Medicaid Analytic Extract Specifications for State-Specific Validation Tables, 2009

March 31, 2012

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Policy Research

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ABBREVIATIONS AND ACRONYMS IN THE VALIDATION TABLES

Abbreviations

Avg = average
Dups = duplicate counts
Pharm = pharmacy
Psych = psychiatric
Tech = technologically

Acronyms

AAA = Social Security area number (first 3 digits of a Social Security number)
AFDC = Aid to Families with Dependent Children
AFDC-U = AFDC for Unemployed Parents
ASD = Autism Spectrum Disorder
BHO = behavioral health organization
CLTC = community long-term care
CLTC FLAG = CLTC flag
CPT-4 = Current Procedural Terminology, 4th Edition
DIV = division
DOB = date of birth
EDB = Medicare Enrollment Database
EDB DUAL = EDB dual status (annual)
EXT SSN SRCE = external source of the Social Security number
FFS = fee-for-service
FP = family planning
FQHC = Federally Qualified Health Center
GG = Social Security group number (middle 2 digits of a Social Security number)
HCPCS = Health Care Common Procedure Coding System
HGT FLAG = high group test flag
HIC = Health Insurance Claim number
HIFA = Health Insurance Flexibility and Accountability
HIO = health insuring organization
HIV/AIDS = human immunodeficiency virus/acquired immunodeficiency syndrome
HMO = health maintenance organization
ICF/MR = intermediate care facility for the mentally retarded
ICD-9-CM = International Classification of Diseases, 9th Edition
IHS = Indian Health Service
ILTC = institutional long-term care
IP = inpatient hospital claims file; inpatient
LT = institutionalized long-term care claims file
LTC = long-term care
MASBOE = maintenance assistance status and basis of eligibility
MAX = Medicaid Analytic Extract
MAX TOS = MAX type of service
MC = managed care
MC COMBO = MC combination code
MC TYPE = MC type
MDCR ORIG REAS CD = Medicare original reason code
MH = mental hospital
MI/SED = mental illness/serious emotional disturbance
MR/DD = mentally retardation/development disability
MSIS = Medicaid Statistical Information System
M-CHIP = Medicaid State Children's Health Insurance Program
N/A = not applicable or not available
NF = nursing facility

OT = other, non-institutional claims file; occupational therapy
PACE = Program of All-Inclusive Care for the Elderly
PCCM = primary care case management
PGM TYPE = program type
PHP = prepaid health plan
PRFT = Psychiatric Residential Treatment Facilities
PT = physical therapy
PVT INS CD = private insurance code
RBF = restricted benefits flag
QDWI = Qualified Disabled and Working Individuals
QI-1 = Qualified Individuals 1
QI-2 = Qualified Individuals 2
QMB = Qualified Medicare Beneficiary
RCPNT IND = recipiend indicator
RHC = Rural Health Clinic
RX = prescription drug claims file
SLMB = Specified Low-Income Medicare Beneficiary
S-CHIP = state-financed State Children's Health Insurance Program
SCHIP = SCHIP code
SSSS = Social Security serial number (last 4 digits of a Social Security number)
TANF = Temporary Assistance for Needy Families
TANF FLAG = TANF flag
TOS = type of service
TPL = Third-Party Liability
WVR TYPE = waiver type

Measure	Measure Description
All IP Stays	
Total Number of IP MSIS Quarters	Total number of IP MSIS quarters included in MAX production. One additional quarter (FY2009 Q1), which is not included in this measure, is included in IP processing to allow hospital stays that began in the previous calendar year to be included.
Total Number of Stays	Count records in the file
% Encounter Stays	Count records with type claim code equal to 3, divide by total record count, *100
% Supplemental Stays	Count records with type claim code equal to 5, divide by total record count, *100
% Stays with NPI (not 0/8/9-filled)	Count records with 10-digit numeric NPI, excluding 0-fill, 8-fill, and 9-fill, divide by total record count, *100
% Stays with NPI = Billing Provider ID (for Stays with NPI)	Count records with 10-digit numeric NPI (excluding 0-fill, 8-fill, and 9-fill) equal to Billing Provider ID, divide by count records with 10-digit numeric NPI (excluding 0-fill, 8-fill, and 9-fill), *100
% Stays with Provider Taxonomy (not 0/8/9-filled)	Count records with 10-character Taxonomy, excluding 0-fill, 8-fill, and 9-fill, divide by total record count, *100
Total FFS Stays	Count records with type claim code equal to 1, divide by total record count
% Crossover	Among records with type claim code equal to 1, count records with Medicare crossover code - claim based - equal to 1, divide by total record count, *100
% Adjusted Stays	Among records with type claim code equal to 1, count records with adjustment code equal to 1 or 2, divide by total record count, *100
Avg Medicaid Paid, Adjusted Stays (Include $0)	Among records with type claim code equal to 1 and adjustment code equal to 1 or 2, sum total Medicaid amount paid, divide by total record count
# of Stays with Missing Medicaid Eligibility and > $0 Paid (Excludes S-CHIP Only)	Count records with missing eligibility data equal to 1
Avg Medicaid Paid for Stays with Missing Medicaid Eligibility and > $0 Paid (Excludes S-CHIP Only)	Among records with Medicaid amount paid > 0 and missing eligibility data equal to 1, sum total Medicaid amount paid, divide by total record count
# Stays with > $1 Million Paid	Count records with Medicaid amount paid > 200,000
% Section 1915(c) Waiver Stays (PGM TYPE = 6, 7)	Count records with type of program equal to 6 or 7, divide by total record count, *100
Total Medicaid Paid among Section 1915(c) Waiver Stays (PGM TYPE = 6, 7)	Sum total Medicaid payments (where Program Type = 6 or 7)

Measure	Measure Description
FFS Non-Crossover Stays (Type of Claim=1, Crossover Claim Indicator=0)	
Total Number of Stays	Count records
% Stays with > $0 Paid	Count records with Medicaid amount paid > 0, divide by total record count, *100
% Stays with < $0 Paid	Count records with Medicaid amount paid < 0, divide by total record count, *100
Avg Medicaid Paid (Stays with > $0 Paid)	Among records with Medicaid amount paid > 0, sum total Medicaid amount paid, divide by total record count
Avg Medicaid Paid per Covered Day (> $0 Paid and > 0 Days)	Among records with Medicaid amount paid > 0 and covered inpatient days > 0, sum total Medicaid amount paid, divide by total number of covered inpatient days
% Stays with TPL	Count records with third-party payment amount > 0, divide by total record count, *100
Avg TPL Paid for Stays with TPL	Among records with third-party payment amount > 0, sum third-party payment amount, divide by total record count
% Stays with UB-92 Accommodation Codes	Count records with at least one UB-92 revenue code equal to 0100 through 0219, divide by total record count, *100
Avg # of UB-92 Accomodation Codes (> 0 Codes)	Among records with at least one UB-92 revenue code equal to 0100 through 0219, count number of UB-92 revenue codes equal to 0100 through 0219, divide by total record count
% Stays with UB-92 Ancillary Codes	Count records with at least one UB-92 revenue code > 0219 (and not 8-fill or 9-fill), divide by total record count, *100
Avg # of UB-92 Ancillary Codes (> 0 Codes)	Among records with at least one UB-92 revenue code > 0219 (and not 8-fill or 9-fill), count number of UB-92 revenue codes > 0219 (and not 8-fill or 9-fill), divide by total record count
Avg Length of Stay	Among records with length of stay > 0, sum length of stay, divide by total record count Length of stay = service end date - service begin date, if service end date >= service begin date Length of stay = 1, if service end date = service begin date Length of stay = 0, if service end date < service begin date
Avg Covered Days (> 0 Days)	Among records with covered inpatient days > 0, sum covered inpatient days, divide by total record count
% Stays with Admission Date	Count records with valid admission date not equal to spaces, 0-fill, 8-fill, 9-fill, divide by total record count, *100
% Begin Date = Admission Date	Count records with service begin date equal to admission date, divide by total record count, *100
% IP Stays (MAX TOS = 01)	Count records with MAX type of service equal to 01, divide by total record count, *100
% Family Planning Stays (PGM TYPE = 2)	Count records with type of program equal to 2, divide by total record count, *100

Measure	Measure Description
% Stays with Primary Diagnosis Code	Count records with principal diagnosis code not equal to spaces, 0-fill, 8-fill, 9-fill, divide by total record count, *100
Avg # of Diagnosis Codes (> 0 Codes)	Among records with principal diagnosis code not equal to spaces, 0-fill, 8-fill, 9-fill, count number of diagnosis codes not equal to spaces, 0-fill, 8-fill, 9-fill, divide by total record count
% Primary Diagnosis Code Stays with Length = 3	Among records with principal diagnosis code not equal to spaces, 0-fill, 8-fill, 9-fill, count records with principal diagnosis code length equal to 3, divide by total record count, *100
% Primary Diagnosis Code Stays with Length = 4	Among records with principal diagnosis code not equal to spaces, 0-fill, 8-fill, 9-fill, count records with principal diagnosis code length equal to 4, divide by total record count, *100
% Primary Diagnosis Code Stays with Length = 5	Among records with principal diagnosis code not equal to spaces, 0-fill, 8-fill, 9-fill, count records with principal diagnosis code length equal to 5, divide by total record count, *100
% Stays with a Procedure Code	Count records with principal procedure code not equal to spaces, 0-fill, 8-fill, 9-fill, divide by total record count, *100
Avg # of Procedure Codes (> 0 Codes)	Among records with principal procedure code not equal to spaces, 0-fill, 8-fill, 9-fill, count number of procedure codes not equal to spaces, 0-fill, 8-fill, 9-fill, divide by total record count
% Stays with Procedure Code with CPT-4 Indicator	Among records with principal procedure code not equal to spaces, 0-fill, 8-fill, 9-fill, count records with principal procedure coding system code equal to 01, divide by total record count, *100
% Stays with Procedure Code with ICD-9 Indicator	Among records with principal procedure code not equal to spaces, 0-fill, 8-fill, 9-fill, count records with principal procedure coding system code equal to 02, divide by total record count, *100
% CPT-4 Indicator Stays with CPT-4 Format = 5 Digits	Among records with principal procedure code not equal to spaces, 0-fill, 8-fill, 9-fill and principal procedure coding system code equal to 01, count records with principal procedure code equal to 5 digits, divide by total record count, *100
% ICD-9-CM Indicator Stays with ICD-9-CM Format = 3 or 4 Digits	Among records with principal procedure code not equal to spaces, 0-fill, 8-fill, 9-fill and principal procedure coding system code equal to 02, count records with principal procedure code equal to 3 digits or 4 digits, divide by total record count, *100
% Stays with Diagnosis Related Group	Count records with diagnosis related group not equal spaces, 0-fill, 8-fill, 9-fill, divide by total record count, *100
% Stays Maternal Delivery Indicator	Count records with recipient delivery code equal to 1, divide by total record count, *100
% Stays Newborn Delivery Indicator (Only for Separate Infant Delivery Stays Using Mother's ID)	Count records with recipient delivery code equal to 2, divide by total record count, *100
PATIENT STATUS	
% Home	Count records with patient status code equal to 01, 07, 08, or 50, divide by total record count, *100
% Transferred	Count records with patient status code equal to 02, 03, 04, 05, 06, or 51, divide by total record count, *100
% Still a Patient	Count records with patient status code equal to 09 or 30, divide by total record count, *100

Measure	Measure Description
% Died	Count records with patient status code equal to 20, 40, 41, or 42, divide by total record count, *100
FFS Crossover Stays (Type of Claim=1, Crossover Claim Indicator=1)	
Total Number of Stays	Count records
% Stays with > $0 Paid	Count records with Medicaid amount paid > 0, divide by total record count, *100
% Stays with < $0 Paid	Count records with Medicaid amount paid < 0, divide by total record count, *100
Avg Medicaid Paid (Stays with > $0 Paid)	Among records with Medicaid amount paid > 0, sum total Medicaid amount paid, divide by total record count
% Stays with TPL	Count records with third-party payment amount > 0, divide by total record count, *100
Avg TPL Paid for Stays with TPL	Among records with third-party payment amount > 0, sum third-party payment amount, divide by total record count
% Stays with UB-92 Accommodation Codes	Count records with at least one UB-92 revenue code equal to 0100 through 0219, divide by total record count, *100
Avg # of UB-92 Accomodation Codes (> 0 Codes)	Among records with at least one UB-92 revenue code equal to 0100 through 0219, count number of UB-92 revenue codes equal to 0100 through 0219, divide by total record count
% Stays with UB-92 Ancillary Codes	Count records with at least one UB-92 revenue code > 0219 (and not 8-fill or 9-fill), divide by total record count, *100
Avg # of UB-92 Ancillary Codes (> 0 Codes)	Among records with at least one UB-92 revenue code > 0219 (and not 8-fill or 9-fill), count number of UB-92 revenue codes > 0219 (and not 8-fill or 9-fill), divide by total record count
Avg Length of Stay	Among records with length of stay > 0, sum length of stay, divide by total record count, *100 Length of stay = service end date - service begin date, if service end date >= service begin date Length of stay = 1, if service end date = service begin date Length of stay = 0, if service end date < service begin date
% Stays with Admission Date	Count records with valid admission date not equal to spaces, 0-fill, 8-fill, 9-fill, divide by total record count, *100
% Begin Date = Admission Date	Count records with service begin date equal to admission date, divide by total record count, *100
% IP Stays (MAX TOS = 01)	Count records with MAX type of service equal to 01, divide by total record count, *100
% Stays with Primary Diagnosis Code	Count records with principal diagnosis code not equal to spaces, 0-fill, 8-fill, 9-fill, divide by total record count, *100
Avg # of Diagnosis Codes (> 0 Codes)	Among records with principal diagnosis code not equal to spaces, 0-fill, 8-fill, 9-fill, count number of diagnosis codes not equal to spaces, 0-fill, 8-fill, 9-fill, divide by total record count

Measure	Measure Description
% Primary Diagnosis Code Stays with Length = 3	Among records with principal diagnosis code not equal to spaces, 0-fill, 8-fill, 9-fill, count records with principal diagnosis code length equal to 3, divide by total record count, *100
% Primary Diagnosis Code Stays with Length = 4	Among records with principal diagnosis code not equal to spaces, 0-fill, 8-fill, 9-fill, count records with principal diagnosis code length equal to 4, divide by total record count, *100
% Primary Diagnosis Code Stays with Length = 5	Among records with principal diagnosis code not equal to spaces, 0-fill, 8-fill, 9-fill, count records with principal diagnosis code length equal to 5, divide by total record count, *100
% Stays with a Procedure Code	Count records with principal procedure code not equal to spaces, 0-fill, 8-fill, 9-fill, divide by total record count, *100
Avg # of Procedure Codes (> 0 Codes)	Among records with principal procedure code not equal to spaces, 0-fill, 8-fill, 9-fill, count number of procedure codes not equal to spaces, 0-fill, 8-fill, 9-fill, divide by total record count
% Stays with Procedure Code with CPT-4 Indicator	Among records with principal procedure code not equal to spaces, 0-fill, 8-fill, 9-fill, count records with principal procedure coding system code equal to 01, divide by total record count, *100
% Stays with Procedure Code with ICD-9 Indicator	Among records with principal procedure code not equal to spaces, 0-fill, 8-fill, 9-fill, count records with principal procedure coding system code equal to 02, divide by total record count, *100
% CPT-4 Indicator Stays with CPT-4 Format = 5 Digits	Among records with principal procedure code not equal to spaces, 0-fill, 8-fill, 9-fill and principal procedure coding system code equal to 01, count records with principal procedure code equal to 5 digits, divide by total record count, *100
% ICD-9-CM Indicator Stays with ICD-9-CM Format = 3 or 4 Digits	Among records with principal procedure code not equal to spaces, 0-fill, 8-fill, 9-fill and principal procedure coding system code equal to 02, count records with principal procedure code equal to 3 digits or 4 digits, divide by total record count, *100
% Stays with Diagnosis Related Group	Count records with drug related group not equal spaces, 0-fill, 8-fill, 9-fill, divide by total record count, *100
Encounter Stays (Type of Claim=3)	
Total Number of Stays	Count encounter records (type claim code equal to 3)
% Aged	Count encounter records with MAX uniform eligibility code - month of service equal to 11, 21, 31, 41, or 51, divide by total record count, *100
% Disabled	Count encounter records with MAX uniform eligibility code - month of service equal to 12, 22, 32, 3A, 42, or 52, divide by total record count, *100
% Child	Count encounter records with MAX uniform eligibility code - month of service equal to 14, 16, 24, 34, 44, 48, or 54, divide by total record count, *100
% Adult	Count encounter records with MAX uniform eligibility code - month of service equal to 15, 17, 25, 35, 45, or 55, divide by total record count, *100
% Stays with > 0 Prepaid Plan Value	Count encounter records with Prepaid Plan Service Value > 0, divide by total record count, *100
% Stays with UB-92 Accommodation Codes	Count encounter records with at least one UB-92 revenue code equal to 0100 through 0219, divide by total record count, *100

Measure	Measure Description
Avg # of UB-92 Accomodation Codes (> 0 Codes)	Among encounter records with at least one UB-92 revenue code equal to 0100 through 0219, count number of UB-92 revenue codes equal to 0100 through 0219, divide by total record count
% Stays with UB-92 Ancillary Codes	Count encounter records with at least one UB-92 revenue code > 0219 (and not 8-fill or 9-fill), divide by total record count, *100
Avg # of UB-92 Ancillary Codes (> 0 Codes)	Among encounter records with at least one UB-92 revenue code > 0219 (and not 8-fill or 9-fill), count number of UB-92 revenue codes > 0219 (and not 8-fill or 9-fill), divide by total record count
Avg Length of Stay	Among encounter records with length of stay > 0, sum length of stay, divide by total record count, *100 Length of stay = service end date - service begin date, if service end date >= service begin date Length of stay = 1, if service end date = service begin date Length of stay = 0, if service end date < service begin date
Avg Covered Days (> 0 Days)	Among encounter records with covered days > 0, sum covered days, divide by total record count, *100
% Stays with Admission Date	Count encounter records with valid admission date not equal to spaces, 0-fill, 8-fill, 9-fill, divide by total record count, *100
% Begin Date = Admission Date	Count encounter records with service begin date equal to admission date, divide by total record count, *100
% IP Stays (MAX TOS = 01)	Count encounter records with MAX type of service equal to 01, divide by total record count, *100
% Family Planning Stays (PGM TYPE = 2)	Count encounter records with MSIS type of program code equal to 02, divide by total record count, *100
% Stays with Primary Diagnosis Code	Count encounter records with principal diagnosis code not equal to spaces, 0-fill, 8-fill, 9-fill, divide by total record count, *100
Avg # of Diagnosis Codes (> 0 Codes)	Among encounter records with principal diagnosis code not equal to spaces, 0-fill, 8-fill, 9-fill, count number of diagnosis codes not equal to spaces, 0-fill, 8-fill, 9-fill, divide by total record count
% Primary Diagnosis Code Stays with Length = 3	Among encounter records with principal diagnosis code not equal to spaces, 0-fill, 8-fill, 9-fill, count records with principal diagnosis code length equal to 3, divide by total record count, *100
% Primary Diagnosis Code Stays with Length = 4	Among encounter records with principal diagnosis code not equal to spaces, 0-fill, 8-fill, 9-fill, count records with principal diagnosis code length equal to 4, divide by total record count, *100
% Primary Diagnosis Code Stays with Length = 5	Among encounter records with principal diagnosis code not equal to spaces, 0-fill, 8-fill, 9-fill, count records with principal diagnosis code length equal to 5, divide by total record count, *100
% Stays with a Procedure Code	Count encounter records with principal procedure code not equal to spaces, 0-fill, 8-fill, 9-fill, divide by total record count, *100
Avg # of Procedure Codes (> 0 Codes)	Among encounter records with principal procedure code not equal to spaces, 0-fill, 8-fill, 9-fill, count number of procedure codes not equal to spaces, 0-fill, 8-fill, 9-fill, divide by total record count
% Stays with Procedure Code with CPT-4 Indicator	Among encounter records with principal procedure code not equal to spaces, 0-fill, 8-fill, 9-fill, count records with principal procedure coding system code equal to 01, divide by total record count, *100
% Stays with Procedure Code with ICD-9 Indicator	Among encounter records with principal procedure code not equal to spaces, 0-fill, 8-fill, 9-fill, count records with principal procedure coding system code equal to 02, divide by total record count, *100

Measure	Measure Description
% CPT-4 Indicator Stays with CPT-4 Format = 5 Digits	Among encounter records with principal procedure code not equal to spaces, 0-fill, 8-fill, 9-fill and principal procedure coding system code equal to 01, count records with principal procedure code equal to 5 digits, divide by total record count, *100
% ICD-9-CM Indicator Stays with ICD-9-CM Format = 3 or 4 Digits	Among encounter records with principal procedure code not equal to spaces, 0-fill, 8-fill, 9-fill and principal procedure coding system code equal to 02, count records with principal procedure code equal to 3 digits or 4 digits, divide by total record count, *100
% Stays with Diagnosis Related Group	Count encounter records with diagnosis related group not equal spaces, 0-fill, 8-fill, 9-fill, divide by total record count, *100
% Stays Maternal Delivery Indicator	Count encounter records with recipient delivery code equal to 1, divide by total record count, *100
% Stays Newborn Delivery Indicator (Only for Separate Infant Delivery Stays Using Mother's ID)	Count encounter records with recipient delivery code equal to 2, divide by total record count, *100
PATIENT STATUS	
% Home	Count encounter records with patient status code equal to 01, 07, 08, or 50, divide by total record count, *100
% Transferred	Count encounter records with patient status code equal to 02, 03, 04, 05, 06, or 51, divide by total record count, *100
% Still a Patient	Count encounter records with patient status code equal to 09 or 30, divide by total record count, *100
% Died	Count encounter records with patient status code equal to 20, 40, 41, or 42, divide by total record count, *100

Measure	Measure Description
All LT Claims	
Total Number of LT MSIS Quarters	Total number of LT MSIS quarters included in MAX production. We include 7 quarters, when available, to allow adjustment records to update the original claim.
Total Number of Claims	Count records in the file
% Encounter Claims	Count records with type claim code equal to 3, divide by total record count, *100
% Supplemental Claims	Count records with type claim code equal to 5, divide by total record count, *100
% Claims with NPI (not 0/8/9-filled)	Count records with 10-digit numeric NPI, excluding 0-fill, 8-fill, and 9-fill, divide by total record count, *100
% Claims with NPI = Billing Provider ID (for claims with NPI)	Count records with 10-digit numeric NPI (excluding 0-fill, 8-fill, and 9-fill) equal to Billing Provider ID, divide by count records with 10-digit numeric NPI (excluding 0-fill, 8-fill, and 9-fill), *100
% Claims with Provider Taxonomy (not 0/8/9-filled)	Count records with 10-character Taxonomy, excluding 0-fill, 8-fill, and 9-fill, divide by total record count, *100
Total FFS Claims	Count records with type claim code equal to 1, divide by total record count
% Crossover	Among records with type claim code equal to 1, count records with Medicare crossover code - claim based - equal to 1, divide by total record count, *100
% Adjusted Claims	Among records with type claim code equal to 1, count records with adjustment code equal to 1 or 2, divide by total record count, *100
Avg Medicaid Paid, Adjusted Claims (Include $0)	Among records with type claim code equal to 1 and adjustment code equal to 1 or 2, sum total Medicaid amount paid, divide by total record count
# of Claims with Missing Medicaid Eligibility and > $0 Paid (Excludes S-CHIP Only)	Count records with missing eligibility data equal to 1
Avg Medicaid Paid for Claims with Missing Medicaid Eligibility and > $0 Paid (Excludes S-CHIP Only)	Among records with Medicaid amount paid > 0 and missing eligibility data equal to 1, sum total Medicaid amount paid, divide by total record count
# Claims with > $200,000 Paid	Count records with Medicaid amount paid > 200,000
% Section 1915(c) Waiver Claims (PGM TYPE = 6, 7)	Count records with type of program equal to 6 or 7, divide by total record count, *100
Total Medicaid Paid among Section 1915(c) Waiver Claims (PGM TYPE = 6, 7)	Sum total Medicaid payments (where Program Type = 6 or 7)

Measure	Measure Description
FFS Non-Crossover Claims (Type of Claim=1, Crossover Claim Indicator=0)	
Total Number of Claims	Count records
% Claims with > $0 Paid	Count records with Medicaid amount paid > 0, divide by total record count, *100
% Claims with < $0 Paid	Count records with Medicaid amount paid < 0, divide by total record count, *100
AVERAGE MEDICAID AMOUNT PAID PER COVERED DAY BY MAX TYPE OF SERVICE (CLAIMS WITH >$0 PAID)	
NF (MAX TOS = 07)	Among records with Medicaid amount paid > 0 and MAX type of service equal to 07 and nursing facility day count > 0, sum total Medicaid amount paid, divide by total number of days at facility
ICF/MR (MAX TOS = 05)	Among records with Medicaid amount paid > 0 and MAX type of service equal to 05 and Intermediate Care Facility for the Mentally Retarded day count > 0, sum total Medicaid amount paid, divide by total number of days at facility
MH Aged (MAX TOS = 02)	Among records with Medicaid amount paid > 0 and MAX type of service equal to 02 and mental hospital for the aged day count > 0, sum total Medicaid amount paid, divide by total number of days at facility
IP Psych, Age < 21 (MAX TOS = 04)	Among records with Medicaid amount paid > 0 and MAX type of service equal to 04 and inpatient psychiatric facility day count > 0, sum total Medicaid amount paid, divide by total number of days at facility
TYPE OF SERVICE	
% NF (MAX TOS = 07)	Count records with MAX type of service equal to 07, divide by total record count, *100
% NF claims with NF Covered Days	Among records with MAX type of service equal to 07, count records with nursing facility day count > 0, divide by total record count, *100
Avg days for NF claims with Covered Days	Among records with MAX type of service equal to 07 and nursing facility day count > 0, sum nursing facility day count, divide by total record count
% ICF/MR (MAX TOS = 05)	Count records with MAX type of service equal to 05, divide by total record count, *100
% ICF/MR claims with ICF/MR Covered Days	Among records with MAX type of service equal to 05, count records with Intermediate Care Facility for the Mentally Retarded day count > 0, divide by total record count, *100
Avg days for ICF/MR claims with Covered Days	Among records with MAX type of service equal to 05 and Intermediate Care Facility for the Mentally Retarded day count > 0, sum Intermediate Care Facility for the Mentally Retarded day count, divide by total record count
% MH Aged (MAX TOS = 02)	Count records with MAX type of service equal to 02, divide by total record count, *100
% MH Aged claims with MH Aged Covered Days	Among records with MAX type of service equal to 02, count records with mental hospital for the aged day count > 0, divide by total record count, *100

Measure	Measure Description
Avg days for MH Aged claims with Covered Days	Among records with MAX type of service equal to 02 and mental hospital for the aged day count > 0, sum mental hospital for the aged day count, divide by total record count
% IP Psych, Age < 21 (MAX TOS = 04)	Count records with MAX type of service equal to 04, divide by total record count, *100
% IP Psych, Age < 21 Claims with IP Psych Covered Days	Among records with MAX type of service equal to 04, count records with inpatient psychiatric facility day count > 0, divide by total record count, *100
Avg days for IP Psych, Age < 21 Claims with Covered Days	Among records with MAX type of service equal to 04 and inpatient psychiatric facility day count > 0, sum inpatient psychiatric facility day count, divide by total record count
LEAVE DAYS	
% Claims with Leave Days	Count records with long-term care leave day count > 0, divide by total record count, *100
ADMISSION DATE	
% Claims with Admission Date	Count records with long-term care admission date not equal to 0, 8-fill or 9-fill, divide by total record count, *100
DIAGNOSIS CODES	
% Claims with Primary Diagnosis Code	Count records with first diagnosis code not equal to spaces, 0-fill, 8-fill, 9-fill, divide by total record count, *100
% Primary Diagnosis Code Claims with Length = 3	Among records with first diagnosis code not equal to spaces, 0-fill, 8-fill, 9-fill , count records with first diagnosis code equal to 3 digits, divide by total record count, *100
% Primary Diagnosis Code Claims with Length = 4	Among records with first diagnosis code not equal to spaces, 0-fill, 8-fill, 9-fill , count records with first diagnosis code equal to 4 digits, divide by total record count, *100
% Primary Diagnosis Code Claims with Length = 5	Among records with first diagnosis code not equal to spaces, 0-fill, 8-fill, 9-fill , count records with first diagnosis code equal to 5 digits, divide by total record count, *100
PATIENT STATUS	
% Claims with Patient Status	Count records with patient status code not equal to 0, 8-fill or 9-fill, divide by total record count, *100
% Home	Count records with patient status code equal to 01, 07, 08, or 50, divide by total record count, *100
% Still a Patient	Count records with patient status code equal to 09 or 30, divide by total record count, *100
% Died	Count records with patient status code equal to 20, 40, 41, or 42, divide by total record count, *100

Measure	Measure Description
FFS Crossover Claims (Type of Claim=1, Crossover Claim Indicator=1)	
Total Number of Claims	Count records
% Claims with > $0 Paid	Count records with Medicaid amount paid > 0, divide by total record count, *100
% Claims with < $0 Paid	Count records with Medicaid amount paid < 0, divide by total record count, *100
Avg Medicaid Paid (Claims with > $0 Paid)	Among records with Medicaid amount paid > 0, sum total Medicaid amount paid, divide by total record count
TYPE OF SERVICE	
% NF (MAX TOS = 07)	Count records with MAX type of service equal to 07, divide by total record count, *100
% ICF/MR (MAX TOS = 05)	Count records with MAX type of service equal to 05, divide by total record count, *100
% MH Aged (MAX TOS = 02)	Count records with MAX type of service equal to 02, divide by total record count, *100
% IP Psych, Age < 21 (MAX TOS = 04)	Count records with MAX type of service equal to 04, divide by total record count, *100
ADMISSION DATE	
% Claims with Admission Date	Count records with long-term care admission date not equal to 0, 8-fill or 9-fill, divide by total record count, *100
DIAGNOSIS CODES	
% Claims with Primary Diagnosis Code	Count records with first diagnosis code not equal to spaces, 0-fill, 8-fill, 9-fill, divide by total record count, *100
% Primary Diagnosis Code Claims with Length = 3	Count records with first diagnosis code not equal to spaces, 0-fill, 8-fill, 9-fill and first diagnosis code equal to 3 digits, divide by total record count, *100
% Primary Diagnosis Code Claims with Length = 4	Count records with first diagnosis code not equal to spaces, 0-fill, 8-fill, 9-fill and first diagnosis code equal to 4 digits, divide by total record count, *100
% Primary Diagnosis Code Claims with Length = 5	Count records with first diagnosis code not equal to spaces, 0-fill, 8-fill, 9-fill and first diagnosis code equal to 5 digits, divide by total record count, *100

Measure	Measure Description
PATIENT STATUS	
% Claims with Patient Status	Count records with patient status code not equal to 0, 8-fill or 9-fill, divide by total record count, *100
% Home	Count records with patient status code equal to 01, 07, 08, or 50, divide by total record count, *100
% Still a Patient	Count records with patient status code equal to 09 or 30, divide by total record count, *100
% Died	Count records with patient status code equal to 20, 40, 41, or 42, divide by total record count, *100
Encounter Claims (Type of Claim=3)	
Total Number of Claims	Count encounter records (type claim code equal to 3)
% Aged	Count encounter records with MAX uniform eligibility code - month of service equal to 11, 21, 31, 41, or 51, divide by total record count, *100
% Disabled	Count encounter records with MAX uniform eligibility code - month of service equal to 12, 22, 32, 3A, 42, or 52, divide by total record count, *100
% Child	Count encounter records with MAX uniform eligibility code - month of service equal to 14, 16, 24, 34, 44, 48, or 54, divide by total record count, *100
% Adult	Count encounter records with MAX uniform eligibility code - month of service equal to 15, 17, 25, 35, 45, or 55, divide by total record count, *100
% Claims with > 0 Prepaid Plan Value	Count encounter records with Prepaid Plan Service Value > 0, divide by total record count, *100
TYPE OF SERVICE	
% NF (MAX TOS = 07)	Count encounter records with MAX type of service equal to 07, divide by total record count, *100
% NF claims with NF Covered Days > 0	Among encounter records with MAX type of service equal to 07, count number of claims with NF covered days > 0, divide by total record count, * 100
Avg days for NF claims with Covered Days > 0	Among encounter records with MAX type of service equal to 07 and ICF/MR covered days > 0, count number of NF covered days, divide by total record count
% ICF/MR (MAX TOS = 05)	Count encounter records with MAX type of service equal to 05, divide by total record count, *100
% ICF/MR claims with ICF/MR Covered Days > 0	Among encounter records with MAX type of service equal to 05, count number of claims with ICF/MR covered days > 0, divide by total record count, * 100

Measure	Measure Description
Avg days for ICF/MR claims with Covered Days > 0	Among encounter records with MAX type of service equal to 05 and ICF/MR covered days > 0, count number of ICF/MR covered days, divide by total record count
% MH Aged (MAX TOS = 02)	Count encounter records with MAX type of service equal to 02, divide by total record count, *100
% MH Aged claims with MH Aged Covered Days > 0	Among encounter records with MAX type of service equal to 02, count number of claims with MH Aged covered days > 0, divide by total record count, * 100
Avg days for MH Aged claims with Covered Days > 0	Among encounter records with MAX type of service equal to 02 and MH Aged covered days > 0, count number of ICF/MR covered days, divide by total record count
% IP Psych, Age < 21 (MAX TOS = 04)	Count encounter records with MAX type of service equal to 04, divide by total record count, *100
% IP Psych, Age < 21 Claims with IP Psych Covered Days > 0	Among encounter records with MAX type of service equal to 04, count number of claims with IP Psych covered days > 0, divide by total record count, * 100
Avg days for IP Psych, Age < 21 Claims with Covered Days > 0	Among encounter records with MAX type of service equal to 04 and MH Aged covered days > 0, count number of IP/Psych covered days, divide by total record count
LEAVE DAYS	
% Claims with Leave Days	Count encounter records with leave day count not equal to spaces, 0-fill, 8-fill, 9-fill, divide by total record count, *100
ADMISSION DATE	
% Claims with Admission Date	Count encounter records with admission date not equal to spaces, 0-fill, 8-fill, 9-fill, divide by total record count, *100
DIAGNOSIS CODES	
% Claims with Primary Diagnosis Code	Count encounter records with principal diagnosis code not equal to spaces, 0-fill, 8-fill, 9-fill, divide by total record count, *100
PATIENT STATUS	
% Claims with Patient Status	Count records with patient status code not equal to 0, 8-fill or 9-fill, divide by total record count, *100
% Home	Count records with patient status code equal to 01, 07, 08, or 50, divide by total record count, *100
% Still a Patient	Count encounter records with patient status code equal to 09 or 30, divide by total record count, *100
% Died	Count encounter records with patient status code equal to 20, 40, 41, or 42, divide by total record count, *100

Measure	Measure Description
All OT Claims	
Total Number of OT MSIS Quarters	Total number of OT MSIS quarters included in MAX production. We include 7 quarters, when available, to allow adjustment records to update the original claim.
Total Number of Claims	Count records in the file
% Encounter Claims	Count records with type claim code equal to 3, divide by total record count, *100
% Supplemental Claims	Count records with type claim code equal to 5, divide by total record count, *100
% Capitation Claims **	Count records with type claim code equal to 2 and MAX type of service = 20, 21, or 22, divide by total record count, *100
% Claims with NPI (not 0/8/9-filled, Excluding Capitation Claims)	Count records with 10-digit numeric NPI, excluding 0-fill, 8-fill, and 9-fill, divide by total record count excluding capitation claims, *100
% Claims with NPI = Servicing Provider ID (for claims with NPI)	Count records with 10-digit numeric NPI (excluding 0-fill, 8-fill, and 9-fill) equal to Servicing Provider ID, divide by count records with 10-digit numeric NPI (excluding 0-fill, 8-fill, and 9-fill), *100
% Claims with NPI = Billing Provider ID (for claims with NPI)	Count records with 10-digit numeric NPI (excluding 0-fill, 8-fill, and 9-fill) equal to Billing Provider ID, divide by count records with 10-digit numeric NPI (excluding 0-fill, 8-fill, and 9-fill), *100
% Claims with Provider Taxonomy (not 0/8/9-filled, Excluding Capitation Claims)	Count records with 10-character Taxonomy, excluding 0-fill, 8-fill, and 9-fill, divide by total record count excluding capitation claims, *100
Total FFS Claims	Count records with type claim code equal to 1
% Crossover	Among records with type claim code equal to 1, count records with Medicare crossover code - claim based - equal to 1, divide by total record count, *100
% Adjusted Claims	Among records with type claim code equal to 1, count records with adjustment code equal to 1 or 2, divide by total record count, *100
Avg Medicaid Paid, Adjusted Claims (Include $0)	Among records with type claim code equal to 1 and adjustment code equal to 1 or 2, sum total Medicaid amount paid, divide by total record count
% Claims with HMO Capitation Payment	Among records with type claim code equal to 1 or 2, count records with MAX type of service = 20, divide by total record count, *100
% Claims with PHP Capitation Payment	Among records with type claim code equal to 1 or 2, count records with MAX type of service = 21, divide by total record count, *100
% Claims with PCCM Capitation Payment	Among records with type claim code equal to 1 or 2, count records with MAX type of service = 22, divide by total record count, *100
Avg Medicaid Paid per HMO Capitation Claim	Among records with Medicaid amount paid > 0 and type claim code equal to 1 or 2, and MAX type of service = 20, sum Medicaid amount paid, divide by total record count

