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Medicaid Analytic Extract Specifications for State-Specific Validation Tables, 2003

June 30, 2011

MATHEMATICA
Policy Research, Inc.

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Medicaid Analytic Extract Specifications for State-Specific Validation Tables, 2003

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ABBREVIATIONS AND ACRONYMS IN THE VALIDATION TABLES

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

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
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
MAX = Medicaid Analytic Extract
MAX ELIG CD = MAX eligibility code
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
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 Records	**This section has no exclusions.**
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
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
% Standard Adjustments	Among records with type claim code equal to 1 and adjustment code equal to 1 or 2, count records with with adjustment code equal to 1, divide by total record count, *100
Aver. Amt. Pd Adjust. (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
FFS Non-Crossover Claims (Type of Claim=1, Crossover Claim Indicator=0)	**This section includes records with type claim code equal to 1 and Medicare crossover code - claim based - equal to 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
Aver. Medicaid Amount Paid (claims with >$0 paid)	Among records with Medicaid amount paid > 0, sum total Medicaid amount paid, divide by total record count
Aver. Medicaid Amt Paid per Covered Day (>$0 paid and >0 days claims)	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
% Claims with TPL	Count records with third-party payment amount > 0, divide by total record count, *100
Aver. TPL Paid for claims with TPL	

Measure	Measure Description
% Claims 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
Average # UB-92 Accom. Codes (at least 1 accom code)	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
% Claims 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
Average # UB-92 Ancillary Codes (at least 1 Ancillary code)	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
Average LOS	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
Average Covered Days (> 0 day)	Among records with covered inpatient days > 0, sum covered inpatient days, divide by total record count
% Begin Date = Admit Date	Count records with service begin date equal to admission date, divide by total record count, *100
% IP Claims (MAX TOS 01)	Count records with MAX type of service equal to 01, divide by total record count, *100
% Family Planning Claims (pgm type=2)	Count records with type of program equal to 2, divide by total record count, *100
% Claims with PDX	Count records with principal diagnosis code not equal to spaces, 0-fill, 8-fill, 9-fill, divide by total record count, *100
Average Number of DX Codes (at least 1 DX)	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
% Claims with PDX, where 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
% Claims with PDX, where 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
% Claims with PDX, where 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
% Claims 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
Average Number of Procedures for claims with at least 1 procedure code	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
% Claims with Procedures that have CPT-4 Indicator	

Measure	Measure Description
% Claims with Procedures that have 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
% Claims with Procedures that have CPT-4 Indicator & CPT-4 format of 5n	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
% Claims with Procedures that have ICD-9-CM Indicator & ICD-9-CM Format 3n or 4n	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
% Claims with DRG	Count records with drug related group not equal spaces, 0-fill, 8-fill, 9-fill, divide by total record count, *100
% Claims Maternal Delivery Indicator	Count records with recipient delivery code equal to 1, divide by total record count, *100
% Claims Newborn Delivery Indicator (only for separate infant delivery claims 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
% Died	Count records with patient status code equal to 20, 40, 41, or 42, divide by total record count, *100
FFS Crossover Claims (Type of Claim=1, Crossover Claim Indicator=1)	**This section includes records with type claim code equal to 1 and Medicare crossover code - claim based - equal to 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
Aver. Medicaid Amount 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
Aver. TPL Paid -claims with TPL	

Measure	Measure Description
% Claims withUB-92 Accommodation Codes	Count records with at least one UB-92 revenue code equal to 0100 through 0219, divide by total record count, *100
Average # UB-92 Accom. Codes (at least 1 accom code)	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
% Claims 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
Average # UB-92 Ancillary Codes (at least 1 Ancillary code)	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
Average LOS	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
% Begin Date = Admit Date	Count records with service begin date equal to admission date, divide by total record count, *100
% Claims with IP TOS	Count records with MAX type of service equal to 01, divide by total record count, *100
% Claims with DX	Count records with principal diagnosis code not equal to spaces, 0-fill, 8-fill, 9-fill, divide by total record count, *100
Average Number of DX Codes (at least 1 DX)	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
% Claims with PDX, where 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
% Claims with PDX, where 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
% Claims with PDX, where 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
% Claims 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
Average Number of Procedures for claims with at least 1 procedure code	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
% Claims with Procedures that have 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
% Claims with Procedures that have 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
% Claims with Procedures that have CPT-4 Indicator & CPT-4 format of 5n	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
% Claims with Procedures that have ICD-9-CM Indicator & ICD-9-CM Format 3n or 4n	

Measure	Measure Description
% Claims with DRG	Count records with drug related group not equal spaces, 0-fill, 8-fill, 9-fill, divide by total record count, *100

Measure	Measure Description
All Records	**This section has no exclusions.**
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
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
% Standard Adjustments	Among records with type claim code equal to 1 and adjustment code equal to 1 or 2, count records with with adjustment code equal to 1, divide by total record count, *100
Aver. Amt. Pd Adjust. (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
FFS Non-Crossover Claims (Type of Claim=1 Crossover Claim Indicator=0)	**This section includes records with type claim code equal to 1 and Medicare crossover code - claim based - equal to 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 (claims with >$0 paid)	
NF (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 (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
Aged/MH (TOS 02)	

