT ARE TAKEN FROM THE LAST CLAIM IN THE SET.</p> <p>THE FILE FOR A GIVEN YEAR CONTAINS STAY RECORDS WHERE THE LAST DATE OF SERVICE IS IN THAT YEAR (EVEN IF THE STAY BEGAN IN A PREVIOUS YEAR).</p>
33. RECIPIENT TOTAL INPATIENT DISCHARGE COUNT	NUM	3	293	295	<p>TOTAL NUMBER OF INPATIENT HOSPITAL DISCHARGES, FOR THE CALENDAR YEAR.</p> <p>3 DIGITS SIGNED</p> <p>USER NOTE: THIS DATA ELEMENT COUNTS THE NUMBER OF INPATIENT HOSPITAL (TOS = 1) STAYS WITH A DISCHARGE STATUS > 1 (ANY CODE OTHER THAN 1 = STILL A PATIENT). SINCE SOME COMPLETED STAYS MAY NOT HAVE A DISCHARGE STATUS > 1, DUE TO INCOMPLETE REPORTING, THIS COUNT MAY DIFFER FROM THE COUNT IN DATA ELEMENT #34. FOR THIS REASON AND OTHER REASONS DISCUSSED ABOVE, THIS DATA ELEMENT MAY UNDERCOUNT THE ACTUAL NUMBER OF COMPLETE HOSPITAL STAYS.</p> <p>SOURCE: CREATED USING MSIS INPATIENT HOSPITAL CLAIMS (TOS = 1).</p>
34. RECIPIENT TOTAL INPATIENT STAY COUNT	NUM	3	296	298	<p>TOTAL NUMBER OF INPATIENT HOSPITAL STAYS, FOR THE CALENDAR YEAR.</p> <p>USER NOTE: THIS DATA ELEMENT COUNTS THE NUMBER OF INPATIENT HOSPITAL (TOS = 1) STAYS, REGARDLESS OF DISCHARGE STATUS. SINCE SOME COMPLETED STAYS MAY NOT HAVE A DISCHARGE STATUS >1, DUE TO INCOMPLETE REPORTING, THIS COUNT MAY DIFFER FROM THE COUNT IN DATA ELEMENT #33. FOR REASONS DISCUSSED ABOVE, THIS DATA ELEMENT MAY OVERCOUNT THE ACTUAL NUMBER OF COMPLETE HOSPITAL STAYS.</p> <p>3 DIGITS SIGNED</p> <p>SOURCE: CREATED USING MSIS INPATIENT HOSPITAL CLAIMS (TOS = 1).</p>

NAME	TYPE	POSITIONS			CONTENTS
		LENGTH	BEG	END	
35. RECIPIENT TOTAL INPATIENT LENGTH OF STAY (LOS), IN DAYS (FOR DISCHARGES)	NUM	3	299	301	<p>TOTAL LENGTH OF STAY, IN DAYS, FOR INPATIENT HOSPITAL DISCHARGES, FOR THE CALENDAR YEAR.</p> <p>3 DIGITS SIGNED</p> <p>USER NOTE: THIS DATA ELEMENT COUNTS THE NUMBER OF DAYS FOR INPATIENT HOSPITAL (TOS = 1) STAYS WITH A DISCHARGE STATUS > 1 (ANY CODE OTHER THAN 1 = STILL A PATIENT). SINCE SOME COMPLETED STAYS MAY NOT HAVE A DISCHARGE STATUS > 1, DUE TO INCOMPLETE REPORTING, THIS COUNT MAY DIFFER FROM THE COUNT IN DATA ELEMENT #36.</p> <p>SOURCE: CREATED USING THE NUMBER OF DAYS FROM FIRST DATE OF SERVICE TO THE LAST DATE OF SERVICE (+1 DAY IF THEY OCCUR ON THE SAME DAY) FROM MSIS CLAIMS FOR TOS = 1 (INPATIENT HOSPITAL). IF EITHER FIRST DATE OF SERVICE OR DATE OF DISCHARGE ARE "BAD", LOS IS ZERO-FILLED. LOS IS CALCULATED FOR CROSSOVER CLAIMS.</p>
36. RECIPIENT TOTAL INPATIENT LENGTH OF STAY (LOS), IN DAYS (FOR STAYS)	NUM	3	302	304	<p>TOTAL LENGTH OF STAY, IN DAYS, FOR INPATIENT HOSPITAL STAYS, FOR THE CALENDAR YEAR.</p> <p>3 DIGITS SIGNED</p> <p>USER NOTE: THIS DATA ELEMENT COUNTS THE NUMBER OF DAYS FOR INPATIENT HOSPITAL (TOS = 1) STAYS, REGARDLESS OF DISCHARGE STATUS. SINCE SOME COMPLETED STAYS MAY NOT HAVE A DISCHARGE STATUS > 1, DUE TO INCOMPLETE REPORTING, THIS COUNT MAY DIFFER FROM THE COUNT IN DATA ELEMENT #35.</p> <p>SOURCE: CREATED USING THE NUMBER OF DAYS FROM FIRST DATE OF SERVICE TO THE LAST DATE OF SERVICE (+1 DAY IF THEY OCCUR ON THE SAME DAY) FROM MSIS CLAIMS FOR TOS = 1 (INPATIENT HOSPITAL). IF EITHER FIRST DATE OR LAST DATE OF SERVICE ARE "BAD", LOS IS ZERO-FILLED. LOS IS CALCULATED FOR CROSSOVER CLAIMS.</p>