Measure	Measure Description
Avg Medicaid Paid per PHP Capitation Claim	Among records with Medicaid amount paid > 0 and type claim code equal to 1 or 2, and MAX type of service = 21, sum Medicaid amount paid, divide by total record count
Avg Medicaid Paid per PCCM Capitation Claim	Among records with Medicaid amount paid > 0 and type claim code equal to 1 or 2, and MAX type of service = 22, sum Medicaid amount paid, divide by total record count
# of Claims with Missing Medicaid Eligibility and > $0 Paid (Excludes S-CHIP Only)	Count records with missing eligibility data equal to 1
Avg Medicaid Paid for Claims with Missing Medicaid Eligibility and > $0 Paid (Excludes S-CHIP Only)	Among records with Medicaid amount paid > 0 and missing eligibility data equal to 1, sum total Medicaid amount paid, divide by total record count
# Claims with > $200,000 Paid	Count records with Medicaid amount paid > 200,000
# HMO or PACE Capitation Claims	Count records with type claim code equal to 2 and MAX type of service = 20
% with HMO or PACE Enrollment	Count records with managed care type of plan equal to 01 or 06, divide by total record count, * 100
% with PHP Enrollment	Count records with managed care type of plan equal to 02, 03, 04, 05, or 08, divide by total record count, * 100
% with PCCM Enrollment	Count records with managed care type of plan equal to 07, divide by total record count, * 100
% with Unknown Enrollment	Count records with managed care type of plan equal to 77 or 99, divide by total record count, * 100
# PHP Capitation Claims	Count records with type claim code equal to 2 and MAX type of service = 21
% with Dental PHP Enrollment	Count records with managed care type of plan equal to 02, divide by total record count, * 100
% with BHO PHP Enrollment	Count records with managed care type of plan equal to 03, divide by total record count, * 100
% with Prenatal PHP Enrollment	Count records with managed care type of plan equal to 04, divide by total record count, * 100
% with LTC PHP Enrollment	Count records with managed care type of plan equal to 05, divide by total record count, * 100
% with Other PHP Enrollment	Count records with managed care type of plan equal to 08, divide by total record count, * 100
% with PHP Enrollment	Count records with managed care type of plan equal to 02, 03, 04, 05, or 08, divide by total record count, * 100
% with HMO or PACE Enrollment	Count records with managed care type of plan equal to 01 or 06, divide by total record count, * 100

Measure	Measure Description
% with PCCM Enrollment	Count records with managed care type of plan equal to 07, divide by total record count, * 100
% with Unknown Enrollment	Count records with managed care type of plan equal to 77 or 99, divide by total record count, * 100
# PCCM Capitation Claims	Count records with type claim code equal to 2 and MAX type of service = 22
% with PCCM Enrollment	Count records with managed care type of plan equal to 07, divide by total record count, * 100
% with HMO or PACE Enrollment	Count records with managed care type of plan equal to 01 or 06, divide by total record count, * 100
% with PHP Enrollment	Count records with managed care type of plan equal to 02, 03, 04, 05, or 08, divide by total record count, * 100
% with Unknown Enrollment	Count records with managed care type of plan equal to 77 or 99, divide by total record count, * 100
# Encounter Claims	Count records with type claim code equal to 3
% Encounter Claims for HMO or PACE	Among records with type claim code equal to 3, count records with managed care type of plan = 01 or 06, divide by total record count, *100
% Encounter Claims for PHP	Among records with type claim code equal to 3, count records with managed care type of plan = 02, 03, 04, 05, 08, divide by total record count, *100
FFS Non-Crossover Claims (Type of Claim=1, Crossover Claim Indicator=0)	
Total Number of Claims	Count records
% Claims with > $0 Paid	Count records with Medicaid amount paid > 0, divide by total record count, *100
% Claims with < $0 Paid	Count records with Medicaid amount paid < 0, divide by total record count, *100
% Claims with Span Bill	Count records with service end date > service begin date, divide by total record count, *100
% Outpatient Claims with Span Bill	Among records with MAX type of service equal to 11, count records with service end date > service begin date, divide by total record count, *100
% Home Health Claims with Span Bill	Among records with MAX type of service equal to 13, count records with service end date > service begin date, divide by total record count, *100
% Other Claims with Span Bill	Among records with MAX type of service not equal to 11 and 13, count records with service end date > service begin date, divide by total record count, *100

Measure	Measure Description
% Waiver Claims (PGM TYPE = 6,7) with Span Bill	Among records with program type = 6 or 7, count records with service end date > service begin date, divide by total record count, *100
% CLTC Claims (Excluding CLTC Flag = 16-20) with Span Bill	Among records with CLTC flag > 0 but excluding values 16 through 20, count records with service end date > service begin date, divide by total record count, *100
% Claims with Servicing Provider ID = Billing Provider ID	Count records with servicing provider ID = billing provider ID and servicing provider ID not equal to spaces, 0-fill, 8-fill or 9-fill, divide by total record count, *100
PLACE OF SERVICE	
% Claims with Place of Service	Count records with place of service not equal to 0, 8-fill, or 9-fill, divide by total record count, *100
% Claims with Place of Service = Office (PLC OF SVC CD = 11)	Count records with place of service equal to 11, divide by total record count, *100
% Claims with Place of Service = Home (PLC OF SVC CD = 12)	Count records with place of service equal to 12, divide by total record count, *100
% Claims with Place of Service = Hospital (PLC OF SVC CD = 21)	Count records with place of service equal to 21, divide by total record count, *100
% Claims with Place of Service = Nursing Facility (PLC OF SVC CD = 32)	Count records with place of service equal to 32, divide by total record count, *100
% Claims with Place of Service = Inpatient Psychiatric (PLC OF SVC CD = 51)	Count records with place of service equal to 51, divide by total record count, *100
% Claims with Place of Service = ICF/MR (PLC OF SVC CD = 54)	Count records with place of service equal to 54, divide by total record count, *100
% Claims with Place of Service = Psychiatric Residential (PLC OF SVC CD = 56)	Count records with place of service equal to 56, divide by total record count, *100
% Claims with Place of Service = Emergency Room (PLC OF SVC CD = 23)	Count records with place of service equal to 23, divide by total record count, *100
% Claims with Place of Service = Outpatient (PLC OF SVC CD = 22)	Count records with place of service equal to 22, divide by total record count, *100
% Claims with Place of Service = Unknown/Other (PLC OF SVC CD = 99)	Count records with place of service equal to 99, divide by total record count, *100
THIRD-PARTY LIABILITY	
% Claims with TPL	Count records with third-party payment amount > 0, divide by total record count, *100
Avg TPL Paid for Claims with TPL	Among records with third-party payment amount > 0, sum third-party payment amount, divide by total record count

Measure	Measure Description
PERCENT OF CLAIMS BY MAX TYPE OF SERVICE	
Physician Services (MAX TOS = 08)	Count records with MAX type of service equal to 08, divide by total record count, *100
Dental Services (MAX TOS = 09)	Count records with MAX type of service equal to 09, divide by total record count, *100
Other Practitioner Services (MAX TOS = 10)	Count records with MAX type of service equal to 10, divide by total record count, *100
Outpatient Services (MAX TOS = 11)	Count records with MAX type of service equal to 11, divide by total record count, *100
Clinic Services (MAX TOS = 12)	Count records with MAX type of service equal to 12, divide by total record count, *100
Home Health Services (MAX TOS = 13)	Count records with MAX type of service equal to 13, divide by total record count, *100
Lab/Xray Services (MAX TOS = 15)	Count records with MAX type of service equal to 15, divide by total record count, *100
Drugs (MAX TOS = 16)	Count records with MAX type of service equal to 16, divide by total record count, *100
Other Services (MAX TOS = 19)	Count records with MAX type of service equal to 19, divide by total record count, *100
Durable Medical Equipment (MAX TOS = 51)	Count records with MAX type of service equal to 51, divide by total record count, *100
Transportation Services (MAX TOS = 26)	Count records with MAX type of service equal to 26, divide by total record count, *100
Sterilizations (MAX TOS = 24)	Count records with MAX type of service equal to 24, divide by total record count, *100
Abortions (MAX TOS = 25)	Count records with MAX type of service equal to 25, divide by total record count, *100
Personal Care Services (MAX TOS = 30)	Count records with MAX type of service equal to 30, divide by total record count, *100
Targeted Case Management (MAX TOS = 31)	Count records with MAX type of service equal to 31, divide by total record count, *100
Rehabilitation Services (MAX TOS = 33)	Count records with MAX type of service equal to 33, divide by total record count, *100
PT/OT/Hearing/Speech Services (MAX TOS = 34)	Count records with MAX type of service equal to 34, divide by total record count, *100

Measure	Measure Description
Hospice Services (MAX TOS = 35)	Count records with MAX type of service equal to 35, divide by total record count, *100
Nurse Midwife Services (MAX TOS = 36)	Count records with MAX type of service equal to 36, divide by total record count, *100
Nurse Practitioner Services (MAX TOS = 37)	Count records with MAX type of service equal to 37, divide by total record count, *100
Private Nursing Services (MAX TOS = 38)	Count records with MAX type of service equal to 38, divide by total record count, *100
Religious Non-Medical Services (MAX TOS = 39)	Count records with MAX type of service equal to 39, divide by total record count, *100
Residential Care Services (MAX TOS = 52)	Count records with MAX type of service equal to 52, divide by total record count, *100
Psychiatric Services (MAX TOS = 53)	Count records with MAX type of service equal to 53, divide by total record count, *100
Adult Day Care (MAX TOS = 54)	Count records with MAX type of service equal to 54, divide by total record count, *100
Unknown Services (MAX TOS = 99)	Count records with MAX type of service equal to 99, divide by total record count, *100
AVERAGE MEDICAID AMOUNT PAID BY MAX TYPE OF SERVICE (CLAIMS WITH >$0 PAID)	
Total	Among records with Medicaid amount paid > 0, sum total Medicaid amount paid, divide by total record count
Physician Services (MAX TOS = 08)	Among records with Medicaid amount paid > 0 and MAX type of service = 08, sum total Medicaid amount paid, divide by total record count
Dental Services (MAX TOS = 09)	Among records with Medicaid amount paid > 0 and MAX type of service = 09, sum total Medicaid amount paid, divide by total record count
Other Practitioner Services (MAX TOS = 10)	Among records with Medicaid amount paid > 0 and MAX type of service = 10, sum total Medicaid amount paid, divide by total record count
Outpatient Services (MAX TOS = 11)	Among records with Medicaid amount paid > 0 and MAX type of service = 11, sum total Medicaid amount paid, divide by total record count
Clinic Services (MAX TOS = 12)	Among records with Medicaid amount paid > 0 and MAX type of service = 12, sum total Medicaid amount paid, divide by total record count
Home Health Services (MAX TOS = 13)	Among records with Medicaid amount paid > 0 and MAX type of service = 13, sum total Medicaid amount paid, divide by total record count
Lab/Xray Services (MAX TOS = 15)	Among records with Medicaid amount paid > 0 and MAX type of service = 15, sum total Medicaid amount paid, divide by total record count

Measure	Measure Description
Drugs (MAX TOS = 16)	Among records with Medicaid amount paid > 0 and MAX type of service = 16, sum total Medicaid amount paid, divide by total record count
Other Services (MAX TOS = 19)	Among records with Medicaid amount paid > 0 and MAX type of service = 19, sum total Medicaid amount paid, divide by total record count
Durable Medical Equipment (MAX TOS = 51)	Among records with Medicaid amount paid > 0 and MAX type of service = 51, sum total Medicaid amount paid, divide by total record count
Transportation Services (MAX TOS = 26)	Among records with Medicaid amount paid > 0 and MAX type of service = 26, sum total Medicaid amount paid, divide by total record count
Personal Care Services (MAX TOS = 30)	Among records with Medicaid amount paid > 0 and MAX type of service = 30, sum total Medicaid amount paid, divide by total record count
Targeted Case Management (MAX TOS = 31)	Among records with Medicaid amount paid > 0 and MAX type of service = 31, sum total Medicaid amount paid, divide by total record count
Rehabilitation Services (MAX TOS = 33)	Among records with Medicaid amount paid > 0 and MAX type of service = 33, sum total Medicaid amount paid, divide by total record count
PT/OT/Hearing/Speech Services (MAX TOS = 34)	Among records with Medicaid amount paid > 0 and MAX type of service = 34, sum total Medicaid amount paid, divide by total record count
Hospice Services (MAX TOS = 35)	Among records with Medicaid amount paid > 0 and MAX type of service = 35, sum total Medicaid amount paid, divide by total record count
Residential Care Services (MAX TOS = 52)	Among records with Medicaid amount paid > 0 and MAX type of service = 52, sum total Medicaid amount paid, divide by total record count
Psychiatric Services (MAX TOS = 53)	Among records with Medicaid amount paid > 0 and MAX type of service = 53, sum total Medicaid amount paid, divide by total record count
Adult Day Care (MAX TOS = 54)	Among records with Medicaid amount paid > 0 and MAX type of service = 54, sum total Medicaid amount paid, divide by total record count
PERCENT OF CLAIMS BY PROGRAM TYPE	
Family Planning (PGM TYPE = 2)	Count records with type of program equal to 2, divide by total record count, *100
Rural Health Clinic (PGM TYPE = 3)	Count records with type of program equal to 3, divide by total record count, *100
Federally Qualified Health Center (PGM TYPE = 4)	Count records with type of program equal to 4, divide by total record count, *100
Indian Health Services (PGM TYPE = 5)	Count records with type of program equal to 5, divide by total record count, *100
Home and Community Based Waiver (PGM TYPE = 6,7)	Count records with type of program equal to 6 or 7, divide by total record count, *100

Measure	Measure Description
AVERAGE EXPENDITURES BY PROGRAM TYPE	
Family Planning (PGM TYPE = 2)	Among records with Medicaid amount paid > 0 and type of program equal to 2, sum total Medicaid amount paid, divide by total record count
Rural Health Clinic (PGM TYPE = 3)	Among records with Medicaid amount paid > 0 and type of program equal to 3, sum total Medicaid amount paid, divide by total record count
Federally Qualified Health Center (PGM TYPE = 4)	Among records with Medicaid amount paid > 0 and type of program equal to 4, sum total Medicaid amount paid, divide by total record count
Indian Health Services (PGM TYPE = 5)	Among records with Medicaid amount paid > 0 and type of program equal to 5, sum total Medicaid amount paid, divide by total record count
Home and Community Based Waiver (PGM TYPE = 6,7)	Among records with Medicaid amount paid > 0 and type of program equal to 6 or 7, sum total Medicaid amount paid, divide by total record count
DIAGNOSIS AND PROCEDURE CODES	
% Claims with Primary Diagnosis Code	Count records with first diagnosis code not equal to spaces, 0-fill, 8-fill, 9-fill, divide by total record count, *100
% Physician, Outpatient, or Clinic Claims with Primary Diagnosis Code	Among records with MAX type of service = 08, 11, or 12, count records with first diagnosis code not equal to spaces, 0-fill, 8-fill, 9-fill, divide by total record count, *100
% Primary Diagnosis Claims with Secondary Diagnosis Code	Among records with first diagnosis code not equal to spaces, 0-fill, 8-fill, 9-fill,, count records with second diagnosis code not equal to spaces, 0-fill, 8-fill, 9-fill, divide by total record count, *100
% Primary Diagnosis Code Claims with Length = 3	Among records with first diagnosis code not equal to spaces, 0-fill, 8-fill, 9-fill , count records with first diagnosis code equal to 3 digits, divide by total record count, *100
% Primary Diagnosis Code Claims with Length = 4	Among records with first diagnosis code not equal to spaces, 0-fill, 8-fill, 9-fill , count records with first diagnosis code equal to 4 digits, divide by total record count, *100
% Primary Diagnosis Code Claims with Length = 5	Among records with first diagnosis code not equal to spaces, 0-fill, 8-fill, 9-fill , count records with first diagnosis code equal to 5 digits, divide by total record count, *100
% Claims with Procedure Code	Count records with procedure (service) code not equal to spaces, 0-fill, 8-fill, 9-fill, divide by total record count, *100
% Outpatient Claims with Procedure Code or UB-92 Revenue Code	Among records with MAX type of service equal to 11, count records with procedure (service) code not equal to spaces, 0-fill, 8-fill, 9-fill and UB-92 revenue code not equal to spaces, 0-fill, 8-fill, 9-fill, divide by total record count, *100
% Home Health Claims with Procedure Code or UB-92 Revenue Code	Among records with MAX type of service equal to 13, count records with procedure (service) code not equal to spaces, 0-fill, 8-fill, 9-fill and UB-92 revenue code not equal to spaces, 0-fill, 8-fill, 9-fill, divide by total record count, *100
% Waiver Claims (PGM TYPE = 6,7) with Procedure Code	Among records with type of program equal to 6 or 7, count records with procedure (service) code not equal to spaces, 0-fill, 8-fill, 9-fill, divide by total record count, *100
% CLTC Claims (Excluding CLTC Flag = 16-20) with Procedure Code	Among records with CLTC flag > 0 but excluding values 16 through 20, count records with procedure (service) code not equal to spaces, 0-fill, 8-fill, 9-fill, divide by total record count, *100

Measure	Measure Description
% Other Claims with Procedure Code	Among records with MAX type of service not equal to 11 and 13, count records with procedure (service) code not equal to spaces, 0-fill, 8-fill, 9-fill, divide by total record count, *100
% Claims with Procedure Code with CPT-4 Indicator	Among records with procedure (service) code not equal to spaces, 0-fill, 8-fill, 9-fill, count records with procedure coding system code equal to 01, divide by total record count, *100
% Claims with Procedure Code with HCPCS (II & III) Indicator	Among records with procedure (service) code not equal to spaces, 0-fill, 8-fill, 9-fill, count records with procedure coding system code equal to 06, divide by total record count, *100
% with Procedure Code with Other National Indicator	Among records with procedure (service) code not equal to spaces, 0-fill, 8-fill, 9-fill, count records with procedure coding system code equal to 02, 03, 04, 05, 07, 08, or 09, divide by total record count, *100
% with Procedure Code with State-Specific Indicator	Among records with procedure (service) code not equal to spaces, 0-fill, 8-fill, 9-fill, count records with procedure coding system code equal to 10 through 87, divide by total record count, *100
% CPT-4 Indicator Claims with CPT-4 Format = 5 Digits	Among records with procedure (service) code not equal to spaces, 0-fill, 8-fill, 9-fill and procedure coding system code equal to 01, count records with procedure (service) code equal to 5 digits, divide by total record count, *100
% HCPCS (II & III) Indicator Claims with HCPCS Format = Either 1 Character and 4 Digits or 2 Characters and 3 Digits	Among records with procedure (service) code not equal to spaces, 0-fill, 8-fill, 9-fill and procedure coding system code equal to 06, count records with procedure (service) code equal to Cnnnn or CCnnn, divide by total record count, *100 Cnnnn = 1 character and 4 digits CCnnn = 2 characters and 3 digits
PHYSICIAN SPECIALTY	
% Physician Claims with Physician Specialty	Among records with MAX type of service equal to 08, count records with provider specialty code not equal to spaces, divide by total record count, *100
PERCENT OF CLAIMS BY CLTC CODE	
Not a CLTC Claim (CLTC FLAG = 00)	Count records with community-based long-term care flag equal to 00, divide by total record count, *100
CLTC Non-Waiver Claims (CLTC FLAG = 11-20)	Count records with community-based long-term care flag equal to 11 through 20, divide by total record count, *100
CLTC Non-Waiver Personal Care (CLTC FLAG = 11)	Count records with community-based long-term care flag equal to 11, divide by total record count, *100
CLTC Non-Waiver Private Duty Nurse (CLTC FLAG = 12)	Count records with community-based long-term care flag equal to 12, divide by total record count, *100
CLTC Non-Waiver Adult Day Care (CLTC FLAG = 13)	Count records with community-based long-term care flag equal to 13, divide by total record count, *100
CLTC Non-Waiver Home Health (CLTC FLAG = 14)	Count records with community-based long-term care flag equal to 14, divide by total record count, *100
CLTC Non-Waiver Residential Care (CLTC FLAG = 15)	Count records with community-based long-term care flag equal to 15, divide by total record count, *100
CLTC Non-Waiver Rehabilitation (CLTC FLAG = 16)	Count records with community-based long-term care flag equal to 16, divide by total record count, *100

Measure	Measure Description
CLTC Non-Waiver Targeted Case Management (CLTC FLAG = 17)	Count records with community-based long-term care flag equal to 17, divide by total record count, *100
CLTC Non-Waiver Transportation (CLTC FLAG = 18)	Count records with community-based long-term care flag equal to 18, divide by total record count, *100
CLTC Non-Waiver Hospice (CLTC FLAG = 19)	Count records with community-based long-term care flag equal to 19, divide by total record count, *100
CLTC Non-Waiver Durable Medical Equipment (CLTC FLAG = 20)	Count records with community-based long-term care flag equal to 20, divide by total record count, *100
CLTC Waiver Claims (CLTC FLAG = 30-40)	Count records with community-based long-term care flag equal to 30 through 40, divide by total record count, *100
CLTC Other Waiver (CLTC FLAG = 30)	Count records with community-based long-term care flag equal to 30, divide by total record count, *100
CLTC Waiver Personal Care (CLTC FLAG = 31)	Count records with community-based long-term care flag equal to 31, divide by total record count, *100
CLTC Waiver Private Duty Nurse (CLTC FLAG = 32)	Count records with community-based long-term care flag equal to 32, divide by total record count, *100
CLTC Waiver Adult Day Care (CLTC FLAG = 33)	Count records with community-based long-term care flag equal to 33, divide by total record count, *100
CLTC Waiver Home Health (CLTC FLAG = 34)	Count records with community-based long-term care flag equal to 34, divide by total record count, *100
CLTC Waiver Residential Care (CLTC FLAG = 35)	Count records with community-based long-term care flag equal to 35, divide by total record count, *100
CLTC Waiver Rehabilitation (CLTC FLAG = 36)	Count records with community-based long-term care flag equal to 36, divide by total record count, *100
CLTC Waiver Targeted Case Management (CLTC FLAG = 37)	Count records with community-based long-term care flag equal to 37, divide by total record count, *100
CLTC Waiver Transportation (CLTC FLAG = 38)	Count records with community-based long-term care flag equal to 38, divide by total record count, *100
CLTC Waiver Hospice (CLTC FLAG = 39)	Count records with community-based long-term care flag equal to 39, divide by total record count, *100
CLTC Waiver Durable Medical Equipment (CLTC FLAG = 40)	Count records with community-based long-term care flag equal to 40, divide by total record count, *100
FFS Crossover Claims (Type of Claim=1, Crossover Claim Indicator=1)	
Total Number of Claims	Count records

Measure	Measure Description
% Claims with > $0 Paid	Count records with Medicaid amount paid > 0, divide by total record count, *100
% Claims with < $0 Paid	Count records with Medicaid amount paid < 0, divide by total record count, *100
Avg Medicaid Paid (Claims with > $0 Paid)	Among records with Medicaid amount paid > 0, sum total Medicaid amount paid, divide by total record count
% Claims with Span Bill	Count records with service end date > service begin date, divide by total record count, *100
% Outpatient Claims with Span Bill	Among records with MAX type of service equal to 11, count records with service end date > service begin date, divide by total record count, *100
% Home Health Claims with Span Bill	Among records with MAX type of service equal to 13, count records with service end date > service begin date, divide by total record count, *100
% Other Claims with Span Bill	Among records with MAX type of service not equal to 11 and 13, count records with service end date > service begin date, divide by total record count, *100
PERCENT OF CLAIMS BY MAX TYPE OF SERVICE (EXCLUDING 20-22)	
Physician Services (MAX TOS = 08)	Count records with MAX type of service equal to 08, divide by total record count, *100
Other Practitioner Services (MAX TOS = 10)	Count records with MAX type of service equal to 10, divide by total record count, *100
Outpatient Services (MAX TOS = 11)	Count records with MAX type of service equal to 11, divide by total record count, *100
Clinic Services (MAX TOS = 12)	Count records with MAX type of service equal to 12, divide by total record count, *100
Home Health Services (MAX TOS = 13)	Count records with MAX type of service equal to 13, divide by total record count, *100
Lab/Xray Services (MAX TOS = 15)	Count records with MAX type of service equal to 15, divide by total record count, *100
Other Services (MAX TOS = 19)	Count records with MAX type of service equal to 19, divide by total record count, *100
Durable Medical Equipment (MAX TOS = 51)	Count records with MAX type of service equal to 51, divide by total record count, *100
Transportation Services (MAX TOS = 26)	Count records with MAX type of service equal to 26, divide by total record count, *100
Personal Care Services (MAX TOS = 30)	Count records with MAX type of service equal to 30, divide by total record count, *100

Measure	Measure Description
Targeted Case Management (MAX TOS = 31)	Count records with MAX type of service equal to 31, divide by total record count, *100
Rehabilitation Services (MAX TOS = 33)	Count records with MAX type of service equal to 33, divide by total record count, *100
PT/OT/Hearing/Speech Services (MAX TOS = 34)	Count records with MAX type of service equal to 34, divide by total record count, *100
Hospice Services (MAX TOS = 35)	Count records with MAX type of service equal to 35, divide by total record count, *100
Residential Care Services (MAX TOS = 52)	Count records with MAX type of service equal to 52, divide by total record count, *100
Psychiatric Services (MAX TOS = 53)	Count records with MAX type of service equal to 53, divide by total record count, *100
Adult Day Care (MAX TOS = 54)	Count records with MAX type of service equal to 54, divide by total record count, *100
DIAGNOSIS AND PROCEDURE CODES	
% Claims with Primary Diagnosis Code	Count records with first diagnosis code not equal to spaces, 0-fill, 8-fill, 9-fill, divide by total record count, *100
% Physician, Outpatient, or Clinic Claims with Primary Diagnosis Code	Among records with MAX type of service = 08, 11, or 12, count records with first diagnosis code not equal to spaces, 0-fill, 8-fill, 9-fill, divide by total record count, *100
% Primary Diagnosis Claims with Secondary Diagnosis Code	Among records with first diagnosis code not equal to spaces, 0-fill, 8-fill, 9-fill,, count records with second diagnosis code not equal to spaces, 0-fill, 8-fill, 9-fill, divide by total record count, *100
% Primary Diagnosis Code Claims with Length = 3	Among records with first diagnosis code not equal to spaces, 0-fill, 8-fill, 9-fill , count records with first diagnosis code equal to 3 digits, divide by total record count, *100
% Primary Diagnosis Code Claims with Length = 4	Among records with first diagnosis code not equal to spaces, 0-fill, 8-fill, 9-fill , count records with first diagnosis code equal to 4 digits, divide by total record count, *100
% Primary Diagnosis Code Claims with Length = 5	Among records with first diagnosis code not equal to spaces, 0-fill, 8-fill, 9-fill , count records with first diagnosis code equal to 5 digits, divide by total record count, *100
% Claims with Procedure Code	Count records with procedure (service) code not equal to spaces, 0-fill, 8-fill, 9-fill, divide by total record count, *100
% Outpatient Claims with Procedure Code or UB-92 Revenue Code	Among records with MAX type of service equal to 11, count records with procedure (service) code not equal to spaces, 0-fill, 8-fill, 9-fill and UB-92 revenue code not equal to spaces, 0-fill, 8-fill, 9-fill, divide by total record count, *100
% Home Health Claims with Procedure Code or UB-92 Revenue Code	Among records with MAX type of service equal to 13, count records with procedure (service) code not equal to spaces, 0-fill, 8-fill, 9-fill and UB-92 revenue code not equal to spaces, 0-fill, 8-fill, 9-fill, divide by total record count, *100
% Other Claims with Procedure Code	Among records with MAX type of service not equal to 11 and 13, count records with procedure (service) code not equal to spaces, 0-fill, 8-fill, 9-fill, divide by total record count, *100

Measure	Measure Description
% Claims with Procedure Code with CPT-4 Indicator	Among records with procedure (service) code not equal to spaces, 0-fill, 8-fill, 9-fill, count records with procedure coding system code equal to 01, divide by total record count, *100
% Claims with Procedure Code with HCPCS (II & III) Indicator	Among records with procedure (service) code not equal to spaces, 0-fill, 8-fill, 9-fill, count records with procedure coding system code equal to 06, divide by total record count, *100
% with Procedure Code with Other Code Indicator	Among records with procedure (service) code not equal to spaces, 0-fill, 8-fill, 9-fill, count records with procedure coding system code equal to 02 through 87, divide by total record count, *100
PERCENT OF CLAIMS BY CLTC CODE	
Not a CLTC Claim (CLTC FLAG = 00)	Count records with community-based long-term care flag equal to 00, divide by total record count, *100
CLTC Non-Waiver Claims (CLTC FLAG = 11-20)	Count records with community-based long-term care flag equal to 11 through 20, divide by total record count, *100
CLTC Non-Waiver Claims (CLTC Flag = 11-15)	Count records with community-based long-term care flag equal to 11 through 15, divide by total record count, *100
CLTC Waiver Claims (CLTC FLAG = 30-40)	Count records with community-based long-term care flag equal to 30 through 40, divide by total record count, *100
Encounter Claims (Type of Claim=3)	
Total Number of Claims	Count encounter records (type claim code equal to 3)
% Aged	Count encounter records with MAX uniform eligibility code - month of service equal to 11, 21, 31, 41, or 51, divide by total record count, *100
% Disabled	Count encounter records with MAX uniform eligibility code - month of service equal to 12, 22, 32, 3A, 42, or 52, divide by total record count, *100
% Child	Count encounter records with MAX uniform eligibility code - month of service equal to 14, 16, 24, 34, 44, 48, or 54, divide by total record count, *100
% Adult	Count encounter records with MAX uniform eligibility code - month of service equal to 15, 17, 25, 35, 45, or 55, divide by total record count, *100
% Claims with > $0 Prepaid Plan Service Value	Count encounter records with Prepaid Plan Service Value > 0, divide by total record count, *100
% Claims with Span Bill	Count encounter records with service end date > service begin date, divide by total record count, *100
% Outpatient Claims with Span Bill	Among encounter records with MAX type of service equal to 11, count records with service end date > service begin date, divide by total record count, *100
% Home Health Claims with Span Bill	Among encounter records with MAX type of service equal to 13, count records with service end date > service begin date, divide by total record count, *100

Measure	Measure Description
% Other Claims with Span Bill	Among encounter records with MAX type of service not equal to 11 and 13, count records with service end date > service begin date, divide by total record count, *100
PERCENT OF CLAIMS BY MAX TYPE OF SERVICE (EXCLUDING 20-22)	
Physician Services (MAX TOS = 08)	Count encounter records with MAX type of service equal to 08, divide by total record count, *100
Dental Services (MAX TOS = 09)	Count encounter records with MAX type of service equal to 09, divide by total record count, *100
Other Practitioner Services (MAX TOS = 10)	Count encounter records with MAX type of service equal to 10, divide by total record count, *100
Outpatient Services (MAX TOS = 11)	Count encounter records with MAX type of service equal to 11, divide by total record count, *100
Clinic Services (MAX TOS = 12)	Count encounter records with MAX type of service equal to 12, divide by total record count, *100
Home Health Services (MAX TOS = 13)	Count encounter records with MAX type of service equal to 13, divide by total record count, *100
Lab/Xray Services (MAX TOS = 15)	Count encounter records with MAX type of service equal to 15, divide by total record count, *100
Drugs (MAX TOS = 16)	Count encounter records with MAX type of service equal to 16, divide by total record count, *100
Other Services (MAX TOS = 19)	Count encounter records with MAX type of service equal to 19, divide by total record count, *100
Durable Medical Equipment (MAX TOS = 51)	Count encounter records with MAX type of service equal to 51, divide by total record count, *100
Transportation Services (MAX TOS = 26)	Count encounter records with MAX type of service equal to 26, divide by total record count, *100
Sterilizations (MAX TOS = 24)	Count encounter records with MAX type of service equal to 24, divide by total record count, *100
Abortions (MAX TOS = 25)	Count encounter records with MAX type of service equal to 25, divide by total record count, *100
Personal Care Services (MAX TOS = 30)	Count encounter records with MAX type of service equal to 30, divide by total record count, *100
Targeted Case Management (MAX TOS = 31)	Count encounter records with MAX type of service equal to 31, divide by total record count, *100
Rehabilitation Services (MAX TOS = 33)	Count encounter records with MAX type of service equal to 33, divide by total record count, *100

Measure	Measure Description
PT/OT/Hearing/Speech Services (MAX TOS = 34)	Count encounter records with MAX type of service equal to 34, divide by total record count, *100
Hospice Services (MAX TOS = 35)	Count encounter records with MAX type of service equal to 35, divide by total record count, *100
Nurse Midwife Services (MAX TOS = 36)	Count encounter records with MAX type of service equal to 36, divide by total record count, *100
Nurse Practitioner Services (MAX TOS = 37)	Count encounter records with MAX type of service equal to 37, divide by total record count, *100
Private Nursing Services (MAX TOS = 38)	Count encounter records with MAX type of service equal to 38, divide by total record count, *100
Religious Non-Medical Services (MAX TOS = 39)	Count encounter records with MAX type of service equal to 39, divide by total record count, *100
Residential Care Services (MAX TOS = 52)	Count encounter records with MAX type of service equal to 52, divide by total record count, *100
Psychiatric Services (MAX TOS = 53)	Count encounter records with MAX type of service equal to 53, divide by total record count, *100
Adult Day Care (MAX TOS = 54)	Count encounter records with MAX type of service equal to 54, divide by total record count, *100
Unknown Services (MAX TOS = 99)	Count encounter records with MAX type of service equal to 99, divide by total record count, *100
DIAGNOSIS AND PROCEDURE CODES	
% Claims with Primary Diagnosis Code	Count encounter records with principal diagnosis code not equal to spaces, 0-fill, 8-fill, 9-fill, divide by total record count, *100
% Physician, Outpatient, or Clinic Claims with Primary Diagnosis Code	Among encounter records with MAX type of service = 08, 11, or 12, count records with first diagnosis code not equal to spaces, 0-fill, 8-fill, 9-fill, divide by total record count, *100
% Primary Diagnosis Claims with Secondary Diagnosis Code	Among encounter records with first diagnosis code not equal to spaces, 0-fill, 8-fill, 9-fill,, count records with second diagnosis code not equal to spaces, 0-fill, 8-fill, 9-fill, divide by total record count, *100
% Claims with Procedure Code	Count encounter records with procedure (service) code not equal to spaces, 0-fill, 8-fill, 9-fill, divide by total record count, *100
% Outpatient Claims with Procedure Code or UB-92 Revenue Code	Among encounter records with MAX type of service equal to 11, count records with procedure (service) code not equal to spaces, 0-fill, 8-fill, 9-fill and UB-92 revenue code not equal to spaces, 0-fill, 8-fill, 9-fill, divide by total record count, *100
% Home Health Claims with Procedure Code or UB-92 Revenue Code	Among encounter records with MAX type of service equal to 13, count records with procedure (service) code not equal to spaces, 0-fill, 8-fill, 9-fill and UB-92 revenue code not equal to spaces, 0-fill, 8-fill, 9-fill, divide by total record count, *100
% Other Claims with Procedure Code	Among encounter records with MAX type of service not equal to 11 and 13, count records with procedure (service) code not equal to spaces, 0-fill, 8-fill, 9-fill, divide by total record count, *100

Measure	Measure Description
% Claims with Procedure Code with CPT-4 Indicator	Among encounter records with procedure (service) code not equal to spaces, 0-fill, 8-fill, 9-fill, count records with procedure coding system code equal to 01, divide by total record count, *100
% Claims with Procedure Code with HCPCS (II & III) Indicator	Among encounter records with procedure (service) code not equal to spaces, 0-fill, 8-fill, 9-fill, count records with procedure coding system code equal to 06, divide by total record count, *100
% with Procedure Code with Other Code Indicator	Among encounter records with procedure (service) code not equal to spaces, 0-fill, 8-fill, 9-fill, count records with procedure coding system code equal to 02 through 87, divide by total record count, *100