Measure	Measure Description
IP Psych. < 21 (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
% NF (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 (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
% Aged/MH (TOS 02)	Count records with MAX type of service equal to 02, divide by total record count, *100
% Aged/MH claims with Aged/MH 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
Avg days for Aged/MH 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. < 21 (TOS 04)	Count records with MAX type of service equal to 04, divide by total record count, *100
% IP Psych. < 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. < 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
% Claims with Leave Days	Count records with long-term care leave day count > 0, divide by total record count, *100
% Claims with DX	Count records with first diagnosis code not equal to spaces, 0-fill, 8-fill, 9-fill, divide by total record count, *100
% Claims with DX, where 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
% Claims with DX, where 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
% Claims with DX, where 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

Measure	Measure Description
Patient Status	
% 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
FFS Crossover Claims (Type of Claim=1, Crossover Claim Indicator=1)	**This section includes records with type claim code equal to 1 and Medicare crossover code - claim based - equal to 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
Aver. Medicaid Amount Paid (claims with >$0 paid)	Among records with Medicaid amount paid > 0, sum total Medicaid amount paid, divide by total record count
% NF (TOS 07)	Count records with MAX type of service equal to 07, divide by total record count, *100
% ICF/MR (TOS 05)	Count records with MAX type of service equal to 05, divide by total record count, *100
% Aged/MH (TOS 02)	Count records with MAX type of service equal to 02, divide by total record count, *100
% IP Psych. < 21 (TOS 04)	Count records with MAX type of service equal to 04, divide by total record count, *100
% Claims with DX	Count records with first diagnosis code not equal to spaces, 0-fill, 8-fill, 9-fill, divide by total record count, *100
% Claims with DX, where 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
% Claims with DX, where 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
% Claims with DX, where 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
% 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	

Measure	Measure Description
All Records	**This section has no exclusions.**
Total Number of Claims	Count records in the file
% Encounter Claims (Claim Type=3)	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
% Cap Claims (Claim Type=2, and MAX TOS 20,21,22)	Count records with type claim code equal to 2 and MAX type of service = 20, 21, or 22, divide by total record count, *100
Total FFS Claims Excluding Capitation Payments	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
% Standard Adjustments	Among records with type claim code equal to 1 and adjustment code equal to 1 or 2, count records with with adjustment code equal to 1, divide by total record count, *100
Aver. Amt. Pd Adjust. (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(TOC 1,2) TOS 20: HMO Cap 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(TOC 1,2) TOS 21: PHP Cap Payments	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(TOC 1,2) TOS 22: PCCM Cap Pay.	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
Average Paid per HMO Cap Clms (TOS 20)	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
Average Paid per PHP Cap Clms (TOS 21)	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
Average Paid per PCCM Cap Clms (TOS 22)	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
FFS Non-Crossover Claims (Type of Claim=1, Crossover Claim Indicator=0, excluding capitation claims)	

Measure	Measure Description
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
% OPD Claims with Span Bill/ All OPD Claims(TOS 11)	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
% HH Claims with Span Bill/All HH Claims (TOS 13)	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 Bills/All Other Claims	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
% Claims W/ Service Place 11- Office	Count records with place of service equal to 11, divide by total record count, *100
% Claims W/ Service Place 12 - Home	Count records with place of service equal to 12, divide by total record count, *100
% Claims W/ Service Place 21 - Hospital	Count records with place of service equal to 21, divide by total record count, *100
% Claims W/ Service Place 32 - NF	Count records with place of service equal to 32, divide by total record count, *100
% Claims W/ Service Place 23 - ER	Count records with place of service equal to 23, divide by total record count, *100
% Claims w/ Service Place 22 - OPD	Count records with place of service equal to 22, divide by total record count, *100
% Claims W/ Service Place 99 - Unknown/Other	Count records with place of service equal to 99, divide by total record count, *100
% Claims with TPL	Count records with third-party payment amount > 0, divide by total record count, *100
Aver. TPL Paid -claims with TPL	Among records with third-party payment amount > 0, sum third-party payment amount, divide by total record count
PERCENT CLAIMS/MAX TOS	
% claims MAX TOS 08: Physicians	

Measure	Measure Description
% claims MAX TOS 09: Dental	Count records with MAX type of service equal to 09, divide by total record count, *100
% claims MAX TOS 10: Other Practioner	Count records with MAX type of service equal to 10, divide by total record count, *100
% claims MAX TOS 11: OPD	Count records with MAX type of service equal to 11, divide by total record count, *100
% claims MAX TOS 12: Clinic	Count records with MAX type of service equal to 12, divide by total record count, *100
% claims MAX TOS 13: HH	Count records with MAX type of service equal to 13, divide by total record count, *100
% claims MAX TOS 15: Lab/Xray	Count records with MAX type of service equal to 15, divide by total record count, *100
% claims MAX TOS 16: Drugs	Count records with MAX type of service equal to 16, divide by total record count, *100
% claims MAX TOS 19: Other Services	Count records with MAX type of service equal to 19, divide by total record count, *100
% claims MAX TOS 51: DME	Count records with MAX type of service equal to 51, divide by total record count, *100
% claims MAX TOS 26: Transportation	Count records with MAX type of service equal to 26, divide by total record count, *100
% claims MAX TOS 24: Sterilizations	Count records with MAX type of service equal to 24, divide by total record count, *100
% claims MAX TOS 25: Abortions	Count records with MAX type of service equal to 25, divide by total record count, *100
% claims MAX TOS 30: PCS	Count records with MAX type of service equal to 30, divide by total record count, *100
% claims MAX TOS 31: TCM	Count records with MAX type of service equal to 31, divide by total record count, *100
% claims MAX TOS 33: Rehabilitation	Count records with MAX type of service equal to 33, divide by total record count, *100
% claims MAX TOS 34: PT/OT/hear/speech	Count records with MAX type of service equal to 34, divide by total record count, *100
% claims MAX TOS 35: Hospice	Count records with MAX type of service equal to 35, divide by total record count, *100
% claims MAX TOS 36: Nurse Midwife	