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			BEG	END	
37. RECIPIENT TOTAL INPATIENT COVERED DAY COUNT (FOR DISCHARGES)	NUM	3	305	307	<p>TOTAL MEDICAID COVERED DAYS OF CARE FOR INPATIENT HOSPITAL DISCHARGES, FOR THE CALENDAR YEAR.</p> <p>3 DIGITS SIGNED</p> <p>USER NOTE: THIS DATA ELEMENT COUNTS THE NUMBER OF MEDICAID COVERED INPATIENT DAYS FOR INPATIENT HOSPITAL (TOS = 1) STAYS WITH A DISCHARGE STATUS > 1 (ANY CODE OTHER THAN 1 = STILL A PATIENT). SINCE SOME COMPLETED STAYS MAY NOT HAVE A DISCHARGE STATUS > 1, DUE TO INCOMPLETE REPORTING, THIS COUNT MAY DIFFER FROM THE COUNT IN DATA ELEMENT #38.</p> <p>SOURCE: CREATED USING MEDICAID COVERED INPATIENT DAYS FOR CLAIMS FROM MSIS CLAIMS FOR TOS = 1 (INPATIENT HOSPITAL SERVICES). AS THIS COUNT IS BEING AGGREGATED ACROSS CLAIMS, THERE ARE TWO DECISION RULES THAT APPLY: (1) IF AN INDIVIDUAL CLAIM IS A MEDICARE CROSSOVER CLAIM, THEN COVERED DAYS IS SET VALUE = 0, AND (2) IF AN INDIVIDUAL CLAIM IS NOT A MEDICARE CROSSOVER CLAIM AND COVERED DAYS ARE MISSING, THEN COVERED DAYS IS SET VALUE = THE NUMBER OF DAYS FROM BEGINNING TO ENDING DATE OF SERVICE (+1 DAY IF THEY OCCUR ON THE SAME DAY).</p>
38. RECIPIENT TOTAL INPATIENT COVERED DAY COUNT (FOR STAYS)	NUM	3	308	310	<p>TOTAL MEDICAID COVERED DAYS OF CARE FOR INPATIENT HOSPITAL STAYS, FOR THE CALENDAR YEAR.</p> <p>3 DIGITS SIGNED</p> <p>USER NOTE: THIS DATA ELEMENT COUNTS THE NUMBER OF MEDICAID COVERED INPATIENT (TOS = 1) DAYS FOR INPATIENT HOSPITAL STAYS, REGARDLESS OF DISCHARGE STATUS. SINCE SOME COMPLETED STAYS MAY NOT HAVE A DISCHARGE STATUS > 1, DUE TO INCOMPLETE REPORTING, THIS COUNT MAY DIFFER FROM THE COUNT IN DATA ELEMENT #37.</p> <p>SOURCE: CREATED USING MEDICAID COVERED INPATIENT DAYS FOR CLAIMS FROM MSIS CLAIMS FOR TOS = 1 (INPATIENT HOSPITAL SERVICES). AS THIS COUNT IS BEING AGGREGATED ACROSS CLAIMS, THERE ARE TWO DECISION RULES THAT APPLY: (1) IF AN INDIVIDUAL CLAIM IS A MEDICARE CROSSOVER CLAIM, THEN COVERED DAYS IS SET VALUE = 0, AND (2) IF AN INDIVIDUAL CLAIM IS NOT A MEDICARE CROSSOVER CLAIM AND COVERED DAYS IS MISSING, THEN COVERED DAYS IS SET VALUE = THE NUMBER OF DAYS FROM BEGINNING TO ENDING DATE OF SERVICE (+1 DAY IF THEY OCCUR ON THE SAME DAY).</p>

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	NAME	TYPE	LENGTH	POSITIONS		CONTENTS
				BEG	END	
**	LONG TERM CARE UTILIZATION SUMMARY	GROUP	15	311	325	DAY COUNTS FOR SELECTED TYPES OF LONG TERM CARE SERVICES.
39.	RECIPIENT LONG TERM CARE MENTAL HOSPITAL FOR THE AGED COVERED DAY COUNT	NUM	3	311	313	TOTAL NUMBER OF MEDICAID COVERED DAYS FOR THE RECIPIENT IN A MENTAL HOSPITAL FOR THE AGED (NOT A HOSPITAL) FOR THE CALENDAR YEAR.
						3 DIGITS SIGNED
						SOURCE: CREATED USING THE NUMBER OF MEDICAID COVERED INPATIENT DAYS FROM MSIS CLAIMS FOR TOS = 2 (MENTAL HOSPITAL SERVICES FOR THE AGED). THE TOTAL IS EDITED TO BE <= 365 DAYS. AS THIS COUNT IS BEING AGGREGATED ACROSS CLAIMS, THERE IS A DECISION RULE THAT APPLIES: IF, IN AN INDIVIDUAL CLAIM, THE SUM OF COPAYMENTS AND DEDUCTIBLES IS GREATER THAN OR EQUAL TO MEDICAID PAYMENTS (E.G. IN A CROSSOVER CLAIM), THEN THESE DAYS ARE SET VALUE = 0. THIS IS BECAUSE MEDICAID WOULD BE PAYING ONLY COPAYMENT OR DEDUCTIBLE AMOUNTS, NOT FOR ACTUAL COVERED DAYS OF STAY. FOR 1995 AND EARLIER YEARS, THESE DAYS WERE NOT SET VALUE = 0 FOR CROSSOVER CLAIMS. IF THE CLAIM IS NOT A MEDICARE CROSSOVER CLAIM AND THESE DAYS ARE MISSING, THE CLAIM IS NOT EDITED. THIS IS BECAUSE IT IS NOT POSSIBLE TO DETERMINE WHETHER THE CLAIM IS FOR ACTUAL DAYS OF STAY (ROOM AND BOARD) OR ANCILLARY SERVICES (DURING THE STAY). BECAUSE OF THIS AMBIGUITY, EDITING THE CLAIM COULD INTRODUCE ERRORS AND/OR DOUBLE COUNT THESE DAYS.