Measure	Measure Description
All RX Claims	
Total Number of RX MSIS Quarters	Total number of RX MSIS quarters included in MAX production. We include 7 quarters, when available, to allow adjustment records to update the original claim.
Total Number of Claims	Count records in the file
% Encounter Claims	Count records with type claim code equal to 3, divide by total record count, *100
% Supplemental Claims	Count records with type claim code equal to 5, divide by total record count, *100
% Claims with NPI (not 0/8/9-filled)	Count records with 10-digit numeric NPI, excluding 0-fill, 8-fill, and 9-fill, divide by total record count, *100
% Claims with NPI = Billing Provider ID (for claims with NPI)	Count records with 10-digit numeric NPI (excluding 0-fill, 8-fill, and 9-fill) equal to Billing Provider ID, divide by count records with 10-digit numeric NPI (excluding 0-fill, 8-fill, and 9-fill), *100
% Claims with Provider Taxonomy (not 0/8/9-filled)	Count records with 10-character Taxonomy, excluding 0-fill, 8-fill, and 9-fill, divide by total record count, *100
Total FFS Claims	Count records with type claim code equal to 1, divide by total record count
% Adjusted Claims	Among records with type claim code equal to 1, count records with adjustment code equal to 1 or 2, divide by total record count, *100
Avg Medicaid Paid, Adjusted Claims (Include $0)	Among records with type claim code equal to 1 and adjustment code equal to 1 or 2, sum total Medicaid amount paid, divide by total record count
# of Claims with Missing Medicaid Eligibility and > $0 Paid (Excludes S-CHIP Only)	Count records with missing eligibility data equal to 1
Avg Medicaid Paid for Claims with Missing Medicaid Eligibility and > $0 Paid (Excludes S-CHIP Only)	Among records with Medicaid amount paid > 0 and missing eligibility data equal to 1, sum total Medicaid amount paid, divide by total record count
# Claims with > $200,000 Paid	Count records with Medicaid amount paid > 200,000
% Section 1915(c) Waiver Claims (PGM TYPE = 6, 7)	Count records with type of program equal to 6 or 7, divide by total record count, *100
Total Medicaid Paid among Section 1915(c) Waiver Claims (PGM TYPE = 6, 7)	Sum total Medicaid payments (where Program Type = 6 or 7)
FFS Claims (Type of Claim=1)	
Total Number of Claims	Count records

Measure	Measure Description
% Claims with > $0 Paid	Count records with Medicaid amount paid > 0, divide by total record count, *100
% Claims with < $0 Paid	Count records with Medicaid amount paid < 0, divide by total record count, *100
Avg Medicaid Paid (Claims with > $0 Paid)	Among records with Medicaid amount paid > 0, sum total Medicaid amount paid, divide by total record count
% Claims with TPL	Count records with third-party payment amount > 0, divide by total record count, *100
Avg TPL Paid for Claims with TPL	Among records with third-party payment amount > 0, sum third-party payment amount, divide by total record count
% Family Planning Claims (PGM TYPE = 2)	Count records with type of program equal to 2, divide by total record count, *100
% Drug Claims (MAX TOS = 16)	Count records with MAX type of service equal to 16, divide by total record count, *100
% Durable Medical Equipment Claims (MAX TOS = 51)	Count records with MAX type of service equal to 51 and quantity of service equal to 0, 8-fill or 9-fill, divide by total record count, *100
% Drug Claims with Prescribing Physician	Among records with MAX type of service equal to 16, count records with Prescribing Physician ID number not equal to spaces, 0-fill, 8-fill or 9-fill, divide by total record count, *100
% Drug Claims with Date Prescribed	Among records with MAX type of service equal to 16, count records with prescribed date not equal to 0, 8-fill or 9-fill, divide by total record count, *100
% Drug Claims with Quantity	Among records with MAX type of service equal to 16, count records with quantity of service not equal to 0, 8-fill or 9-fill, divide by total record count, *100
% Drug Claims with Days Supply	Among records with MAX type of service equal to 16, count records with days supply quantity not equal to 0, 8-fill or 9-fill, divide by total record count, *100
DRUG CLASSIFICATION	
% Claims with Medispan	Count records with Medi-span therapeutic classification system code not equal to spaces, divide by total record count, *100
% Claims with Generic Therapeutic Class	Count records with therapeutic class code (generic) not equal to spaces, divide by total record count, *100
% Claims with Specific Therapeutic Class	Count records with therapeutic class code (specific) not equal to spaces, divide by total record count, *100
NDC CONFIGURATION INDICATOR	
% Prescription (NDC FMT IND = 0-3)	Count records with National Drug Code format indicator equal to 0, 1, 2, or 3, divide by total record count, *100

Measure	Measure Description
% Products (NDC FMT IND = 4-6)	Count records with National Drug Code format indicator equal to 4, 5, or 6, divide by total record count, *100
% Health Related Item (NDC FMT IND = 7)	Count records with National Drug Code format indicator equal to 7, divide by total record count, *100
% Claims with Clinical Formulation Identifier	Count records with clinical formulation Identifier not equal 0-fill, 8-fill, 9-fill, or spaces, divide by total record count, *100
% Claims with Ingredient List Identifier	Count records with ingredient list identifier not equal 0-fill, 8-fill, 9-fill, or spaces, divide by total record count, *100
% Claims with Hierarchical Specific Therapeutic Class Code Sequence Number	Count records with hierarchical specific therapeutic class code sequence number not equal 0-fill, 8-fill, 9-fill, or spaces, divide by total record count, *100
% Claims with Over-the-Counter Drug Class	Count records with drug class code equal to 'O', divide by total record count, *100
% Claims with Prescription Drug Class	Count records with drug class code equal to 'F', divide by total record count, *100
% Claims with Multiple Sources	Count records with multi-source code equal to 'Y', divide by total record count, *100
% Claims with Single Source (No Generic)	Count records with multi-source code equal to 'N', divide by total record count, *100
Encounter Claims (Type of Claim=3)	
Total Number of Claims	Count encounter records (type claim code equal to 3)
% Aged	Count encounter records with MAX uniform eligibility code - month of service equal to 11, 21, 31, 41, or 51, divide by total record count, *100
% Disabled	Count encounter records with MAX uniform eligibility code - month of service equal to 12, 22, 32, 3A, 42, or 52, divide by total record count, *100
% Child	Count encounter records with MAX uniform eligibility code - month of service equal to 14, 16, 24, 34, 44, 48, or 54, divide by total record count, *100
% Adult	Count encounter records with MAX uniform eligibility code - month of service equal to 15, 17, 25, 35, 45, or 55, divide by total record count, *100
% Claims with > 0 Prepaid Plan Service Value	Count encounter records with Prepaid Plan Service Value > 0, divide by total record count, *100
% Family Planning Claims (PGM TYPE = 2)	Count encounter records with MSIS type of program code equal to 02, divide by total record count, *100
% Drug Claims (MAX TOS = 16)	Count encounter records with MAX type of service equal to 16, divide by total record count, *100

Measure	Measure Description
% Durable Medical Equipment Claims (MAX TOS = 51)	Count encounter records with MAX type of service equal to 51, divide by total record count, *100
% Drug Claims with Prescribing Physician	Among encounter records with MAX type of service equal to 16, count records with Prescribing Physician ID number not equal to spaces, 0-fill, 8-fill or 9-fill, divide by total record count, *100
% Drug Claims with Date Prescribed	Among encounter records with MAX type of service equal to 16, count records with prescribed date not equal to 0, 8-fill or 9-fill, divide by total record count, *100
% Drug Claims with Quantity	Among encounter records with MAX type of service equal to 16, count records with quantity of service not equal to 0, 8-fill or 9-fill, divide by total record count, *100
% Drug Claims with Days Supply	Among encounter records with MAX type of service equal to 16, count records with days supply quantity not equal to 0, 8-fill or 9-fill, divide by total record count, *100
DRUG CLASSIFICATION	
% Claims with Medispan	Count encounter records with Medi-span therapeutic classification system code not equal to spaces, divide by total record count, *100
% Claims with Generic Therapeutic Class	Count encounter records with therapeutic class code (generic) not equal to spaces, divide by total record count, *100
% Claims with Specific Therapeutic Class	Count encounter records with therapeutic class code (specific) not equal to spaces, divide by total record count, *100
NDC CONFIGURATION INDICATOR	
% Prescription (NDC FMT IND = 0-3)	Count encounter records with National Drug Code format indicator equal to 0, 1, 2, or 3, divide by total record count, *100
% Products (NDC FMT IND = 4-6)	Count encounter records with National Drug Code format indicator equal to 4, 5, or 6, divide by total record count, *100
% Health Related Item (NDC FMT IND = 7)	Count encounter records with National Drug Code format indicator equal to 7, divide by total record count, *100
% Claims with Clinical Formulation Identifier	Count encounter records with clinical formulation Identifier not equal 0-fill, 8-fill, 9-fill, or spaces, divide by total record count, *100
% Claims with Ingredient List Identifier	Count encounter records with ingredient list identifier not equal 0-fill, 8-fill, 9-fill, or spaces, divide by total record count, *100
% Claims with Hierarchical Specific Therapeutic Class Code Sequence Number	Count encounter records with hierarchical specific therapeutic class code sequence number not equal 0-fill, 8-fill, 9-fill, or spaces, divide by total record count, *100
% Claims with Over-the-Counter Drug Class	Count encounter records with drug class code equal to 'O', divide by total record count, *100
% Claims with Prescription Drug Class	Count encounter records with drug class code equal to 'F', divide by total record count, *100

Measure	Measure Description
% Claims with Multiple Sources	Count encounter records with multi-source code equal to 'Y', divide by total record count, *100
% Claims with Single Source (No Generic)	Count encounter records with multi-source code equal to 'N', divide by total record count, *100

Measure	Measure Description
All Records	
Total Number of EL MSIS Quarters	Total number of EL MSIS quarters included in MAX production. We include 7 quarters, when available, to allow retroactive and correction records to be used. Many states do not submit them and therefore do not need more than 4 quarters.
Total Number of Records	Count records in the file
Total Medicaid Paid	Sum Medicaid amount paid
% with No Claims (RCPNT IND = 0)	Count records with recipient indicator equal to zero, divide by total record count, *100
% with FFS Only Claims (RCPNT IND = 1)	Count records with recipient indicator equal to 1, divide by total record count, *100
% with Only Capitation Claims (RCPNT IND = 2)	Count records with recipient indicator equal to 2, divide by total record count, *100
% with Only Encounter Claims (RCPNT IND = 3)	Count records with recipient indicator equal to 3, divide by total record count, *100
% with FFS and Capitation Claims (RCPNT IND = 4)	Count records with recipient indicator equal to 4, divide by total record count, *100
% with Capitation and Encounter Claims Only (RCPNT IND = 5)	Count records with recipient indicator equal to 5, divide by total record count, *100
% with FFS and Encounter Claims Only (RCPNT IND = 6)	Count records with recipient indicator equal to 6, divide by total record count, *100
% with FFS, Capitation, and Encounter Claims (RCPNT IND = 7)	Count records with recipient indicator equal to 7, divide by total record count, *100
# with Claims and Missing Medicaid Eligibility (Excludes S-CHIP Only)	Count records with missing eligibility data switch equal to 1
% with Claims and Missing Medicaid Eligibility (Excludes S-CHIP Only)	Count records with missing eligibility data switch equal to 1, divide by total record count, *100
Total Medicaid Paid for People Missing Medicaid Eligibility (Excludes S-CHIP Only Enrollees)	Sum Medicaid amount paid where the missing eligibility data switch equal to 1
Avg Medicaid Paid for People Missing Medicaid Eligibility (Excludes S-CHIP Only Enrollees)	Among records with missing eligibility data equal to 1, sum total Medicaid amount paid, divide by total record count

Measure	Measure Description
# with FFS Claims and Missing Medicaid Eligibility (Excludes S-CHIP Only)	Count records with missing eligibility data switch equal to 1 and recipient indicator equal to 1, 4, 6, or 7
% with FFS Claims and Missing Medicaid Eligibility (Excludes S-CHIP Only)	Count records with missing eligibility data switch equal to 1 and recipient indicator equal to 1, 4, 6, or 7, divide by total record count, *100
Total Medicaid Paid for People with FFS Claims and Missing Medicaid Eligibility (Excludes S-CHIP Only)	Sum Medicaid amount paid where the missing eligibility data switch equal to 1 and recipient indicator equal to 1, 4, 6, or 7
Avg Medicaid Paid for People with FFS Claims and Missing Medicaid Eligibility (Excludes S-CHIP Only)	Among records with missing eligibility data equal to 1 and recipient indicator equal to 1, 4, 6, or 7, sum total Medicaid amount paid, divide by total record count
S-CHIP ENROLLMENT	
# with ONLY S-CHIP Enrollment	Count records with at least 1 month with SCHIP code equal to 3 and no months with SCHIP codes equal to 1 or 2
% with ONLY S-CHIP Enrollment	Count records with at least 1 month with SCHIP code equal to 3 and no months with SCHIP codes equal to 1 or 2, divide by total record count, *100
# with ANY S-CHIP Enrollment	Count records with at least 1 month with SCHIP code equal to 3
% with ANY S-CHIP Enrollment	Count records with at least 1 month with SCHIP code equal to 3, divide by total record count, *100
Total Person-Years of Enrollment with ANY S-CHIP Enrollment	Number of months with SCHIP code equal to 3, divide by 12, sum over all records with at least 1 month with SCHIP code equal to 3
Total Medicaid Enrollees (excludes people with missing Medicaid eligibility information or S-CHIP only)	
Total Medicaid Enrollees	Count records
Total Medicaid Person-Years of Enrollment	Number of months of enrollment, divide by 12, sum over all records with at least one month of enrollment
# with Any M-CHIP Enrollment	Count records with at least 1 month with SCHIP code equal to 2
# Child (Age < 19 Years)	Count records with at least 1 month with CHIP code equal to 2 and age (as of Dec 31) < 19
# Adult (Age > 18 Years)	Count records with at least 1 month with CHIP code equal to 2 and age (as of Dec 31) > 18

Measure	Measure Description
% with ANY M-CHIP Enrollment	Count records with at least 1 month with CHIP code equal to 2, divide by total record count, *100
Total Person-Years of Enrollment Any M-CHIP	Number of months with SCHIP code equal to 2, divide by 12, sum over all records with at least 1 month with SCHIP code equal to 2
Demographic Characteristics	
% Records with Valid SSN Format	Count records with 9-digit numeric SSN, excluding 0-fill, 8-fill, and 9-fill, divide by total record count, *100
% Records Whose MSIS SSN Passed High Group Test (HGT FLAG = 1)	Count records with SSN High Group Test flag equal to 1, divide by total record count, *100
% Records Whose MSIS SSN Failed High Group Test Due to Invalid AAA (HGT FLAG = 2)	Count records with SSN High Group Test flag equal to 2, divide by total record count, *100
% Records Whose MSIS SSN Failed High Group Test Due to GG = 00 (HGT FLAG = 3)	Count records with SSN High Group Test flag equal to 3, divide by total record count, *100
% Records Whose MSIS SSN Failed High Group Test Due to SSSS = 0000 (HGT FLAG = 4)	Count records with SSN High Group Test flag equal to 4, divide by total record count, *100
% Records Whose MSIS SSN Failed High Group Test Due to GG Not Yet Issued (HGT FLAG = 5)	Count records with SSN High Group Test flag equal to 5, divide by total record count, *100
% Records Whose MSIS SSN Failed High Group Test Due to Railroad Retirement Number with Invalid DOB (HGT FLAG = 6)	Count records with SSN High Group Test flag equal to 6, divide by total record count, *100
# Records Without Valid SSN	Count records with SSN equal to spaces, 0-fill, 8-fill, 9-fill, or alphanumeric or SSN High Group Test flag > 1
% Records Without Valid SSN	Count records with SSN equal to spaces, 0-fill, 8-fill, 9-fill, or alphanumeric or SSN High Group Test flag > 1, divide by total record count, *100
% for Children Under Age 21	Count records with SSN equal to spaces, 0-fill, 8-fill, 9-fill, or alphanumeric or SSN High Group Test flag > 1 and age group code equal to 0, 1, 2, 3, divide by total records with SSN equal to spaces, 0-fill, 8-fill, 9-fill, or alphanumeric or SSN High Group Test flag > 1, * 100
% for Infants Under Age 1	Count records with SSN equal to spaces, 0-fill, 8-fill, 9-fill, or alphanumeric or SSN High Group Test flag > 1 and age group code equal to 0 divide by total records with SSN equal to spaces, 0-fill, 8-fill, 9-fill, or alphanumeric or SSN High Group Test flag > 1, * 100
% Ever Aliens Eligible for Only Emergency Services	Count records with SSN equal to spaces, 0-fill, 8-fill, 9-fill, or alphanumeric or SSN High Group Test flag > 1 and restricted benefits flag equal to 2 in at least one month divide by total records with SSN equal to spaces, 0-fill, 8-fill, 9-fill, or alphanumeric or SSN High Group Test flag > 1, * 100
% Ever Eligible for Only Family Planning Services	Count records with SSN equal to spaces, 0-fill, 8-fill, 9-fill, or alphanumeric or SSN High Group Test flag > 1 and restricted benefits flag equal to 6 in at least one month, divide by total records with SSN equal to spaces, 0-fill, 8-fill, 9-fill, or alphanumeric or SSN High Group Test flag > 1, * 100

Measure	Measure Description
# SSNs with More Than One MSIS ID	Count records with more than one MSIS ID per Social Security Number (SSN), excluding 0-fill, 8-fill, 9-fill SSNs
% Records with Duplicated SSNs	Count records with more than one MSIS ID per Social Security Number (SSN), excluding 0-fill, 8-fill, 9-fill SSNs, divide by total record count, *100
% for Children Under Age 21	Among records with more than one MSIS ID per Social Security Number (SSN), excluding 0-fill, 8-fill, 9-fill SSNs, count records with age group code equal to 0, 1, 2, or 3, divide by total record count, *100
% for Infants Under Age 1	Among records with more than one MSIS ID per Social Security Number (SSN), excluding 0-fill, 8-fill, 9-fill SSNs, count records with age group code equal to 0, divide by total record count, *100
% Ever Aliens Eligible for Only Emergency Services	Among records with more than one MSIS ID per Social Security Number (SSN), excluding 0-fill, 8-fill, 9-fill SSNs, count records with restricted benefits flag equal to 2 in at least one month, divide by total record count, *100
% Ever Eligible for Only Family Planning Services	Among records with more than one MSIS ID per Social Security Number (SSN), excluding 0-fill, 8-fill, 9-fill SSNs, count records with restricted benefits flag equal to 6 in at least one month, divide by total record count, *100
% with External SSN from EDB (EXT SSN SRCE = 1)	Count records with external SSN Source equal to 1, divide by total record count, *100
% with External SSN from State-Provided Cross-Reference File (EXT SSN SRCE = 2)	Count records with external SSN Source equal to 2, divide by total record count, *100
% with County Code	Count records with valid county code, divide by total record count, *100. Valid county code = 1, if county code has 3 digits and not equal to 0-fill, 8-fill, and 9-fill
% with Valid 5 Digit Zip Code Format	Count records with valid ZIP code, divide by total record count, *100 Valid ZIP code = 1, if ZIP code has 5 digits and not equal to 0-fill, 8-fill, and 9-fill
% White	Count records with race - White equal to 1, divide by total record count, *100
% Black	Count records with race - Black/African American equal to 1, divide by total record count, *100
% Native American/Alaskan Native	Count records with race - American Indian/Alaskan Native equal to 1, divide by total record count, *100
% Asian	Count records with race - Asian equal to 1, divide by total record count, *100
% Native Hawaiian or Other Pacific Islander	Count records with race - Native Hawaiian/Other Pacific Islander equal to 1, divide by total record count, *100
% More Than One Race	Count records with more than one race indicator equal to 1, divide by total record count, *100

Measure	Measure Description
% Unknown Race	Count records with all 5 race indicators equal to 0, divide by total record count, *100
% Hispanic/Latino (Included with Race Categories Prior to 2005)	Count records with ethnicity - Hispanic/Latino equal to 1, divide by total record count, *100
% of Hispanic/Latino with Unknown Race	Count records with ethnicity - Hispanic/Latino equal to 1 and all 5 race indicators equal to 0, divide by total record count, *100
% Age 0	Count records with age group code equal to 0, divide by total record count, *100
% Age 1-5	Count records with age group code equal to 1, divide by total record count, *100
% Age 6-18	Count records with 6 <= age (as of Dec 31) <=18, divide by total record count, *100
% Age 19-20	Count records with 19 <= age (as of Dec 31) <=20, divide by total record count, *100
% Age 21-44	Count records with age group code equal to 4, divide by total record count, *100
% Age 45-64	Count records with age group code equal to 5, divide by total record count, *100
% Age 65-74	Count records with age group code equal to 6, divide by total record count, *100
% Age 75-84	Count records with age group code equal to 7, divide by total record count, *100
% Age 85+	Count records with age group code equal to 8, divide by total record count, *100
# Age 0-18, Excluding Instititionalized	Count records with age (as of Dec 31) <=18, excluding those with ILTC claims (MAX TOS equal to 02, 04, 05, or 07)
# Age 19-20, Excluding Institutionalized	Count records with 19 <= age (as of Dec 31) <=20, excluding those with ILTC claims (MAX TOS equal to 02, 04, 05, or 07)
# Age 21-64, Excluding Institutionalized	Count records with 21 <= age (as of Dec 31) <=64, excluding those with ILTC claims (MAX TOS equal to 02, 04, 05, or 07)
# Age 65+, Excluding Institutionalized	Count records with age (as of Dec 31) >=65, excluding those with ILTC claims (MAX TOS equal to 02, 04, 05, or 07)

Measure	Measure Description
% with Century of Birth '18' , '19', '20'	Count records where birth date is between 1800 and 2099, inclusively, divide by total record count, *100
% with Gender Code 'M' or 'F'	Count records with sex code equal to M or F, divide by total record count, *100
% Female	Count records with gender code equal to F, divide by total record count, *100
% Male	Count records with gender code equal to M, divide by total record count, *100
% Enrollees with 12 Months Enrollment	Count records where the number of months enrolled equals 12, divide by total record count, *100
% Aged Enrollees with 12 Months Enrollment	Count records where the number of months enrolled equals 12 among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, divide by total records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, *100
% Disabled Enrollees with 12 Months Enrollment	Count records where the number of months enrolled equals 12 among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, divide by total records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, *100
% Child Enrollees with 12 Months Enrollment	Count records where the number of months enrolled equals 12 among records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54, divide by total records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54, *100
% Adult Enrollees with 12 Months Enrollment	Count records where the number of months enrolled equals 12 among records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55, divide by total records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55, *100
# with 0 Days but Positive Months of Enrollment	Count records where the number of months enrolled is >0, but the number of days enrolled = 0 for the year
% Enrollees with MSIS Date of Death During Year	Count records where MSIS date of death equals the MAX calendar year, divide by total record count, *100
% Enrollees with SSA Date of Death During Year	Count records where SSA date of death equals the MAX calendar year, divide by total record count, *100
% Enrollees with MSIS, SSA, or EDB Date of Death During Year	Count records where MSIS, SSA or Medicare (EDB) date of death equals the MAX calendar year, divide by total record count, *100
# with MSIS Date of Death not equal to SSA Date of Death	Count records where MSIS date of death not equal to SSA date of death, after recoding 88888888 and 99999999 to 0
# with MSIS Date of Death Prior to MAX CY	Count records where 0 < MSIS year of death < MAX calendar year
# with SSA Date of Death Prior to MAX CY	Count records where 0 < SSA year of death < MAX calendar year

Measure	Measure Description
% with SSA Death Prior to MAX CY Who Have $0 Medicaid Paid	Count records where Medicaid Paid = $0 among records where 0 < SSA year of death < MAX calendar year, divide by number of records where 0 < SSA year of death < MAX calendar year, * 100
EDB Dual Eligibles	
Total EDB Duals (Duals Confirmed by EDB)	Count records where Medicare Dual Code - Annual equals 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98
Total EDB Dual Person-Years of Enrollment	Number of months of enrollment, divide by 12, sum over all records with Medicare Dual Code - Annual equals 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 98
% Age > 64 Years Who Are EDB Duals	Count records where Medicare Dual Code - Annual equals 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, among records with age group equal to 6, 7, or 8, divide by total records with age group equal to 6, 7, or 8, *100
% Aged Groups (MAX ELIG CD = 11,21,31,41,51) Who Are EDB Duals	Count records where Medicare Dual Code - Annual equals 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, divide by total records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, *100
% Disabled Groups (MAX ELIG CD = 12,22,32,3A,42,52) Who Are EDB Duals	Count records where Medicare Dual Code - Annual equals 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, divide by total records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, *100
% EDB Dual Not Reported in MSIS (EDB DUAL = 50)	Count records where Medicare Dual Code - Annual equals 50, divide by total records with Medicare Dual Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, *100
% EDB QMB Only (EDB DUAL = 51)	Count records where Medicare Dual Code - Annual equals 51, divide by total records with Medicare Dual Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, *100
% EDB QMB Plus (EDB DUAL = 52)	Count records where Medicare Dual Code - Annual equals 52, divide by total records with Medicare Dual Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, *100
% EDB SLMB Only (EDB DUAL = 53)	Count records where Medicare Dual Code - Annual equals 53, divide by total records with Medicare Dual Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, *100
% EDB SLMB Plus (EDB DUAL = 54)	Count records where Medicare Dual Code - Annual equals 54, divide by total records with Medicare Dual Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, *100
% EDB QDWI (EDB DUAL = 55)	Count records where Medicare Dual Code - Annual equals 55, divide by total records with Medicare Dual Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, *100
% EDB QI-1 (EDB DUAL = 56)	Count records where Medicare Dual Code - Annual equals 56, divide by total records with Medicare Dual Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, *100
% EDB QI-2 (EDB DUAL = 57)	Count records where Medicare Dual Code - Annual equals 57, divide by total records with Medicare Dual Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, *100
% EDB Other (EDB DUAL = 58)	Count records where Medicare Dual Code - Annual equals 58, divide by total records with Medicare Dual Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, *100

Measure	Measure Description
% EDB Dual Type Unknown (EDB DUAL = 59)	Count records where Medicare Dual Code - Annual equals 59, divide by total records with Medicare Dual Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, *100
% EDB Dual Status Unknown (EDB DUAL = 98)	Count records where Medicare Dual Code - Annual equals 98, divide by total records with Medicare Dual Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, *100
% EDB Duals with Full Benefits (EDB DUAL = 50,52,54,58)	Count records where Medicare Dual Code - Annual equals 50, 52, 54, or 58, divide by total records with Medicare Dual Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, *100
% EDB Duals with Restricted Benefits (EDB DUAL = 51,53,55,56,57)	Count records where Medicare Dual Code - Annual equals 51, 53, 55, 56, or 57, divide by total records with Medicare Dual Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, *100
Total Non-EDB Duals (Duals Reported in MSIS, Not Found in EDB)	Count records where Medicare Dual Code - Annual equals 01, 02, 03, 04, 05, 06, 07, 08, or 09
% Non-EDB Duals Without Valid SSN	Count records with invalid SSN, among records with Medicare Dual Code - Annual equals 01, 02, 03, 04, 05, 06, 07, 08, or 09, divide by total records with Medicare Dual Code - Annual equal to 01, 02, 03, 04, 05, 06, 07, 08, or 09, *100. Invalid SSN = 1, if SSN is not 9-digit numeric or 9-digit numeric and 0-fill, 8-fill, or 9-fill
% Non-EDB Duals Who Are Children/Adults	Count records of children and adults with Medicare Dual Code - Annual equals 01, 02, 03, 04, 05, 06, 07, 08, or 09, divide by total records with Medicare Dual Code - Annual equals 01, 02, 03, 04, 05, 06, 07, 08, or 09, *100. Children = 1, if MAX uniform eligibility code - most recent equals 14, 16, 24, 34, 44, 48, or 54 Adults = 1, if MAX uniform eligibility code - most recent equals 15, 17, 25, 35, 45, or 55
% EDB Duals with Spanish Language	Count records where Medicare Language code equals 'S', among records with Medicare Dual Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, divide by total records with Medicare Dual Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, *100
% EDB Duals - Female	Count records where gender code equals 'F', among records with Medicare Dual Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, divide by total records with Medicare Dual Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, *100
% EDB Duals - Male	Count records where gender code equals 'M', among records with Medicare Dual Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, divide by total records with Medicare Dual Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, *100
% EDB Duals with EDB Date of Death During Year	Count records where Medicare year of death equals MAX year, among records with Medicare Dual Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, divide by total records with Medicare Dual Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, *100
% EDB Duals with MSIS Date of Death During Year	Count records where MSIS year of death equals MAX year, among records with Medicare Dual Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, divide by total records with Medicare Dual Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, *100
% EDB Duals with SSA Date of Death During Year	Count records where SSA year of death equals MAX year, among records with Medicare Dual Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, divide by total records with Medicare Dual Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, *100
% EDB Duals with EDB, MSIS, or SSA Date of Death During Year	Count records where Medicare, MSIS, or SSA year of death equals MAX year, among records with Medicare Dual Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, divide by total records with Medicare Dual Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, *100
# EDB Duals with EDB Date of Death ≠ MSIS Date of Death	Count records where Medicare date of death not equal to MSIS date of death, after recoding 88888888 and 99999999 to 0, among records with Medicare Dual Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98
# EDB Duals with EDB Date of Death ≠ SSA Date of Death	Count records where Medicare year of death not equal to SSA date of death, after recoding 88888888 and 99999999 to 0, among records with Medicare Dual Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98

Measure	Measure Description
% EDB Duals with Medicaid Reported HIC	Count records with valid HIC, among records with Medicare Dual Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, divide by total records with Medicare Dual Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, *100 Valid HIC = 1, if length of Medicare HIC (from MSIS) > 1 and HIC <> 88888888, 99999999, 8888888888, 9999999999, 888888888888, and 999999999999
% EDB Duals with Medicaid Reported HIC = Medicare HIC	Count records where Medicare HIC (from MSIS) equals Medicare HIC (from EDB), among records with valid HIC and Medicare Dual Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, divide by total records with valid HIC and Medicare Dual Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, *100 Valid HIC = 1, if length of Medicare HIC (from MSIS) > 1 and Medicare HIC (from MSIS) <> 88888888, 99999999, 8888888888, 9999999999, 888888888888, and 999999999999
Total EDB Dual Enrollees in June	Count records where Medicare Beneficiary Code (June) = 1, 2, or 3, among records with Medicare Dual Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98
JUNE MEDICARE ELIGIBILITY GROUP	
June % with Part A Medicare Only	Count records where Medicare Beneficiary Code (June) = 1, among records with Medicare Beneficiary Code (June) = 1, 2, or 3, divide by total records with Medicare Beneficiary Code (June) = 1, 2, or 3, *100
June % with Part B Medicare Only	Count records where Medicare Beneficiary Code (June) = 2, among records with Medicare Beneficiary Code (June) = 1, 2, or 3, divide by total records with Medicare Beneficiary Code (June) = 1, 2, or 3, *100
June % Part A/B Medicare	Count records where Medicare Beneficiary Code (June) = 3, among records with Medicare Beneficiary Code (June) = 1, 2, or 3, divide by total records with Medicare Beneficiary Code (June) = 1, 2, or 3, *100
ORIGINAL REASON FOR MEDICARE ENTITLEMENT	
% Aged (MDCR ORIG REAS CD = 0)	Count records where Medicare Original Entitlement Reason = 0, among records with Medicare Original Entitlement Reason = 0, 1, 2, or 3, divide by total records with Medicare Original Entitlement Reason = 0, 1, 2, or 3, *100
% Disabled (MDCR ORIG REAS CD = 1)	Count records where Medicare Original Entitlement Reason = 1, among records with Medicare Original Entitlement Reason = 0, 1, 2, or 3, divide by total records with Medicare Original Entitlement Reason = 0, 1, 2, or 3, *100
% End Stage Renal Disease (MDCR ORIG REAS CD = 2)	Count records where Medicare Original Entitlement Reason = 2, among records with Medicare Original Entitlement Reason = 0, 1, 2, or 3, divide by total records with Medicare Original Entitlement Reason = 0, 1, 2, or 3, *100
% Disabled with End Stage Renal Disease (MDCR ORIG REAS CD = 3)	Count records where Medicare Original Entitlement Reason = 3, among records with Medicare Original Entitlement Reason = 0, 1, 2, or 3, divide by total records with Medicare Original Entitlement Reason = 0, 1, 2, or 3, *100
Other Eligibility Characteristics (All Enrollees)	
% Aged Groups (MAX ELIG CD = 11,21,31,41,51) Who Are > 64 Years	Count records with age group equal to 6, 7, or 8, among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, divide by total records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, *100
% Disabled Groups (MAX ELIG CD = 12,22,32,3A,42,52) Who Are > 64 Years	Count records with age group equal to 6, 7, or 8, among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, divide by total records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, *100

Measure	Measure Description
% Child Groups (MAX ELIG CD = 14,16, 24, 34, 44, 48, 54) Who Are < 21 Years	Count records with age group equal to 0, 1, 2, or 3, among records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54, divide by total records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54, *100
% Adult Groups (MAX ELIG CD = 15,17,25,35,45,55) Who Are > 20 Years	Count records with age group equal to 4, 5, 6, 7, or 8, among records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55, divide by total records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55, *100
% MAX 1115 Expansion Enrollees (MAX ELIG CD = 51,52,54,55) with 1115 Waiver Enrollment (WVR TYPE = 1,5,6,A,F)	Count records with waiver type (in any month in any waiver) = 1, 5, 6, A, or F, among records with MAX uniform eligibility code - most recent equal to 51, 52, 54, or 55, divide by total records with MAX uniform eligibility code - most recent equal to 51, 52, 54, or 55, *100
JUNE % MAX 1115 Expansion Group (MAX ELIG CD = 51,52,54,55) with 1115 Waiver Enrollment (WVR TYPE = 1,5,6,A, F)	Count records with waiver type (June) = 1, 5, 6, A, or F, among records with MAX uniform eligibility code (June) equal to 51, 52, 54, or 55, divide by total records with MAX uniform eligibility code (June) equal to 51, 52, 54, or 55, *100
% MAX 1115 Waiver Enrollees (WVR TYPE = 1,5,6,A,F) in MAX 1115 Expansion Group (MAX ELIG CD = 51,52,54,55)	Count records with MAX uniform eligibility code - most recent equal to 51, 52, 54, or 55, among records with waiver type (in any month in any waiver) = 1, 5, 6, A, or F, divide by total records with waiver type (in any month in any waiver) = 1, 5, 6, A, or F, *100
JUNE % MAX 1115 Waiver Enrollees (WVR TYPE = 1,5,6,A,F) in MAX 1115 Expansion Group (MAX ELIG CD = 51,52,54,55)	Count records with MAX uniform eligibility code (June) equal to 51, 52, 54, or 55, among records with wiaver type (June) = 1, 5, 6, A, or F, divide by total records with waiver type (June) = 1, 5, 6, A, or, 5, * 100
Aged Total	Count records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51
Aged, Cash (MAX ELIG CD = 11)	Count records with MAX uniform eligibility code - most recent equal to 11
Aged, Medically Needy (MAX ELIG CD = 21)	Count records with MAX uniform eligibility code - most recent equal to 21
Aged, Poverty (MAX ELIG CD = 31)	Count records with MAX uniform eligibility code - most recent equal to 31
Other Aged (MAX ELIG CD = 41)	Count records with MAX uniform eligibility code - most recent equal to 41
1115 Aged (MAX ELIG CD = 51)	Count records with MAX uniform eligibility code - most recent equal to 51
Disabled Total	Count records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52
Disabled, Cash (MAX ELIG CD = 12)	Count records with MAX uniform eligibility code - most recent equal to 12

Measure	Measure Description
Disabled, Medically Needy (MAX ELIG CD = 22)	Count records with MAX uniform eligibility code - most recent equal to 22
Disabled, Poverty (MAX ELIG CD = 32, 3A)	Count records with MAX uniform eligibility code - most recent equal to 32 or 3A
Other Disabled (MAX ELIG CD = 42)	Count records with MAX uniform eligibility code - most recent equal to 42
1115 Disabled (MAX ELIG CD = 52)	Count records with MAX uniform eligibility code - most recent equal to 52
Child Total	Count records with external SSN Source equal to 1, divide by total record count, *100
AFDC Child, Cash (MAX ELIG CD = 14)	Count records with MAX uniform eligibility code - most recent equal to 14
AFDC-U Child, Cash (MAX ELIG CD = 16)	Count records with MAX uniform eligibility code - most recent equal to 16
AFDC Child, Medically Needy (MAX ELIG CD = 24)	Count records with MAX uniform eligibility code - most recent equal to 24
Child Poverty (MAX ELIG CD = 34)	Count records with MAX uniform eligibility code - most recent equal to 34
Other Child (MAX ELIG CD = 44)	Count records with MAX uniform eligibility code - most recent equal to 44
Foster Care Child (MAX ELIG CD = 48)	Count records with MAX uniform eligibility code - most recent equal to 48
1115 Child (MAX ELIG CD = 54)	Count records with MAX uniform eligibility code - most recent equal to 54
Adult Total	Count records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55
AFDC Adult, Cash (MAX ELIG CD = 15)	Count records with MAX uniform eligibility code - most recent equal to 15
AFDC-U Adult, Cash (MAX ELIG CD = 17)	Count records with MAX uniform eligibility code - most recent equal to 17
AFDC Adult, Medically Needy (MAX ELIG CD = 25)	Count records with MAX uniform eligibility code - most recent equal to 25