Measure	Measure Description
% claims MAX TOS 37: Nurse Practitioner	Count records with MAX type of service equal to 37, divide by total record count, *100
% claims MAX TOS 38: Private Nursing	Count records with MAX type of service equal to 38, divide by total record count, *100
% claims MAX TOS 39: Religious Non-Med.	Count records with MAX type of service equal to 39, divide by total record count, *100
% claims MAX TOS 52: Residential Care	Count records with MAX type of service equal to 52, divide by total record count, *100
% claims MAX TOS 53: Psych. Services	Count records with MAX type of service equal to 53, divide by total record count, *100
% claims MAX TOS 54: Adult Day Care	Count records with MAX type of service equal to 54, divide by total record count, *100
% claims MAX TOS 99: Unknown	Count records with MAX type of service equal to 99, divide by total record count, *100
Average Medicaid Amount Paid For Selected MAX TOS (excluding claims with <=$0 paid)	
Total	Among records with Medicaid amount paid > 0, sum total Medicaid amount paid, divide by total record count
08: Physicians	Among records with Medicaid amount paid > 0 and MAX type of service = 08, sum total Medicaid amount paid, divide by total record count
09: Dental	Among records with Medicaid amount paid > 0 and MAX type of service = 09, sum total Medicaid amount paid, divide by total record count
10: Other Practioner	Among records with Medicaid amount paid > 0 and MAX type of service = 10, sum total Medicaid amount paid, divide by total record count
11: OPD	Among records with Medicaid amount paid > 0 and MAX type of service = 11, sum total Medicaid amount paid, divide by total record count
12: Clinic	Among records with Medicaid amount paid > 0 and MAX type of service = 12, sum total Medicaid amount paid, divide by total record count
13: HH	Among records with Medicaid amount paid > 0 and MAX type of service = 13, sum total Medicaid amount paid, divide by total record count
15: Lab/Xray	Among records with Medicaid amount paid > 0 and MAX type of service = 15, sum total Medicaid amount paid, divide by total record count
16: Drugs	Among records with Medicaid amount paid > 0 and MAX type of service = 16, sum total Medicaid amount paid, divide by total record count
19: Other Services	

Measure	Measure Description
51: DME	Among records with Medicaid amount paid > 0 and MAX type of service = 51, sum total Medicaid amount paid, divide by total record count
26: Transportation	Among records with Medicaid amount paid > 0 and MAX type of service = 26, sum total Medicaid amount paid, divide by total record count
30: PCS	Among records with Medicaid amount paid > 0 and MAX type of service = 30, sum total Medicaid amount paid, divide by total record count
31: Targeted Case Management	Among records with Medicaid amount paid > 0 and MAX type of service = 31, sum total Medicaid amount paid, divide by total record count
33: Rehabiltation	Among records with Medicaid amount paid > 0 and MAX type of service = 33, sum total Medicaid amount paid, divide by total record count
34: PT/OT/speech/hear	Among records with Medicaid amount paid > 0 and MAX type of service = 34, sum total Medicaid amount paid, divide by total record count
35: Hospice	Among records with Medicaid amount paid > 0 and MAX type of service = 35, sum total Medicaid amount paid, divide by total record count
52: Residential Care	Among records with Medicaid amount paid > 0 and MAX type of service = 52, sum total Medicaid amount paid, divide by total record count
53: Psych. Services	Among records with Medicaid amount paid > 0 and MAX type of service = 53, sum total Medicaid amount paid, divide by total record count
54: Adult Day Care	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 (claim type 1)	
% Family Planning (code 2)	Count records with type of program equal to 2, divide by total record count, *100
% RHC (code 3)	Count records with type of program equal to 3, divide by total record count, *100
% FQHC (code 4)	Count records with type of program equal to 4, divide by total record count, *100
% IHS (code 5)	Count records with type of program equal to 5, divide by total record count, *100
% Waiver (code 6,7)	Count records with type of program equal to 6 or 7, divide by total record count, *100
AVERAGE EXPENDITURES BY PROGRAM	
Family Planning (code 2)	

Measure	Measure Description
RHC (code 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
FQHC (code 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
IHS (code 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
Waiver (code 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
% Claims with DX	Count records with first diagnosis code not equal to spaces, 0-fill, 8-fill, 9-fill, divide by total record count, *100
% Claims with DX (MAX TOS 8, 11, 12)	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
% Claims with 1 DX that have 2 DX	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
% Claims with DX, where 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
% Claims with DX, where 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
% Claims with DX, where 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
% OPD Claims with Service Code or UB-92/OPD Claims (TOS 11)	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
% HH Claims with Service Code or UB-92/HH Claims (TOS13)	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 Service Codes /All Other Claims (Excluding OPD/HH)	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
% CPT-4 Service Code Indicator (code 01)/Claims with Service Codes	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
% HCPCS (II & III) Service Codes Indicator (code 06)/ Claims with Service Codes	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
% Other National Code Indicator (codes 2-5, 7- 9)/Claims with Service Codes	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
% State Specific Serv. Indicator (10-87)/Claims with Service Codes	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 Format Codes- 5n/Claims with CPT-4	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