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NAME	TYPE	POSITIONS			CONTENTS
		LENGTH	BEG	END	
40. RECIPIENT LONG TERM CARE INPATIENT PSYCHIATRIC FACILITY (AGE<21) COVERED DAY COUNT	NUM	3	314	316	TOTAL NUMBER OF MEDICAID COVERED DAYS FOR THE RECIPIENT IN AN INPATIENT PSYCHIATRIC FACILITY FOR INDIVIDUALS UNDER THE AGE OF 21 (NOT A HOSPITAL) FOR THE CALENDAR YEAR. 3 DIGITS SIGNED SOURCE: CREATED USING THE NUMBER OF MEDICAID COVERED INPATIENT DAYS FROM MSIS CLAIMS FOR THE TOS = 4 (INPATIENT PSYCHIATRIC FACILITY FOR INDIVIDUALS UNDER THE AGE OF 21). THE TOTAL IS EDITED TO BE <= 365 DAYS. AS THIS COUNT IS BEING AGGREGATED ACROSS CLAIMS, THERE IS A DECISION RULE THAT APPLIES: IF, IN AN INDIVIDUAL CLAIM, THE SUM OF COPAYMENTS AND DEDUCTIBLES IS GREATER THAN OR EQUAL TO MEDICAID PAYMENTS (E.G. IN A CROSSOVER CLAIM), THEN THESE DAYS ARE SET VALUE = 0. THIS IS BECAUSE MEDICAID WOULD BE PAYING ONLY COPAYMENT OR DEDUCTIBLE AMOUNTS, NOT FOR ACTUAL COVERED DAYS OF STAY. FOR 1995 AND EARLIER YEARS, THESE DAYS WERE NOT SET VALUE = 0 FOR CROSSOVER CLAIMS. IF THE CLAIM IS NOT A MEDICARE CROSSOVER CLAIM AND THESE DAYS ARE MISSING, THE CLAIM IS NOT EDITED. THIS IS BECAUSE IT IS NOT POSSIBLE TO DETERMINE WHETHER THE CLAIM IS FOR ACTUAL DAYS OF STAY (ROOM AND BOARD) OR ANCILLARY SERVICES (DURING THE STAY). BECAUSE OF THIS AMBIGUITY, EDITING THE CLAIM COULD INTRODUCE ERRORS AND/OR DOUBLE COUNT THESE DAYS.

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NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
41. RECIPIENT INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED - ICF-MR - COVERED DAY COUNT	NUM	3	317	319	<p>TOTAL NUMBER OF MEDICAID COVERED DAYS FOR THE RECIPIENT IN AN INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED - ICF-MR - FOR THE CALENDAR YEAR.</p> <p>3 DIGITS SIGNED</p> <p>USER NOTE: THIS COUNT EXCLUDE LEAVE DAYS. IF MEDICAID PAYMENTS WERE MADE FOR LEAVE DAYS, PAYMENTS PER DAY (USING THESE DAY COUNTS) MAY BE OVERSTATED. CONVERSELY, IF MEDICAID DID NOT PAY FOR LEAVE DAYS AND LEAVE DAYS WERE ADDED TO COVERED DAY COUNTS, PAYMENTS PER DAY MAY BE UNDERSTATED. STATES MAY PAY LOWER AMOUNTS THAN STANDARD DAY RATES OR MAY NOT PAY AT ALL FOR LEAVE DAYS. SINCE IT IS NOT POSSIBLE TO DETERMINE WHEN TO ADD (AND WHEN NOT TO ADD) LEAVE DAYS TO COVERED DAY COUNTS.</p> <p>SOURCE: CREATED USING THE NUMBER OF MEDICAID NURSING FACILITY DAYS FROM MSIS CLAIMS FOR THE TOS = 5 (INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED - ICF-MR). THE TOTAL IS EDITED TO BE <= 365 DAYS. AS THIS COUNT IS BEING AGGREGATED ACROSS CLAIMS, THERE IS A DECISION RULE THAT APPLIES: IF, IN AN INDIVIDUAL CLAIM, THE SUM OF COPAYMENTS AND DEDUCTIBLES IS GREATER THAN OR EQUAL TO MEDICAID PAYMENTS (E.G. IN A CROSSOVER CLAIM), THEN THESE DAYS ARE SET VALUE = 0. THIS IS BECAUSE MEDICAID WOULD BE PAYING ONLY COPAYMENT OR DEDUCTIBLE AMOUNTS, NOT FOR ACTUAL COVERED DAYS OF STAY. FOR 1995 AND EARLIER YEARS, THESE DAYS WERE NOT SET VALUE = 0 FOR CROSSOVER CLAIMS. IF THE CLAIM IS NOT A MEDICARE CROSSOVER CLAIM AND THESE DAYS ARE MISSING, THE CLAIM IS NOT EDITED. THIS IS BECAUSE IT IS NOT POSSIBLE TO DETERMINE WHETHER THE CLAIM IS FOR ACTUAL DAYS OF STAY (ROOM AND BOARD) OR ANCILLARY SERVICES (DURING THE STAY). BECAUSE OF THIS AMBIGUITY, EDITING THE CLAIM COULD INTRODUCE ERRORS AND/OR DOUBLE COUNT THESE DAYS.</p>