Measure	Measure Description
Adult, Poverty (MAX ELIG CD = 35)	Count records with MAX uniform eligibility code - most recent equal to 35
Other Adult (MAX ELIG CD = 45)	Count records with MAX uniform eligibility code - most recent equal to 45
1115 Adult (MAX ELIG CD = 55)	Count records with MAX uniform eligibility code - most recent equal to 55
Long-Term Care Enrollees	
INSTITUTIONAL STATUS	
# with Any ILTC FFS Claims (Includes NF, ICF/MR, Aged Mental Hospital, IP Psych Age < 21 years, MAX TOS = 02, 04, 05, 07)	Count records with ILTC FFS claims ILTC claims = 1, if total Medicaid Fee-for-Service payment amount (for MAX TOS equal to 02, 04, 05, or 07) > 0
% Enrollees with Any ILTC FFS Claims	Count records with ILTC FFS claims, divide by total record count, *100 ILTC claims = 1, if total Medicaid Fee-for-Service payment amount (for MAX TOS equal to 02, 04, 05, or 07) > 0
% Aged Enrollees with Any ILTC FFS Claims	Count records with ILTC FFS claims, among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, divide by total records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, *100 ILTC claims = 1, if total Medicaid Fee-for-Service payment amount (for MAX TOS equal to 02, 04, 05, or 07) > 0
% Disabled Enrollees with Any ILTC FFS Claims	Count records with ILTC FFS claims, among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, divide by total records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, *100 ILTC claims = 1, if total Medicaid Fee-for-Service payment amount (for MAX TOS equal to 02, 04, 05, or 07) > 0
% Child Enrollees with Any ILTC FFS Claims	Count records with ILTC FFS claims, among records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54, divide by total records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54, *100 ILTC claims = 1, if total Medicaid Fee-for-Service payment amount (for MAX TOS equal to 02, 04, 05, or 07) > 0
% Adult Enrollees with Any ILTC FFS Claims	Count records with ILTC FFS claims, among records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55, divide by total records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55, *100 ILTC claims = 1, if total Medicaid Fee-for-Service payment amount (for MAX TOS equal to 02, 04, 05, or 07) > 0
COMMUNITY LONG-TERM CARE STATUS	
# with Any CLTC FFS Claims (Excludes CLTC FLAG = 16-20)	Count records with CLTC FFS claims CLTC claims = 1, if total Medicaid Fee-for-Service payment amount (for CLTC code = 11, 12, 13, 14, 15, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, or 40) > 0

Measure	Measure Description
% Enrollees with Any CLTC FFS Claims (Excludes CLTC FLAG = 16-20)	Count records with CLTC FFS claims, divide by total record count, *100 CLTC claims = 1, if total Medicaid Fee-for-Service payment amount (for CLTC code = 11, 12, 13, 14, 15, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, or 40) > 0
% Aged Enrollees with Any CLTC FFS Claims (Excludes CLTC FLAG = 16-20)	Count records with CLTC FFS claims, among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, divide by total records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, *100 CLTC claims = 1, if total Medicaid Fee-for-Service payment amount (for CLTC code = 11, 12, 13, 14, 15, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, or 40) > 0
% Disabled Enrollees with Any CLTC FFS Claims (Excludes CLTC FLAG = 16-20)	Count records with CLTC FFS claims, among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, divide by total records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, *100 CLTC claims = 1, if total Medicaid Fee-for-Service payment amount (for CLTC code = 11, 12, 13, 14, 15, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, or 40) > 0
% Child Enrollees with Any CLTC FFS Claims (Excludes CLTC FLAG = 16-20)	Count records with CLTC claims, among records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54, divide by total records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54, *100 CLTC claims = 1, if total Medicaid Fee-for-Service payment amount (for CLTC code = 11, 12, 13, 14, 15, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, or 40) > 0
% Adult Enrollees with Any CLTC FFS Claims (Excludes CLTC FLAG = 16-20)	Count records with CLTC claims, among records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55, divide by total records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55, *100 CLTC claims = 1, if total Medicaid Fee-for-Service payment amount (for CLTC code = 11, 12, 13, 14, 15, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, or 40) > 0
# with ILTC FFS Claims and CLTC FFS Claims (Excludes CLTC FLAG = 16-20)	Count records with ILTC FFS claims and CLTC FFS claims ILTC claims = 1, if total Medicaid Fee-for-Service payment amount (for MAX TOS equal to 02, 04, 05, or 07) > 0 CLTC claims = 1, if total Medicaid Fee-for-Service payment amount (for CLTC code = 11, 12, 13, 14, 15, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, or 40) > 0
# Ever Enrolled in Section 1915(c) Waiver or with Any CLTC FFS Claims (Excludes CLTC FLAG = 16-20)	Count records with 1915(c) waiver or CLTC FFS claims 1915(c) waiver = 1, if 1915(c) waiver type - most recent equal to G, H, I, J, K, L, M, N, O, or P CLTC claims = 1, if total Medicaid Fee-for-Service payment amount (for CLTC code = 11, 12, 13, 14, 15, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, or 40) > 0
SECTION 1915(c) WAIVER ENROLLMENT - MOST RECENT	
# Ever Enrolled in Any Section 1915(c) Waiver (WVR TYPE = G-P)	Count records with 1915(c) waiver type - most recent equal to G, H, I, J, K, L, M, N, O, or P
% Enrolled in Any Section 1915(c) Waiver	Count records with 1915(c) waiver type - most recent equal to G, H, I, J, K, L, M, N, O, or P, divide by total record count, *100

Measure	Measure Description
% Aged Enrollees in Section 1915(c) Waiver	Count records with Section 1915(c) waiver- most recent equal to G, H, I, J, K, L, M, N, O, or P, among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, divide by total records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, *100
% Disabled Enrollees in Section 1915(c) Waiver	Count records with Section 1915(c) waiver- most recent equal to G, H, I, J, K, L, M, N, O, or P, among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, divide by total records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, *100
% Child Enrollees in Section 1915(c) Waiver	Count records with Section 1915(c) waiver- most recent equal to G, H, I, J, K, L, M, N, O, or P, among records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54, divide by total records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54, *100
% Adult Enrollees in Section 1915(c) Waiver	Count records with Section 1915(c) waiver- most recent equal to G, H, I, J, K, L, M, N, O, or P, among records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55, divide by total records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55, *100
# Aged, EDB Dual	Count records with Section 1915(c) waiver- most recent equal to G, H, I, J, K, L, M, N, O, or P and MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51 and Medicare Dual Code - Annual equals 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98
# Aged, Non-Dual	Count records with Section 1915(c) waiver- most recent equal to G, H, I, J, K, L, M, N, O, or P and MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51 and Medicare Dual Code - Annual equals 00, 01, 02, 03, 04, 05, 06, 07, 08, 09, or 99
# Disabled, EDB Dual	Count records with Section 1915(c) waiver- most recent equal to G, H, I, J, K, L, M, N, O, or P and MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52 and Medicare Dual Code - Annual equals 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98
# Disabled, Non-Dual	Count records with Section 1915(c) waiver- most recent equal to G, H, I, J, K, L, M, N, O, or P and MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52 and Medicare Dual Code - Annual equals 00, 01, 02, 03, 04, 05, 06, 07, 08, 09, or 99
# Other (Child or Adult)	Count records with Section 1915(c) waiver- most recent equal to G, H, I, J, K, L, M, N, O, or P and MAX uniform eligibility code - most recent equal to 14, 15, 16, 17, 24, 25, 34, 35, 44, 45, 48, 54, or 55
# with Section 1915(c) Waiver for Aged and Disabled (WVR TYPE = G)	Count records with Section 1915(c) waiver- most recent equal to G
# Aged, EDB Dual	Count records with Section 1915(c) waiver- most recent equal to G and MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51 and Medicare Dual Code - Annual equals 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98
# Aged, Non-Dual	Count records with Section 1915(c) waiver- most recent equal to G and MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51 and Medicare Dual Code - Annual equals 00, 01, 02, 03, 04, 05, 06, 07, 08, 09, or 99
# Disabled, EDB Dual	Count records with Section 1915(c) waiver- most recent equal to G and MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52 and Medicare Dual Code - Annual equals 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98
# Disabled, Non-Dual	Count records with Section 1915(c) waiver- most recent equal to G and MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52 and Medicare Dual Code - Annual equals 00, 01, 02, 03, 04, 05, 06, 07, 08, 09, or 99

Measure	Measure Description
# Other (Child or Adult)	Count records with Section 1915(c) waiver- most recent equal to G and MAX uniform eligibility code - most recent equal to 14, 15, 16, 17, 24, 25, 34, 35, 44, 45, 48, 54, or 55
# with Section 1915(c) Waiver for Aged (WVR TYPE = H)	Count records with Section 1915(c) waiver- most recent equal to H
# Aged, EDB Dual	Count records with Section 1915(c) waiver- most recent equal to H and MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51 and Medicare Dual Code - Annual equals 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98
# Aged, Non-Dual	Count records with Section 1915(c) waiver- most recent equal to H and MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51 and Medicare Dual Code - Annual equals 00, 01, 02, 03, 04, 05, 06, 07, 08, 09, or 99
# Disabled, EDB Dual	Count records with Section 1915(c) waiver- most recent equal to H and MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52 and Medicare Dual Code - Annual equals 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98
# Disabled, Non-Dual	Count records with Section 1915(c) waiver- most recent equal to H and MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52 and Medicare Dual Code - Annual equals 00, 01, 02, 03, 04, 05, 06, 07, 08, 09, or 99
# Other (Child or Adult)	Count records with Section 1915(c) waiver- most recent equal to H and MAX uniform eligibility code - most recent equal to 14, 15, 16, 17, 24, 25, 34, 35, 44, 45, 48, 54, or 55
# with Section 1915(c) Waiver for Physically Disabled (WVR TYPE = I)	Count records with Section 1915(c) waiver- most recent equal to I
# Aged, EDB Dual	Count records with Section 1915(c) waiver- most recent equal to I and MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51 and Medicare Dual Code - Annual equals 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98
# Aged, Non-Dual	Count records with Section 1915(c) waiver- most recent equal to I and MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51 and Medicare Dual Code - Annual equals 00, 01, 02, 03, 04, 05, 06, 07, 08, 09, or 99
# Disabled, EDB Dual	Count records with Section 1915(c) waiver- most recent equal to I and MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52 and Medicare Dual Code - Annual equals 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98
# Disabled, Non-Dual	Count records with Section 1915(c) waiver- most recent equal to I and MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52 and Medicare Dual Code - Annual equals 00, 01, 02, 03, 04, 05, 06, 07, 08, 09, or 99
# Other (Child or Adult)	Count records with Section 1915(c) waiver- most recent equal to I and MAX uniform eligibility code - most recent equal to 14, 15, 16, 17, 24, 25, 34, 35, 44, 45, 48, 54, or 55
# with Section 1915(c) Waiver for People with Brain Injuries (WVR TYPE = J)	Count records with Section 1915(c) waiver- most recent equal to J
# Aged, EDB Dual	Count records with Section 1915(c) waiver- most recent equal to J and MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51 and Medicare Dual Code - Annual equals 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98
# Aged, Non-Dual	Count records with Section 1915(c) waiver- most recent equal to J and MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51 and Medicare Dual Code - Annual equals 00, 01, 02, 03, 04, 05, 06, 07, 08, 09, or 99

Measure	Measure Description
# Disabled, EDB Dual	Count records with Section 1915(c) waiver- most recent equal to J and MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52 and Medicare Dual Code - Annual equals 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98
# Disabled, Non-Dual	Count records with Section 1915(c) waiver- most recent equal to J and MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52 and Medicare Dual Code - Annual equals 00, 01, 02, 03, 04, 05, 06, 07, 08, 09, or 99
# Other (Child or Adult)	Count records with Section 1915(c) waiver- most recent equal to J and MAX uniform eligibility code - most recent equal to 14, 15, 16, 17, 24, 25, 34, 35, 44, 45, 48, 54, or 55
# with Section 1915(c) Waiver for People with HIV/AIDS (WVR TYPE = K)	Count records with Section 1915(c) waiver- most recent equal to K
# Aged, EDB Dual	Count records with Section 1915(c) waiver- most recent equal to K and MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51 and Medicare Dual Code - Annual equals 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98
# Aged, Non-Dual	Count records with Section 1915(c) waiver- most recent equal to K and MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51 and Medicare Dual Code - Annual equals 00, 01, 02, 03, 04, 05, 06, 07, 08, 09, or 99
# Disabled, EDB Dual	Count records with Section 1915(c) waiver- most recent equal to K and MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52 and Medicare Dual Code - Annual equals 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98
# Disabled, Non-Dual	Count records with Section 1915(c) waiver- most recent equal to K and MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52 and Medicare Dual Code - Annual equals 00, 01, 02, 03, 04, 05, 06, 07, 08, 09, or 99
# Other (Child or Adult)	Count records with Section 1915(c) waiver- most recent equal to K and MAX uniform eligibility code - most recent equal to 14, 15, 16, 17, 24, 25, 34, 35, 44, 45, 48, 54, or 55
# with Section 1915(c) Waiver for People with MR/DD (WVR TYPE = L)	Count records with Section 1915(c) waiver- most recent equal to L
# Aged, EDB Dual	Count records with Section 1915(c) waiver- most recent equal to L and MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51 and Medicare Dual Code - Annual equals 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98
# Aged, Non-Dual	Count records with Section 1915(c) waiver- most recent equal to L and MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51 and Medicare Dual Code - Annual equals 00, 01, 02, 03, 04, 05, 06, 07, 08, 09, or 99
# Disabled, EDB Dual	Count records with Section 1915(c) waiver- most recent equal to L and MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52 and Medicare Dual Code - Annual equals 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98
# Disabled, Non-Dual	Count records with Section 1915(c) waiver- most recent equal to L and MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52 and Medicare Dual Code - Annual equals 00, 01, 02, 03, 04, 05, 06, 07, 08, 09, or 99
# Other (Child or Adult)	Count records with Section 1915(c) waiver- most recent equal to L and MAX uniform eligibility code - most recent equal to 14, 15, 16, 17, 24, 25, 34, 35, 44, 45, 48, 54, or 55
# with Section 1915(c) Waiver for People with MI/SED (WVR TYPE = M)	Count records with Section 1915(c) waiver- most recent equal to M

Measure	Measure Description
# Aged, EDB Dual	Count records with Section 1915(c) waiver- most recent equal to M and MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51 and Medicare Dual Code - Annual equals 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98
# Aged, Non-Dual	Count records with Section 1915(c) waiver- most recent equal to M and MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51 and Medicare Dual Code - Annual equals 00, 01, 02, 03, 04, 05, 06, 07, 08, 09, or 99
# Disabled, EDB Dual	Count records with Section 1915(c) waiver- most recent equal to M and MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52 and Medicare Dual Code - Annual equals 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98
# Disabled, Non-Dual	Count records with Section 1915(c) waiver- most recent equal to M and MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52 and Medicare Dual Code - Annual equals 00, 01, 02, 03, 04, 05, 06, 07, 08, 09, or 99
# Other (Child or Adult)	Count records with Section 1915(c) waiver- most recent equal to M and MAX uniform eligibility code - most recent equal to 14, 15, 16, 17, 24, 25, 34, 35, 44, 45, 48, 54, or 55
# with Section 1915(c) Waiver for Tech Dependent/Medically Fragile (WVR TYPE = N)	Count records with Section 1915(c) waiver- most recent equal to N
# Aged, EDB Dual	Count records with Section 1915(c) waiver- most recent equal to N and MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51 and Medicare Dual Code - Annual equals 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98
# Aged, Non-Dual	Count records with Section 1915(c) waiver- most recent equal to N and MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51 and Medicare Dual Code - Annual equals 00, 01, 02, 03, 04, 05, 06, 07, 08, 09, or 99
# Disabled, EDB Dual	Count records with Section 1915(c) waiver- most recent equal to N and MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52 and Medicare Dual Code - Annual equals 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98
# Disabled, Non-Dual	Count records with Section 1915(c) waiver- most recent equal to N and MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52 and Medicare Dual Code - Annual equals 00, 01, 02, 03, 04, 05, 06, 07, 08, 09, or 99
# Other (Child or Adult)	Count records with Section 1915(c) waiver- most recent equal to N and MAX uniform eligibility code - most recent equal to 14, 15, 16, 17, 24, 25, 34, 35, 44, 45, 48, 54, or 55
# with Section 1915(c) Waiver for People with Autism/ASD (WVR TYPE = P)	Count records with Section 1915(c) waiver- most recent equal to P
# Aged, EDB Dual	Count records with Section 1915(c) waiver- most recent equal to P and MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51 and Medicare Dual Code - Annual equals 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98
# Aged, Non-Dual	Count records with Section 1915(c) waiver- most recent equal to P and MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51 and Medicare Dual Code - Annual equals 00, 01, 02, 03, 04, 05, 06, 07, 08, 09, or 99
# Disabled, EDB Dual	Count records with Section 1915(c) waiver- most recent equal to P and MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52 and Medicare Dual Code - Annual equals 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98
# Disabled, Non-Dual	Count records with Section 1915(c) waiver- most recent equal to P and MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52 and Medicare Dual Code - Annual equals 00, 01, 02, 03, 04, 05, 06, 07, 08, 09, or 99

Measure	Measure Description
# Other (Child or Adult)	Count records with Section 1915(c) waiver- most recent equal to P and MAX uniform eligibility code - most recent equal to 14, 15, 16, 17, 24, 25, 34, 35, 44, 45, 48, 54, or 55
# with Section 1915(c) Waiver for Unspecified or Unknown Populations (WVR TYPE = O)	Count records with Section 1915(c) waiver- most recent equal to O
# Aged, EDB Dual	Count records with Section 1915(c) waiver- most recent equal to O and MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51 and Medicare Dual Code - Annual equals 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98
# Aged, Non-Dual	Count records with Section 1915(c) waiver- most recent equal to O and MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51 and Medicare Dual Code - Annual equals 00, 01, 02, 03, 04, 05, 06, 07, 08, 09, or 99
# Disabled, EDB Dual	Count records with Section 1915(c) waiver- most recent equal to O and MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52 and Medicare Dual Code - Annual equals 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98
# Disabled, Non-Dual	Count records with Section 1915(c) waiver- most recent equal to O and MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52 and Medicare Dual Code - Annual equals 00, 01, 02, 03, 04, 05, 06, 07, 08, 09, or 99
# Other (Child or Adult)	Count records with Section 1915(c) waiver- most recent equal to O and MAX uniform eligibility code - most recent equal to 14, 15, 16, 17, 24, 25, 34, 35, 44, 45, 48, 54, or 55
% of Section 1915(c) Waiver Enrollees with No Waiver claim (PGM TYPE = 6 or 7)	Count records with HCBS Aged (program type 6) record count = 0 and HCBS Waiver (program type 7) record count = 0, among records with Section 1915(c) waiver- most recent equal to G, H, I, J, K, L, M, N, O, or P, divide by total records with Section 1915(c) waiver- most recent equal to G, H, I, J, K, L, M, N, O, or P, *100
% of Section 1915(c) Claim (PGM TYPE = 6 or 7) Recipients with No Waiver Enrollment	Count records with Section 1915(c) waiver- most recent not equal to G, H, I, J, K, L, M, N, O, or P, among records with HCBS Aged (program type 6) record count > 0 or HCBS Waiver (program type 7) record count > 0, divide by total records with HCBS Aged (program type 6) record count > 0 or HCBS Waiver (program type 7) record count > 0, *100
% of Section 1915(c) Waiver Enrollees with Any HMO/HIO Enrollment	Count records with months of Comprehensive Managed Care Plan or PACE > 0, among records with Section 1915(c) waiver- most recent equal to G, H, I, J, K, L, M, N, O, or P, divide by total records with Section 1915(c) waiver- most recent equal to G, H, I, J, K, L, M, N, O, or P, *100
% of Section 1915(c) Waiver Enrollees not Enrolled in HMOs/ HIOs with No Waiver claim (PGM TYPE = 6 or 7)	Count records with no months of Comprehensive Managed Care Plan or PACE and HCBS Aged (program type 6) record count = 0 and HCBS Waiver (program type 7) record count = 0, among records with Section 1915(c) waiver- most recent equal to G, H, I, J, K, L, M, N, O, or P, divide by total records with Section 1915(c) waiver- most recent equal to G, H, I, J, K, L, M, N, O, or P, *100
# Section 1915(c) Waiver Enrollees Enrolled in More Than One Section 1915(c) Waiver During the Year	Count records with more than one unique waiver (in any month in any waiver) with waiver type equal to G, H, I, J, K, L, M, N, O, or P
# Section 1915(c) Claim (PGM TYPE=6 or 7) Recipients	Total records with HCBS Aged (program type 6) record count > 0 or HCBS Waiver (program type 7) record count > 0, *100

Measure	Measure Description
Other Waiver Enrollment (Enrolled Any Time During the Year)	
# with Any 1115 Waiver (WVR TYPE = 1,5,6,A,F)	Count records with waiver type (any month any waiver) equal to 1, 5, 6, A, or F
% Aged Enrollees with Any 1115 Waiver	Count records with waiver type (any month any waiver) equal to 1, 5, 6, A, or F, among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, divide by total records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, *100
% Disabled Enrollees with Any 1115 Waiver	Count records with waiver type (any month any waiver) equal to 1, 5, 6, A, or F, among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, divide by total records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, *100
% Child Enrollees with Any 1115 Waiver	Count records with waiver type (any month any waiver) equal to 1, 5, 6, A, or F, among records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54, divide by total records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54, *100
% Adult Enrollees with Any 1115 Waiver	Count records with waiver type (any month any waiver) equal to 1, 5, 6, A, or F, among records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55, divide by total records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55, *100
% with Any HMO/HIO Enrollment	Count records with months of Comprehensive Managed Care Plan or PACE > 0, among records with waiver type (any month any waiver) equal to 1, 5, 6, A, or F, divide by total records with waiver type (any month any waiver) equal to 1, 5, 6, A, or F, *100
# with Any 1915(b) Waiver (WVR TYPE = 2)	Count records with waiver type (any month any waiver) equal to 2
% Aged Enrollees with Any 1915(b) Waiver	Count records with waiver type (any month any waiver) equal to 2, among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, divide by total records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, *100
% Disabled Enrollees with Any 1915(b) Waiver	Count records with waiver type (any month any waiver) equal to 2, among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, divide by total records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, *100
% Child Enrollees with Any 1915(b) Waiver	Count records with waiver type (any month any waiver) equal to 2, among records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54, divide by total records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54, *100
% Adult Enrollees with Any 1915(b) Waiver	Count records with waiver type (any month any waiver) equal to 2, among records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55, divide by total records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55, *100
% with Any HMO/HIO Enrollment	Count records with months of Comprehensive Managed Care Plan or PACE > 0, among records with waiver type (any month any waiver) equal to 2, divide by total records with waiver type (any month any waiver) equal to 2, *100

Measure	Measure Description
% with Any HMO/HIO or PHP Enrollment	Count records with months of any Pre-Paid Plan Type (other than PCCM) > 0, among records with waiver type (any month any waiver) equal to 2, divide by total records with waiver type (any month any waiver) equal to 2, *100
# with Any Combined 1915(b)(c) Waiver (WVR TYPE = 4)	Count records with waiver type (any month any waiver) equal to 4
% Aged Enrollees with Any Combined 1915(b)(c) Waiver	Count records with waiver type (any month any waiver) equal to 4, among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, divide by total records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, *100
% Disabled Enrollees with Any Combined 1915(b)(c) Waiver	Count records with waiver type (any month any waiver) equal to 4, among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, divide by total records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, *100
% Child Enrollees with Any Combined 1915(b)(c) Waiver	Count records with waiver type (any month any waiver) equal to 4, among records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54, divide by total records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54, *100
% Adult Enrollees with Any Combined 1915(b)(c) Waiver	Count records with waiver type (any month any waiver) equal to 4, among records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55, divide by total records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55, *100
% with Any HMO/HIO Enrollment	Count records with months of Comprehensive Managed Care Plan or PACE > 0, among records with waiver type (any month any waiver) equal to 4, divide by total records with waiver type (any month any waiver) equal to 4, *100
% with Any HMO/HIO or PHP Enrollment	Count records with months of any Pre-Paid Plan Type (other than PCCM) > 0, among records with waiver type (any month any waiver) equal to 4, divide by total records with waiver type (any month any waiver) equal to 4, *100
# with 1115 HIFA Waiver (WVR TYPE = 5)	Count records with waiver type (any month any waiver) equal to 5
# with 1115 Pharmacy Waiver Coverage (WVR TYPE = 6)	Count records with waiver type (any month any waiver) equal to 6
% Aged Enrollees with Pharmacy Waiver Coverage	Count records with waiver type (any month any waiver) equal to 6, among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, divide by total records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, *100
% Disabled Enrollees with Any Pharmacy Waiver Coverage	Count records with waiver type (any month any waiver) equal to 6, among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, divide by total records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, *100
% Child Enrollees with Any Pharmacy Waiver Coverage	Count records with waiver type (any month any waiver) equal to 6, among records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54, divide by total records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54, *100

Measure	Measure Description
% Adult Enrollees with Any Pharmacy Waiver Coverage	Count records with waiver type (any month any waiver) equal to 6, among records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55, divide by total records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55, *100
% with Any HMO/HIO Enrollment	Count records with months of Comprehensive Managed Care Plan or PACE > 0, among records with waiver type (any month any waiver) equal to 6, divide by total records with waiver type (any month any waiver) equal to 6, *100
# with Other Type of Waiver (WVR TYPE = 7)	Count records with waiver type (any month any waiver) equal to 7
# with Unknown Type of Waiver (WVR TYPE = 9)	Count records with waiver type (any month any waiver) equal to 9
# with 1115 Disaster-Related Waiver (WVR TYPE = A)	Count records with waiver type (any month any waiver) equal to A
# with 1115 Family Planning Only Waiver (WVR TYPE = F)	Count records with waiver type (any month any waiver) equal to F
# of Waiver IDs with More than One Waiver Type	Count number of waiver IDs (among all people, all months, all waivers) with more than one waiver type
# of Waiver IDs with Reporting in January but Not December	Count waiver IDs in January that are not reported in December, excluding waiver ID = 00, 88,
# of Waiver IDs with Reporting in December but Not January	Count waiver IDs in December that are not reported in January, excluding waiver ID = 00, 88,
Benefit Coverage	
Full Scope Benefits (RBF = 1)	
# with Full Scope Benefits	Count records with restricted benefits flag equal to 1 in at least one month
# Person-Years of Full Scope Benefits	Number of months with restricted benefits flag equal to 1, divide by 12
Alien Benefits (RBF = 2)	
# with ONLY Alien Benefits	Count records with restricted benefits flag equal to 2 in at least one month and restricted benefits flag equal to 1, 3, 4, 5, 6, 7, 8, A, B, W, X, Y, or Z in none of the months
# with Alien Benefits	Count records with restricted benefits flag equal to 2 in at least one month

Measure	Measure Description
# Person-Years of Alien Benefits	Number of months with restricted benefits flag equal to 2, divide by 12, sum over all records with at least 1 month with restricted benefits flag equal to 2
EDB Duals with Medicare Cost Sharing Benefits (RBF = 3)	
# EDB Duals with ONLY Medicare Cost Sharing Benefits	Count records with restricted benefits flag equal to 3 in at least one month and restricted benefits flag equal to 1, 2, 4, 5, 6, 7, 8, A, B, W, X, Y, or Z in none of the months and Medicare Dual Code - Annual equals 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98
# EDB Duals with Medicare Cost Sharing Benefits	Count records with restricted benefits flag equal to 3 in at least one month and Medicare Dual Code - Annual equals 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98
# Person-Years of EDB Dual Medicare Cost Sharing Benefits	Number of months with restricted benefits flag equal to 3 and Medicare Dual Code - Annual equals 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, divide by 12, sum over all records with at least 1 month with restricted benefits flag equal to 3 and Medicare Dual Code - Annual equals 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98
% EDB Duals with Medicare Cost Sharing Benefits	Count records with restricted benefits flag equal to 3 in at least one month and restricted benefits flag equal to 1, 2, 4, 5, 6, 7, 8, A, B, W, X, Y, or Z in none of the months, among records with Medicare Dual Code - Annual equals 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, divide by total records with Medicare Dual Code - Annual equals 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, *100
Pregnancy-Related Benefits (RBF = 4)	
# with Pregnancy-Related Benefits	Count records with restricted benefits flag equal to 4 in at least one month
# Person-Years of Pregnancy-Related Benefits	Number of months with restricted benefits flag equal to 4, divide by 12
Other Benefits (RBF = 5)	
# with Other Benefits	Count records with restricted benefits flag equal to 5 in at least one month
# Person-Years of Other Benefits	Number of months with restricted benefits flag equal to 5, divide by 12
Family Planning Only Benefits (RBF = 6)	
# with ONLY Family Planning Only Benefits	Count records with restricted benefits flag equal to 6 in at least one month and restricted benefits flag equal to 1, 2, 3, 4, 5, 7, 8, A, B, W, X, Y, or Z in none of the months
# with Family Planning Only Benefits	Count records with restricted benefits flag equal to 6 in at least one month

Measure	Measure Description
% with Family Planning Only Benefits Who Are Male	Count number of records with gender code equal to M among those with restricted benefits flag equal to 6 in at least one month, divide by count of those with restricted benefits flag equal to 6 in at least one month, * 100
# Person-Years of Family Planning Only Benefits	Number of months with restricted benefits flag equal to 6, divide by 12, sum over all records with at least 1 month with restricted benefits flag equal to 6
Benchmark-Equivalent Benefits (RBF = 7)	
# with Benchmark-Equivalent Benefits	Count records with restricted benefits flag equal to 7 in at least one month
# Person-Years of Benchmark-Equivalent Benefits	Number of months with restricted benefits flag equal to 7, divide by 12
Money Follows the Person Benefits (RBF = 8)	
# with Money Follows the Person Benefits	Count records with restricted benefits flag equal to 8 in at least one month
# Person-Years of Money Follows the Person Benefits	Number of months with restricted benefits flag equal to 8, divide by 12
PRTF Benefits (RBF = A)	
# with PRTF Benefits	Count records with restricted benefits flag equal to A in at least one month
# Person-Years of PRTF Benefits	Number of months with restricted benefits flag equal to A, divide by 12
Health Opportunity Account Benefits (RBF = B)	
# with Health Opportunity Account Benefits	Count records with restricted benefits flag equal to B in at least one month
# Person-Years of Health Opportunity Account Benefits	Number of months with restricted benefits flag equal to B, divide by 12
Assistance with Purchase of Managed Care Coverage (RBF = W)	
# with ONLY Assistance with Purchase of MC Coverage	Count records with restricted benefits flag equal to W in at least one month and restricted benefits flag equal to 1, 2, 3, 4, 5, 6, 7, 8, A, B, X, Y, Z in none of the months

Measure	Measure Description
# with Assistance with Purchase of MC Coverage	Count records with restricted benefits flag equal to W in at least one month
# Person-Years of Assistance with Purchase of MC Coverage	Number of months with restricted benefits flag equal to W, divide by 12
Prescription Drug Benefits (RBF = X, Y, or Z)	
# with ONLY Prescription Drug Benefits (May Have a Month or More of RBF = 3)	Count records with restricted benefits flag equal to X, Y, or Z in at least one month and restricted benefits flag equal to 1, 2, 4, 5, 6, 7, 8, A, B, or W in none of the months
# with Prescription Drug Benefits	Count records with restricted benefits flag equal to X, Y, or Z in at least one month
# Person-Years of Prescription Drug Benefits	Number of months with restricted benefits flag equal to X, Y, or Z, divide by 12, sum over all records with at least 1 month with restricted benefits flag equal to X, Y, or Z
# with ONLY Prescription Drug Benefits Who Are EDB Duals	Count records with restricted benefits flag equal to X, Y, or Z in at least one month and restricted benefits flag equal to 1, 2, 4, 5, 6, 7, 8, A, B, or W in none of the months and Medicare Dual Code - Annual equals 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98
Only Very Restricted Benefits (RBF = 2, 3, 6, W, X, Y, or Z)	
# with ONLY Very Restricted Benefits	Count records with restricted benefits flag equal to 2, 3, 6, W, X, Y, or Z in at least one month and restricted benefits flag equal to 1, 4, 5, 7, 8, A, or B in none of the months
June Eligibility Profile	
Total Enrollees in June	Count records with restricted benefits flag (in June) equal to 1, 2, 3, 4, 5, 6, 7, 8, 9, A, B, X, Y, or Z
June # Aged	Count records with MAX uniform eligibility code (June) indicating "aged" with restricted benefits flag (in June) equal to 1, 2, 3, 4, 5, 6, 7, 8, 9, A, B, X, Y, or Z
June # Disabled	Count records with MAX uniform eligibility code (June) indicating "disabled" with restricted benefits flag (in June) equal to 1, 2, 3, 4, 5, 6, 7, 8, 9, A, B, X, Y, or Z
June # Child	Count records with MAX uniform eligibility code (June) indicating "child" with restricted benefits flag (in June) equal to 1, 2, 3, 4, 5, 6, 7, 8, 9, A, B, X, Y, or Z
June # Adult	Count records with MAX uniform eligibility code (June) indicating "adult" with restricted benefits flag (in June) equal to 1, 2, 3, 4, 5, 6, 7, 8, 9, A, B, X, Y, or Z
June # Age 0-18, Excluding Instititionalized	Count records with age (as of Dec 31) <=18, excluding those with ILTC claims (MAX TOS equal to 02, 04, 05, or 07)

Measure	Measure Description
June # Age 19-20, Excluding Institutionalized	Count records with 19 <= age (as of Dec 31) <=20, excluding those with ILTC claims (MAX TOS equal to 02, 04, 05, or 07)
June # Age 21-64, Excluding Institutionalized	Count records with 21 <= age (as of Dec 31) <=64, excluding those with ILTC claims (MAX TOS equal to 02, 04, 05, or 07)
June # Age 65+, Excluding Institutionalized	Count records with age (as of Dec 31) >=65, excluding those with ILTC claims (MAX TOS equal to 02, 04, 05, or 07)
June % Full Scope Benefits (RBF = 1)	Count records with restricted benefits flag (in June) equal to 1, divide by total records with restricted benefits flag (in June) equal to 1, 2, 3, 4, 5, 6, 7, 8, A, B, W, X, Y, or Z, *100
June % Alien Benefits (RBF = 2)	Count records with restricted benefits flag (in June) equal to 2, divide by total records with restricted benefits flag (in June) equal to 1, 2, 3, 4, 5, 6, 7, 8, A, B, W, X, Y, or Z, *100
June % EDB Duals with Medicare Cost Sharing Benefits (RBF = 3)	Count records with restricted benefits flag (in June) equal to 3, divide by total records with restricted benefits flag (in June) equal to 1, 2, 3, 4, 5, 6, 7, 8, A, B, W, X, Y, or Z, *100
June % Pregnancy-Related Benefits (RBF = 4)	Count records with restricted benefits flag (in June) equal to 4, divide by total records with restricted benefits flag (in June) equal to 1, 2, 3, 4, 5, 6, 7, 8, A, B, W, X, Y, or Z, *100
June % Other Benefits (RBF = 5)	Count records with restricted benefits flag (in June) equal to 5, divide by total records with restricted benefits flag (in June) equal to 1, 2, 3, 4, 5, 6, 7, 8, A, B, W, X, Y, or Z, *100
June % Family Planning Benefits (RBF = 6)	Count records with restricted benefits flag (in June) equal to 6, divide by total records with restricted benefits flag (in June) equal to 1, 2, 3, 4, 5, 6, 7, 8, A, B, W, X, Y, or Z, *100
June % Benchmark-Equivalent Benefits (RBF = 7)	Count records with restricted benefits flag (in June) equal to 7, divide by total records with restricted benefits flag (in June) equal to 1, 2, 3, 4, 5, 6, 7, 8, A, B, W, X, Y, or Z, *100
June % Money Follows the Person Benefits (RBF = 8)	Count records with restricted benefits flag (in June) equal to 8, divide by total records with restricted benefits flag (in June) equal to 1, 2, 3, 4, 5, 6, 7, 8, A, B, W, X, Y, or Z, *100
June % Unknown Benefits (RBF = 9)	Count records with restricted benefits flag (in June) equal to 9, divide by total records with restricted benefits flag (in June) equal to 1, 2, 3, 4, 5, 6, 7, 8, A, B, W, X, Y, or Z, *100
June % PRTF Benefits (RBF = A)	Count records with restricted benefits flag (in June) equal to A, divide by total records with restricted benefits flag (in June) equal to 1, 2, 3, 4, 5, 6, 7, 8, A, B, W, X, Y, or Z, *100
June % Health Opportunity Account Benefits (RBF = B)	Count records with restricted benefits flag (in June) equal to B, divide by total records with restricted benefits flag (in June) equal to 1, 2, 3, 4, 5, 6, 7, 8, A, B, W, X, Y, or Z, *100
June % Assistance with Purchase of MC Coverage (RBF=W)	Count records with restricted benefits flag (in June) equal to W, divide by total records with restricted benefits flag (in June) equal to 1, 2, 3, 4, 5, 6, 7, 8, A, B, W, X, Y, or Z, *100
June % Non-Dual Pharm Plus Benefits (RBF = X)	Count records with restricted benefits flag (in June) equal to X, divide by total records with restricted benefits flag (in June) equal to 1, 2, 3, 4, 5, 6, 7, 8, A, B, W, X, Y, or Z, *100