Measure	Measure Description
% HCPCS Format Codes Cnnnn or CCnnn /Claims with HCPCS	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
% Claims with TOS 08 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
FFS Crossover Claims (Type of Claim=1), Crossover Claim Indicator=1, excluding capitation claims)	
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
% OPD Claims with Span Bill/ All OPD Claims(TOS 11)	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
% HH Claims with Span Bill/All HH Claims (TOS 13)	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 Bills/All Other Claims	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 CLAIMS/MAX TOS (excluding 20-22)	
% claims MAX TOS 08: Physicians	Among records with Medicaid amount paid > 0 and MAX type of service = 08, sum total Medicaid amount paid, divide by total record count, *100
% claims MAX TOS 10: Other Practioner	Among records with Medicaid amount paid > 0 and MAX type of service = 10, sum total Medicaid amount paid, divide by total record count, *100
% claims MAX TOS 11: OPD	Among records with Medicaid amount paid > 0 and MAX type of service = 11, sum total Medicaid amount paid, divide by total record count, *100
% claims MAX TOS 12: Clinic	Among records with Medicaid amount paid > 0 and MAX type of service = 12, sum total Medicaid amount paid, divide by total record count, *100
% claims MAX TOS 13: HH	Among records with Medicaid amount paid > 0 and MAX type of service = 13, sum total Medicaid amount paid, divide by total record count, *100
% claims MAX TOS 15: Lab/Xray	

Measure	Measure Description
% claims MAX TOS 19: Other Services	Among records with Medicaid amount paid > 0 and MAX type of service = 19, sum total Medicaid amount paid, divide by total record count, *100
% claims MAX TOS 51: DME	Among records with Medicaid amount paid > 0 and MAX type of service = 51, sum total Medicaid amount paid, divide by total record count, *100
% claims MAX TOS 26: Transportation	Among records with Medicaid amount paid > 0 and MAX type of service = 26, sum total Medicaid amount paid, divide by total record count, *100
% claims MAX TOS 30: PCS	Among records with Medicaid amount paid > 0 and MAX type of service = 30, sum total Medicaid amount paid, divide by total record count, *100
% claims MAX TOS 31: TCM	Among records with Medicaid amount paid > 0 and MAX type of service = 31, sum total Medicaid amount paid, divide by total record count, *100
% claims MAX TOS 33: Rehabilitation	Among records with Medicaid amount paid > 0 and MAX type of service = 33, sum total Medicaid amount paid, divide by total record count, *100
% claims MAX TOS 34: PT/OT/hear/speech	Among records with Medicaid amount paid > 0 and MAX type of service = 34, sum total Medicaid amount paid, divide by total record count, *100
% claims MAX TOS 35: Hospice	Among records with Medicaid amount paid > 0 and MAX type of service = 35, sum total Medicaid amount paid, divide by total record count, *100
% claims MAX TOS 52: Residential Care	Among records with Medicaid amount paid > 0 and MAX type of service = 52, sum total Medicaid amount paid, divide by total record count, *100
% claims MAX TOS 53: Psych. Services	Among records with Medicaid amount paid > 0 and MAX type of service = 53, sum total Medicaid amount paid, divide by total record count, *100
% claims MAX TOS 54: Adult Day Care	Among records with Medicaid amount paid > 0 and MAX type of service = 54, sum total Medicaid amount paid, divide by total record count, *100
Average Amount Paid	Among records with Medicaid amount paid > 0, sum total Medicaid amount paid, divide by total record count
% Claims with DX	Count records with first diagnosis code not equal to spaces, 0-fill, 8-fill, 9-fill, divide by total record count, *100
% Claims with DX (MAX TOS 8, 11, 12)	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
% Claims with 1 DX that have 2 DX	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
% Claims with DX, where 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
% Claims with DX, where 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
% Claims with DX, where 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

Measure	Measure Description
% OPD Claims with Service Code or UB-92/OPD Claims (TOS 11)	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
% HH Claims with Service Code or UB-92/HH Claims (TOS13)	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 Service Codes/All Other Claims (Excluding OPD/HH)	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
% CPT-4 Service Code Indicator (code 01)/Claims with Service Codes	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
% HCPCS (II & III) Service Codes Indicator (code 06)/ Claims with Service Codes	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
% Other Codes Indicator /Claims with Service Codes	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

Measure	Measure Description
All Records	**This section has no exclusions.**
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
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
% Standard Adjustments	Among records with type claim code equal to 1 and adjustment code equal to 1 or 2, count records with with adjustment code equal to 1, divide by total record count, *100
Aver. Amt. Pd Adjust. (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
FFS Claims (Type of Claim=1)	**This section includes records with type claim code equal to 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
Aver. Medicaid Amount 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
Aver. 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 (program type=2)	Count records with type of program equal to 2, divide by total record count, *100
% Drug Claims (TOS 16)	