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NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
42. RECIPIENT NURSING FACILITY - NF - COVERED DAY COUNT	NUM	3	320	322	<p>TOTAL NUMBER OF MEDICAID COVERED DAYS FOR THE RECIPIENT IN AN NURSING FACILITY FOR THE CALENDAR YEAR.</p> <p>3 DIGITS SIGNED</p> <p>USER NOTE: THIS COUNT EXCLUDE LEAVE DAYS. IF MEDICAID PAYMENTS WERE MADE FOR LEAVE DAYS, PAYMENTS PER DAY (USING THESE DAY COUNTS) MAY BE OVERSTATED. CONVERSELY, IF MEDICAID DID NOT PAY FOR LEAVE DAYS AND LEAVE DAYS WERE ADDED TO COVERED DAY COUNTS, PAYMENTS PER DAY MAY BE UNDERSTATED. STATES MAY PAY LOWER AMOUNTS THAN STANDARD DAY RATES OR MAY NOT PAY AT ALL FOR LEAVE DAYS. SINCE IT IS NOT POSSIBLE TO DETERMINE WHEN TO ADD (AND WHEN NOT TO ADD) LEAVE DAYS TO COVERED DAY COUNTS.</p> <p>SOURCE: CREATED USING THE NUMBER OF MEDICAID NURSING FACILITY DAYS FROM MSIS CLAIMS FOR THE TOS = 7 (NURSING FACILITY SERVICES - NFS - ALL OTHER). THE TOTAL IS EDITED TO BE <= 365 DAYS. AS THIS COUNT IS BEING AGGREGATED ACROSS CLAIMS, THERE IS A DECISION RULE THAT APPLIES: IF, IN AN INDIVIDUAL CLAIM, THE SUM OF COPAYMENTS AND DEDUCTIBLES IS GREATER THAN OR EQUAL TO MEDICAID PAYMENTS (E.G. IN A CROSSOVER CLAIM), THEN THESE DAYS ARE SET VALUE = 0. THIS IS BECAUSE MEDICAID WOULD BE PAYING ONLY COPAYMENT OR DEDUCTIBLE AMOUNTS, NOT FOR ACTUAL COVERED DAYS OF STAY. FOR 1995 AND EARLIER YEARS, THESE DAYS WERE NOT SET VALUE = 0 FOR CROSSOVER CLAIMS. IF THE CLAIM IS NOT A MEDICARE CROSSOVER CLAIM AND THESE DAYS ARE MISSING, THE CLAIM IS NOT EDITED. THIS IS BECAUSE IT IS NOT POSSIBLE TO DETERMINE WHETHER THE CLAIM IS FOR ACTUAL DAYS OF STAY (ROOM AND BOARD) OR ANCILLARY SERVICES (DURING THE STAY). BECAUSE OF THIS AMBIGUITY, EDITING THE CLAIM COULD INTRODUCE ERRORS AND/OR DOUBLE COUNT THESE DAYS.</p>
43. RECIPIENT LONG TERM CARE COVERED DAY COUNT	NUM	3	323	325	<p>TOTAL NUMBER OF MEDICAID COVERED DAYS FOR THE RECIPIENT IN A LONG TERM CARE FACILITY (NOT A HOSPITAL), FOR THE CALENDAR YEAR.</p> <p>3 DIGITS SIGNED</p> <p>SOURCE: CREATED BY SUMMING THE COVERED DAY COUNTS FROM DATA ELEMENT #39 (RECIPIENT MENTAL HOSPITAL FOR THE AGED COVERED DAY COUNT), DATA ELEMENT #40 (RECIPIENT INPATIENT PSYCHIATRIC FACILITY (AGE < 21) COVERED DAY COUNT), DATA ELEMENT #41 (RECIPIENT INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED - ICF-MR - COVERED DAY COUNT) AND DATA ELEMENT #42 (RECIPIENT NURSING FACILITY - NF - COVERED DAY COUNT). THE TOTAL IS EDITED TO BE <= 365 DAYS.</p>

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	NAME	TYPE	LENGTH	POSITIONS		CONTENTS
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**	CLAIMS PAYMENT SUMMARY	GROUP	29	326	354	THE DATA ELEMENTS IN THIS GROUP SUMMARIZE CLAIMS COUNTS AND PAYMENT AMOUNTS. THROUGH 1995, THESE SMRF DATA ELEMENTS INCLUDED COUNTS OF ENCOUNTER RECORDS (TYPE OF CLAIM = 3). HOWEVER, STATE MEDICAID AGENCIES OFTEN DID NOT SUBMIT ENCOUNTER RECORDS WITH OTHER MSIS DATA PRIOR TO 1999. AS NOTED ABOVE, ENCOUNTER RECORDS ARE EXCLUDED FROM BEING COUNTED IN THESE DATA ELEMENTS BEGINNING IN 1996.
44.	RECIPIENT TOTAL MEDICAID CLAIM COUNT	NUM	5	326	330	RECIPIENT'S TOTAL NUMBER OF CLAIMS FOR THE CALENDAR YEAR. 5 DIGITS SIGNED SOURCE: MSIS CLAIMS FILES.
45.	RECIPIENT TOTAL MEDICAID PAYMENT AMOUNT	NUM	8	331	338	TOTAL AMOUNT OF MONEY PAID BY MEDICAID FOR THE RECIPIENT DURING THE CALENDAR YEAR. 8 DIGITS SIGNED SOURCE: MSIS CLAIMS FILES
46.	RECIPIENT TOTAL MEDICAID CHARGE AMOUNT	NUM	8	339	346	TOTAL AMOUNT OF CHARGES BY PROVIDERS TO MEDICAID FOR THE RECIPIENT DURING THE CALENDAR YEAR. 8 DIGITS SIGNED SOURCE: MSIS CLAIMS FILES
47.	RECIPIENT TOTAL THIRD PARTY PAYMENT AMOUNT	NUM	8	347	354	TOTAL NON-MEDICAID PAYMENTS FOR SERVICES FOR THE RECIPIENT DURING THE CALENDAR YEAR. 8 DIGITS SIGNED <i>USER NOTE: THERE MAY BE SUBSTANTIAL VARIATION IN THE REPORTING OF THIRD PARTY LIABILITY (TPL) AMOUNTS ACROSS STATES. THIS IS BECAUSE STATES USE DIFFERENT METHODS OF COLLECTING TPL PAYMENTS. SOME STATES MAY REQUIRE PROVIDERS TO THOROUGHLY PURSUE COLLECTION OF TPL PAYMENTS BEFORE CLAIMS ARE ADJUDICATED FOR MEDICAID PAYMENT. OTHER STATES MAY DESIRE TO PAY PROVIDERS PROMPTLY AND THEN RECOVER TPL PAYMENTS FROM OTHER PAYERS. FOR THESE REASONS, THE EXTENT TO WHICH TPL COLLECTIONS ARE ACCURATELY REPORTED IN MSIS IS UNKNOWN.</i> SOURCE: MSIS CLAIMS FILES