Measure	Measure Description
June % EDB Dual with Pharm Plus and Medicare Cost Sharing Benefits (RBF = Y)	Count records with restricted benefits flag (in June) equal to Y, divide by total records with restricted benefits flag (in June) equal to 1, 2, 3, 4, 5, 6, 7, 8, A, B, W, X, Y, or Z, *100
June % EDB Dual with Pharm Plus but no Medicare Cost Sharing Benefits (RBF = Z)	Count records with restricted benefits flag (in June) equal to Z, divide by total records with restricted benefits flag (in June) equal to 1, 2, 3, 4, 5, 6, 7, 8, A, B, W, X, Y, or Z, *100
June % Private Health Insurance (PVT INS CD = 2-4)	Count records with private insurance code (in June) equal to 2, 3, or 4, divide by total records with private insurance code (in June) > 0, *100
June Total Enrollees with TANF Flag (TANF FLAG = 2)	Count records with TANF flag (in June) equal to 1
June # with M-CHIP (SCHIP = 2) - Child (Age < 19 Years)	Count records with SCHIP flag (in June) equal to 2 and age (as of Dec 31) < 19
June # with M-CHIP (SCHIP = 2) - Adult (Age > 18 Years)	Count records with SCHIP flag (in June) equal to 2 and age (as of Dec 31) > 18
June # with S-CHIP (SCHIP = 3) - Child (Age < 19 Years)	Count records with SCHIP flag (in June) equal to 3 and age (as of Dec 31) < 19
June # with S-CHIP (SCHIP = 3) - Adult (Age > 18 Years)	Count records with SCHIP flag (in June) equal to 3 and age (as of Dec 31) > 18
Medicaid Expenditures	
Total Medicaid Paid	Sum total Medicaid amount paid
Avg Medicaid Paid per Enrollee	Sum total Medicaid amount paid, divide by total record count
25th Percentile	25th percentile of total Medicaid amount paid
50th Percentile (Median)	50th percentile of total Medicaid amount paid
75th Percentile	75th percentile of total Medicaid amount paid
95th Percentile	95th percentile of total Medicaid amount paid
99th Percentile	99th percentile of total Medicaid amount paid

Measure	Measure Description
Maximum Medicaid Paid	Maximum total Medicaid amount paid
PERCENT OF ENROLLEES WITH ZERO EXPENDITURES	
% of Enrollees with Total Medicaid Paid = $0	Count records with total Medicaid amount paid equal to $0
Aged	Among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, count records with total Medicaid amount paid equal to $0, divide by total record count, *100
Disabled	Among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, count records with total Medicaid amount paid equal to $0, divide by total record count, *100
Child	Among records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54, count records with total Medicaid amount paid equal to $0, divide by total record count, *100
Adult	Among records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55, count records with total Medicaid amount paid equal to $0, divide by total record count, *100
NUMBER OF HIGH-COST ENROLLEES	
# of Enrollees with Total Medicaid Paid > $1,000,000	Count records with total Medicaid amount paid > 1,000,000
# of Enrollees with Total Medicaid Paid > $500,000	Count records with total Medicaid amount paid > 500,000
AVERAGE MEDICAID AMOUNT PAID PER ENROLLEE BY MAX ELIGIBILITY GROUP	
Avg Medicaid Paid per Enrollee	Sum total Medicaid amount paid, divide by total record count
Aged	Among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, sum total Medicaid amount paid, divide by total record count
Disabled	Among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, sum total Medicaid amount paid, divide by total record count
Child	Among records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54, sum total Medicaid amount paid, divide by total record count
Adult	Among records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55, sum total Medicaid amount paid, divide by total record count

Measure	Measure Description
AVERAGE MEDICAID AMOUNT PAID BY GENDER	
Avg Medicaid Paid per Female Enrollee	Among records with gender code equal to F, sum total Medicaid amount paid; divide by total (female) record count
Avg Medicaid Paid per Male Enrollee	Among records with gender code equal to M, sum total Medicaid amount paid; divide by total (male) record count
AVERAGE MEDICAID AMOUNT PAID PER EDB DUAL ENROLLEE	
Avg Medicaid Paid per EDB Dual Enrollee	Among records with Medicare Dual Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, sum total Medicaid amount paid, divide by total record count
Aged	Among records with Medicare Dual Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98 and MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, sum total Medicaid amount paid, divide by total record count
Disabled	Among records with Medicare Dual Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98 and MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, sum total Medicaid amount paid, divide by total record count
Female	Among records with gender code equal to F and MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, sum total Medicaid amount paid, divide by total record count
Male	Among records with gender code equal to M and MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, sum total Medicaid amount paid, divide by total record count
EDB Dual Not Reported in MSIS (EDB DUAL = 50)	Among records with Medicare Dual Code - Annual equal to 50, sum total Medicaid amount paid, divide by total record count
EDB QMB Only (EDB DUAL = 51)	Among records with Medicare Dual Code - Annual equal to 51, sum total Medicaid amount paid, divide by total record count
EDB QMB Plus (EDB DUAL = 52)	Among records with Medicare Dual Code - Annual equal to 52, sum total Medicaid amount paid, divide by total record count
EDB SLMB Only (EDB DUAL = 53)	Among records with Medicare Dual Code - Annual equal to 53, sum total Medicaid amount paid, divide by total record count
EDB SLMB Plus (EDB DUAL = 54)	Among records with Medicare Dual Code - Annual equal to 54, sum total Medicaid amount paid, divide by total record count
EDB QDWI (EDB DUAL = 55)	Among records with Medicare Dual Code - Annual equal to 55, sum total Medicaid amount paid, divide by total record count
EDB QI-1 (EDB DUAL = 56)	Among records with Medicare Dual Code - Annual equal to 56, sum total Medicaid amount paid, divide by total record count

Measure	Measure Description
EDB QI-2 (EDB DUAL = 57)	Among records with Medicare Dual Code - Annual equal to 57, sum total Medicaid amount paid, divide by total record count
EDB Other (EDB DUAL = 58)	Among records with Medicare Dual Code - Annual equal to 58, sum total Medicaid amount paid, divide by total record count
EDB Dual Type Unknown (EDB DUAL = 59)	Among records with Medicare Dual Code - Annual equal to 59, sum total Medicaid amount paid, divide by total record count
EDB Dual Status Unknown (EDB DUAL = 98)	Among records with Medicare Dual Code - Annual equal to 98, sum total Medicaid amount paid, divide by total record count
Avg Medicaid Paid per EDB Duals with Full Benefits (EDB DUAL = 50,52,54,58)	Among records with Medicare Dual Code - Annual equal to 50, 52, 54, or 58, sum total Medicaid amount paid, divide by total record count
Avg Medicaid Paid per EDB Duals with Restricted Benefits (EDB DUAL = 51,53,55,56,57)	Among records with Medicare Dual Code - Annual equal to 51, 53, 55, 56, or 57, sum total Medicaid amount paid, divide by total record count
AVERAGE MEDICAID AMOUNT PAID PER LONG-TERM CARE ENROLLEE	
Avg Medicaid Paid per Enrollee with ILTC Claims (MAX TOS = 02, 04, 05, 07)	Among records with ILTC claims, sum total Medicaid amount paid, divide by total record count ILTC claims = 1, if total Medicaid Fee-for-Service payment amount (for MAX TOS equal to 02, 04, 05, or 07) > 0
Avg Medicaid Paid per Enrollee with CLTC Claims (Excluding CLTC FLAG = 16-20)	Among records with CLTC claims, sum total Medicaid amount paid, divide by total record count CLTC claims = 1, if total Medicaid Fee-for-Service payment amount (for CLTC code = 11, 12, 13, 14, 15, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, or 40) > 0
Avg Medicaid Paid per Enrollee with ILTC (MAX TOS = 02, 04, 05, 07) and CLTC Claims (Excluding CLTC FLAG = 16-20)	Among records with ILTC claims and CLTC claims, sum total Medicaid amount paid, divide by total record count ILTC claims = 1, if total Medicaid Fee-for-Service payment amount (for MAX TOS equal to 02, 04, 05, or 07) > 0 CLTC claims = 1, if total Medicaid Fee-for-Service payment amount (for CLTC code = 11, 12, 13, 14, 15, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, or 40) > 0
AVERAGE MEDICAID AMOUNT PAID PER ENROLLEE IN 1915(c) WAIVER - MOST RECENT	
Avg Medicaid Paid per Section 1915(c) Enrollee	Among records with 1915(c) waiver type - most recent equal to G, H, I, J, K, L, M, N, O, or P, sum total Medicaid amount paid, divide by total record count
Section 1915(c) Waiver for Aged and Disabled (WVR TYPE = G)	Among records with 1915(c) waiver type - most recent equal to G, sum total Medicaid amount paid, divide by total record count
Section 1915(c) Waiver for Aged (WVR TYPE = H)	Among records with 1915(c) waiver type - most recent equal to H, sum total Medicaid amount paid, divide by total record count
Section 1915(c) Waiver for Physically Disabled (WVR TYPE = I)	Among records with 1915(c) waiver type - most recent equal to I, sum total Medicaid amount paid, divide by total record count

Measure	Measure Description
Section 1915(c) Waiver for People with Brain Injuries (WVR TYPE = J)	Among records with 1915(c) waiver type - most recent equal to J, sum total Medicaid amount paid, divide by total record count
Section 1915(c) Waiver for People with HIV/AIDS (WVR TYPE = K)	Among records with 1915(c) waiver type - most recent equal to K, sum total Medicaid amount paid, divide by total record count
Section 1915(c) Waiver for People with MR/DD (WVR TYPE = L)	Among records with 1915(c) waiver type - most recent equal to L, sum total Medicaid amount paid, divide by total record count
Section 1915(c) Waiver for People with MI/SED (WVR TYPE = M)	Among records with 1915(c) waiver type - most recent equal to M, sum total Medicaid amount paid, divide by total record count
Section 1915(c) Waiver for Tech Dependent/Medically Fragile (WVR TYPE = N)	Among records with 1915(c) waiver type - most recent equal to N, sum total Medicaid amount paid, divide by total record count
Section 1915(c) Waiver for People with Autism/ASD (WVR TYPE = P)	Among records with 1915(c) waiver type - most recent equal to P, sum total Medicaid amount paid, divide by total record count
Section 1915(c) Waiver for None of the Above (WVR TYPE = O)	Among records with 1915(c) waiver type - most recent equal to O, sum total Medicaid amount paid, divide by total record count
AVERAGE 1915(c) WAIVER AMOUNT PAID (PROGRAM TYPES 6 OR 7) PER ENROLLEE IN ANY 1915(c) WAIVER - MOST RECENT	
Avg 1915(c) Waiver Amount Paid per Section 1915(c) Enrollee	Among records with 1915(c) waiver type - most recent equal to G, H, I, J, K, L, M, N, O, or P, sum total HCBS Aged (program type 6) Medicaid amount paid and HCBS Waiver (program type 7) Medicaid amount paid, divide by total record count
Section 1915(c) Waiver for Aged and Disabled (WVR TYPE = G)	Among records with 1915(c) waiver type - most recent equal to G, sum total HCBS Aged (program type 6) Medicaid amount paid and HCBS Waiver (program type 7) Medicaid amount paid, divide by total record count
Section 1915(c) Waiver for Aged (WVR TYPE = H)	Among records with 1915(c) waiver type - most recent equal to H, sum total HCBS Aged (program type 6) Medicaid amount paid and HCBS Waiver (program type 7) Medicaid amount paid, divide by total record count
Section 1915(c) Waiver for Physically Disabled (WVR TYPE = I)	Among records with 1915(c) waiver type - most recent equal to I, sum total HCBS Aged (program type 6) Medicaid amount paid and HCBS Waiver (program type 7) Medicaid amount paid, divide by total record count
Section 1915(c) Waiver for People with Brain Injuries (WVR TYPE = J)	Among records with 1915(c) waiver type - most recent equal to J, sum total HCBS Aged (program type 6) Medicaid amount paid and HCBS Waiver (program type 7) Medicaid amount paid, divide by total record count
Section 1915(c) Waiver for People with HIV/AIDS (WVR TYPE = K)	Among records with 1915(c) waiver type - most recent equal to K, sum total HCBS Aged (program type 6) Medicaid amount paid and HCBS Waiver (program type 7) Medicaid amount paid, divide by total record count
Section 1915(c) Waiver for People with MR/DD (WVR TYPE = L)	Among records with 1915(c) waiver type - most recent equal to L, sum total HCBS Aged (program type 6) Medicaid amount paid and HCBS Waiver (program type 7) Medicaid amount paid, divide by total record count
Section 1915(c) Waiver for People with MI/SED (WVR TYPE = M)	Among records with 1915(c) waiver type - most recent equal to M, sum total HCBS Aged (program type 6) Medicaid amount paid and HCBS Waiver (program type 7) Medicaid amount paid, divide by total record count

Measure	Measure Description
Section 1915(c) Waiver for Tech Dependent/Medically Fragile (WVR TYPE = N)	Among records with 1915(c) waiver type - most recent equal to N, sum total HCBS Aged (program type 6) Medicaid amount paid and HCBS Waiver (program type 7) Medicaid amount paid, divide by total record count
Section 1915(c) Waiver for People with Autism/ASD (WVR TYPE = P)	Among records with 1915(c) waiver type - most recent equal to P, sum total HCBS Aged (program type 6) Medicaid amount paid and HCBS Waiver (program type 7) Medicaid amount paid, divide by total record count
Section 1915(c) Waiver for None of the Above (WVR TYPE = O)	Among records with 1915(c) waiver type - most recent equal to O, sum total HCBS Aged (program type 6) Medicaid amount paid and HCBS Waiver (program type 7) Medicaid amount paid, divide by total record count
EXPENDITURES BY BENEFIT COVERAGE	
Expenditures for Enrollees with Full Scope Benefits (RBF = 1)	
Total Medicaid Paid for Enrollees with Full Scope Benefits	Among records with restricted benefits flag equal to 1 in at least one month, sum total Medicaid amount paid
Avg Medicaid Paid per Enrollee with Full Scope Benefits	Among records with restricted benefits flag equal to 1 in at least one month, sum total Medicaid amount paid, divide by total record count
Expenditures for Enrollees with Alien Benefits (RBF = 2)	
Total Medicaid Paid for Enrollees with ONLY Alien Benefits	Among records with restricted benefits flag equal to 2 in at least one month and restricted benefits flag equal to 1, 3, 4, 5, 6, 7, 8, A, B, W, X, Y, or Z in none of the months, sum total Medicaid amount paid
Avg Medicaid Paid per Enrollee with ONLY Alien Benefits	Among records with restricted benefits flag equal to 2 in at least one month and restricted benefits flag equal to 1, 3, 4, 5, 6, 7, 8, A, B, W, X, Y, or Z in none of the months, sum total Medicaid amount paid, divide by total record count
Expenditures for EDB Duals with Medicare Cost Sharing Benefits (RBF = 3)	
Total Medicaid Paid for EDB Duals with ONLY Medicare Cost Sharing Benefits	Among records with restricted benefits flag equal to 3 in at least one month and restricted benefits flag equal to 1, 2, 4, 5, 6, 7, 8, A, B, W, X, Y, or Z in none of the months and Medicare Dual Code - Annual equals 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, sum total Medicaid amount paid
Avg Medicaid Paid per EDB Dual with ONLY Medicare Cost Sharing Benefits	Among records with restricted benefits flag equal to 3 in at least one month and restricted benefits flag equal to 1, 2, 4, 5, 6, 7, 8, A, B, W, X, Y, or Z in none of the months and Medicare Dual Code - Annual equals 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, sum total Medicaid amount paid, divide by total record count
Expenditures for Enrollees with Pregnancy-Related Benefits (RBF = 4)	
Total Medicaid Paid for Enrollees with Pregnancy-Related Benefits	Among records with restricted benefits flag equal to 4 in at least one month, sum total Medicaid amount paid

Measure	Measure Description
Avg Medicaid Paid per Enrollee with Pregancy-Related Benefits	Among records with restricted benefits flag equal to 4 in at least one month, sum total Medicaid amount paid, divide by total record count
Expenditures for Enrollees with Other Benefits (RBF = 5)	
Total Medicaid Paid for Enrollees with Other Benefits	Among records with restricted benefits flag equal to 5 in at least one month, sum total Medicaid amount paid
Avg Medicaid Paid per Enrollee with Other Benefits	Among records with restricted benefits flag equal to 5 in at least one month, sum total Medicaid amount paid, divide by total record count
Expenditures for Enrollees with Family Planning Only Benefits (RBF = 6)	
Total Medicaid Paid for Enrollees with ONLY Family Planning Only Benefits	Among records with restricted benefits flag equal to 6 in at least one month and restricted benefits flag equal to 1, 2, 3, 4, 5, 7, 8, A, B, W, X, Y, or Z in none of the months, sum total Medicaid amount paid
Avg Medicaid Paid per Enrollee with ONLY Family Planning Only Benefits	Among records with restricted benefits flag equal to 6 in at least one month and restricted benefits flag equal to 1, 2, 3, 4, 5, 7, 8, A, B, W, X, Y, or Z in none of the months, sum total Medicaid amount paid, divide by total record count
Expenditures for Enrollees with Benchmark-Equivalent Benefits (RBF = 7)	
Total Medicaid Paid for Enrollees with Benchmark-Equivalent Benefits	Among records with restricted benefits flag equal to 7 in at least one month, sum total Medicaid amount paid
Avg Medicaid Paid per Enrollee with Benchmark-Equivalent Benefits	Among records with restricted benefits flag equal to 7 in at least one month, sum total Medicaid amount paid, divide by total record count
Expenditures for Enrollees with Money Follows the Person Benefits (RBF = 8)	
Total Medicaid Paid for Enrollees with Money Follows the Person Benefits	Among records with restricted benefits flag equal to 8 in at least one month, sum total Medicaid amount paid
Avg Medicaid Paid per Enrollee with Money Follows the Person Benefits	Among records with restricted benefits flag equal to 8 in at least one month, sum total Medicaid amount paid, divide by total record count
Expenditures for Enrollees with PRTF Benefits (RBF = A)	
Total Medicaid Paid for Enrollees with PRTF Benefits	Among records with restricted benefits flag equal to A in at least one month, sum total Medicaid amount paid
Avg Medicaid Paid per Enrollee with PRTF Benefits	Among records with restricted benefits flag equal to A in at least one month, sum total Medicaid amount paid, divide by total record count

Measure	Measure Description
Expenditures for Enrollees with Health Opportunity Account Benefits (RBF = B)	
Total Medicaid Paid for Enrollees with Health Opportunity Account Benefits	Among records with restricted benefits flag equal to B in at least one month, sum total Medicaid amount paid
Avg Medicaid Paid per Enrollee with Health Opportunity Account Benefits	Among records with restricted benefits flag equal to B in at least one month, sum total Medicaid amount paid, divide by total record count
Expenditures for Enrollees with Assistance with Purchase of MC Coverage Benefits (RBF = W)	
Total Medicaid Paid for Enrollees with ONLY Assistance with Purchase of MC Coverage Benefits	Among records with restricted benefits flag equal to W in at least one month and restricted benefits flag equal to 1, 2, 3, 4, 5, 6, 7, 8, A, B, X, Y, or Z in none of the months, sum total Medicaid amount paid
Avg Medicaid Paid per Person ONLY Enrolled in Assistance with Purchase of MC Coverage	Among records with restricted benefits flag equal to W in at least one month and restricted benefits flag equal to 1, 2, 3, 4, 5, 6, 7, 8, A, B, X, Y, or Z in none of the months, sum total Medicaid amount paid, divide by total record count
Expenditures for Enrollees with Prescription Drug Benefits (RBF = X, Y, or Z)	
Total Medicaid Paid for Enrollees with ONLY Prescription Drug Benefits	Among records with restricted benefits flag equal to X, Y, or Z in at least one month and restricted benefits flag equal to 1, 2, 4, 5, 6, 7, 8, A, B, W in none of the months, sum total Medicaid amount paid
Avg Medicaid Paid per Enrollee with ONLY Prescription Drug Benefits	Among records with restricted benefits flag equal to X, Y, or Z in at least one month and restricted benefits flag equal to 1, 2, 4, 5, 6, 7, 8, A, B, W in none of the months, sum total Medicaid amount paid, divide by total record count
Total Medicaid Paid for Enrollees with ONLY Prescription Drug Benefits Who Are EDB Duals	Among records with restricted benefits flag equal to X, Y, or Z in at least one month and restricted benefits flag equal to 1, 2, 4, 5, 6, 7, 8, A, B, W in none of the months and Medicare Dual Code - Annual equals 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, sum total Medicaid amount paid
AVERAGE MEDICAID AMOUNT PAID PER M-CHIP ENROLLEE	
Avg Medicaid Paid per Person Ever Enrolled in M-CHIP	Among records with at least 1 month with CHIP code equal to 2, sum total Medicaid amount paid, divide by total record count
Child (Age < 19 Years)	Among records with at least 1 month with CHIP code equal to 2 and age < 19, sum total Medicaid amount paid, divide by total record count
Adult (Age > 18 Years)	Among records with at least 1 month with CHIP code equal to 2 and age > 18, sum total Medicaid amount paid, divide by total record count

Measure	Measure Description
MEDICAID ENROLLEES - EXCLUDING SELECT RESTRICTED BENEFIT GROUPS (excludes people with missing eligibility information, S-CHIP only, FP Only, Aliens with only restricted benefits, duals with restricted benefits only, prescription drug only , and persons enrolled only in assistance with purchase of MC Coverage enrollees) ---- NOTE: S-CHIP only, FP Only, duals with restricted benefits, and Aliens with restricted benefits were NOT excluded prior to 2001. Prescription drug only enrollees were NOT excluded prior to 2003.	
Total Medicaid Enrollees	Count records
Aged Total	Count records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51
Disabled Total	Count records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52
Child Total	Count records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54
Adult Total	Count records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55
Total Medicaid Person-Years of Enrollment	Number of months of enrollment, divide by 12, sum over all records with at least one month of enrollment
Total EDB Duals	Count records with Medicare Dual Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98
Aged	Count records with Medicare Dual Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98 and MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51
Disabled	Count records with Medicare Dual Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98 and MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52
TOTAL MEDICAID AMOUNT PAID	
Total Medicaid Paid	Sum Medicaid amount paid
AVERAGE MEDICAID AMOUNT PAID PER ENROLLEE BY MAX ELIGIBILITY GROUP	
Avg Medicaid Paid per Enrollee	Sum total Medicaid amount paid, divide by total record count

Measure	Measure Description
Aged	Among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, sum total Medicaid amount paid, divide by total record count
Disabled	Among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, sum total Medicaid amount paid, divide by total record count
Child	Among records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54, sum total Medicaid amount paid, divide by total record count
Adult	Among records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55, sum total Medicaid amount paid, divide by total record count
AVERAGE MEDICAID AMOUNT PAID PER ENROLLEE BY GENDER	
Avg Medicaid Paid per Female Enrollee	Among records with gender code equal to F, sum total Medicaid amount paid, divide by total record count
Avg Medicaid Paid per Male Enrollee	Among records with gender code equal to M, sum total Medicaid amount paid, divide by total record count
AVERAGE MEDICAID AMOUNT PAID PER EDB DUAL ENROLLEE	
Avg Medicaid Paid per EDB Dual Enrollee	Among records with Medicare Dual Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, sum total Medicaid amount paid, divide by total record count
Aged	Among records with Medicare Dual Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98 and MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, sum total Medicaid amount paid, divide by total record count
Disabled	Among records with Medicare Dual Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98 and MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, sum total Medicaid amount paid, divide by total record count
Female	Among records with Medicare Dual Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98 and gender code equal to F, sum total Medicaid amount paid, divide by total record count
Male	Among records with Medicare Dual Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98 and gender code equal to M, sum total Medicaid amount paid, divide by total record count
AVERAGE MEDICAID AMOUNT PAID PER M-CHIP ENROLLEE ENROLLEES	
Avg Medicaid Paid per Person Ever Enrolled in M-CHIP	Among records with at least 1 month with CHIP code equal to 2, sum total Medicaid amount paid, divide by total record count
Child (Age < 19 Years)	Among records with at least 1 month with CHIP code equal to 2 and age < 19 years, sum total Medicaid amount paid, divide by total record count

Measure	Measure Description
Adult (Age > 18 Years)	Among records with at least 1 month with CHIP code equal to 2 and age > 18 years, sum total Medicaid amount paid, divide by total record count
MANAGED CARE PLAN INFORMATION (Enrollees in Capitated Plans - PCCM, HMO, HIO, & PHPs, excludes people with missing eligibility information, S-CHIP only, FP Only, Aliens with only restricted benefits, duals with restricted benefits only, prescription drug only enrollees, and persons enrolled only in assistance with purchase of MC Coverage) ---- NOTE: FP Only, duals with restricted benefits, and Aliens with restricted benefits were NOT excluded prior to 2003. Prescription drug only enrollees were NOT excluded prior to 2003. PACE enrollees are grouped with HMO/HIO rather than PHP enrollees as of 2007.	
% Total Enrollees in MC Anytime During Year	Count records with managed care combination (in any month) equal to 01 - 15, divide by total record count, *100
Total MC Enrollees	Count records with managed care combination (in any month) equal to 01 - 15
Aged	Count records with managed care combination (in any month) equal to 01 - 15 and MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51
Aged, Cash (MAX ELIG CD = 11)	Count records with managed care combination (in any month) equal to 01 - 15 and MAX uniform eligibility code - most recent equal to 11
Aged, Medically Needy (MAX ELIG CD = 21)	Count records with managed care combination (in any month) equal to 01 - 15 and MAX uniform eligibility code - most recent equal to 21
Aged, Poverty (MAX ELIG CD = 31)	Count records with managed care combination (in any month) equal to 01 - 15 and MAX uniform eligibility code - most recent equal to 31
Other Aged (MAX ELIG CD = 41)	Count records with managed care combination (in any month) equal to 01 - 15 and MAX uniform eligibility code - most recent equal to 41
1115 Aged (MAX ELIG CD = 51)	Count records with managed care combination (in any month) equal to 01 - 15 and MAX uniform eligibility code - most recent equal to 51
Disabled	Count records with managed care combination (in any month) equal to 01 - 15 and MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52
Disabled, Cash (MAX ELIG CD = 12)	Count records with managed care combination (in any month) equal to 01 - 15 and MAX uniform eligibility code - most recent equal to 12
Disabled, Medically Needy (MAX ELIG CD = 22)	Count records with managed care combination (in any month) equal to 01 - 15 and MAX uniform eligibility code - most recent equal to 22

Measure	Measure Description
Disabled, Poverty (MAX ELIG CD = 32)	Count records with managed care combination (in any month) equal to 01 - 15 and MAX uniform eligibility code - most recent equal to 32
Disabled, Poverty (MAX ELIG CD = 3A)	Count records with managed care combination (in any month) equal to 01 - 15 and MAX uniform eligibility code - most recent equal to 3A
Other Disabled (MAX ELIG CD = 42)	Count records with managed care combination (in any month) equal to 01 - 15 and MAX uniform eligibility code - most recent equal to 42
1115 Disabled (MAX ELIG CD = 52)	Count records with managed care combination (in any month) equal to 01 - 15 and MAX uniform eligibility code - most recent equal to 52
Child	Count records with managed care combination (in any month) equal to 01 - 15 and MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54
AFDC Child, Cash (MAX ELIG CD = 14)	Count records with managed care combination (in any month) equal to 01 - 15 and MAX uniform eligibility code - most recent equal to 14
AFDC-U Child, Cash (MAX ELIG CD = 16)	Count records with managed care combination (in any month) equal to 01 - 15 and MAX uniform eligibility code - most recent equal to 16
AFDC Child, Medically Needy (MAX ELIG CD = 24)	Count records with managed care combination (in any month) equal to 01 - 15 and MAX uniform eligibility code - most recent equal to 24
Child Poverty (MAX ELIG CD = 34)	Count records with managed care combination (in any month) equal to 01 - 15 and MAX uniform eligibility code - most recent equal to 34
Other Child (MAX ELIG CD = 44)	Count records with managed care combination (in any month) equal to 01 - 15 and MAX uniform eligibility code - most recent equal to 44
Foster Care Child (MAX ELIG CD = 48)	Count records with managed care combination (in any month) equal to 01 - 15 and MAX uniform eligibility code - most recent equal to 48
1115 Child (MAX ELIG CD = 54)	Count records with managed care combination (in any month) equal to 01 - 15 and MAX uniform eligibility code - most recent equal to 54
Adult	Count records with managed care combination (in any month) equal to 01 - 15 and MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55
AFDC Adult, Cash (MAX ELIG CD = 15)	Count records with managed care combination (in any month) equal to 01 - 15 and MAX uniform eligibility code - most recent equal to 15
AFDC-U Adult, Cash (MAX ELIG CD = 17)	Count records with managed care combination (in any month) equal to 01 - 15 and MAX uniform eligibility code - most recent equal to 17
AFDC Adult, Medically Needy (MAX ELIG CD = 25)	Count records with managed care combination (in any month) equal to 01 - 15 and MAX uniform eligibility code - most recent equal to 25

Measure	Measure Description
Adult, Poverty (MAX ELIG CD = 35)	Count records with managed care combination (in any month) equal to 01 - 15 and MAX uniform eligibility code - most recent equal to 35
Other Adult (MAX ELIG CD = 45)	Count records with managed care combination (in any month) equal to 01 - 15 and MAX uniform eligibility code - most recent equal to 45
1115 Adult (MAX ELIG CD = 55)	Count records with managed care combination (in any month) equal to 01 - 15 and MAX uniform eligibility code - most recent equal to 55
# in HMO/HIO (MC TYPE = 1)	Count records with Comprehensive Managed Care Plan months > 0, among records with managed care combination (in any month) equal to 01 - 15
# in Dental (MC TYPE = 2)	Count records with Dental Managed Care Plan months > 0, among records with managed care combination (in any month) equal to 01 - 15
# in BHO (MC TYPE = 3)	Count records with Behavioral Managed Care Plan months > 0, among records with managed care combination (in any month) equal to 01 - 15
# in Prenatal (MC TYPE = 4)	Count records with Prenatal/Delivery Managed Care Plan months > 0, among records with managed care combination (in any month) equal to 01 - 15
# in LTC (MC TYPE = 5)	Count records with Long-Term Care Managed Care Plan months > 0, among records with managed care combination (in any month) equal to 01 - 15
# in PACE (MC TYPE = 6)	Count records with All-Inclusive Care for the Elderly Managed Care Plan months > 0, among records with managed care combination (in any month) equal to 01 - 15
# in PCCM (MC TYPE = 7)	Count records with Primary Care Case Management Plan months > 0, among records with managed care combination (in any month) equal to 01 - 15
# in Other MC (MC TYPE = 8)	Count records with Other Managed Care Plan months > 0, among records with managed care combination (in any month) equal to 01 - 15
# in Any PHP (MC TYPE = 2,3,4,5,8)	Count records with any Dental, BHO, Prenatal, LTC, or Other Managed Care Plan months > 0, among records with managed care combination (in any month) equal to 01 - 15
% EDB Duals Ever Enrolled in HMO/HIOs	Count records with Pre-paid Plan type = 01 or 06 (among all 4 variables), among records with Medicare Dual Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, divide by total records with Medicare Dual Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, *100
% EDB Duals in PHP Only or PHP/PCCM Only	Count records with Pre-paid Plan type = 02, 03, 04, 05, 08 (among all 4 variables), among records with Medicare Dual Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, divide by total records with Medicare Dual Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, *100
% EDB Duals in PCCM Only	Count records with Primary Care Case Management months > 0 and no other months with Pre-paid Health Plan or HMO, among records with Medicare Dual Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, divide by total records with Medicare Dual Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, *100

Measure	Measure Description
% Section 1915(c) Waiver Enrollees Ever Enrolled in HMO/HIOs	Count records with Pre-paid Plan type = 01 or 06 (among all 4 variables), among records with 1915(c) waiver type - most recent equal to G, H, I, J, K, L, M, N, O, or P, divide by total records with 1915(c) waiver type - most recent equal to G, H, I, J, K, L, M, N, O, or P, *100
% Section 1915(c) Waiver Enrollees in PHP Only or PHP and PCCM Only	Count records with Pre-paid Plan type = 02, 03, 04, 05, 08 (among all 4 variables), among records with 1915(c) waiver type - most recent equal to G, H, I, J, K, L, M, N, O, or P, divide by total records with 1915(c) waiver type - most recent equal to G, H, I, J, K, L, M, N, O, or P, *100
% Section 1915(c) Waiver Enrollees in PCCM Only	Count records with Primary Care Case Management > 0 and no other months with Pre-paid Health Plan or HMO, among records with 1915(c) waiver type - most recent equal to G, H, I, J, K, L, M, N, O, or P, divide by total records with 1915(c) waiver type - most recent equal to G, H, I, J, K, L, M, N, O, or P, *100
% M-CHIP Children (<19) Ever Enrolled in HMO/HIOs	Among records with at least 1 month with CHIP code equal to 2 and age < 19, count records with Pre-paid Plan type = 01 or 06 (among all 4 sets of variables), divide by total records, *100
% M-CHIP Children (<19) in PHP Only or PHP/PCCM Only	Among records with CHIP code equal to 2 and age < 19, count records with Pre-paid Plan type = 02, 03, 04, 05, 08 (among all 4 variables) and no months with HMO, divide by total records, *100
% M-CHIP Children (<19) in PCCM Only	Among records with CHIP code equal to 2 and age < 19, count records with Primary Care Case Management months > 0 and no other months with Pre-paid Health Plan or HMO, divide by total records, *100
% M-CHIP Adults (>18) Ever Enrolled in HMO/HIOs	Among records with CHIP code equal to 2 and age > 18, count records with Pre-paid Plan type = 01 or 06 (among all 4 sets of variables), divide by total records, *100
% M-CHIP Adults (>18) in PHP Only or PHP/PCCM Only	Among records with CHIP code equal to 2 and age > 18, count records with Pre-paid Plan type = 02, 03, 04, 05, 08 (among all 4 variables) and no months with HMO, divide by total records, *100
% M-CHIP Adults (>18) in PCCM Only	Among records with CHIP code equal to 2 and age > 18, count records with Primary Care Case Management months > 0 and no other months with Pre-paid Health Plan or HMO, divide by total records, *100
Total Enrollees in June	Count records with managed care combination (in June) > 0
June % HMO/HIO Only (MC COMBO = 01)	Count records with managed care combination (in June) equal to 1, divide by total records with managed care combination (in June) > 0, *100
June % Dental Plan Only (MC COMBO = 02)	Count records with managed care combination (in June) equal to 2, divide by total records with managed care combination (in June) > 0, *100
June % BHO Only (MC COMBO = 03)	Count records with managed care combination (in June) equal to 3, divide by total records with managed care combination (in June) > 0, *100
June % PCCM Only (MC COMBO = 04)	Count records with managed care combination (in June) equal to 4, divide by total records with managed care combination (in June) > 0, *100
June % Other MC Only (MC COMBO = 05)	Count records with managed care combination (in June) equal to 5, divide by total records with managed care combination (in June) > 0, *100

Measure	Measure Description
June % HMO/HIO & Dental (MC COMBO = 06)	Count records with managed care combination (in June) equal to 6, divide by total records with managed care combination (in June) > 0, *100
June % HMO/HIO & BHO (MC COMBO = 07)	Count records with managed care combination (in June) equal to 7, divide by total records with managed care combination (in June) > 0, *100
June % HMO/HIO & Other MC (MC COMBO = 08)	Count records with managed care combination (in June) equal to 8, divide by total records with managed care combination (in June) > 0, *100
June % HMO/HIO & Dental & BHO (MC COMBO = 09)	Count records with managed care combination (in June) equal to 9, divide by total records with managed care combination (in June) > 0, *100
June % Dental & PCCM (MC COMBO = 10)	Count records with managed care combination (in June) equal to 10, divide by total records with managed care combination (in June) > 0, *100
June % BHO & PCCM (MC COMBO = 11)	Count records with managed care combination (in June) equal to 11, divide by total records with managed care combination (in June) > 0, *100
June % Other MC & PCCM (MC COMBO = 12)	Count records with managed care combination (in June) equal to 12, divide by total records with managed care combination (in June) > 0, *100
June % Dental & BHO & PCCM (MC COMBO = 13)	Count records with managed care combination (in June) equal to 13, divide by total records with managed care combination (in June) > 0, *100
June % Dental & BHO (MC COMBO = 14)	Count records with managed care combination (in June) equal to 14, divide by total records with managed care combination (in June) > 0, *100
June % Other Combinations (MC COMBO = 15)	Count records with managed care combination (in June) equal to 15, divide by total records with managed care combination (in June) > 0, *100
June % FFS Only (MC COMBO = 16)	Count records with managed care combination (in June) equal to 16, divide by total records with managed care combination (in June) > 0, *100
June % MC Status Unknown (MC COMBO = 99)	Count records with managed care combination (in June) equal to 99, divide by total records with managed care combination (in June) > 0, *100
CAPITATION CLAIMS	
Total Capitation Payments	Sum Comprehensive Managed Care Plan capitated payment amount, Pre-paid Health Plan capitated payment amount, and Primary Care Case Management capitated payment amount
HMO/HIO	Sum Comprehensive Managed Care Plan capitated payment amount
PHP	Sum Pre-paid Health Plan capitated payment amount