Measure	Measure Description
% DME Claims (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 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
% Claims with HICL	Count records with hierarchical ingredient code list not equal to spaces, divide by total record count, *100
% Claims with Medispan	Count records with Medi-span therapeutic classification system code not equal to spaces, divide by total record count, *100
% Claims with AHFS	Count records with American Hospital Formulary System class code not equal to spaces, divide by total record count, *100
% Claims with Generic (GTC)	Count records with therapeutic class code (generic) not equal to spaces, divide by total record count, *100
% Claims with GC3	Count records with therapeutic class code (specific) not equal to spaces, divide by total record count, *100
NDC Configuration Indicator	
% Prescription (codes 0-3)	Count records with National Drug Code format indicator equal to 0, 1, 2, or 3, divide by total record count, *100
% Products (codes 4-6)	Count records with National Drug Code format indicator equal to 4, 5, or 6, divide by total record count, *100
% HRI (code 7)	Count records with National Drug Code format indicator equal to 7, divide by total record count, *100
% Claims with Smart Key	Count records with smart key not equal to spaces, divide by total record count, *100
% OTC-Drug Class	Count records with drug class code equal to 'O', divide by total record count, *100
% Prescription-Drug Class	Count records with drug class code equal to 'F', divide by total record count, *100
% Multiple Source (Code Y)	Count records with multi-source code equal to 'Y', divide by total record count, *100
% Single Source (Code N)	

Measure	Measure Description
All Records	**This section has no exclusions. This dataset is called BASE1.ALLRECS.**
Total Number of Records	Count records in the file
Total Medicaid Amount Paid	Sum Medicaid amount paid
% with no services (code 0)	Count records with recipient indicator equal to zero, divide by total record count, *100
% with FFS only claims (code 1)	Count records with recipient indicator equal to 1, divide by total record count, *100
% with only cap claims (code 2)	Count records with recipient indicator equal to 2, divide by total record count, *100
% with only encounter claims (code 3)	Count records with recipient indicator equal to 3, divide by total record count, *100
% with FFS and cap claims (code 4)	Count records with recipient indicator equal to 4, divide by total record count, *100
% with cap and encounter claims only (code 5)	Count records with recipient indicator equal to 5, divide by total record count, *100
% with FFS and encounter claims only (code 6)	Count records with recipient indicator equal to 6, divide by total record count, *100
% with FFS, cap and encounter records (code 7)	Count records with recipient indicator equal to 7, divide by total record count, *100
# with missing Medicaid eligibility (excludes S-SCHIP only)	Count records with missing eligibility data switch equal to 1
% with missing Medicaid eligibility (excludes S-SCHIP only)	Count records with missing eligibility data switch equal to 1, divide by total record count, *100
# with FFS claims and missing Medicaid eligibility (excludes S-SCHIP 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-SCHIP 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
Expenditures for people missing Medicaid eligibility (excludes S-SCHIP only enrollees)	Sum Medicaid amount paid where the missing eligibility data switch equal to 1
Expenditures for people with FFS claims and missing Medicaid eligibility (excludes S-SCHIP only enrollees)	Sum Medicaid amount paid where the missing eligibility data switch equal to 1 and recipient indicator equal to 1, 4, 6, or 7

Measure	Measure Description
S-SCHIP ENROLLMENT	
# with ONLY S-SCHIP 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-SCHIP 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-SCHIP enrollment	Count records with at least 1 month with SCHIP code equal to 3
% with ANY S-SCHIP enrollment	Count records with at least 1 month with SCHIP code equal to 3, divide by total record count, *100
Total PYE ANY S-SCHIP 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-SCHIP only)	**This section excludes people with missing eligibility data switch equal to 1 or S-SCHIP only. S-SCHIP only = 1, if SCHIP code = 3 in at least one month and SCHIP code = 1 or 2 in none of the months. This dataset is called BASE2.TOTENR.**
Total Medicaid Enrollees	Count records
Total Medicaid PYE (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-SCHIP enrollment (Medicaid enrollees)	Count records with at least 1 month with SCHIP code equal to 2
Total PYE any M-SCHIP	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
INSTITUTIONAL STATUS	
# enrollees with any ILTC claims (includes NF, ICF/MR, Aged Mental Hospital, IP Psych < 21 years)	Count records with ILTC 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 claims	Count records with ILTC 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 claims	Count records with ILTC 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 claims	Count records with ILTC claims, among records with MAX uniform eligibility code - most recent equal to 12, 22, 3A, 32, 42, or 52, divide by total records with MAX uniform eligibility code - most recent equal to 12, 22, 3A, 32, 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

Measure	Measure Description
% CHILD enrollees with any ILTC claims	Count records with ILTC 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 claims	Count records with ILTC 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
Other Eligibility Demographics	
% 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
#SSNs with duplicate records	Count records with more than one MSIS ID per Social Security Number (SSN), excluding 0-fill, 8-fill, 9-fill SSNs
% 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
% Enrollees who Died During Year	Count records where year of death equals MAX year, divide by total record count, *100
% White (Code 1)	Count records with race/ethnicity code equal to 1, divide by total record count, *100
% Black (Code 2)	Count records with race/ethnicity code equal to 2, divide by total record count, *100
% Native American/Alaskan Native (Code 3)	Count records with race/ethnicity code to 3, divide by total record count, *100
% Hispanic/Latino (Code 5)	Count records with race/ethnicity code equal to 5, divide by total record count, *100
% Unknown (Code 9)	Count records with race/ethnicity code equal to 9, divide by total record count, *100
% Asian (Code 4)	Count records with race/ethnicity code equal to 4, divide by total record count, *100
% Native Hawaiian or other Pacific Islander (Code 6)	Count records with race/ethnicity code equal to 6, divide by total record count, *100
% Hispanic/Latino AND one or more races (Code 7)	Count records with race/ethnicity code equal to 7, divide by total record count, *100
% More than one race (Code 8)	Count records with race/ethnicity code equal to 8, divide by total record count, *100