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	NAME	TYPE	POSITIONS			CONTENTS
			LENGTH	BEG	END	
**	RECIPIENT DELIVERY SUMMARY	GROUP	1	355	355	THE DATA ELEMENTS IN THIS GROUP PROVIDE INFORMATION ABOUT WHETHER OR NOT THE ENROLLEE HAD A DELIVERY IN THE CALENDAR YEAR.
	48. RECIPIENT DELIVERY CODE	NUM	1	355	355	<p>CODE INDICATING WHETHER OR NOT THE ELIGIBLE HAD AT LEAST ONE INPATIENT HOSPITAL STAY IN THE YEAR WITH A MATERNAL DELIVERY CODE.</p> <p>1 DIGIT</p> <p>CODES:</p> <p>0 = NO SMRF INPATIENT STAY DURING THE YEAR WITH A MATERNAL DELIVERY CODE.</p> <p>1 = AT LEAST ONE SMRF INPATIENT STAY DURING THE YEAR WITH A MATERNAL DELIVERY CODE.</p> <p>USER NOTE: SOME INPATIENT HOSPITAL DELIVERY CLAIMS ARE FOR THE MOTHER ONLY AND SOME INCLUDE THE NEWBORN AS WELL. IN THE 1992-95 SMRF FILES THERE WAS ALSO A FIELD CONTAINING A SUMMARY OF THE MEDICAID AMOUNT PAID FOR ALL DELIVERY CLAIMS. THAT DATA ELEMENT HAS BEEN ELIMINATED IN THE 1996-98 SMRF FILES SINCE IT MAY MISREPRESENT DELIVERY EXPENDITURES FOR A NUMBER OF REASONS, INCLUDING:</p> <ul style="list-style-type: none"> - BOTH THE NEWBORN AND MOTHER'S EXPENDITURES ARE INCLUDED ON COMBINED MOTHER/NEWBORN CLAIMS. - ONLY THE MOTHER'S EXPENDITURES ARE INCLUDED WHEN THERE ARE SEPARATE CLAIMS FOR MOTHERS AND NEWBORNS. - THERE ARE SOMETIMES MULTIPLE INPATIENT HOSPITAL DELIVERY CLAIMS FOR ONE DELIVERY (E.G. FALSE LABOR OR COMPLICATIONS AFTER DELIVERY) DUE TO MISCODING ON THE CLAIMS. IN THESE INSTANCES, ALL OF THESE EXPENDITURES ARE INCLUDED. <p>ONLY A VERY SMALL PERCENTAGE OF DELIVERIES OCCUR IN PLACES OF SERVICE OTHER THAN THE INPATIENT HOSPITAL.</p> <p>SOURCE: CREATED USING MSIS CLAIMS DATA ELEMENTS FROM THE INPATIENT HOSPITAL FILE ONLY, SINCE ONLY A SMALL PERCENTAGE OF DELIVERIES OCCUR IN OTHER PLACES OF SERVICE. DETAILED DOCUMENTATION ON THE ALGORITHM TO CREATE THIS DATA ELEMENT CAN BE FOUND IN THE "APPENDIX".</p>

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NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	
** TYPE OF SERVICE DATA	GROUP	660	356 1015	<p>22 OCCURRENCES; ONE FOR EACH OF THE SMRF TYPES OF SERVICE, AS FOLLOWS:</p> <p>01 = INPATIENT HOSPITAL (POSITIONS 356 TO 385) RECIPIENT INDICATOR (POSITION 356) RECIPIENT CLAIM COUNT (POSITIONS 357 TO 361) RECIPIENT PAYMENT AMOUNT (POSITIONS 362 TO 369) RECIPIENT CHARGE AMOUNT (POSITIONS 370 TO 377) RECIPIENT THIRD PARTY PAYMENT AMOUNT (POSITIONS 378 TO 385)</p> <p>02 = MENTAL HOSPITAL SERVICES FOR THE AGED (POSITIONS 386 TO 415) RECIPIENT INDICATOR (POSITION 386) RECIPIENT CLAIM COUNT (POSITIONS 387 TO 391) RECIPIENT PAYMENT AMOUNT (POSITIONS 392 TO 399) RECIPIENT CHARGE AMOUNT (POSITIONS 400 TO 407) RECIPIENT THIRD PARTY PAYMENT AMOUNT (POSITIONS 408 TO 415)</p> <p>04 = INPATIENT PSYCHIATRIC FACILITY FOR INDIVIDUALS UNDER THE AGE OF 21 (POSITIONS 416 TO 445) RECIPIENT INDICATOR (POSITION 416) RECIPIENT CLAIM COUNT (POSITIONS 417 TO 421) RECIPIENT PAYMENT AMOUNT (POSITIONS 422 TO 429) RECIPIENT CHARGE AMOUNT (POSITIONS 430 TO 437) RECIPIENT THIRD PARTY PAYMENT AMOUNT (POSITIONS 438 TO 445)</p> <p>05 = INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED (POSITIONS 446 TO 475) RECIPIENT INDICATOR (POSITION 446) RECIPIENT CLAIM COUNT (POSITIONS 447 TO 451) RECIPIENT PAYMENT AMOUNT (POSITIONS 452 TO 459) RECIPIENT CHARGE AMOUNT (POSITIONS 460 TO 467) RECIPIENT THIRD PARTY PAYMENT AMOUNT (POSITIONS 468 TO 475)</p> <p>07 = NURSING FACILITY SERVICES - ALL OTHER (POSITIONS 476 TO 505) RECIPIENT INDICATOR (POSITION 476) RECIPIENT CLAIM COUNT (POSITIONS 477 TO 481) RECIPIENT PAYMENT AMOUNT (POSITIONS 482 TO 489) RECIPIENT CHARGE AMOUNT (POSITIONS 490 TO 497) RECIPIENT THIRD PARTY PAYMENT AMOUNT (POSITIONS 498 TO 505)</p> <p>08 = PHYSICIANS (POSITIONS 506 TO 535) RECIPIENT INDICATOR (POSITION 506) RECIPIENT CLAIM COUNT (POSITIONS 507 TO 511) RECIPIENT PAYMENT AMOUNT (POSITIONS 512 TO 519) RECIPIENT CHARGE AMOUNT (POSITIONS 520 TO 527) RECIPIENT THIRD PARTY PAYMENT AMOUNT (POSITIONS 528 TO 535)</p>