Measure	Measure Description
PCCM	Sum Primary Care Case Management capitated payment amount
Ratio of Capitation Claims to Person-Month Enrolled in MC	Sum number of Comprehensive Managed Care Plan claims, number of Pre-paid Health Plan claims, and Primary Care Case Management claims, divide by sum of Comprehensive Managed Care Plan or PACE months, Pre-paid Health Plan months, and Primary Care Case Management months
HMO/HIO	Number of Comprehensive Managed Care Plan claims, divide by months of Comprehensive Managed Care Plan or PACE
PHP	Number of Pre-paid Health Plan claims, divide by Pre-paid Health Plan months
PCCM	Number of Primary Care Case Management claims, divide by Primary Care Case Management months
Avg Capitation Payment per Person-Month Enrolled in MC	Sum Comprehensive Managed Care Plan capitated payment amount, Pre-paid Health Plan capitated payment amount, and Primary Care Case Management capitated payment amount, divide by sum of Comprehensive Managed Care Plan or PACE months, Pre-paid Health Plan months, and Primary Care Case Management months
HMO/HIO	Comprehensive Managed Care Plan capitated payment amount, divide by months of Comprehensive Managed Care Plan or PACE
PHP	Pre-paid Health Plan capitated payment amount, divide by Pre-paid Health Plan months
PCCM	Primary Care Case Management capitated payment amount, divide by Primary Care Case Management months
Percent with Reported MC Enrollment Who Have Capitated Payments	Among enrollees with months of any Comprehensive Managed Care Plan greater than zero, count records with any capitated payments, divide by total count, * 100
HMO/HIO	Among enrollees with months of Comprehensive Managed Care Plan or PACE months greater than zero, count records with any capitated payments for Comprehensive Managed Care Plan or PACE, divide by total count, * 100
PHP	Among enrollees with months of Pre-paid Health Plan months greater than zero, count records with any capitated payments for Pre-paid Health Plan, divide by total count, * 100
PCCM	Among enrollees with months of Primary Care Case Management months greater than zero, count records with any capitated payments for Primary Care Case Management, divide by total count, * 100
ENCOUNTER CLAIMS	
Number of HMO/HIO or PHP Enrollees	Count records with Pre-paid Health Plan months > 0 (excluding persons with Primary Care Case Management only)

Measure	Measure Description
Percentage of HMO/HIO or PHP Enrollees with Encounter Records	Among HMO/HIO or PHP Enrollees , count the number with any Encounter records, divide by record count, * 100
PERSONS ENROLLED IN PHP ONLY OR PHP AND PCCM ONLY	
Total Capitation Payments	Among records with Pre-paid Health Plan months > 0 (excluding persons with Comprehensive Managed Care, PACE or Primary Care Case Management only), sum Comprehensive Managed Care Plan capitated payment amount, Pre-paid Health Plan capitated payment amount, and Primary Care Case Management capitated payment amount
Total Medicaid Paid	Among records with Pre-paid Health Plan months > 0 (excluding persons with Comprehensive Managed Care, PACE or Primary Care Case Management only), sum total Medicaid amount paid
Count of Enrollees	Count records with Pre-paid Health Plan months > 0 (excluding persons with Comprehensive Managed Care, PACE or Primary Care Case Management only)
Aged	Count records with months of PHP Only or PHP and PCCM Only > 0 and MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51
Disabled	Count records with months of PHP Only or PHP and PCCM Only > 0 and MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52
Child	Count records with months of PHP Only or PHP and PCCM Only > 0 and MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54
Adult	Count records with months of PHP Only or PHP and PCCM Only > 0 and MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55
Percentage of Enrollees with Encounter Records	Among enrollees with months of Pre-paid Plan type = 02, 03, 04, 05, 08 (among all 4 variables) and no months with HMO, count records with any Encounter records, divide by total record count, * 100
Aged	Among PHP Only or PHP and PCCM Only Enrollees with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, count the number with any encounter records, divide by total record count, * 100
Disabled	Among PHP Only or PHP and PCCM Only Enrollees with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, count the number with any encounter records, divide by total record count, * 100
Child	Among PHP Only or PHP and PCCM Only Enrollees with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54, count the number with any encounter records, divide by total record count, * 100
Adult	Among PHP Only or PHP and PCCM Only Enrollees with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, count the number with any encounter records, divide by total record count, * 100
Dental (MAX TOS = 09)	Among PHP Only or PHP and PCCM Only Enrollees, count the number with any Dental Encounter records, divide by total record count, * 100
Home Health (MAX TOS = 13)	Among PHP Only or PHP and PCCM Only Enrollees, count the number with any Home Health Encounter records, divide by total record count, * 100

Measure	Measure Description
Drugs (MAX TOS = 16)	Among PHP Only or PHP and PCCM Only Enrollees, count the number with any Drug Encounter records, divide by total record count, * 100
Transportation Services (MAX TOS = 26)	Among PHP Only or PHP and PCCM Only Enrollees, count the number with any Transportation Services Encounter records, divide by total record count, * 100
Personal Care Services (MAX TOS = 30)	Among PHP Only or PHP and PCCM Only Enrollees, count the number with any Personal Care Services Encounter records, divide by total record count, * 100
Psych Services (MAX TOS = 53)	Among PHP Only or PHP and PCCM Only Enrollees, count the number with any Psych Services Encounter records, divide by total record count, * 100
Unknown (MAX TOS = 99)	Among PHP Only or PHP and PCCM Only Enrollees, count the number with any Unknown TOS Encounter records, divide by total record count, * 100
All Other (All Other MAX TOS, Excluding Capitation Payments)	Among PHP Only or PHP and PCCM Only Enrollees, count the number with any encounter records for all other MAX TOS (all MAX TOS excluding 09,13,16,20,21,22,26,30,53,99), divide by total record count, * 100
PERSONS ENROLLED IN PCCM ONLY	
Total Capitation Payments	Among records with Primary Care Case Management > 0 and no other months with Pre-paid Health Plan or HMO or PACE, sum Comprehensive Managed Care Plan capitated payment amount, Pre-paid Health Plan capitated payment amount, and Primary Care Case Management capitated payment amount
Count of Enrollees	Count records with Primary Care Case Management > 0 and and no other months with Pre-paid Health Plan or HMO or PACE
PERSONS EVER ENROLLED IN HMO OR HIO DURING YEAR	
Count of Enrollees	Count records with months of Comprehensive Managed Care Plan or PACE > 0
Aged	Count records with months of Comprehensive Managed Care Plan or PACE > 0 and MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51
Disabled	Count records with months of Comprehensive Managed Care Plan or PACE > 0 and MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52
Child	Count records with months of Comprehensive Managed Care Plan or PACE > 0 and MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54
Adult	Count records with months of Comprehensive Managed Care Plan or PACE > 0 and MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55
Total Ever Enrolled in HMO/HIO Person-Years of Enrollment	Number of months of Comprehensive Managed Care Plan or PACE, divide by 12, sum over all records with months of Comprehensive Managed Care Plan or PACE > 0

Measure	Measure Description
Total Capitation Payments	Among records with months of Comprehensive Managed Care Plan or PACE > 0, sum Comprehensive Managed Care Plan capitated payment amount, Pre-paid Health Plan capitated payment amount, and Primary Care Case Management capitated payment amount
Avg Capitation Payments	Among records with months of Comprehensive Managed Care Plan or PACE > 0, sum Comprehensive Managed Care Plan capitated payment amount, Pre-paid Health Plan capitated payment amount, and Primary Care Case Management capitated payment amount, divide by total record count
Aged	Among records with months of Comprehensive Managed Care Plan or PACE > 0 and MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, sum Comprehensive Managed Care Plan capitated payment amount, Pre-paid Health Plan capitated payment amount, and Primary Care Case Management capitated payment amount, divide by total record count
Disabled	Among records with months of Comprehensive Managed Care Plan or PACE > 0 and MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, sum Comprehensive Managed Care Plan capitated payment amount, Pre-paid Health Plan capitated payment amount, and Primary Care Case Management capitated payment amount, divide by total record count
Child	Among records with months of Comprehensive Managed Care Plan or PACE > 0 and MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54, sum Comprehensive Managed Care Plan capitated payment amount, Pre-paid Health Plan capitated payment amount, and Primary Care Case Management capitated payment amount, divide by total record count
Adult	Among records with months of Comprehensive Managed Care Plan or PACE > 0 and MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55, sum Comprehensive Managed Care Plan capitated payment amount, Pre-paid Health Plan capitated payment amount, and Primary Care Case Management capitated payment amount, divide by total record count
Total FFS Payments	Among records with months of Comprehensive Managed Care Plan or PACE > 0, sum total FFS payments
Avg FFS Payments per Enrollee	Among records with months of Comprehensive Managed Care Plan or PACE > 0, sum total FFS payments, divide by number of records
Aged	Among records with months of Comprehensive Managed Care Plan or PACE > 0 and MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, sum total FFS payments, divide by number of records
Disabled	Among records with months of Comprehensive Managed Care Plan or PACE > 0 and MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, sum total FFS payments, divide by number of records
Child	Among records with months of Comprehensive Managed Care Plan or PACE > 0 and MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54, sum total FFS payments, divide by number of records
Adult	Among records with months of Comprehensive Managed Care Plan or PACE > 0 and MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55, sum total FFS payments, divide by number of records

Measure	Measure Description
Total FFS Payments by Type of Service	
IP (MAX TOS = 01)	Among records with months of Comprehensive Managed Care Plan or PACE > 0, sum total FFS payments (where MAX TOS = 01)
ILTC (MAX TOS = 02, 04, 05, 07)	Among records with months of Comprehensive Managed Care Plan or PACE > 0, sum total FFS payments (where MAX TOS = 02, 04, 05, 07)
Drug (MAX TOS = 16)	Among records with months of Comprehensive Managed Care Plan or PACE > 0, sum total FFS payments (where MAX TOS = 16)
All Other (Excluding Capitation Payments)	Among records with months of Comprehensive Managed Care Plan or PACE > 0, sum total FFS payments (where MAX TOS excludes 01, 02, 04, 05, 07, 16, 20, 21, 22)
Average FFS Payments by Type of Service	
IP (MAX TOS = 01)	Among records with months of Comprehensive Managed Care Plan or PACE > 0, sum total FFS payments (where MAX TOS = 01), divide by number of records
ILTC (MAX TOS = 02, 04, 05, 07)	Among records with months of Comprehensive Managed Care Plan or PACE > 0, sum total FFS payments (where MAX TOS = 02, 04, 05, 07, 16), divide by number of records
Drug (MAX TOS = 16)	Among records with months of Comprehensive Managed Care Plan or PACE > 0, sum total FFS payments (where MAX TOS = 16), divide by number of records
All Other (Excluding Capitation Payments)	Among records with months of Comprehensive Managed Care Plan or PACE > 0, sum total FFS payments (where MAX TOS excludes 01, 02, 04, 05, 07, 16, 20, 21, 22), divide by number of records
Percentage of Enrollees with Encounter Records	Among enrollees with months of Comprehensive Managed Care Plan or PACE > 0, count records with any Encounter records, divide by total record count, * 100
Aged	Among Comprehensive Managed Care Plan or PACE Enrollees with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, count the number with any Encounter records, divide by total record count, * 100
Disabled	Among Comprehensive Managed Care Plan or PACE Enrollees with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, count the number with any Encounter records, divide by total record count, * 100
Child	Among Comprehensive Managed Care Plan or PACE Enrollees with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54, count the number with any Encounter records, divide by total record count, * 100
Adult	Among Comprehensive Managed Care Plan or PACE Enrollees with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, count the number with any Encounter records, divide by total record count, * 100
IP (MAX TOS = 01)	Among Comprehensive Managed Care Plan or PACE Enrollees, count with any IP Encounter records, divide by total record count, * 100

Measure	Measure Description
MH Aged (MAX TOS = 02)	Among Comprehensive Managed Care Plan or PACE Enrollees, count with any MH Aged Encounter records, divide by total record count, * 100
IP Psych, Age < 21 (MAX TOS = 04)	Among Comprehensive Managed Care Plan or PACE Enrollees, count with any IP Psych Encounter records, divide by total record count, * 100
ICF/MR (MAX TOS = 05)	Among Comprehensive Managed Care Plan or PACE Enrollees, count with any ICF/MR Encounter records, divide by total record count, * 100
Nursing Faclities (MAX TOS = 07)	Among Comprehensive Managed Care Plan or PACE Enrollees, count with any Nursing Facilities Encounter records, divide by total record count, * 100
Physician (MAX TOS = 08)	Among Comprehensive Managed Care Plan or PACE Enrollees, count with any Physician Encounter records, divide by total record count, * 100
Dental (MAX TOS = 09)	Among Comprehensive Managed Care Plan or PACE Enrollees, count with any Dental Encounter records, divide by total record count, * 100
Other Practitioner (MAX TOS = 10)	Among Comprehensive Managed Care Plan or PACE Enrollees, count with any Other Practitioner Encounter records, divide by total record count, * 100
Outpatient (MAX TOS = 11)	Among Comprehensive Managed Care Plan or PACE Enrollees, count with any Outpatient Encounter records, divide by total record count, * 100
Clinic (MAX TOS = 12)	Among Comprehensive Managed Care Plan or PACE Enrollees, count with any Clinic Encounter records, divide by total record count, * 100
Home Health (MAX TOS = 13)	Among Comprehensive Managed Care Plan or PACE Enrollees, count with any Home Health Encounter records, divide by total record count, * 100
Lab/Xray (MAX TOS = 15)	Among Comprehensive Managed Care Plan or PACE Enrollees, count with any Lab/Xray Encounter records, divide by total record count, * 100
Drugs (MAX TOS = 16)	Among Comprehensive Managed Care Plan or PACE Enrollees, count with any Drug Encounter records, divide by total record count, * 100
Other Services (MAX TOS = 19)	Among Comprehensive Managed Care Plan or PACE Enrollees, count with any Other Services Encounter records, divide by total record count, * 100
Transportation (MAX TOS = 26)	Among Comprehensive Managed Care Plan or PACE Enrollees, count with any Transportation Encounter records, divide by total record count, * 100
Personal Care Services (MAX TOS = 30)	Among Comprehensive Managed Care Plan or PACE Enrollees, count with any Personal Care Services Encounter records, divide by total record count, * 100
Targeted Case Mgmt (MAX TOS = 31)	Among Comprehensive Managed Care Plan or PACE Enrollees, count with any Targeted Case Mgmt Encounter records, divide by total record count, * 100

Measure	Measure Description
Rehabilitation Services (MAX TOS = 33)	Among Comprehensive Managed Care Plan or PACE Enrollees, count with any Rehabilitation Services Encounter records, divide by total record count, * 100
PT/OT/Speech/Hearing (MAX TOS = 34)	Among Comprehensive Managed Care Plan or PACE Enrollees, count with any PTO/OT/Speech/Hearing Encounter records, divide by total record count, * 100
Hospice (MAX TOS = 35)	Among Comprehensive Managed Care Plan or PACE Enrollees, count with any Hospice Encounter records, divide by total record count, * 100
Nurse Practitioner (MAX TOS = 37)	Among Comprehensive Managed Care Plan or PACE Enrollees, count with any Nurse Practitioner Encounter records, divide by total record count, * 100
Private Duty Nursing (MAX TOS = 38)	Among Comprehensive Managed Care Plan or PACE Enrollees, count with any Private Duty Nursing Encounter records, divide by total record count, * 100
Durable Medical Equipment (MAX TOS = 51)	Among Comprehensive Managed Care Plan or PACE Enrollees, count with any Durable Medical Equipment Encounter records, divide by total record count, * 100
Residential Care (MAX TOS = 52)	Among Comprehensive Managed Care Plan or PACE Enrollees, count with any Residential Care Encounter records, divide by total record count, * 100
Psych Services (MAX TOS = 53)	Among Comprehensive Managed Care Plan or PACE Enrollees, count with any Psych Services Encounter records, divide by total record count, * 100
Adult Day Care (MAX TOS = 54)	Among Comprehensive Managed Care Plan or PACE Enrollees, count with any Adult Day Care Encounter records, divide by total record count, * 100
Unknown (MAX TOS = 99)	Among Comprehensive Managed Care Plan or PACE Enrollees, count with any Unknown TOS Encounter records, divide by total record count, * 100
All Other (All Other MAX TOS, Excluding Capitation Payments)	Among Comprehensive Managed Care Plan or PACE Enrollees, count the number with any encounter records for all other MAX TOS (24, 25, 36, and 39), divide by total record count, * 100
FFS INFORMATION FOR NON-DUAL MEDICAID ENROLLEES (excludes EDB Duals, people ever enrolled in HMO/HIOs or PACE, with missing eligibility information, S-CHIP only, FP Only, Aliens with restricted benefits only, prescription drug only enrollees, and persons enrolled only in assistance with purchase of MC Coverage) ---- NOTE: S-CHIP only, FP Only, and Aliens with restricted benefits were NOT excluded prior to 2001. Prescription drug only enrollees were NOT excluded prior to 2003. PACE enrollees were not excluded prior to 2007.	
Total Non-Dual FFS Enrollees	Count records

Measure	Measure Description
Total Non-Dual FFS Recipients	Count records with FFS claims > 0
Total Non-Dual FFS Person-Years of Enrollment	Number of months of enrollment, divide by 12, sum over all records with FFS claims > 0
Aged Total	Count records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51
Aged, Cash (MAX ELIG CD = 11)	Count records with MAX uniform eligibility code - most recent equal to 11
Aged, Medically Needy (MAX ELIG CD = 21)	Count records with MAX uniform eligibility code - most recent equal to 21
Aged, Poverty (MAX ELIG CD = 31)	Count records with MAX uniform eligibility code - most recent equal to 31
Other Aged (MAX ELIG CD = 41)	Count records with MAX uniform eligibility code - most recent equal to 41
1115 Aged (MAX ELIG CD = 51)	Count records with MAX uniform eligibility code - most recent equal to 51
Disabled Total	Count records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52
Disabled, Cash (MAX ELIG CD = 12)	Count records with MAX uniform eligibility code - most recent equal to 12
Disabled, Medically Needy (MAX ELIG CD = 22)	Count records with MAX uniform eligibility code - most recent equal to 22
Disabled, Poverty (MAX ELIG CD = 32, 3A)	Count records with MAX uniform eligibility code - most recent equal to 32 or 3A
Other Disabled (MAX ELIG CD = 42)	Count records with MAX uniform eligibility code - most recent equal to 42
1115 Disabled (MAX ELIG CD = 52)	Count records with MAX uniform eligibility code - most recent equal to 52
Child Total	Count records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54
AFDC Child, Cash (MAX ELIG CD = 14)	Count records with MAX uniform eligibility code - most recent equal to 14

Measure	Measure Description
AFDC-U Child, Cash (MAX ELIG CD = 16)	Count records with MAX uniform eligibility code - most recent equal to 16
AFDC Child, Medically Needy (MAX ELIG CD = 24)	Count records with MAX uniform eligibility code - most recent equal to 24
Child Poverty (MAX ELIG CD = 34)	Count records with MAX uniform eligibility code - most recent equal to 34
Other Child (MAX ELIG CD = 44)	Count records with MAX uniform eligibility code - most recent equal to 44
Foster Care Child (MAX ELIG CD = 48)	Count records with MAX uniform eligibility code - most recent equal to 48
1115 Child (MAX ELIG CD = 54)	Count records with MAX uniform eligibility code - most recent equal to 54
Adult Total	Count records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55
AFDC Adult, Cash (MAX ELIG CD = 15)	Count records with MAX uniform eligibility code - most recent equal to 15
AFDC-U Adult, Cash (MAX ELIG CD = 17)	Count records with MAX uniform eligibility code - most recent equal to 17
AFDC Adult, Medically Needy (MAX ELIG CD = 25)	Count records with MAX uniform eligibility code - most recent equal to 25
Adult, Poverty (MAX ELIG CD = 35)	Count records with MAX uniform eligibility code - most recent equal to 35
Other Adult (MAX ELIG CD = 45)	Count records with MAX uniform eligibility code - most recent equal to 45
1115 Adult (MAX ELIG CD = 55)	Count records with MAX uniform eligibility code - most recent equal to 55
# Non-Dual FFS Enrollees with MSIS Dual Code but No EDB Confirmation	Count records with Medicare Dual Code - Annual equal to 01, 02, 03, 04, 05, 06, 07, 08, or 09
Total FFS Medicaid Paid	Sum total FFS payments
Avg FFS Medicaid Paid per Non-Dual FFS Enrollee	Sum total FFS payments, divide by total record count

Measure	Measure Description
Avg FFS Medicaid Paid per Non-Dual FFS Recipient (User of Any service)	Sum total FFS payments, divide by total record count with FFS claims > 0
Total Capitation Payments	Sum Medicaid HMO, PHP, and PCCM premium payments
# with HMO/HIO Payments but No Enrollment in HMO/HIO or PACE	Sum Medicaid HMO premium indicator
Total HMO/HIO Payments (Among People not Enrolled)	Sum Medicaid HMO premium payments
Avg HMO/HIO Payments (Among People not Enrolled)	Sum Medicaid HMO premium payments, divide by Sum Medicaid HMO premium indicator
AVERAGE FFS MEDICAID AMOUNT PAID PER NON-DUAL FFS ENROLLEE BY MAX ELIGIBILITY GROUP MAX ELIG GRP	
Aged	Among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, sum total FFS payments, divide by total record count
Aged, Cash (MAX ELIG CD = 11)	Among records with MAX uniform eligibility code - most recent equal to 11, sum total FFS payments, divide by total record count
Aged, Medically Needy (MAX ELIG CD = 21)	Among records with MAX uniform eligibility code - most recent equal to 21, sum total FFS payments, divide by total record count
Aged, Poverty (MAX ELIG CD = 31)	Among records with MAX uniform eligibility code - most recent equal to 31, sum total FFS payments, divide by total record count
Other Aged (MAX ELIG CD = 41)	Among records with MAX uniform eligibility code - most recent equal to 41, sum total FFS payments, divide by total record count
1115 Aged (MAX ELIG CD = 51)	Among records with MAX uniform eligibility code - most recent equal to 51, sum total FFS payments, divide by total record count
Disabled	Among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, sum total FFS payments, divide by total record count
Disabled, Cash (MAX ELIG CD = 12)	Among records with MAX uniform eligibility code - most recent equal to 12, sum total FFS payments, divide by total record count
Disabled, Medically Needy (MAX ELIG CD = 22)	Among records with MAX uniform eligibility code - most recent equal to 22, sum total FFS payments, divide by total record count
Disabled, Poverty (MAX ELIG CD = 32, 3A)	Among records with MAX uniform eligibility code - most recent equal to 32 or 3A, sum total FFS payments, divide by total record count

Measure	Measure Description
Other Disabled (MAX ELIG CD = 42)	Among records with MAX uniform eligibility code - most recent equal to 42, sum total FFS payments, divide by total record count
1115 Disabled (MAX ELIG CD = 52)	Among records with MAX uniform eligibility code - most recent equal to 52, sum total FFS payments, divide by total record count
Child	Among records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54, sum total FFS payments, divide by total record count
AFDC Child, Cash (MAX ELIG CD = 14)	Among records with MAX uniform eligibility code - most recent equal to 14, sum total FFS payments, divide by total record count
AFDC-U Child, Cash (MAX ELIG CD = 16)	Among records with MAX uniform eligibility code - most recent equal to 16, sum total FFS payments, divide by total record count
AFDC Child, Medically Needy (MAX ELIG CD = 24)	Among records with MAX uniform eligibility code - most recent equal to 24, sum total FFS payments, divide by total record count
Child Poverty (MAX ELIG CD = 34)	Among records with MAX uniform eligibility code - most recent equal to 34, sum total FFS payments, divide by total record count
Other Child (MAX ELIG CD = 44)	Among records with MAX uniform eligibility code - most recent equal to 44, sum total FFS payments, divide by total record count
Foster Care Child (MAX ELIG CD = 48)	Among records with MAX uniform eligibility code - most recent equal to 48, sum total FFS payments, divide by total record count
1115 Child (MAX ELIG CD = 54)	Among records with MAX uniform eligibility code - most recent equal to 54, sum total FFS payments, divide by total record count
Adult	Among records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55, sum total FFS payments, divide by total record count
AFDC Adult, Cash (MAX ELIG CD = 15)	Among records with MAX uniform eligibility code - most recent equal to 15, sum total FFS payments, divide by total record count
AFDC-U Adult, Cash (MAX ELIG CD = 17)	Among records with MAX uniform eligibility code - most recent equal to 17, sum total FFS payments, divide by total record count
AFDC Adult, Medically Needy (MAX ELIG CD = 25)	Among records with MAX uniform eligibility code - most recent equal to 25, sum total FFS payments, divide by total record count
Adult, Poverty (MAX ELIG CD = 35)	Among records with MAX uniform eligibility code - most recent equal to 35, sum total FFS payments, divide by total record count
Other Adult (MAX ELIG CD = 45)	Among records with MAX uniform eligibility code - most recent equal to 45, sum total FFS payments, divide by total record count

Measure	Measure Description
1115 Adult (MAX ELIG CD = 55)	Among records with MAX uniform eligibility code - most recent equal to 55, sum total FFS payments, divide by total record count
FFS EXPENDITURES AND USERS BY MAX TYPE OF SERVICE	
IP: Total Medicaid Paid (MAX TOS = 01)	Sum total FFS payments (where MAX TOS = 01)
IP: Number of Users	Count records with number of FFS claims (where MAX TOS = 01) > 0
IP: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 01), divide by total record count with number of FFS claims (where MAX TOS = 01) > 0
IP: Avg Medicaid Covered Days Per User	Sum number of inpatient covered day counts (for stays), divide by total record count with number of FFS claims (where MAX TOS = 01) > 0
MH Aged: Total Medicaid Paid (MAX TOS = 02)	Sum total FFS payments (where MAX TOS = 02)
MH Aged: Number of Users	Count records with number of FFS claims (where MAX TOS = 02) > 0
MH Aged: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 02), divide by total record count with number of FFS claims (where MAX TOS = 02) > 0
IP Psych, Age < 21: Total Medicaid Paid (MAX TOS = 04)	Sum total FFS payments (where MAX TOS = 04)
IP Psych, Age < 21: Number of Users	Count records with number of FFS claims (where MAX TOS = 04) > 0
IP Psych, Age < 21: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 04), divide by total record count with number of FFS claims (where MAX TOS = 04) > 0
ICF/MR: Total Medicaid Paid (MAX TOS = 05)	Sum total FFS payments (where MAX TOS = 05)
ICF/MR: Number of Users	Count records with number of FFS claims (where MAX TOS = 05) > 0
ICF/MR: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 05), divide by total record count with number of FFS claims (where MAX TOS = 05) > 0
NF: Total Medicaid Paid (MAX TOS = 07)	Sum total FFS payments (where MAX TOS = 07)

Measure	Measure Description
NF: Number of Users	Count records with number of FFS claims (where MAX TOS = 07) > 0
NF:Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 07), divide by total record count with number of FFS claims (where MAX TOS = 07) > 0
Physician: Total Medicaid Paid (MAX TOS = 08)	Sum total FFS payments (where MAX TOS = 08)
Physician: Number of Users	Count records with number of FFS claims (where MAX TOS = 08) > 0
Physician: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 08), divide by total record count with number of FFS claims (where MAX TOS = 08) > 0
Dental: Total Medicaid Paid (MAX TOS = 09)	Sum total FFS payments (where MAX TOS = 09)
Dental: Number of Users	Count records with number of FFS claims (where MAX TOS = 09) > 0
Dental: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 09), divide by total record count with number of FFS claims (where MAX TOS = 09) > 0
Other Practitioner: Total Medicaid Paid (MAX TOS = 10)	Sum total FFS payments (where MAX TOS = 10)
Other Practitioner: Number of Users	Count records with number of FFS claims (where MAX TOS = 10) > 0
Other Practitioner: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 10), divide by total record count with number of FFS claims (where MAX TOS = 10) > 0
Outpatient: Total Medicaid Paid (MAX TOS = 11)	Sum total FFS payments (where MAX TOS = 11)
Outpatient: Number of Users	Count records with number of FFS claims (where MAX TOS = 11) > 0
Outpatient: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 11), divide by total record count with number of FFS claims (where MAX TOS = 11) > 0
Clinic: Total Medicaid Paid (MAX TOS = 12)	Sum total FFS payments (where MAX TOS = 12)
Clinic: Number of Users	Count records with number of FFS claims (where MAX TOS = 12) > 0

Measure	Measure Description
Clinic: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 12), divide by total record count with number of FFS claims (where MAX TOS = 12) > 0
Home Health: Total Medicaid Paid (MAX TOS = 13)	Sum total FFS payments (where MAX TOS = 13)
Home Health: Number of Users	Count records with number of FFS claims (where MAX TOS = 13) > 0
Home Health: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 13), divide by total record count with number of FFS claims (where MAX TOS = 13) > 0
Lab/Xray: Total Medicaid Paid (MAX TOS = 15)	Sum total FFS payments (where MAX TOS = 15)
Lab/Xray: Number of Users	Count records with number of FFS claims (where MAX TOS = 15) > 0
Lab/Xray:Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 15), divide by total record count with number of FFS claims (where MAX TOS = 15) > 0
Drugs: Total Medicaid Paid (MAX TOS = 16)	Sum total FFS payments (where MAX TOS = 16)
Drugs: Number of Users	Count records with number of FFS claims (where MAX TOS = 16) > 0
Drugs: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 16), divide by total record count with number of FFS claims (where MAX TOS = 16) > 0
Other Services: Total Medicaid Paid (MAX TOS = 19)	Sum total FFS payments (where MAX TOS = 19)
Other Services: Number of Users	Count records with number of FFS claims (where MAX TOS = 19) > 0
Other Services: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 19), divide by total record count with number of FFS claims (where MAX TOS = 19) > 0
Transportation: Total Medicaid Paid (MAX TOS = 26)	Sum total FFS payments (where MAX TOS = 26)
Transportation: Number of Users	Count records with number of FFS claims (where MAX TOS = 26) > 0
Transportation: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 26), divide by total record count with number of FFS claims (where MAX TOS = 26) > 0

Measure	Measure Description
Personal Care Services: Total Medicaid Paid (MAX TOS = 30)	Sum total FFS payments (where MAX TOS = 30)
Personal Care Services: Number of Users	Count records with number of FFS claims (where MAX TOS = 30) > 0
Personal Care Services: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 30), divide by total record count with number of FFS claims (where MAX TOS = 30) > 0
Targeted Case Mgmt: Total Medicaid Paid (MAX TOS = 31)	Sum total FFS payments (where MAX TOS = 31)
Targeted Case Management: Number of Users	Count records with number of FFS claims (where MAX TOS = 31) > 0
Targeted Case Management: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 31), divide by total record count with number of FFS claims (where MAX TOS = 31) > 0
Rehabilitation Services: Total Medicaid Paid (MAX TOS = 33)	Sum total FFS payments (where MAX TOS = 33)
Rehabilitation Services: Number of Users	Count records with number of FFS claims (where MAX TOS = 33) > 0
Rehabilitation Services: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 33), divide by total record count with number of FFS claims (where MAX TOS = 33) > 0
PT/OT/Speech/Hearing: Total Medicaid Paid (MAX TOS = 34)	Sum total FFS payments (where MAX TOS = 34)
PT/OT/Speech/Hearing: Number of Users	Count records with number of FFS claims (where MAX TOS = 34) > 0
PT/OT/Speech/Hearing: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 34), divide by total record count with number of FFS claims (where MAX TOS = 34) > 0
Hospice: Total Medicaid Paid (MAX TOS = 35)	Sum total FFS payments (where MAX TOS = 35)
Hospice: Number of Users	Count records with number of FFS claims (where MAX TOS = 35) > 0
Hospice: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 35), divide by total record count with number of FFS claims (where MAX TOS = 35) > 0
Nurse Practitioner: Total Medicaid Paid (MAX TOS = 37)	Sum total FFS payments (where MAX TOS = 37)

Measure	Measure Description
Nurse Practitioner: Number of Users	Count records with number of FFS claims (where MAX TOS = 37) > 0
Nurse Practitioner: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 35), divide by total record count with number of FFS claims (where MAX TOS = 37) > 0
Private Duty Nursing: Total Medicaid Paid (MAX TOS = 38)	Sum total FFS payments (where MAX TOS = 38)
Private Duty Nursing: Number of Users	Count records with number of FFS claims (where MAX TOS = 38) > 0
Private Duty Nursing: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 35), divide by total record count with number of FFS claims (where MAX TOS = 38) > 0
Durable Medical Equipmt: Total Medicaid Paid (MAX TOS = 51)	Sum total FFS payments (where MAX TOS = 51)
Durable Medical Equipment: Number of Users	Count records with number of FFS claims (where MAX TOS = 51) > 0
Durable Medical Equipment: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 51), divide by total record count with number of FFS claims (where MAX TOS = 51) > 0
Residential Care: Total Medicaid Paid (MAX TOS = 52)	Sum total FFS payments (where MAX TOS = 52)
Residential Care: Number of Users	Count records with number of FFS claims (where MAX TOS = 52) > 0
Residential Care: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 52), divide by total record count with number of FFS claims (where MAX TOS = 52) > 0
Psych Services: Total Medicaid Paid (MAX TOS = 53)	Sum total FFS payments (where MAX TOS = 53)
Psych Services: Number of Users	Count records with number of FFS claims (where MAX TOS = 53) > 0
Psych Services: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 53), divide by total record count with number of FFS claims (where MAX TOS = 53) > 0
Adult Day Care: Total Medicaid Paid (MAX TOS = 54)	Sum total FFS payments (where MAX TOS = 54)
Adult Day Care: Number of Users	Count records with number of FFS claims (where MAX TOS = 54) > 0

Measure	Measure Description
Adult Day Care: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 54), divide by total record count with number of FFS claims (where MAX TOS = 54) > 0
AVERAGE FFS MEDICAID AMOUNT PAID PER NON-DUAL FFS ENROLLEE BY MAX TYPE OF SERVICE	
Inpatient Hospital (MAX TOS = 01)	Sum total FFS payments (where MAX TOS = 01), divide by total record count with total FFS claims (where MAX TOS = 01) > 0
Aged	Among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, sum total FFS payments (where MAX TOS = 01), divide by total record count with total FFS claims (where MAX TOS = 01) > 0
Disabled	Among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, sum total FFS payments (where MAX TOS = 01), divide by total record count with total FFS claims (where MAX TOS = 01) > 0
Child	Among records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54, sum total FFS payments (where MAX TOS = 01), divide by total record count with total FFS claims (where MAX TOS = 01) > 0
Adult	Among records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55, sum total FFS payments (where MAX TOS = 01), divide by total record count with total FFS claims (where MAX TOS = 01) > 0
ILTC (MAX TOS = 02,04,05,07)	Sum total FFS payments (where MAX TOS = 02, 04, 05, 07), divide by total record count with total FFS claims (where MAX TOS = 02, 04, 05, 07) > 0
Aged	Among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, sum total FFS payments (where MAX TOS = 02, 04, 05, 07), divide by total record count with total FFS claims (where MAX TOS = 02, 04, 05, 07) > 0
Disabled	Among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, sum total FFS payments (where MAX TOS = 02, 04, 05, 07), divide by total record count with total FFS claims (where MAX TOS = 02, 04, 05, 07) > 0
Child	Among records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54, sum total FFS payments (where MAX TOS = 02, 04, 05, 07), divide by total record count with total FFS claims (where MAX TOS = 02, 04, 05, 07) > 0
Adult	Among records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55, sum total FFS payments (where MAX TOS = 02, 04, 05, 07), divide by total record count with total FFS claims (where MAX TOS = 02, 04, 05, 07) > 0
Drugs (MAX TOS = 16)	Sum total FFS payments (where MAX TOS = 16), divide by total record count with total FFS claims (where MAX TOS = 16) > 0
Aged	Among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, sum total FFS payments (where MAX TOS = 16), divide by total record count with total FFS claims (where MAX TOS = 16) > 0
Disabled	Among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, sum total FFS payments (where MAX TOS = 16), divide by total record count with total FFS claims (where MAX TOS = 16) > 0
Child	Among records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54, sum total FFS payments (where MAX TOS = 16), divide by total record count with total FFS claims (where MAX TOS = 16) > 0