Measure	Measure Description
% Age 0	Count records with age group code equal to 0, divide by total record count, *100
% Age 0-20 Years	Count records with age group code equal to 0, 1, 2, or 3, divide by total record count, *100
% Age > 64 Years	Count records with age group code equal to 6, 7, or 8, divide by total record count, *100
% 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
% Enrollees with 12 months enrollment	Count records where the number of months enrolled equals 12, divide by total record count, *100
EDB Dual Eligibles	
Total EDB Duals (Duals confirmed by EDB)	Count records where Medicare Crossover Code - Annual equals 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98
Total EDB Dual PYE	Number of months of enrollment, divide by 12, sum over all records with Medicare Crossover 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 Crossover 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
% MAX Aged Groups (11,21,31,41,51) who are EDB Duals	Count records where Medicare Crossover 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
% MAX Disabled Groups (12,22,32,42,52) who are EDB Duals	Count records where Medicare Crossover 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, 3A, 32, 42, or 52, divide by total records with MAX uniform eligibility code - most recent equal to 12, 22, 3A, 32, 42, or 52, *100
% EDB Only (50)	Count records where Medicare Crossover Code - Annual equals 50, among records with Medicare Crossover Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, divide by total records with Medicare Crossover Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, *100
% EDB QMB Only (51)	Count records where Medicare Crossover Code - Annual equals 51, among records with Medicare Crossover Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, divide by total records with Medicare Crossover Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, *100
% EDB QMB Plus (52)	Count records where Medicare Crossover Code - Annual equals 52, among records with Medicare Crossover Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, divide by total records with Medicare Crossover Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, *100

Measure	Measure Description
% EDB SLMB Only (53)	Count records where Medicare Crossover Code - Annual equals 53, among records with Medicare Crossover Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, divide by total records with Medicare Crossover Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, *100
% EDB SLMB Plus (54)	Count records where Medicare Crossover Code - Annual equals 54, among records with Medicare Crossover Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, divide by total records with Medicare Crossover Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, *100
% EDB QDWI (55)	Count records where Medicare Crossover Code - Annual equals 55, among records with Medicare Crossover Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, divide by total records with Medicare Crossover Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, *100
% EDB QI-1 (56)	Count records where Medicare Crossover Code - Annual equals 56, among records with Medicare Crossover Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, divide by total records with Medicare Crossover Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, *100
% EDB QI-2 (57)	Count records where Medicare Crossover Code - Annual equals 57, among records with Medicare Crossover Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, divide by total records with Medicare Crossover Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, *100
% EDB Other (58)	Count records where Medicare Crossover Code - Annual equals 58, among records with Medicare Crossover Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, divide by total records with Medicare Crossover Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, *100
% EDB dual type unknown (59)	Count records where Medicare Crossover Code - Annual equals 59, among records with Medicare Crossover Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, divide by total records with Medicare Crossover Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, *100
% EDB dual status unknown (98)	Count records where Medicare Crossover Code - Annual equals 98, among records with Medicare Crossover Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, divide by total records with Medicare Crossover Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, *100
Total Non-EDB Duals (Duals rptd in MSIS, not found in EDB)	Count records where Medicare Crossover 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 Crossover Code - Annual equals 01, 02, 03, 04, 05, 06, 07, 08, or 09, divide by total records with Medicare Crossover 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 Crossover Code - Annual equals 01, 02, 03, 04, 05, 06, 07, 08, or 09, divide by total records with Medicare Crossover 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 Crossover Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, divide by total records with Medicare Crossover Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, *100

Measure	Measure Description
% EDB Duals with EDB Date of Death During Year	Count records where Medicare year of death equals MAX year, among records with Medicare Crossover Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, divide by total records with Medicare Crossover Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, *100
% EDB Duals with Medicaid Reported HIC	Count records with valid HIC, among records with Medicare Crossover Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, divide by total records with Medicare Crossover 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 Crossover 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 Crossover 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 Crossover Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98
June Medicare Type	
June % with Part A Medicare	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	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 (Code 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 (Code 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
% ESRD (Code 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 ESRD (Code 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
Eligibility Characteristics (All Enrollees)	
% MAX Aged Groups (11,21,31,41,51) >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