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				09 = DENTAL (POSITIONS 536 TO 565)
				RECIPIENT INDICATOR (POSITION 536)
				RECIPIENT CLAIM COUNT (POSITIONS 537 TO 541)
				RECIPIENT PAYMENT AMOUNT (POSITIONS 542 TO 549)
				RECIPIENT CHARGE AMOUNT (POSITIONS 550 TO 557)
				RECIPIENT THIRD PARTY PAYMENT AMOUNT (POSITIONS 558 TO 5565)
				10 = OTHER PRACTITIONERS (POSITIONS 566 TO 595)
				RECIPIENT INDICATOR (POSITION 566)
				RECIPIENT CLAIM COUNT (POSITIONS 567 TO 571)
				RECIPIENT PAYMENT AMOUNT (POSITIONS 572 TO 579)
				RECIPIENT CHARGE AMOUNT (POSITIONS 580 TO 587)
				RECIPIENT THIRD PARTY PAYMENT AMOUNT (POSITIONS 588 TO 595)
				11 = OUTPATIENT HOSPITAL (POSITIONS 596 TO 625)
				RECIPIENT INDICATOR (POSITION 596)
				RECIPIENT CLAIM COUNT (POSITIONS 597 TO 601)
				RECIPIENT PAYMENT AMOUNT (POSITIONS 602 TO 609)
				RECIPIENT CHARGE AMOUNT (POSITIONS 610 TO 617)
				RECIPIENT THIRD PARTY PAYMENT AMOUNT (POSITIONS 618 TO 625)
				12 = CLINIC (POSITIONS 626 TO 655)
				RECIPIENT INDICATOR (POSITION 626)
				RECIPIENT CLAIM COUNT (POSITIONS 627 TO 631)
				RECIPIENT PAYMENT AMOUNT (POSITIONS 632 TO 639)
				RECIPIENT CHARGE AMOUNT (POSITIONS 640 TO 647)
				RECIPIENT THIRD PARTY PAYMENT AMOUNT (POSITIONS 648 TO 655)
				13 = HOME HEALTH (POSITIONS 656 TO 685)
				RECIPIENT INDICATOR (POSITION 656)
				RECIPIENT CLAIM COUNT (POSITIONS 657 TO 661)
				RECIPIENT PAYMENT AMOUNT (POSITIONS 662 TO 669)
				RECIPIENT CHARGE AMOUNT (POSITIONS 670 TO 677)
				RECIPIENT THIRD PARTY PAYMENT AMOUNT (POSITIONS 678 TO 685)
				14 = FAMILY PLANNING (POSITIONS 686 TO 715)
				RECIPIENT INDICATOR (POSITION 686)
				RECIPIENT CLAIM COUNT (POSITIONS 687 TO 691)
				RECIPIENT PAYMENT AMOUNT (POSITIONS 692 TO 699)
				RECIPIENT CHARGE AMOUNT (POSITIONS 700 TO 707)
				RECIPIENT THIRD PARTY PAYMENT AMOUNT (POSITIONS 708 TO 715)

STATE MEDICAID RESEARCH FILES PERSON SUMMARY RECORD (1996-98)

NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	
<hr/>				
				15 = LAB AND X-RAY (POSITIONS 716 TO 745)
				RECIPIENT INDICATOR (POSITION 716)
				RECIPIENT CLAIM COUNT (POSITIONS 717 TO 721)
				RECIPIENT PAYMENT AMOUNT (POSITIONS 722 TO 729)
				RECIPIENT CHARGE AMOUNT (POSITIONS 730 TO 737)
				RECIPIENT THIRD PARTY PAYMENT AMOUNT (POSITIONS 738 TO 745)
				16 = PRESCRIBED DRUGS (POSITIONS 746 TO 775)
				RECIPIENT INDICATOR (POSITION 746)
				RECIPIENT CLAIM COUNT (POSITIONS 747 TO 751)
				RECIPIENT PAYMENT AMOUNT (POSITIONS 752 TO 759)
				RECIPIENT CHARGE AMOUNT (POSITIONS 760 TO 767)
				RECIPIENT THIRD PARTY PAYMENT AMOUNT (POSITIONS 768 TO 775)
				17 = EARLY PERIODIC SCREENING DIAGNOSIS AND TREATMENT (EPSDT)
				(POSITIONS 776 TO 805)
				RECIPIENT INDICATOR (POSITION 776)
				RECIPIENT CLAIM COUNT (POSITIONS 777 TO 781)
				RECIPIENT PAYMENT AMOUNT (POSITIONS 782 TO 789)
				RECIPIENT CHARGE AMOUNT (POSITIONS 790 TO 797)
				RECIPIENT THIRD PARTY PAYMENT AMOUNT (POSITIONS 798 TO 805)
				18 = RURAL HEALTH SERVICES (POSITIONS 806 TO 835)
				RECIPIENT INDICATOR (POSITION 806)
				RECIPIENT CLAIM COUNT (POSITIONS 807 TO 811)
				RECIPIENT PAYMENT AMOUNT (POSITIONS 812 TO 819)
				RECIPIENT CHARGE AMOUNT (POSITIONS 820 TO 827)
				RECIPIENT THIRD PARTY PAYMENT AMOUNT (POSITIONS 828 TO 835)
				19 = OTHER SERVICES (POSITIONS 836 TO 865)
				RECIPIENT INDICATOR (POSITION 836)
				RECIPIENT CLAIM COUNT (POSITIONS 837 TO 841)
				RECIPIENT PAYMENT AMOUNT (POSITIONS 842 TO 849)
				RECIPIENT CHARGE AMOUNT (POSITIONS 850 TO 857)
				RECIPIENT THIRD PARTY PAYMENT AMOUNT (POSITIONS 858 TO 865)
				20 = PREMIUM PAYMENT ([POSITIONS 866 TO 895)
				RECIPIENT INDICATOR (POSITION 866)
				RECIPIENT CLAIM COUNT (POSITIONS 867 TO 871)
				RECIPIENT PAYMENT AMOUNT (POSITIONS 872 TO 879)
				RECIPIENT CHARGE AMOUNT (POSITIONS 880 TO 887)
				RECIPIENT THIRD PARTY PAYMENT AMOUNT (POSITIONS 888 TO 895)

STATE MEDICAID RESEARCH FILES PERSON SUMMARY RECORD (1996-98)

NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	

				21 = DME AND SUPPLIES (POSITIONS 896 TO 925)
				RECIPIENT INDICATOR (POSITION 896)
				RECIPIENT CLAIM COUNT (POSITIONS 897 TO 901)
				RECIPIENT PAYMENT AMOUNT (POSITIONS 902 TO 909)
				RECIPIENT CHARGE AMOUNT (POSITIONS 910 TO 917)
				RECIPIENT THIRD PARTY PAYMENT AMOUNT (POSITIONS 918 TO 925)
				22 = CASE MANAGEMENT SERVICES (POSITIONS 926 TO 955)
				RECIPIENT INDICATOR (POSITION 926)
				RECIPIENT CLAIM COUNT (POSITIONS 927 TO 931)
				RECIPIENT PAYMENT AMOUNT (POSITIONS 932 TO 939)
				RECIPIENT CHARGE AMOUNT (POSITIONS 940 TO 947)
				RECIPIENT THIRD PARTY PAYMENT AMOUNT (POSITIONS 948 TO 955)
				23 = TRANSPORTATION (POSITIONS 956 TO 985)
				RECIPIENT INDICATOR (POSITION 956)
				RECIPIENT CLAIM COUNT (POSITIONS 957 TO 961)
				RECIPIENT PAYMENT AMOUNT (POSITIONS 962 TO 969)
				RECIPIENT CHARGE AMOUNT (POSITIONS 970 TO 977)
				RECIPIENT THIRD PARTY PAYMENT AMOUNT (POSITIONS 978 TO 985)
				99 = UNKNOWN (POSITIONS 986 TO 1015)
				RECIPIENT INDICATOR (POSITION 986)
				RECIPIENT CLAIM COUNT (POSITIONS 987 TO 991)
				RECIPIENT PAYMENT AMOUNT (POSITIONS 992 TO 999)
				RECIPIENT CHARGE AMOUNT (POSITIONS 1000 TO 1007)
				RECIPIENT THIRD PARTY PAYMENT AMOUNT (POSITIONS 1008 TO 1015)
USER NOTE: FOR TYPE OF SERVICE = 17 (EPSDT), THERE IS SUBSTANTIAL VARIATION IN REPORTING ACROSS STATES.				
THE FOLLOWING TYPES OF SERVICE ARE OBSOLETE:				
03 = SKILLED NURSING FACILITY / INTERMEDIATE CARE FACILITY SERVICES FOR THE AGED				
06 = INTERMEDIATE CARE FACILITY - ICF - ALL OTHER				

1	STATE MEDICAID RESEARCH FILES PERSON SUMMARY RECORD (1996-98)					
	NAME	TYPE	LENGTH	POSITIONS		CONTENTS
	-----	----	-----	BEG	END	-----
*	TYPE OF SERVICE TABLE GROUP	GROUP	30	356	385	DATA ELEMENTS #49-53 OCCUR 22 TIMES, ONCE FOR EACH TYPE OF SERVICE LISTED ABOVE. THE EXAMPLES ARE FOR THE FIRST TYPE OF SERVICE, TOS = 01 (INPATIENT HOSPITAL).
49.	RECIPIENT TYPE OF SERVICE INDICATOR	NUM	1	356	356	<p>INDICATOR TO SHOW IF AND HOW THE ELIGIBLE RECEIVED A MEDICAID SERVICE DURING THE CALENDAR YEAR, FOR THIS TYPE OF SERVICE</p> <p>1 DIGIT</p> <p>0 = NO MEDICAID PAYMENT OR SERVICE USE FOR THIS ELIGIBLE 1 = ELIGIBLE HAD ONE OR MORE MEDICAID COVERED SERVICE(S) OF THIS TYPE, WHERE MEDICAID PAYMENT WAS > \$0 IN AT LEAST ONE OF THOSE SERVICE(S). 2 = ELIGIBLE HAD ONE OR MORE MEDICAID COVERED SERVICE(S) OF THIS TYPE, BUT MEDICAID PAYMENT WAS NEVER > \$0 FOR ANY OF THOSE SERVICE(S).</p> <p>USER NOTE: SEE DATA ELEMENT #32 WHICH IS SIMILAR TO DATA ELEMENT #49, EXCEPT THAT DATA ELEMENT #49 IS CREATED BY TYPE OF SERVICE, FOR EACH OF THE LISTED TYPES OF SERVICES.</p> <p>SOURCE MSIS FILES CONTAIN RECORDS WITH MEDICAID PAYMENT AMOUNT = \$0 IF THE SERVICE WAS COVERED, BUT FULL PAYMENT WAS MADE BY ANOTHER PAYER (E.G. THIRD PARTY LIABILITY).</p> <p>SOURCE: CREATED USING MSIS CLAIMS FILES</p>
50.	RECIPIENT TYPE OF SERVICE CLAIM COUNT	NUM	5	357	361	<p>TOTAL NUMBER OF CLAIMS FOR THE RECIPIENT FOR A SPECIFIED TYPE OF SERVICE.</p> <p>5 DIGITS SIGNED</p> <p>SOURCE: MSIS CLAIMS FILES</p>
51.	RECIPIENT TYPE OF SERVICE PAYMENT AMOUNT	NUM	8	362	369	<p>TOTAL MEDICAID PAYMENTS FOR THIS TYPE OF SERVICE FOR THE RECIPIENT DURING THE CALENDAR YEAR.</p> <p>8 DIGITS SIGNED</p> <p>SOURCE: MSIS CLAIMS FILES</p>