Measure	Measure Description
Adult	Among records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55, sum total FFS payments (where MAX TOS = 16), divide by total record count with total FFS claims (where MAX TOS = 16) > 0
All Other Services	Sum total FFS payments (where MAX TOS excludes 01, 02, 04, 05, 07, 16, 20, 21, 22), divide by total record count with total FFS claims (where MAX TOS excludes 01, 02, 04, 05, 07, 16, 20, 21, 22) > 0
Aged	Among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, sum total FFS payments (where MAX TOS excludes 01, 02, 04, 05, 07, 16, 20, 21, 22), divide by total record count with total FFS claims (where MAX TOS excludes 01, 02, 04, 05, 07, 16, 20, 21, 22) > 0
Disabled	Among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, sum total FFS payments (where MAX TOS excludes 01, 02, 04, 05, 07, 16, 20, 21, 22), divide by total record count with total FFS claims (where MAX TOS excludes 01, 02, 04, 05, 07, 16, 20, 21, 22) > 0
Child	Among records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54, sum total FFS payments (where MAX TOS excludes 01, 02, 04, 05, 07, 16, 20, 21, 22), divide by total record count with total FFS claims (where MAX TOS excludes 01, 02, 04, 05, 07, 16, 20, 21, 22) > 0
Adult	Among records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55, sum total FFS payments (where MAX TOS excludes 01, 02, 04, 05, 07, 16, 20, 21, 22), divide by total record count with total FFS claims (where MAX TOS excludes 01, 02, 04, 05, 07, 16, 20, 21, 22) > 0
PERCENT OF NON-DUAL FFS ENROLLEES WITH CLAIMS BY SELECTED MAX TYPE OF SERVICE	
% Non-Dual FFS Enrollees with IP Claims (MAX TOS = 01)	Sum total record count with total FFS claims (where MAX TOS = 01) > 0, divide by total record count, *100
Aged	Among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, sum total record count with total FFS claims (where MAX TOS = 01) > 0, divide by total record count, *100
Disabled	Among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, sum total record count with total FFS claims (where MAX TOS = 01) > 0, divide by total record count, *100
Child	Among records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54, sum total record count with total FFS claims (where MAX TOS = 01) > 0, divide by total record count, *100
Adult	Among records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55, sum total record count with total FFS claims (where MAX TOS = 01) > 0, divide by total record count, *100
% Non-Dual FFS Enrollees with ILTC Claims (MAX TOS = 02,04,05,07)	Sum total record count with total FFS claims (where MAX TOS = 02, 04, 05, 07) > 0, divide by total record count, *100
Aged	Among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, sum total record count with total FFS claims (where MAX TOS = 02, 04, 05, 07) > 0, divide by total record count, *100

Measure	Measure Description
Disabled	Among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, sum total record count with total FFS claims (where MAX TOS = 02, 04, 05, 07) > 0, divide by total record count, *100
Child	Among records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54, sum total record count with total FFS claims (where MAX TOS = 02, 04, 05, 07) > 0, divide by total record count, *100
Adult	Among records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55, sum total record count with total FFS claims (where MAX TOS = 02, 04, 05, 07) > 0, divide by total record count, *100
% with Ratio of ILTC Days/Enrollment Days > 1	Count number of records with ILTC_GE_ENROLL_DAYS equal to 1, divide by total record count with total FFS claims (where MAX TOS = 02, 04, 05, 07) > 0, *100 ILTC_GE_ENROLL_DAYS = 1, if number of long-term care covered days > 31 * number of months of Medicaid eligibility
% Non-Dual FFS Enrollees with Drug Claims (MAX TOS = 16)	Sum total record count with total FFS claims (where MAX TOS = 16) > 0, divide by total record count, *100
Aged	Among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, sum total record count with total FFS claims (where MAX TOS = 16) > 0, divide by total record count, *100
Disabled	Among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, sum total record count with total FFS claims (where MAX TOS = 16) > 0, divide by total record count, *100
Child	Among records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54, sum total record count with total FFS claims (where MAX TOS = 16) > 0, divide by total record count, *100
Adult	Among records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55, sum total record count with total FFS claims (where MAX TOS = 16) > 0, divide by total record count, *100
% Non-Dual FFS Enrollees with All Other Claims	Sum total record count with total FFS claims (where MAX TOS excludes 01, 02, 04, 05, 07, 16, 20, 21, 22) > 0, divide by total record count, *100
Aged	Among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, sum total record count with total FFS claims (where MAX TOS excludes 01, 02, 04, 05, 07, 16, 20, 21, 22) > 0, divide by total record count, *100
Disabled	Among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, sum total record count with total FFS claims (where MAX TOS excludes 01, 02, 04, 05, 07, 16, 20, 21, 22) > 0, divide by total record count, *100
Child	Among records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54, sum total record count with total FFS claims (where MAX TOS excludes 01, 02, 04, 05, 07, 16, 20, 21, 22) > 0, divide by total record count, *100
Adult	Among records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55, sum total record count with total FFS claims (where MAX TOS excludes 01, 02, 04, 05, 07, 16, 20, 21, 22) > 0, divide by total record count, *100
Avg # IP Days per Non-Dual FFS User	Sum number of inpatient covered day counts (for stays), divide by sum of total record count with total FFS claims (where MAX TOS = 01) > 0
Aged	Among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, sum number of inpatient covered day counts (for stays), divide by sum of total record count with total FFS claims (where MAX TOS = 01) > 0

Measure	Measure Description
Disabled	Among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, sum number of inpatient covered day counts (for stays), divide by sum of total record count with total FFS claims (where MAX TOS = 01) > 0
Child	Among records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54, sum number of inpatient covered day counts (for stays), divide by sum of total record count with total FFS claims (where MAX TOS = 01) > 0
Adult	Among records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55, sum number of inpatient covered day counts (for stays), divide by sum of total record count with total FFS claims (where MAX TOS = 01) > 0
Avg # ILTC Days per Non-Dual FFS User	Sum number of long-term care covered days, divide by sum of total record count with total FFS claims (where MAX TOS = 02. 04, 05, 07) > 0
Aged	Among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, sum number of long-term care covered days, divide by sum of total record count with total FFS claims (where MAX TOS = 02. 04, 05, 07) > 0
Disabled	Among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, sum number of long-term care covered days, divide by sum of total record count with total FFS claims (where MAX TOS = 02. 04, 05, 07) > 0
Child	Among records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54, sum number of long-term care covered days, divide by sum of total record count with total FFS claims (where MAX TOS = 02. 04, 05, 07) > 0
Adult	Among records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55, sum number of long-term care covered days, divide by sum of total record count with total FFS claims (where MAX TOS = 02. 04, 05, 07) > 0
% Non-Dual FFS Enrollees with Maternal Delivery	Count records with delivery code equal to 1, divide by total record count, *100
HIGH-COST FFS NON-DUALS AND EXPENDITURES BY SELECTED MAX TYPE OF SERVICE	
Number of FFS Non-Duals with FFS Medicaid Paid > $1,000,000	Count records with total FFS payments > 1,000,000
Number of FFS Non-Duals with FFS Medicaid Paid > $500,000	Count records with total FFS payments > 500,000
Inpatient Hospital (MAX TOS = 01) > $500,000	Count records with total FFS payments (where MAX TOS = 01) > 500,000
ILTC (MAX TOS = 02,04,05,07) > $200,000	Count records with total FFS payments (where MAX TOS = 02, 04, 05, 07) > 200,000
Drugs (MAX TOS = 16) > $200,000	Count records with total FFS payments (where MAX TOS = 16) > 200,000
All Other Services > $200,000	Count records with total FFS payments (where MAX TOS excludes 01, 02, 04, 05, 07, 16, 20, 21, 22) > 200,000

Measure	Measure Description
Maximum FFS Medicaid Paid	Maximum total FFS payment
Inpatient Hospital (MAX TOS = 01)	Maximum total FFS payments (where MAX TOS = 01)
ILTC (MAX TOS = 02,04,05,07)	Maximum total FFS payments (where MAX TOS = 02, 04, 05, 07)
Drugs (MAX TOS = 16)	Maximum total FFS payments (where MAX TOS = 16)
All Other Services	Maximum total FFS payments (where MAX TOS excludes 01, 02, 04, 05, 07, 16, 20, 21, 22)
FFS EXPENDITURES AND USERS BY MAX PROGRAM TYPE	
FP: Total Medicaid Paid (PGM TYPE = 2)	Sum total Medicaid payments (where Program Type = 2)
FP: Number of Users	Count records with number of claims (where Program Type = 2) > 0
FP: Avg Medicaid Paid per User	Sum total Medicaid payments (where Program Type = 2), divide by total record count with number of claims (where Program Type = 2) > 0
RHC: Total Medicaid Paid (PGM TYPE = 3)	Sum total Medicaid payments (where Program Type = 3)
RHC: Number of Users	Count records with number of claims (where Program Type = 3) > 0
RHC: Avg Medicaid Paid per User	Sum total Medicaid payments (where Program Type = 3), divide by total record count with number of claims (where Program Type = 3) > 0
FQHC: Total Medicaid Paid (PGM TYPE = 4)	Sum total Medicaid payments (where Program Type = 4)
FQHC: Number of Users	Count records with number of claims (where Program Type = 4) > 0
FQHC: Avg Medicaid Paid per User	Sum total Medicaid payments (where Program Type = 4), divide by total record count with number of claims (where Program Type = 4) > 0
IHS: Total Medicaid Paid (PGM TYPE = 5)	Sum total Medicaid payments (where Program Type = 5)

Measure	Measure Description
IHS: Number of Users	Count records with number of claims (where Program Type = 5) > 0
IHS: Avg Medicaid Paid per User	Sum total Medicaid payments (where Program Type = 5), divide by total record count with number of claims (where Program Type = 5) > 0
Section 1915(c) Waiver: Total Medicaid Paid (PGM TYPE = 6,7)	Sum total Medicaid payments (where Program Type = 6 or 7)
Section 1915(c) Waiver: Number of Users	Count records with number of claims (where Program Type = 6 or 7) > 0
Section 1915(c) Waiver: Avg Medicaid Paid per User	Sum total Medicaid payments (where Program Type = 6 or 7), divide by total record count with number of claims (where Program Type = 6 or 7) > 0
FFS COMMUNITY-BASED LONG-TERM CARE EXPENDITURES AND USERS	
Total FFS CLTC Medicaid Paid (Excludes CLTC FLAG = 16-20)	Sum total FFS CLTC Medicaid payment amount (where CLTC code = 11, 12, 13, 14, 15, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40)
Number Non-Dual CLTC Users (Excludes CLTC FLAG = 16-20)	Count records with total FFS CLTC Medicaid payment amount (where CLTC code = 11, 12, 13, 14, 15, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0
Avg FFS CLTC Medicaid Paid per Non-Dual User (Excludes CLTC FLAG = 16-20)	Sum total FFS CLTC Medicaid payment amount (where CLTC code = 11, 12, 13, 14, 15, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40), divide by total record count with total FFS CLTC Medicaid payment amount (where CLTC code = 11, 12, 13, 14, 15, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0
Aged	Among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, count records with total FFS CLTC Medicaid payment amount (where CLTC code = 11, 12, 13, 14, 15, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0, divide by total record count, *100
Disabled	Among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, count records with total FFS CLTC Medicaid payment amount (where CLTC code = 11, 12, 13, 14, 15, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0, divide by total record count, *100
Child	Among records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54, count records with total FFS CLTC Medicaid payment amount (where CLTC code = 11, 12, 13, 14, 15, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0, divide by total record count, *100
Adult	Among records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55, count records with total FFS CLTC Medicaid payment amount (where CLTC code = 11, 12, 13, 14, 15, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0, divide by total record count, *100
% Non-Dual FFS Enrollees with CLTC Claims (Excludes CLTC FLAG = 16-20)	Count records with total FFS CLTC Medicaid payment amount (where CLTC code = 11, 12, 13, 14, 15, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0, divide by total record count, *100

Measure	Measure Description
Aged	Among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, count records with total FFS CLTC Medicaid payment amount (where CLTC code = 11, 12, 13, 14, 15, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0, divide by total record count, *100
Disabled	Among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, count records with total FFS CLTC Medicaid payment amount (where CLTC code = 11, 12, 13, 14, 15, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0, divide by total record count, *100
Child	Among records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54, count records with total FFS CLTC Medicaid payment amount (where CLTC code = 11, 12, 13, 14, 15, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0, divide by total record count, *100
Adult	Among records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55, count records with total FFS CLTC Medicaid payment amount (where CLTC code = 11, 12, 13, 14, 15, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0, divide by total record count, *100
Total FFS CLTC Medicaid Paid (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	Sum total FFS CLTC Medicaid payment amount (where CLTC code = 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40)
# Non-Dual CLTC Users (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	Count records with total FFS CLTC Medicaid payment amount (where CLTC code = 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0
Avg FFS CLTC Medicaid Paid per Non-Dual User (Section 1915 (c) Claims Only - Excludes CLTC FLAG = 11-20)	Sum total FFS CLTC Medicaid payment amount (where CLTC code = 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40), divide by total record count with total FFS CLTC Medicaid payment amount (where CLTC code = 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0
Aged	Among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, sum total FFS CLTC Medicaid payment amount (where CLTC code = 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40), divide by total record count with total FFS CLTC Medicaid payment amount (where CLTC code = 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0
Disabled	Among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, sum total FFS CLTC Medicaid payment amount (where CLTC code = 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40), divide by total record count with total FFS CLTC Medicaid payment amount (where CLTC code = 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0
Child	Among records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54, sum total FFS CLTC Medicaid payment amount (where CLTC code = 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40), divide by total record count with total FFS CLTC Medicaid payment amount (where CLTC code = 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0
Adult	Among records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55, sum total FFS CLTC Medicaid payment amount (where CLTC code = 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40), divide by total record count with total FFS CLTC Medicaid payment amount (where CLTC code = 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0
% Non-Dual FFS Enrollees with CLTC Claims (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	Count records with total FFS CLTC Medicaid payment amount (where CLTC code = 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0, divide by total record count, *100

Measure	Measure Description
Aged	Among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, count records with total FFS CLTC Medicaid payment amount (where CLTC code = 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0, divide by total record count, *100
Disabled	Among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, count records with total FFS CLTC Medicaid payment amount (where CLTC code = 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0, divide by total record count, *100
Child	Among records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54, count records with total FFS CLTC Medicaid payment amount (where CLTC code = 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0, divide by total record count, *100
Adult	Among records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55, count records with total FFS CLTC Medicaid payment amount (where CLTC code = 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0, divide by total record count, *100
FFS INFORMATION FOR DUAL MEDICAID ENROLLEES (excludes non-EDB duals, duals ever enrolled in HMO/HIOs or PACE, duals with only restricted benefits, duals with missing eligibility information, prescription drug only enrollees, and persons enrolled only in assistance with purchase of MC Coverage)--- NOTE: non-EDB duals and duals with restricted benefits were not excluded prior to 2001. Prescription drug only enrollees were NOT excluded prior to 2003. PACE enrollees were not excluded prior to 2007.	
Total EDB Dual FFS Enrollees	Count records
Number of EDB Dual FFS Recipients	Count records with FFS claims > 0
Total EDB Dual FFS Person-Years of Enrollment	Number of months of enrollment, divide by 12, sum over all records with FFS claims > 0
% EDB Dual Not Reported in MSIS (EDB DUAL = 50)	Count records with Medicare Dual Code - Annual equal to 50, divide by total record count, *100
% QMB Only (EDB DUAL = 51)	Count records with Medicare Dual Code - Annual equal to 51, divide by total record count, *100
% QMB Plus (EDB DUAL = 52)	Count records with Medicare Dual Code - Annual equal to 52, divide by total record count, *100
% SLMB Only (EDB DUAL = 53)	Count records with Medicare Dual Code - Annual equal to 53, divide by total record count, *100

Measure	Measure Description
% SLMB Plus (EDB DUAL = 54)	Count records with Medicare Dual Code - Annual equal to 54, divide by total record count, *100
% QDWI (EDB DUAL = 55)	Count records with Medicare Dual Code - Annual equal to 55, divide by total record count, *100
% QI 1 (EDB DUAL = 56)	Count records with Medicare Dual Code - Annual equal to 56, divide by total record count, *100
% QI 2 (EDB DUAL = 57)	Count records with Medicare Dual Code - Annual equal to 57, divide by total record count, *100
% Other Type Dual (EDB DUAL = 58)	Count records with Medicare Dual Code - Annual equal to 58, divide by total record count, *100
% Dual Type Unknown (EDB DUAL = 59)	Count records with Medicare Dual Code - Annual equal to 59, divide by total record count, *100
% EDB Duals with Full Benefits (EDB DUAL = 50,52,54,58)	Count records where Medicare Dual Code - Annual equals 50, 52, 54, or 58, divide by total record count, *100
% EDB Duals with Restricted Benefits (EDB DUAL = 51,53,55,56,57)	Count records where Medicare Dual Code - Annual equals 51, 53, 55, 56, or 57, divide by total record count, *100
Aged EDB Dual FFS Total	Count records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51
Aged, Cash (MAX ELIG CD = 11)	Count records with MAX uniform eligibility code - most recent equal to 11
Aged, Medically Needy (MAX ELIG CD = 21)	Count records with MAX uniform eligibility code - most recent equal to 21
Aged, Poverty (MAX ELIG CD = 31)	Count records with MAX uniform eligibility code - most recent equal to 31
Other Aged (MAX ELIG CD = 41)	Count records with MAX uniform eligibility code - most recent equal to 41
1115 Aged (MAX ELIG CD = 51)	Count records with MAX uniform eligibility code - most recent equal to 51
Disabled EDB Dual FFS Total	Count records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52
Disabled, Cash (MAX ELIG CD = 12)	Count records with MAX uniform eligibility code - most recent equal to 12

Measure	Measure Description
Disabled, Medically Needy (MAX ELIG CD = 22)	Count records with MAX uniform eligibility code - most recent equal to 22
Disabled, Poverty (MAX ELIG CD = 32, 3A)	Count records with MAX uniform eligibility code - most recent equal to 32 or 3A
Other Disabled (MAX ELIG CD = 42)	Count records with MAX uniform eligibility code - most recent equal to 42
1115 Disabled (MAX ELIG CD = 52)	Count records with MAX uniform eligibility code - most recent equal to 52
Total FFS Medicaid Paid	Sum total FFS payments
Avg FFS Medicaid Paid per FFS Dual	Sum total FFS payments, divide by total record count
Avg FFS Medicaid Paid per FFS Dual Recipient (User of Any Service)	Sum total FFS payments, divide by total record count with FFS claims > 0
Total Capitation Payments	Sum Medicaid HMO, PHP, and PCCM premium payments
# with HMO/HIO Payments but No Enrollment in HMO/HIO or PACE	Sum Medicaid HMO premium indicator
Total HMO/HIO Payments (Among People not Enrolled)	Sum Medicaid HMO premium payments
Avg HMO/HIO Payments (Among People not Enrolled)	Sum Medicaid HMO premium payments, divide by Sum Medicaid HMO premium indicator
AVERAGE FFS MEDICAID AMOUNT PAID PER FFS DUAL BY MAX ELIGIBILITY GROUP	
Aged	Among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, sum total FFS payments, divide by total record count
Aged, Cash (MAX ELIG CD = 11)	Among records with MAX uniform eligibility code - most recent equal to 11, sum total FFS payments, divide by total record count
Aged, Medically Needy (MAX ELIG CD = 21)	Among records with MAX uniform eligibility code - most recent equal to 21, sum total FFS payments, divide by total record count
Aged, Poverty (MAX ELIG CD = 31)	Among records with MAX uniform eligibility code - most recent equal to 31, sum total FFS payments, divide by total record count

Measure	Measure Description
Other Aged (MAX ELIG CD = 41)	Among records with MAX uniform eligibility code - most recent equal to 41, sum total FFS payments, divide by total record count
1115 Aged (MAX ELIG CD = 51)	Among records with MAX uniform eligibility code - most recent equal to 51, sum total FFS payments, divide by total record count
Disabled	Among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, sum total FFS payments, divide by total record count
Disabled, Cash (MAX ELIG CD = 12)	Among records with MAX uniform eligibility code - most recent equal to 12, sum total FFS payments, divide by total record count
Disabled, Medically Needy (MAX ELIG CD = 22)	Among records with MAX uniform eligibility code - most recent equal to 22, sum total FFS payments, divide by total record count
Disabled, Poverty (MAX ELIG CD = 32, 3A)	Among records with MAX uniform eligibility code - most recent equal to 32 or 3A, sum total FFS payments, divide by total record count
Other Disabled (MAX ELIG CD = 42)	Among records with MAX uniform eligibility code - most recent equal to 42, sum total FFS payments, divide by total record count
1115 Disabled (MAX ELIG CD = 52)	Among records with MAX uniform eligibility code - most recent equal to 52, sum total FFS payments, divide by total record count
FFS EXPENDITURES AND USERS BY MAX TYPE OF SERVICE	
IP: Total Medicaid Paid (MAX TOS = 01)	Sum total FFS payments (where MAX TOS = 01)
IP: Number of Users	Count records with number of FFS claims (where MAX TOS = 01) > 0
IP: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 01), divide by total record count with number of FFS claims (where MAX TOS = 01) > 0
IP: Avg Medicaid Covered Days Per User	Sum number of inpatient covered day counts (for stays), divide by total record count with number of FFS claims (where MAX TOS = 01) > 0
MH Aged: Total Medicaid Paid (MAX TOS = 02)	Sum total FFS payments (where MAX TOS = 02)
MH Aged: Number of Users	Count records with number of FFS claims (where MAX TOS = 02) > 0
MH Aged: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 02), divide by total record count with number of FFS claims (where MAX TOS = 02) > 0

Measure	Measure Description
IP Psych, Age < 21: Total Medicaid Paid (MAX TOS = 04)	Sum total FFS payments (where MAX TOS = 04)
IP Psych, Age < 21: Number of Users	Count records with number of FFS claims (where MAX TOS = 04) > 0
IP Psych, Age < 21: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 04), divide by total record count with number of FFS claims (where MAX TOS = 04) > 0
ICF/MR: Total Medicaid Paid (MAX TOS = 05)	Sum total FFS payments (where MAX TOS = 05)
ICF/MR: Number of Users	Count records with number of FFS claims (where MAX TOS = 05) > 0
ICF/MR: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 05), divide by total record count with number of FFS claims (where MAX TOS = 05) > 0
NF: Total Medicaid Paid (MAX TOS = 07)	Sum total FFS payments (where MAX TOS = 07)
NF: Number of Users	Count records with number of FFS claims (where MAX TOS = 07) > 0
NF:Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 07), divide by total record count with number of FFS claims (where MAX TOS = 07) > 0
Physician: Total Medicaid Paid (MAX TOS = 08)	Sum total FFS payments (where MAX TOS = 08)
Physician: Number of Users	Count records with number of FFS claims (where MAX TOS = 08) > 0
Physician: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 08), divide by total record count with number of FFS claims (where MAX TOS = 08) > 0
Dental: Total Medicaid Paid (MAX TOS = 09)	Sum total FFS payments (where MAX TOS = 09)
Dental: Number of Users	Count records with number of FFS claims (where MAX TOS = 09) > 0
Dental: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 09), divide by total record count with number of FFS claims (where MAX TOS = 09) > 0
Other Practitioner: Total Medicaid Paid (MAX TOS = 10)	Sum total FFS payments (where MAX TOS = 10)

Measure	Measure Description
Other Practitioner: Number of Users	Count records with number of FFS claims (where MAX TOS = 10) > 0
Other Practitioner: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 10), divide by total record count with number of FFS claims (where MAX TOS = 10) > 0
Outpatient: Total Medicaid Paid (MAX TOS = 11)	Sum total FFS payments (where MAX TOS = 11)
Outpatient: Number of Users	Count records with number of FFS claims (where MAX TOS = 11) > 0
Outpatient: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 11), divide by total record count with number of FFS claims (where MAX TOS = 11) > 0
Clinic: Total Medicaid Paid (MAX TOS = 12)	Sum total FFS payments (where MAX TOS = 12)
Clinic: Number of Users	Count records with number of FFS claims (where MAX TOS = 12) > 0
Clinic: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 12), divide by total record count with number of FFS claims (where MAX TOS = 12) > 0
Home Health: Total Medicaid Paid (MAX TOS = 13)	Sum total FFS payments (where MAX TOS = 13)
Home Health: Number of Users	Count records with number of FFS claims (where MAX TOS = 13) > 0
Home Health: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 13), divide by total record count with number of FFS claims (where MAX TOS = 13) > 0
Lab/Xray: Total Medicaid Paid (MAX TOS = 15)	Sum total FFS payments (where MAX TOS = 15)
Lab/Xray: Number of Users	Count records with number of FFS claims (where MAX TOS = 15) > 0
Lab/Xray:Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 15), divide by total record count with number of FFS claims (where MAX TOS = 15) > 0
Drugs: Total Medicaid Paid (MAX TOS = 16)	Sum total FFS payments (where MAX TOS = 16)
Drugs: Number of Users	Count records with number of FFS claims (where MAX TOS = 16) > 0

Measure	Measure Description
Drugs: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 16), divide by total record count with number of FFS claims (where MAX TOS = 16) > 0
Other Services: Total Medicaid Paid (MAX TOS = 19)	Sum total FFS payments (where MAX TOS = 19)
Other Services: Number of Users	Count records with number of FFS claims (where MAX TOS = 19) > 0
Other Services: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 19), divide by total record count with number of FFS claims (where MAX TOS = 19) > 0
Transportation: Total Medicaid Paid (MAX TOS = 26)	Sum total FFS payments (where MAX TOS = 26)
Transportation: Number of Users	Count records with number of FFS claims (where MAX TOS = 26) > 0
Transportation: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 26), divide by total record count with number of FFS claims (where MAX TOS = 26) > 0
Personal Care Services: Total Medicaid Paid (MAX TOS = 30)	Sum total FFS payments (where MAX TOS = 30)
Personal Care Services: Number of Users	Count records with number of FFS claims (where MAX TOS = 30) > 0
Personal Care Services: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 30), divide by total record count with number of FFS claims (where MAX TOS = 30) > 0
Targeted Case Mgmt: Total Medicaid Paid (MAX TOS = 31)	Sum total FFS payments (where MAX TOS = 31)
Targeted Case Management: Number of Users	Count records with number of FFS claims (where MAX TOS = 31) > 0
Targeted Case Management: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 31), divide by total record count with number of FFS claims (where MAX TOS = 31) > 0
Rehabilitation Services: Total Medicaid Paid (MAX TOS = 33)	Sum total FFS payments (where MAX TOS = 33)
Rehabilitation Services: Number of Users	Count records with number of FFS claims (where MAX TOS = 33) > 0
Rehabilitation Services: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 33), divide by total record count with number of FFS claims (where MAX TOS = 33) > 0

Measure	Measure Description
PT/OT/Speech/Hearing: Total Medicaid Paid (MAX TOS = 34)	Sum total FFS payments (where MAX TOS = 34)
PT/OT/Speech/Hearing: Number of Users	Count records with number of FFS claims (where MAX TOS = 34) > 0
PT/OT/Speech/Hearing: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 34), divide by total record count with number of FFS claims (where MAX TOS = 34) > 0
Hospice: Total Medicaid Paid (MAX TOS = 35)	Sum total FFS payments (where MAX TOS = 35)
Hospice: Number of Users	Count records with number of FFS claims (where MAX TOS = 35) > 0
Hospice: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 35), divide by total record count with number of FFS claims (where MAX TOS = 35) > 0
Nurse Practitioner: Total Medicaid Paid (MAX TOS = 37)	Sum total FFS payments (where MAX TOS = 37)
Nurse Practitioner: Number of Users	Count records with number of FFS claims (where MAX TOS = 37) > 0
Nurse Practitioner: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 35), divide by total record count with number of FFS claims (where MAX TOS = 37) > 0
Private Duty Nursing: Total Medicaid Paid (MAX TOS = 38)	Sum total FFS payments (where MAX TOS = 38)
Private Duty Nursing: Number of Users	Count records with number of FFS claims (where MAX TOS = 38) > 0
Private Duty Nursing: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 35), divide by total record count with number of FFS claims (where MAX TOS = 38) > 0
Durable Medical Equipmt: Total Medicaid Paid (MAX TOS = 51)	Sum total FFS payments (where MAX TOS = 51)
Durable Medical Equipment: Number of Users	Count records with number of FFS claims (where MAX TOS = 51) > 0
Durable Medical Equipment: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 51), divide by total record count with number of FFS claims (where MAX TOS = 51) > 0
Residential Care: Total Medicaid Paid (MAX TOS = 52)	Sum total FFS payments (where MAX TOS = 52)

Measure	Measure Description
Residential Care: Number of Users	Count records with number of FFS claims (where MAX TOS = 52) > 0
Residential Care: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 52), divide by total record count with number of FFS claims (where MAX TOS = 52) > 0
Psych Services: Total Medicaid Paid (MAX TOS = 53)	Sum total FFS payments (where MAX TOS = 53)
Psych Services: Number of Users	Count records with number of FFS claims (where MAX TOS = 53) > 0
Psych Services: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 53), divide by total record count with number of FFS claims (where MAX TOS = 53) > 0
Adult Day Care: Total Medicaid Paid (MAX TOS = 54)	Sum total FFS payments (where MAX TOS = 54)
Adult Day Care: Number of Users	Count records with number of FFS claims (where MAX TOS = 54) > 0
Adult Day Care: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 54), divide by total record count with number of FFS claims (where MAX TOS = 54) > 0
AVERAGE FFS MEDICAID AMOUNT PAID PER FFS DUAL BY SELECTED MAX TYPE OF SERVICE	
Inpatient Hospital (MAX TOS = 01)	Sum total FFS payments (where MAX TOS = 01), divide by total record count with total FFS claims (where MAX TOS = 01) > 0
Aged	Among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, sum total FFS payments (where MAX TOS = 01), divide by total record count with total FFS claims (where MAX TOS = 01) > 0
Disabled	Among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, sum total FFS payments (where MAX TOS = 01), divide by total record count with total FFS claims (where MAX TOS = 01) > 0
ILTC (MAX TOS = 02,04,05,07)	Sum total FFS payments (where MAX TOS = 02, 04, 05, 07), divide by total record count with total FFS claims (where MAX TOS = 02, 04, 05, 07) > 0
Aged	Among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, sum total FFS payments (where MAX TOS = 02, 04, 05, 07), divide by total record count with total FFS claims (where MAX TOS = 02, 04, 05, 07) > 0
Disabled	Among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, sum total FFS payments (where MAX TOS = 02, 04, 05, 07), divide by total record count with total FFS claims (where MAX TOS = 02, 04, 05, 07) > 0
Drugs (MAX TOS = 16)	Sum total FFS payments (where MAX TOS = 16), divide by total record count with total FFS claims (where MAX TOS = 16) > 0

Measure	Measure Description
Aged	Among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, sum total FFS payments (where MAX TOS = 16), divide by total record count with total FFS claims (where MAX TOS = 16) > 0
Disabled	Among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, sum total FFS payments (where MAX TOS = 16), divide by total record count with total FFS claims (where MAX TOS = 16) > 0
All Other Services	Sum total FFS payments (where MAX TOS excludes 01, 02, 04, 05, 07, 16, 20, 21, 22), divide by total record count with total FFS claims (where MAX TOS excludes 01, 02, 04, 05, 07, 16, 20, 21, 22) > 0
Aged	Among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, sum total FFS payments (where MAX TOS excludes 01, 02, 04, 05, 07, 16, 20, 21, 22), divide by total record count with total FFS claims (where MAX TOS excludes 01, 02, 04, 05, 07, 16, 20, 21, 22) > 0
Disabled	Among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, sum total FFS payments (where MAX TOS excludes 01, 02, 04, 05, 07, 16, 20, 21, 22), divide by total record count with total FFS claims (where MAX TOS excludes 01, 02, 04, 05, 07, 16, 20, 21, 22) > 0
PERCENT OF FFS DUALS WITH CLAIMS BY SELECTED MAX TYPE OF SERVICE	
% FFS Duals with IP Claims (MAX TOS = 01)	Sum total record count with total FFS claims (where MAX TOS = 01) > 0, divide by total record count, *100
Aged	Among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, sum total record count with total FFS claims (where MAX TOS = 01) > 0, divide by total record count, *100
Disabled	Among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, sum total record count with total FFS claims (where MAX TOS = 01) > 0, divide by total record count, *100
% FFS Duals with ILTC Claims (MAX TOS = 02,04,05,07)	Sum total record count with total FFS claims (where MAX TOS = 02, 04, 05, 07) > 0, divide by total record count, *100
Aged	Among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, sum total record count with total FFS claims (where MAX TOS = 02, 04, 05, 07) > 0, divide by total record count, *100
Disabled	Among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, sum total record count with total FFS claims (where MAX TOS = 02, 04, 05, 07) > 0, divide by total record count, *100
% FFS Duals with Drug Claims (MAX TOS = 16)	Sum total record count with total FFS claims (where MAX TOS = 16) > 0, divide by total record count, *100
Aged	Among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, sum total record count with total FFS claims (where MAX TOS = 16) > 0, divide by total record count, *100
Disabled	Among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, sum total record count with total FFS claims (where MAX TOS = 16) > 0, divide by total record count, *100

Measure	Measure Description
% FFS Duals with All Other Claims	Sum total record count with total FFS claims (where MAX TOS excludes 01, 02, 04, 05, 07, 16, 20, 21, 22) > 0, divide by total record count, *100
Aged	Among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, sum total record count with total FFS claims (where MAX TOS excludes 01, 02, 04, 05, 07, 16, 20, 21, 22) > 0, divide by total record count, *100
Disabled	Among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, sum total record count with total FFS claims (where MAX TOS excludes 01, 02, 04, 05, 07, 16, 20, 21, 22) > 0, divide by total record count, *100
Avg # IP Days per FFS Dual User (MAX TOS = 01)	Sum number of inpatient covered day counts (for stays), divide by sum of total record count with total FFS claims (where MAX TOS = 01) > 0
Aged	Among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, sum number of inpatient covered day counts (for stays), divide by sum of total record count with total FFS claims (where MAX TOS = 01) > 0
Disabled	Among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, sum number of inpatient covered day counts (for stays), divide by sum of total record count with total FFS claims (where MAX TOS = 01) > 0
Avg # ILTC Days per FFS Dual User (MAX TOS = 02, 04, 05, 07)	Sum number of long-term care covered days, divide by sum of total record count with total FFS claims (where MAX TOS = 02. 04, 05, 07) > 0
Aged	Among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, sum number of long-term care covered days, divide by sum of total record count with total FFS claims (where MAX TOS = 02. 04, 05, 07) > 0
Disabled	Among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, sum number of long-term care covered days, divide by sum of total record count with total FFS claims (where MAX TOS = 02. 04, 05, 07) > 0
HIGH-COST FFS DUALS AND EXPENDITURES BY SELECTED MAX TYPE OF SERVICE	
Number of FFS Duals with FFS Medicaid Paid > $1,000,000	Count records with total FFS payments > 1,000,000
Number of FFS Duals with FFS Medicaid Paid > $500,000	Count records with total FFS payments > 500,000
Inpatient Hospital (MAX TOS = 01) > $500,000	Count records with total FFS payments (where MAX TOS = 01) > 500,000
ILTC (MAX TOS = 02,04,05,07) > $200,000	Count records with total FFS payments (where MAX TOS = 02, 04, 05, 07) > 200,000
Drugs (MAX TOS = 16) > $200,000	Count records with total FFS payments (where MAX TOS = 16) > 200,000
All Other Services > $200,000	Count records with total FFS payments (where MAX TOS excludes 01, 02, 04, 05, 07, 16, 20, 21, 22) > 200,000

Measure	Measure Description
Maximum FFS Medicaid Paid	Maximum total FFS payment
Inpatient Hospital (MAX TOS = 01)	Maximum total FFS payments (where MAX TOS = 01)
ILTC (MAX TOS = 02,04,05,07)	Maximum total FFS payments (where MAX TOS = 02, 04, 05, 07)
Drugs (MAX TOS = 16)	Maximum total FFS payments (where MAX TOS = 16)
All Other Services	Maximum total FFS payments (where MAX TOS excludes 01, 02, 04, 05, 07, 16, 20, 21, 22)
FFS EXPENDITURES AND USERS BY MAX PROGRAM TYPE	
FP: Total Medicaid Paid (PGM TYPE = 2)	Sum total Medicaid payments (where Program Type = 2)
FP: Number of Users	Count records with number of claims (where Program Type = 2) > 0
FP: Avg Medicaid Paid per User	Sum total Medicaid payments (where Program Type = 2), divide by total record count with number of claims (where Program Type = 2) > 0
RHC: Total Medicaid Paid (PGM TYPE = 3)	Sum total Medicaid payments (where Program Type = 3)
RHC: Number of Users	Count records with number of claims (where Program Type = 3) > 0
RHC: Avg Medicaid Paid per User	Sum total Medicaid payments (where Program Type = 3), divide by total record count with number of claims (where Program Type = 3) > 0
FQHC: Total Medicaid Paid (PGM TYPE = 4)	Sum total Medicaid payments (where Program Type = 4)
FQHC: Number of Users	Count records with number of claims (where Program Type = 4) > 0
FQHC: Avg Medicaid Paid per User	Sum total Medicaid payments (where Program Type = 4), divide by total record count with number of claims (where Program Type = 4) > 0
IHS: Total Medicaid Paid (PGM TYPE = 5)	Sum total Medicaid payments (where Program Type = 5)