Measure	Measure Description
% MAX Disabled Groups (12,22,32,42,52) >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, 3A, 32, 42, or 52, divide by total records with MAX uniform eligibility code - most recent equal to 12, 22, 3A, 32, 42, or 52, *100
% MAX Child Grps (14,16, 24, 34, 44, 48, 54) <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
% MAX Adult Groups (15,17,25,35,45,55) >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 Aged Total	Count records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51
11: Aged, Cash	Count records with MAX uniform eligibility code - most recent equal to 11
21: Aged, MN	Count records with MAX uniform eligibility code - most recent equal to 21
31: Aged, Poverty	Count records with MAX uniform eligibility code - most recent equal to 31
41: Other Aged	Count records with MAX uniform eligibility code - most recent equal to 41
51: 1115 Aged	Count records with MAX uniform eligibility code - most recent equal to 51
MAX Disabled Total	Count records with MAX uniform eligibility code - most recent equal to 12, 22, 3A, 32, 42, or 52
12: Disabled, Cash	Count records with MAX uniform eligibility code - most recent equal to 12
22: Disabled, MN	Count records with MAX uniform eligibility code - most recent equal to 22
32: Disabled, Poverty	Count records with MAX uniform eligibility code - most recent equal to 32 or 3A
42: Other Disabled	Count records with MAX uniform eligibility code - most recent equal to 42
52: 1115 Disabled	Count records with MAX uniform eligibility code - most recent equal to 52
MAX Child Total	Count records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54
14: AFDC Child, Cash	Count records with MAX uniform eligibility code - most recent equal to 14
16: AFDC-U Child, Cash	Count records with MAX uniform eligibility code - most recent equal to 16

Measure	Measure Description
24: AFDC Child, MN	Count records with MAX uniform eligibility code - most recent equal to 24
34: Child Poverty	Count records with MAX uniform eligibility code - most recent equal to 34
44: Other Child	Count records with MAX uniform eligibility code - most recent equal to 44
48: Foster Care Child	Count records with MAX uniform eligibility code - most recent equal to 48
54: 1115 Child	Count records with MAX uniform eligibility code - most recent equal to 54
MAX Adult Total	Count records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55
15: AFDC Adult, Cash	Count records with MAX uniform eligibility code - most recent equal to 15
17: AFDC-U Adult, Cash	Count records with MAX uniform eligibility code - most recent equal to 17
25: AFDC Adult, MN	Count records with MAX uniform eligibility code - most recent equal to 25
35: Adult, Poverty	Count records with MAX uniform eligibility code - most recent equal to 35
45: Other Adult	Count records with MAX uniform eligibility code - most recent equal to 45
55: 1115 Adult	Count records with MAX uniform eligibility code - most recent equal to 55
Family Planning enrollees with Restricted Benefits	
# with ONLY Family Planning Only enrollment	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, X, Y, or Z in none of the months
# with ANY Family Planning Only enrollment	Count records with restricted benefits flag equal to 6 in at least one month
# PYE ANY FP Only	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
Aliens with Restricted Benefits	
# Aliens with ONLY restricted 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, X, Y, or Z in none of the months

Measure	Measure Description
# Aliens with ANY restricted benefits	Count records with restricted benefits flag equal to 2 in at least one month
# PYE Aliens with ANY restricted 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 Restricted Benefits (Medicare Cost Sharing Only - Code 3)	
# EDB Duals with ONLY restricted benefits enrollment	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, X, Y, or Z in none of the months and Medicare Crossover Code - Annual equals 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98
# EDB Duals with ANY restricted benefits enrollment	Count records with restricted benefits flag equal to 3 in at least one month and Medicare Crossover Code - Annual equals 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98
# PYE EDB Duals with ANY restricted benefits	Number of months with restricted benefits flag equal to 3 and Medicare Crossover 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 Crossover Code - Annual equals 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98
Prescription Drug Enrollees	
# with ONLY Prescription Drug enrollment	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, 3, 4, 5, 6 in none of the months
# with ANY Prescription Drug enrollment	Count records with restricted benefits flag equal to X, Y, or Z in at least one month
# PYE ANY Prescription Drug enrollment	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
Dual Prescription Drug Enrollees	
# with ONLY prescription drugs who are also 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, 3, 4, 5, 6 in none of the months and Medicare Crossover Code - Annual equals 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98
June Eligibility Profile	
TOTAL ENROLLEES IN JUNE	Count records with restricted benefits flag (in June) equal to 1, 2, 3, 4, 5, 6, 9, X, Y, or Z
June % Full Scope Benefits (Code 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, 9, X, Y, or Z, *100
June % Restricted Benefits Alien (Code 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, 9, X, Y, or Z, *100
June % Restricted Benefits Dual (Code 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, 9, X, Y, or Z, *100
June % Restricted Benefits Pregnant (Code 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, 9, X, Y, or Z, *100