STATE MEDICAID RESEARCH FILES PERSON SUMMARY RECORD (1996-98)

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
52. RECIPIENT TYPE OF SERVICE CHARGE AMOUNT	NUM	8	370	377	TOTAL AMOUNT OF CHARGES UNDER THIS TYPE OF SERVICE FOR THE RECIPIENT DURING THE CALENDAR YEAR. 8 DIGITS SIGNED SOURCE: MSIS CLAIMS FILES
53. RECIPIENT TYPE OF SERVICE THIRD PARTY PAYMENT AMOUNT	NUM	8	378	385	TOTAL NON-MEDICAID PAYMENTS FOR THIS TYPE OF SERVICE FOR THE RECIPIENT DURING THE CALENDAR YEAR. 8 DIGITS SIGNED SOURCE: MSIS CLAIMS FILES

STATE MEDICAID RESEARCH FILES PERSON SUMMARY RECORD (1996-98)

	NAME	TYPE	LENGTH	POSITIONS		CONTENTS
				BEG	END	
**	ENCOUNTER RECORD SUMMARY	GROUP	20	1016	1035	THE DATA ELEMENTS IN THIS GROUP PROVIDE COUNTS OF ENCOUNTER RECORDS (TYPE OF CLAIM = 3), BY MAJOR TYPES OF SERVICES, AND IS THE EXCEPTION NOTED ABOVE AT THE BEGINNING OF THE "RECIPIENT CLAIMS SUMMARY REGION".
54.	RECIPIENT TOTAL MEDICAID INPATIENT HOSPITAL ENCOUNTER RECORD COUNT.	NUM	5	1016	1020	RECIPIENT'S TOTAL NUMBER OF INPATIENT HOSPITAL ENCOUNTER RECORDS FOR THE CALENDAR YEAR. SOURCE: MSIS CLAIMS FILES.
55.	RECIPIENT TOTAL MEDICAID LONG-TERM CARE ENCOUNTER RECORD COUNT.	NUM	5	1021	1025	RECIPIENT'S TOTAL NUMBER OF LONG-TERM CARE ENCOUNTER RECORDS FOR THE CALENDAR YEAR. SOURCE: MSIS CLAIMS FILES
56.	RECIPIENT TOTAL MEDICAID OTHER SERVICES ENCOUNTER RECORD COUNT.	NUM	5	1026	1030	RECIPIENT'S TOTAL NUMBER OF OTHER SERVICES (EXCLUDING INPATIENT HOSPITAL, LONG TERM CARE AND PRESCRIPTION DRUG) ENCOUNTER RECORDS FOR THE CALENDAR YEAR. SOURCE: MSIS CLAIMS FILES
57.	RECIPIENT TOTAL MEDICAID PRESCRIPTION DRUG ENCOUNTER RECORD COUNT.	NUM	5	1031	1035	RECIPIENT'S TOTAL NUMBER OF PRESCRIPTION DRUG ENCOUNTER RECORDS FOR THE CALENDAR YEAR. SOURCE: MSIS CLAIMS FILES
**	MONTHLY MAINTENANCE ASSISTANCE STATUS (MAS) GROUP	GROUP	12	1036	1047	THE ELIGIBLE'S MAINTENANCE ASSISTANCE STATUS (MAS) FROM JANUARY THROUGH DECEMBER. THE EXAMPLE IS FOR JANUARY.
58.	MAINTENANCE ASSISTANCE STATUS (MAS)	NUM	1	1036	1036	THE ELIGIBLE'S MAINTENANCE ASSISTANCE STATUS (MAS). <i>USER NOTE: THIS DATA ELEMENT IS INCLUDED IN THE FILE ONLY FOR INTERNAL DATA VALIDATION PURPOSES AND SHOULD NOT BE USED.</i>
**	MONTHLY BASIS OF ELIGIBILITY (BOE) GROUP	GROUP	12	1048	1059	THE ELIGIBLE'S BASIS OF ELIGIBILITY (BOE) FROM JANUARY THROUGH DECEMBER. THE EXAMPLE IS FOR JANUARY.
59.	BASIS OF ELIGIBILITY (BOE)	NUM	1	1048	1048	THE ELIGIBLE'S BASIS OF ELIGIBILITY (BOE). <i>USER NOTE: THIS DATA ELEMENT IS INCLUDED IN THE FILE ONLY FOR INTERNAL DATA VALIDATION PURPOSES AND SHOULD NOT BE USED.</i>