Measure	Measure Description
IHS: Number of Users	Count records with number of claims (where Program Type = 5) > 0
IHS: Avg Medicaid Paid per User	Sum total Medicaid payments (where Program Type = 5), divide by total record count with number of claims (where Program Type = 5) > 0
Section 1915(c) Waiver: Total Medicaid Paid (PGM TYPE = 6,7)	Sum total Medicaid payments (where Program Type = 6 or 7)
Section 1915(c) Waiver: Number of Users	Count records with number of claims (where Program Type = 6 or 7) > 0
Section 1915(c) Waiver: Avg Medicaid Paid per User	Sum total Medicaid payments (where Program Type = 6 or 7), divide by total record count with number of claims (where Program Type = 6 or 7) > 0
FFS COMMUNITY-BASED LONG-TERM CARE EXPENDITURES AND USERS	
Total FFS CLTC Medicaid Paid (Excludes CLTC FLAG = 16-20)	Sum total FFS CLTC Medicaid payment amount (where CLTC code = 11, 12, 13, 14, 15, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40)
Number of Dual CLTC Users (Excludes CLTC FLAG = 16-20)	Count records with total FFS CLTC Medicaid payment amount (where CLTC code = 11, 12, 13, 14, 15, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0
Avg FFS CLTC Medicaid Paid per Dual User (Excludes CLTC FLAG = 16-20)	Sum total FFS CLTC Medicaid payment amount (where CLTC code = 11, 12, 13, 14, 15, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40), divide by total record count with total FFS CLTC Medicaid payment amount (where CLTC code = 11, 12, 13, 14, 15, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0
Aged	Among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, count records with total FFS CLTC Medicaid payment amount (where CLTC code = 11, 12, 13, 14, 15, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0, divide by total record count, *100
Disabled	Among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, count records with total FFS CLTC Medicaid payment amount (where CLTC code = 11, 12, 13, 14, 15, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0, divide by total record count, *100
% FFS Dual Enrollees with CLTC Claims (Excludes CLTC FLAG = 16-20)	Count records with total FFS CLTC Medicaid payment amount (where CLTC code = 11, 12, 13, 14, 15, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0, divide by total record count, *100
Aged	Among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, count records with total FFS CLTC Medicaid payment amount (where CLTC code = 11, 12, 13, 14, 15, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0, divide by total record count, *100
Disabled	Among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, count records with total FFS CLTC Medicaid payment amount (where CLTC code = 11, 12, 13, 14, 15, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0, divide by total record count, *100

Measure	Measure Description
Total FFS CLTC Medicaid Paid (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	Sum total FFS CLTC Medicaid payment amount (where CLTC code = 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40)
# Dual CLTC Users (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	Count records with total FFS CLTC Medicaid payment amount (where CLTC code = 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0
Avg CLTC Medicaid Paid per Dual User (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	Sum total FFS CLTC Medicaid payment amount (where CLTC code = 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40), divide by total record count with total FFS CLTC Medicaid payment amount (where CLTC code = 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0
Aged	Among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, sum total FFS CLTC Medicaid payment amount (where CLTC code = 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40), divide by total record count with total FFS CLTC Medicaid payment amount (where CLTC code = 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0
Disabled	Among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, sum total FFS CLTC Medicaid payment amount (where CLTC code = 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40), divide by total record count with total FFS CLTC Medicaid payment amount (where CLTC code = 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0
% FFS Dual Enrollees with CLTC Claims (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	Count records with total FFS CLTC Medicaid payment amount (where CLTC code = 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0, divide by total record count, *100
Aged	Among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, count records with total FFS CLTC Medicaid payment amount (where CLTC code = 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0, divide by total record count, *100
Disabled	Among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, count records with total FFS CLTC Medicaid payment amount (where CLTC code = 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0, divide by total record count, *100
FFS INFORMATION FOR TOTAL MEDICAID ENROLLEES (excludes people ever enrolled in HMO/HIOs or PACE, with missing eligibility information, S-CHIP only, FP Only, Aliens with only restricted benefits, duals with restricted benefits only, prescription drug only enrollees, and persons enrolled only in assistance with purchase of MC Coverage) ---- NOTE: S-CHIP only, FP Only, duals with restricted benefits, and Aliens with restricted benefits were NOT excluded prior to 2001. Prescription drug only enrollees were NOT excluded prior to 2003. PACE enrollees were not excluded prior to 2007.	
Total FFS Enrollees	Count records
# FFS Recipients	Count records with FFS claims > 0

Measure	Measure Description
% FFS Enrollees Who Are Recipients	Count records with FFS claims > 0, divide by total record count
% Aged Who Are Recipients	Count records with FFS claims > 0, among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, divide by total records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, *100
% Disabled Who Are Recipients	Count records with FFS claims > 0, among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, divide by total records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, *100
% Child Who Are Recipients	Count records with FFS claims > 0, among records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54, divide by total records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54, *100
% Adults Who Are Recipients	Count records with FFS claims > 0, among records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55, divide by total records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55, *100
Total FFS Person-Years of Enrollment	Number of months of enrollment, divide by 12, sum over all records with FFS claims > 0
Aged Total	Count records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51
Aged, Cash (MAX ELIG CD = 11)	Count records with MAX uniform eligibility code - most recent equal to 11
Aged, Medically Needy (MAX ELIG CD = 21)	Count records with MAX uniform eligibility code - most recent equal to 21
Aged, Poverty (MAX ELIG CD = 31)	Count records with MAX uniform eligibility code - most recent equal to 31
Other Aged (MAX ELIG CD = 41)	Count records with MAX uniform eligibility code - most recent equal to 41
1115 Aged (MAX ELIG CD = 51)	Count records with MAX uniform eligibility code - most recent equal to 51
Disabled Total	Count records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52
Disabled, Cash (MAX ELIG CD = 12)	Count records with MAX uniform eligibility code - most recent equal to 12
Disabled, Medically Needy (MAX ELIG CD = 22)	Count records with MAX uniform eligibility code - most recent equal to 22
Disabled, Poverty (MAX ELIG CD = 32, 3A)	Count records with MAX uniform eligibility code - most recent equal to 32 or 3A

Measure	Measure Description
Other Disabled (MAX ELIG CD = 42)	Count records with MAX uniform eligibility code - most recent equal to 42
1115 Disabled (MAX ELIG CD = 52)	Count records with MAX uniform eligibility code - most recent equal to 52
Child Total	Count records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54
AFDC Child, Cash (MAX ELIG CD = 14)	Count records with MAX uniform eligibility code - most recent equal to 14
AFDC-U Child, Cash (MAX ELIG CD = 16)	Count records with MAX uniform eligibility code - most recent equal to 16
AFDC Child, Medically Needy (MAX ELIG CD = 24)	Count records with MAX uniform eligibility code - most recent equal to 24
Child Poverty (MAX ELIG CD = 34)	Count records with MAX uniform eligibility code - most recent equal to 34
Other Child (MAX ELIG CD = 44)	Count records with MAX uniform eligibility code - most recent equal to 44
Foster Care Child (MAX ELIG CD = 48)	Count records with MAX uniform eligibility code - most recent equal to 48
1115 Child (MAX ELIG CD = 54)	Count records with MAX uniform eligibility code - most recent equal to 54
Adult Total	Count records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55
AFDC Adult, Cash (MAX ELIG CD = 15)	Count records with MAX uniform eligibility code - most recent equal to 15
AFDC-U Adult, Cash (MAX ELIG CD = 17)	Count records with MAX uniform eligibility code - most recent equal to 17
AFDC Adult, Medically Needy (MAX ELIG CD = 25)	Count records with MAX uniform eligibility code - most recent equal to 25
Adult, Poverty (MAX ELIG CD = 35)	Count records with MAX uniform eligibility code - most recent equal to 35
Other Adult (MAX ELIG CD = 45)	Count records with MAX uniform eligibility code - most recent equal to 45

Measure	Measure Description
1115 Adult (MAX ELIG CD = 55)	Count records with MAX uniform eligibility code - most recent equal to 55
Total FFS Medicaid Paid	Sum total FFS payments
Avg FFS Medicaid Paid per FFS Enrollee	Sum total FFS payments, divide by total record count
Avg FFS Medicaid Paid per FFS Recipient (User of Any Service)	Sum total FFS payments, divide by total record count with FFS claims > 0
Total Capitation Payments	Sum Medicaid HMO, PHP, and PCCM premium payments
# with HMO/HIO Payments but No Enrollment in HMO/HIO or PACE	Sum Medicaid HMO premium indicator
Total HMO/HIO Payments (Among People not Enrolled)	Sum Medicaid HMO premium payments
Avg HMO/HIO Payments (Among People not Enrolled)	Sum Medicaid HMO premium payments, divide by Sum Medicaid HMO premium indicator
AVERAGE FFS MEDICAID AMOUNT PAID PER FFS ENROLLEE BY MAX ELIGIBILITY GROUP	
Aged	Among records MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, sum total FFS payments, divide by total record count
Aged, Cash (MAX ELIG CD = 11)	Among records MAX uniform eligibility code - most recent equal to 11, sum total FFS payments, divide by total record count
Aged, Medically Needy (MAX ELIG CD = 21)	Among records MAX uniform eligibility code - most recent equal to 21, sum total FFS payments, divide by total record count
Aged, Poverty (MAX ELIG CD = 31)	Among records MAX uniform eligibility code - most recent equal to 31, sum total FFS payments, divide by total record count
Other Aged (MAX ELIG CD = 41)	Among records MAX uniform eligibility code - most recent equal to 41, sum total FFS payments, divide by total record count
1115 Aged (MAX ELIG CD = 51)	Among records MAX uniform eligibility code - most recent equal to 51, sum total FFS payments, divide by total record count
Disabled	Among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, sum total FFS payments, divide by total record count

Measure	Measure Description
Disabled, Cash (MAX ELIG CD = 12)	Among records with MAX uniform eligibility code - most recent equal to 12, sum total FFS payments, divide by total record count
Disabled, Medically Needy (MAX ELIG CD = 22)	Among records with MAX uniform eligibility code - most recent equal to 22, sum total FFS payments, divide by total record count
Disabled, Poverty (MAX ELIG CD = 32, 3A)	Among records with MAX uniform eligibility code - most recent equal to 32 or 3A, sum total FFS payments, divide by total record count
Other Disabled (MAX ELIG CD = 42)	Among records with MAX uniform eligibility code - most recent equal to 42, sum total FFS payments, divide by total record count
1115 Disabled (MAX ELIG CD = 52)	Among records with MAX uniform eligibility code - most recent equal to 52, sum total FFS payments, divide by total record count
Child	Among records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54, sum total FFS payments, divide by total record count
AFDC Child, Cash (MAX ELIG CD = 14)	Among records with MAX uniform eligibility code - most recent equal to 14, sum total FFS payments, divide by total record count
AFDC-U Child, Cash (MAX ELIG CD = 16)	Among records with MAX uniform eligibility code - most recent equal to 16, sum total FFS payments, divide by total record count
AFDC Child, Medically Needy (MAX ELIG CD = 24)	Among records with MAX uniform eligibility code - most recent equal to 24, sum total FFS payments, divide by total record count
Child Poverty (MAX ELIG CD = 34)	Among records with MAX uniform eligibility code - most recent equal to 34, sum total FFS payments, divide by total record count
Other Child (MAX ELIG CD = 44)	Among records with MAX uniform eligibility code - most recent equal to 44, sum total FFS payments, divide by total record count
Foster Care Child (MAX ELIG CD = 48)	Among records with MAX uniform eligibility code - most recent equal to 48, sum total FFS payments, divide by total record count
1115 Child (MAX ELIG CD = 54)	Among records with MAX uniform eligibility code - most recent equal to 54, sum total FFS payments, divide by total record count
Adult	Among records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55, sum total FFS payments, divide by total record count
AFDC Adult, Cash (MAX ELIG CD = 15)	Among records with MAX uniform eligibility code - most recent equal to 15, sum total FFS payments, divide by total record count
AFDC-U Adult, Cash (MAX ELIG CD = 17)	Among records with MAX uniform eligibility code - most recent equal to 17, sum total FFS payments, divide by total record count

Measure	Measure Description
AFDC Adult, Medically Needy (MAX ELIG CD = 25)	Among records with MAX uniform eligibility code - most recent equal to 25, sum total FFS payments, divide by total record count
Adult, Poverty (MAX ELIG CD = 35)	Among records with MAX uniform eligibility code - most recent equal to 35, sum total FFS payments, divide by total record count
Other Adult (MAX ELIG CD = 45)	Among records with MAX uniform eligibility code - most recent equal to 45, sum total FFS payments, divide by total record count
1115 Adult (MAX ELIG CD = 55)	Among records with MAX uniform eligibility code - most recent equal to 55, sum total FFS payments, divide by total record count
FFS EXPENDITURES AND USERS BY MAX TYPE OF SERVICE	
IP: Total Medicaid Paid (MAX TOS = 01)	Sum total FFS payments (where MAX TOS = 01)
IP: Number of Users	Count records with number of FFS claims (where MAX TOS = 01) > 0
IP: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 01), divide by total record count with number of FFS claims (where MAX TOS = 01) > 0
IP: Avg Medicaid Covered Days Per User	Sum number of inpatient covered day counts (for stays), divide by total record count with number of FFS claims (where MAX TOS = 01) > 0
MH Aged: Total Medicaid Paid (MAX TOS = 02)	Sum total FFS payments (where MAX TOS = 02)
MH Aged: Number of Users	Count records with number of FFS claims (where MAX TOS = 02) > 0
MH Aged: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 02), divide by total record count with number of FFS claims (where MAX TOS = 02) > 0
IP Psych, Age < 21: Total Medicaid Paid (MAX TOS = 04)	Sum total FFS payments (where MAX TOS = 04)
IP Psych, Age < 21: Number of Users	Count records with number of FFS claims (where MAX TOS = 04) > 0
IP Psych, Age < 21: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 04), divide by total record count with number of FFS claims (where MAX TOS = 04) > 0
ICF/MR: Total Medicaid Paid (MAX TOS = 05)	Sum total FFS payments (where MAX TOS = 05)

Measure	Measure Description
ICF/MR: Number of Users	Count records with number of FFS claims (where MAX TOS = 05) > 0
ICF/MR: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 05), divide by total record count with number of FFS claims (where MAX TOS = 05) > 0
NF: Total Medicaid Paid (MAX TOS = 07)	Sum total FFS payments (where MAX TOS = 07)
NF: Number of Users	Count records with number of FFS claims (where MAX TOS = 07) > 0
NF:Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 07), divide by total record count with number of FFS claims (where MAX TOS = 07) > 0
Physician: Total Medicaid Paid (MAX TOS = 08)	Sum total FFS payments (where MAX TOS = 08)
Physician: Number of Users	Count records with number of FFS claims (where MAX TOS = 08) > 0
Physician: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 08), divide by total record count with number of FFS claims (where MAX TOS = 08) > 0
Dental: Total Medicaid Paid (MAX TOS = 09)	Sum total FFS payments (where MAX TOS = 09)
Dental: Number of Users	Count records with number of FFS claims (where MAX TOS = 09) > 0
Dental: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 09), divide by total record count with number of FFS claims (where MAX TOS = 09) > 0
Other Practitioner: Total Medicaid Paid (MAX TOS = 10)	Sum total FFS payments (where MAX TOS = 10)
Other Practitioner: Number of Users	Count records with number of FFS claims (where MAX TOS = 10) > 0
Other Practitioner: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 10), divide by total record count with number of FFS claims (where MAX TOS = 10) > 0
Outpatient: Total Medicaid Paid (MAX TOS = 11)	Sum total FFS payments (where MAX TOS = 11)
Outpatient: Number of Users	Count records with number of FFS claims (where MAX TOS = 11) > 0

Measure	Measure Description
Outpatient: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 11), divide by total record count with number of FFS claims (where MAX TOS = 11) > 0
Clinic: Total Medicaid Paid (MAX TOS = 12)	Sum total FFS payments (where MAX TOS = 12)
Clinic: Number of Users	Count records with number of FFS claims (where MAX TOS = 12) > 0
Clinic: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 12), divide by total record count with number of FFS claims (where MAX TOS = 12) > 0
Home Health: Total Medicaid Paid (MAX TOS = 13)	Sum total FFS payments (where MAX TOS = 13)
Home Health: Number of Users	Count records with number of FFS claims (where MAX TOS = 13) > 0
Home Health: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 13), divide by total record count with number of FFS claims (where MAX TOS = 13) > 0
Lab/Xray: Total Medicaid Paid (MAX TOS = 15)	Sum total FFS payments (where MAX TOS = 15)
Lab/Xray: Number of Users	Count records with number of FFS claims (where MAX TOS = 15) > 0
Lab/Xray:Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 15), divide by total record count with number of FFS claims (where MAX TOS = 15) > 0
Drugs: Total Medicaid Paid (MAX TOS = 16)	Sum total FFS payments (where MAX TOS = 16)
Drugs: Number of Users	Count records with number of FFS claims (where MAX TOS = 16) > 0
Drugs: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 16), divide by total record count with number of FFS claims (where MAX TOS = 16) > 0
Other Services: Total Medicaid Paid (MAX TOS = 19)	Sum total FFS payments (where MAX TOS = 19)
Other Services: Number of Users	Count records with number of FFS claims (where MAX TOS = 19) > 0
Other Services: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 19), divide by total record count with number of FFS claims (where MAX TOS = 19) > 0

Measure	Measure Description
Transportation: Total Medicaid Paid (MAX TOS = 26)	Sum total FFS payments (where MAX TOS = 26)
Transportation: Number of Users	Count records with number of FFS claims (where MAX TOS = 26) > 0
Transportation: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 26), divide by total record count with number of FFS claims (where MAX TOS = 26) > 0
Personal Care Services: Total Medicaid Paid (MAX TOS = 30)	Sum total FFS payments (where MAX TOS = 30)
Personal Care Services: Number of Users	Count records with number of FFS claims (where MAX TOS = 30) > 0
Personal Care Services: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 30), divide by total record count with number of FFS claims (where MAX TOS = 30) > 0
Targeted Case Mgmt: Total Medicaid Paid (MAX TOS = 31)	Sum total FFS payments (where MAX TOS = 31)
Targeted Case Management: Number of Users	Count records with number of FFS claims (where MAX TOS = 31) > 0
Targeted Case Management: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 31), divide by total record count with number of FFS claims (where MAX TOS = 31) > 0
Rehabilitation Services: Total Medicaid Paid (MAX TOS = 33)	Sum total FFS payments (where MAX TOS = 33)
Rehabilitation Services: Number of Users	Count records with number of FFS claims (where MAX TOS = 33) > 0
Rehabilitation Services: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 33), divide by total record count with number of FFS claims (where MAX TOS = 33) > 0
PT/OT/Speech/Hearing: Total Medicaid Paid (MAX TOS = 34)	Sum total FFS payments (where MAX TOS = 34)
PT/OT/Speech/Hearing: Number of Users	Count records with number of FFS claims (where MAX TOS = 34) > 0
PT/OT/Speech/Hearing: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 34), divide by total record count with number of FFS claims (where MAX TOS = 34) > 0
Hospice: Total Medicaid Paid (MAX TOS = 35)	Sum total FFS payments (where MAX TOS = 35)

Measure	Measure Description
Hospice: Number of Users	Count records with number of FFS claims (where MAX TOS = 35) > 0
Hospice: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 35), divide by total record count with number of FFS claims (where MAX TOS = 35) > 0
Nurse Practitioner: Total Medicaid Paid (MAX TOS = 37)	Sum total FFS payments (where MAX TOS = 37)
Nurse Practitioner: Number of Users	Count records with number of FFS claims (where MAX TOS = 37) > 0
Nurse Practitioner: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 35), divide by total record count with number of FFS claims (where MAX TOS = 37) > 0
Private Duty Nursing: Total Medicaid Paid (MAX TOS = 38)	Sum total FFS payments (where MAX TOS = 38)
Private Duty Nursing: Number of Users	Count records with number of FFS claims (where MAX TOS = 38) > 0
Private Duty Nursing: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 35), divide by total record count with number of FFS claims (where MAX TOS = 38) > 0
Durable Medical Equipmt: Total Medicaid Paid (MAX TOS = 51)	Sum total FFS payments (where MAX TOS = 51)
Durable Medical Equipment: Number of Users	Count records with number of FFS claims (where MAX TOS = 51) > 0
Durable Medical Equipment: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 51), divide by total record count with number of FFS claims (where MAX TOS = 51) > 0
Residential Care: Total Medicaid Paid (MAX TOS = 52)	Sum total FFS payments (where MAX TOS = 52)
Residential Care: Number of Users	Count records with number of FFS claims (where MAX TOS = 52) > 0
Residential Care: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 52), divide by total record count with number of FFS claims (where MAX TOS = 52) > 0
Psych Services: Total Medicaid Paid (MAX TOS = 53)	Sum total FFS payments (where MAX TOS = 53)
Psych Services: Number of Users	Count records with number of FFS claims (where MAX TOS = 53) > 0

Measure	Measure Description
Psych Services: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 53), divide by total record count with number of FFS claims (where MAX TOS = 53) > 0
Adult Day Care: Total Medicaid Paid (MAX TOS = 54)	Sum total FFS payments (where MAX TOS = 54)
Adult Day Care: Number of Users	Count records with number of FFS claims (where MAX TOS = 54) > 0
Adult Day Care: Avg Medicaid Paid per User	Sum total FFS payments (where MAX TOS = 54), divide by total record count with number of FFS claims (where MAX TOS = 54) > 0
AVERAGE FFS MEDICAID AMOUNT PAID PER FFS ENROLLEE BY SELECTED MAX TYPE OF SERVICE	
Inpatient Hospital (MAX TOS = 01)	Sum total FFS payments (where MAX TOS = 01), divide by total record count with total FFS claims (where MAX TOS = 01) > 0
Aged	Among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, sum total FFS payments (where MAX TOS = 01), divide by total record count with total FFS claims (where MAX TOS = 01) > 0
Disabled	Among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, sum total FFS payments (where MAX TOS = 01), divide by total record count with total FFS claims (where MAX TOS = 01) > 0
Child	Among records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54, sum total FFS payments (where MAX TOS = 01), divide by total record count with total FFS claims (where MAX TOS = 01) > 0
Adult	Among records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55, sum total FFS payments (where MAX TOS = 01), divide by total record count with total FFS claims (where MAX TOS = 01) > 0
ILTC (MAX TOS = 02,04,05,07)	Sum total FFS payments (where MAX TOS = 02, 04, 05, 07), divide by total record count with total FFS claims (where MAX TOS = 02, 04, 05, 07) > 0
Aged	Among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, sum total FFS payments (where MAX TOS = 02, 04, 05, 07), divide by total record count with total FFS claims (where MAX TOS = 02, 04, 05, 07) > 0
Disabled	Among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, sum total FFS payments (where MAX TOS = 02, 04, 05, 07), divide by total record count with total FFS claims (where MAX TOS = 02, 04, 05, 07) > 0
Child	Among records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54, sum total FFS payments (where MAX TOS = 02, 04, 05, 07), divide by total record count with total FFS claims (where MAX TOS = 02, 04, 05, 07) > 0
Adult	Among records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55, sum total FFS payments (where MAX TOS = 02, 04, 05, 07), divide by total record count with total FFS claims (where MAX TOS = 02, 04, 05, 07) > 0
Drugs (MAX TOS = 16)	Sum total FFS payments (where MAX TOS = 16), divide by total record count with total FFS claims (where MAX TOS = 16) > 0

Measure	Measure Description
Aged	Among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, sum total FFS payments (where MAX TOS = 16), divide by total record count with total FFS claims (where MAX TOS = 16) > 0
Disabled	Among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, sum total FFS payments (where MAX TOS = 16), divide by total record count with total FFS claims (where MAX TOS = 16) > 0
Child	Among records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54, sum total FFS payments (where MAX TOS = 16), divide by total record count with total FFS claims (where MAX TOS = 16) > 0
Adult	Among records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55, sum total FFS payments (where MAX TOS = 16), divide by total record count with total FFS claims (where MAX TOS = 16) > 0
All Other Services	Sum total FFS payments (where MAX TOS excludes 01, 02, 04, 05, 07, 16, 20, 21, 22), divide by total record count with total FFS claims (where MAX TOS excludes 01, 02, 04, 05, 07, 16, 20, 21, 22) > 0
Aged	Among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, sum total FFS payments (where MAX TOS excludes 01, 02, 04, 05, 07, 16, 20, 21, 22), divide by total record count with total FFS claims (where MAX TOS excludes 01, 02, 04, 05, 07, 16, 20, 21, 22) > 0
Disabled	Among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, sum total FFS payments (where MAX TOS excludes 01, 02, 04, 05, 07, 16, 20, 21, 22), divide by total record count with total FFS claims (where MAX TOS excludes 01, 02, 04, 05, 07, 16, 20, 21, 22) > 0
Child	Among records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54, sum total FFS payments (where MAX TOS excludes 01, 02, 04, 05, 07, 16, 20, 21, 22), divide by total record count with total FFS claims (where MAX TOS excludes 01, 02, 04, 05, 07, 16, 20, 21, 22) > 0
Adult	Among records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55, sum total FFS payments (where MAX TOS excludes 01, 02, 04, 05, 07, 16, 20, 21, 22), divide by total record count with total FFS claims (where MAX TOS excludes 01, 02, 04, 05, 07, 16, 20, 21, 22) > 0
PERCENT OF FFS ENROLLEES WITH CLAIMS BY SELECTED MAX TYPE OF SERVICE	
% FFS Enrollees with IP Claims (MAX TOS = 01)	Sum total record count with total FFS claims (where MAX TOS = 01) > 0, divide by total record count, *100
Aged	Among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, sum total record count with total FFS claims (where MAX TOS = 01) > 0, divide by total record count, *100
Disabled	Among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, sum total record count with total FFS claims (where MAX TOS = 01) > 0, divide by total record count, *100
Child	Among records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54, sum total record count with total FFS claims (where MAX TOS = 01) > 0, divide by total record count, *100

Measure	Measure Description
Adult	Among records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55, sum total record count with total FFS claims (where MAX TOS = 01) > 0, divide by total record count, *100
% FFS Enrollees with ILTC Claims (MAX TOS = 02,04,05,07)	Sum total record count with total FFS claims (where MAX TOS = 02, 04, 05, 07) > 0, divide by total record count, *100
Aged	Among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, sum total record count with total FFS claims (where MAX TOS = 02, 04, 05, 07) > 0, divide by total record count, *100
Disabled	Among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, sum total record count with total FFS claims (where MAX TOS = 02, 04, 05, 07) > 0, divide by total record count, *100
Child	Among records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54, sum total record count with total FFS claims (where MAX TOS = 02, 04, 05, 07) > 0, divide by total record count, *100
Adult	Among records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55, sum total record count with total FFS claims (where MAX TOS = 02, 04, 05, 07) > 0, divide by total record count, *100
% FFS Enrollees with Drug Claims (MAX TOS = 16)	Sum total record count with total FFS claims (where MAX TOS = 16) > 0, divide by total record count, *100
Aged	Among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, sum total record count with total FFS claims (where MAX TOS = 16) > 0, divide by total record count, *100
Disabled	Among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, sum total record count with total FFS claims (where MAX TOS = 16) > 0, divide by total record count, *100
Child	Among records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54, sum total record count with total FFS claims (where MAX TOS = 16) > 0, divide by total record count, *100
Adult	Among records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55, sum total record count with total FFS claims (where MAX TOS = 16) > 0, divide by total record count, *100
% FFS Enrollees with All Other Claims	Sum total record count with total FFS claims (where MAX TOS excludes 01, 02, 04, 05, 07, 16, 20, 21, 22) > 0, divide by total record count, *100
Aged	Among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, sum total record count with total FFS claims (where MAX TOS excludes 01, 02, 04, 05, 07, 16, 20, 21, 22) > 0, divide by total record count, *100
Disabled	Among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, sum total record count with total FFS claims (where MAX TOS excludes 01, 02, 04, 05, 07, 16, 20, 21, 22) > 0, divide by total record count, *100
Child	Among records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54, sum total record count with total FFS claims (where MAX TOS excludes 01, 02, 04, 05, 07, 16, 20, 21, 22) > 0, divide by total record count, *100
Adult	Among records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55, sum total record count with total FFS claims (where MAX TOS excludes 01, 02, 04, 05, 07, 16, 20, 21, 22) > 0, divide by total record count, *100

Measure	Measure Description
Avg # IP Days per FFS User	Sum number of inpatient covered day counts (for stays), divide by sum of total record count with total FFS claims (where MAX TOS = 01) > 0
Aged	Among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, sum number of inpatient covered day counts (for stays), divide by sum of total record count with total FFS claims (where MAX TOS = 01) > 0
Disabled	Among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, sum number of inpatient covered day counts (for stays), divide by sum of total record count with total FFS claims (where MAX TOS = 01) > 0
Child	Among records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54, sum number of inpatient covered day counts (for stays), divide by sum of total record count with total FFS claims (where MAX TOS = 01) > 0
Adult	Among records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55, sum number of inpatient covered day counts (for stays), divide by sum of total record count with total FFS claims (where MAX TOS = 01) > 0
Avg # ILTC Days per FFS User	Sum number of long-term care covered days, divide by sum of total record count with total FFS claims (where MAX TOS = 02. 04, 05, 07) > 0
Aged	Among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, sum number of long-term care covered days, divide by sum of total record count with total FFS claims (where MAX TOS = 02. 04, 05, 07) > 0
Disabled	Among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, sum number of long-term care covered days, divide by sum of total record count with total FFS claims (where MAX TOS = 02. 04, 05, 07) > 0
Child	Among records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54, sum number of long-term care covered days, divide by sum of total record count with total FFS claims (where MAX TOS = 02. 04, 05, 07) > 0
Adult	Among records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55, sum number of long-term care covered days, divide by sum of total record count with total FFS claims (where MAX TOS = 02. 04, 05, 07) > 0
HIGH-COST FFS ENROLLEES AND EXPENDITURES BY SELECTED MAX TYPE OF SERVICE	
Number of FFS Enrollees with FFS Medicaid Paid > $1,000,000	Count records with total FFS payments > 1,000,000
Number of FFS Enrollees with FFS Medicaid Paid > $500,000	Count records with total FFS payments > 500,000
Inpatient Hospital (MAX TOS = 01) > $500,000	Count records with total FFS payments (where MAX TOS = 01) > 500,000
ILTC (MAX TOS = 02,04,05,07) > $200,000	Count records with total FFS payments (where MAX TOS = 02, 04, 05, 07) > 200,000
Drugs (MAX TOS = 16) > $200,000	Count records with total FFS payments (where MAX TOS = 16) > 200,000

Measure	Measure Description
All Other Services > $200,000	Count records with total FFS payments (where MAX TOS excludes 01, 02, 04, 05, 07, 16, 20, 21, 22) > 200,000
Maximum FFS Medicaid Paid	Maximum total FFS payment
Inpatient Hospital (MAX TOS = 01)	Maximum total FFS payments (where MAX TOS = 01)
ILTC (MAX TOS = 02,04,05,07)	Maximum total FFS payments (where MAX TOS = 02, 04, 05, 07)
Drugs (MAX TOS = 16)	Maximum total FFS payments (where MAX TOS = 16)
All Other Services	Maximum total FFS payments (where MAX TOS excludes 01, 02, 04, 05, 07, 16, 20, 21, 22)
FFS EXPENDITURES AND USERS BY MAX PROGRAM TYPE	
FP: Total Medicaid Paid (PGM TYPE = 2)	Sum total Medicaid payments (where Program Type = 2)
FP: Number of Users	Count records with number of claims (where Program Type = 2) > 0
FP: Avg Medicaid Paid per User	Sum total Medicaid payments (where Program Type = 2), divide by total record count with number of claims (where Program Type = 2) > 0
RHC: Total Medicaid Paid (PGM TYPE = 3)	Sum total Medicaid payments (where Program Type = 3)
RHC: Number of Users	Count records with number of claims (where Program Type = 3) > 0
RHC: Avg Medicaid Paid per User	Sum total Medicaid payments (where Program Type = 3), divide by total record count with number of claims (where Program Type = 3) > 0
FQHC: Total Medicaid Paid (PGM TYPE = 4)	Sum total Medicaid payments (where Program Type = 4)
FQHC: Number of Users	Count records with number of claims (where Program Type = 4) > 0
FQHC: Avg Medicaid Paid per User	Sum total Medicaid payments (where Program Type = 4), divide by total record count with number of claims (where Program Type = 4) > 0

Measure	Measure Description
IHS: Total Medicaid Paid (PGM TYPE = 5)	Sum total Medicaid payments (where Program Type = 5)
IHS: Number of Users	Count records with number of claims (where Program Type = 5) > 0
IHS: Avg Medicaid Paid per User	Sum total Medicaid payments (where Program Type = 5), divide by total record count with number of claims (where Program Type = 5) > 0
Section 1915(c) Waiver: Total Medicaid Paid (PGM TYPE = 6,7)	Sum total Medicaid payments (where Program Type = 6 or 7)
Section 1915(c) Waiver: Number of Users	Count records with number of claims (where Program Type = 6 or 7) > 0
Section 1915(c) Waiver: Avg Medicaid Paid per User	Sum total Medicaid payments (where Program Type = 6 or 7), divide by total record count with number of claims (where Program Type = 6 or 7) > 0
FFS COMMUNITY-BASED LONG-TERM CARE EXPENDITURES AND USERS	
Total FFS CLTC Medicaid Paid (Excludes CLTC FLAG = 16-20)	Sum total FFS CLTC Medicaid payment amount (where CLTC code = 11, 12, 13, 14, 15, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40)
Number of CLTC Users (Excludes CLTC FLAG = 16-20)	Count records with total FFS CLTC Medicaid payment amount (where CLTC code = 11, 12, 13, 14, 15, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0
Avg FFS CLTC Medicaid Paid per User (Excludes CLTC FLAG = 16-20)	Sum total FFS CLTC Medicaid payment amount (where CLTC code = 11, 12, 13, 14, 15, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40), divide by total record count with total FFS CLTC Medicaid payment amount (where CLTC code = 11, 12, 13, 14, 15, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0
Aged	Among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, count records with total FFS CLTC Medicaid payment amount (where CLTC code = 11, 12, 13, 14, 15, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0, divide by total record count, *100
Disabled	Among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, count records with total FFS CLTC Medicaid payment amount (where CLTC code = 11, 12, 13, 14, 15, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0, divide by total record count, *100
Child	Among records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54, count records with total FFS CLTC Medicaid payment amount (where CLTC code = 11, 12, 13, 14, 15, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0, divide by total record count, *100
Adult	Among records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55, count records with total FFS CLTC Medicaid payment amount (where CLTC code = 11, 12, 13, 14, 15, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0, divide by total record count, *100

Measure	Measure Description
% FFS Enrollees with CLTC Claims (Excludes CLTC FLAG = 16-20)	Count records with total FFS CLTC Medicaid payment amount (where CLTC code = 11, 12, 13, 14, 15, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0, divide by total record count, *100
Aged	Among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, count records with total FFS CLTC Medicaid payment amount (where CLTC code = 11, 12, 13, 14, 15, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0, divide by total record count, *100
Disabled	Among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, count records with total FFS CLTC Medicaid payment amount (where CLTC code = 11, 12, 13, 14, 15, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0, divide by total record count, *100
Child	Among records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54, count records with total FFS CLTC Medicaid payment amount (where CLTC code = 11, 12, 13, 14, 15, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0, divide by total record count, *100
Adult	Among records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55, count records with total FFS CLTC Medicaid payment amount (where CLTC code = 11, 12, 13, 14, 15, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0, divide by total record count, *100
Total FFS CLTC Medicaid Paid (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	Sum total FFS CLTC Medicaid payment amount (where CLTC code = 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40)
Number of CLTC Users (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	Count records with total FFS CLTC Medicaid payment amount (where CLTC code = 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0
Avg FFS CLTC Medicaid Paid per User (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	Sum total FFS CLTC Medicaid payment amount (where CLTC code = 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40), divide by total record count with total FFS CLTC Medicaid payment amount (where CLTC code = 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0
Aged	Among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, sum total FFS CLTC Medicaid payment amount (where CLTC code = 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40), divide by total record count with total FFS CLTC Medicaid payment amount (where CLTC code = 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0
Disabled	Among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, sum total FFS CLTC Medicaid payment amount (where CLTC code = 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40), divide by total record count with total FFS CLTC Medicaid payment amount (where CLTC code = 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0
Child	Among records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54, sum total FFS CLTC Medicaid payment amount (where CLTC code = 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40), divide by total record count with total FFS CLTC Medicaid payment amount (where CLTC code = 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0
Adult	Among records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55, sum total FFS CLTC Medicaid payment amount (where CLTC code = 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40), divide by total record count with total FFS CLTC Medicaid payment amount (where CLTC code = 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0

Measure	Measure Description
% FFS Enrollees with CLTC Claims (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	Count records with total FFS CLTC Medicaid payment amount (where CLTC code = 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0, divide by total record count, *100
Aged	Among records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51, count records with total FFS CLTC Medicaid payment amount (where CLTC code = 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0, divide by total record count, *100
Disabled	Among records with MAX uniform eligibility code - most recent equal to 12, 22, 32, 3A, 42, or 52, count records with total FFS CLTC Medicaid payment amount (where CLTC code = 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0, divide by total record count, *100
Child	Among records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54, count records with total FFS CLTC Medicaid payment amount (where CLTC code = 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0, divide by total record count, *100
Adult	Among records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55, count records with total FFS CLTC Medicaid payment amount (where CLTC code = 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40) > 0, divide by total record count, *100

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