Measure	Measure Description
June % Restricted Benefits Other (Code 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, 9, X, Y, or Z, *100
June % Restricted Benefits Family Planning (Code 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, 9, X, Y, or Z, *100
June % Unknown Benefits (Code 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, 9, X, Y, or Z, *100
June % Private Health Insurance (codes 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 (code 2)	Count records with TANF flag (in June) equal to 1
June # with M-SCHIP (Code 2) - Child (<19 Years)	Count records with SCHIP flag (in June) equal to 2 and age (as of Dec 31) < 19
June # with M-SCHIP (Code 2) - Adult (>18 Years)	Count records with SCHIP flag (in June) equal to 2 and age (as of Dec 31) > 18
June # with S-SCHIP Flag (Code 3) - Child (<19 Years)	Count records with SCHIP flag (in June) equal to 3 and age (as of Dec 31) < 19
June # with S-SCHIP Flag (Code 3) - Adult (>18 Years)	Count records with SCHIP flag (in June) equal to 3 and age (as of Dec 31) > 18
Total Medicaid Amount Paid	
Total Medicaid Amt Paid	Sum total Medicaid amount paid
Average Medicaid Amt 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
MAX 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
MAX Disabled	Among records with MAX uniform eligibility code - most recent equal to 12, 22, 3A, 32, 42, or 52, sum total Medicaid amount paid, divide by total record count
MAX 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
MAX 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
AVG MEDICAID AMT PD/EDB DUAL ENROLLEE	
All EDB Dual Enrollees	Among records with Medicare Crossover 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
MAX Aged	Among records with with Medicare Crossover 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
MAX Disabled	Among records with with Medicare Crossover 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, 3A, 32, 42, or 52, sum total Medicaid amount paid, divide by total record count
Expenditures for Family Planning enrollees with Restricted Benefits	
Expenditures for ONLY FP Only enrollees	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, X, Y, or Z in none of the months, sum total Medicaid amount paid
Average Medicaid Paid for ONLY FP Only enrollees	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, X, Y, or Z in none of the months, sum total Medicaid amount paid, divide by total record count
Expenditures for Aliens with Restricted Benefits	
Expend for Aliens with restricted benefits ONLY enrollment	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, X, Y, or Z in none of the months, sum total Medicaid amount paid
Avg Medicaid Paid for Alien enrollees with restricted benefits ONLY	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, X, Y, or Z in none of the months, sum total Medicaid amount paid, divide by total record count
Expenditures for EDB Duals with Restricted Benefits (Medicare Cost Sharing Only - Code 3)	
Expenditures for EDB Duals with only restricted benefits enrollment	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, X, Y, or Z in none of the months and Medicare Crossover Code - Annual equals 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, sum total Medicaid amount paid
Avg Medicaid Paid for EDB Duals with only restricted benefit enrollment	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, X, Y, or Z in none of the months and Medicare Crossover 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

Measure	Measure Description
Expenditures for Prescription Drug ONLY enrollees	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, 3, 4, 5, 6 in none of the months, sum total Medicaid amount paid
Avg Medicaid Paid for Prescription Drug ONLY enrollees	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, 3, 4, 5, 6 in none of the months, sum total Medicaid amount paid, divide by total record count
Dual Prescription Drug Enrollees	
Expenditures for ONLY Prescription Drugs who are also 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, 3, 4, 5, 6 in none of the months and Medicare Crossover Code - Annual equals 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, sum total Medicaid amount paid
MEDICAID ENROLLEES - EXCLUDING SELECT RESTRICTED BENEFIT GROUPS (excludes people with missing eligibility information, S-SCHIP only, FP Only, Aliens with only restricted benefits, duals with restricted benefits only, and prescription drug only enrollees) ---- NOTE: S-SCHIP 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.	**This section excludes people with missing eligibility data switch equal to 1, S-SCHIP only, FP Only, Aliens with only restricted benefits, duals with restricted benefits only, and prescription drug only enrollees. S-SCHIP only = 1, if SCHIP code equals 3 in at least one month and SCHIP code equals 1 or 2 in none of the months. FP Only = 1, if restricted benefits flag equals 6 in at least one month and restricted benefits flag equals 1, 2, 3, 4, 5, X, Y, or Z in none of the months. Aliens with only restricted benefits = 1, if restricted benefits flag equals 2 in at least one month and restricted benefits flag equals 1, 3, 4, 5, 6, X, Y, or Z in none of the months. Duals with restricted benefits only = 1, if restricted benefits flag equals 3 in at least one month and restricted benefits flag equals 1, 2, 4, 5, 6, X, Y, or Z in none of the months and Medicare Crossover Code - Annual equals 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98. Prescription drug only = 1, if restricted benefits flag equals X, Y, or Z in at least one month and restricted benefits flag equals 1, 2, 3, 4, 5, 6 in none of the months. The dataset is called BASE3.TE2.**
Total Medicaid Enrollees	Count records
MAX Aged Total	Count records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51
MAX Disabled Total	Count records with MAX uniform eligibility code - most recent equal to 12, 22, 3A, 32, 42, or 52
MAX Child Total	Count records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54
MAX Adult Total	Count records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55
Total Medicaid PYE (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 Crossover Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98

Measure	Measure Description
MAX Aged	Count records with Medicare Crossover 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
MAX Disabled	Count records with Medicare Crossover 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, 3A, 32, 42, or 52
Total Medicaid Amount Paid	
Total Medicaid Amt Paid	Sum Medicaid amount paid
Average Medicaid Amt Paid per Enrollee	Sum total Medicaid amount paid, divide by total record count
AVG MEDICAID AMT PD/ENROLLEE BY MAX ELIGIBILITY GROUP	
MAX 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
MAX Disabled	Among records with MAX uniform eligibility code - most recent equal to 12, 22, 3A, 32, 42, or 52, sum total Medicaid amount paid, divide by total record count
MAX 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
MAX 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
AVG MEDICAID AMT PD/EDB DUAL ENROLLEE	
All EDB Dual Enrollees	Among records with Medicare Crossover 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
MAX Aged	Among records with Medicare Crossover 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
MAX Disabled	Among records with Medicare Crossover 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, 3A, 32, 42, or 52, 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-SCHIP only, FP Only, Aliens with only restricted benefits, duals with restricted benefits only, and prescription drug only enrollees) ---- 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.	
% 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 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
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, 3A, 32, 42, or 52

Measure	Measure Description
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
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
% of MC Enrollees in HMO/HIO (Dups)	Count records with Comprehensive Managed Care Plan months > 0, among records with with managed care combination (in any month) equal to 01 - 15, divide by total records with managed care combination (in any month) equal to 01 - 15, * 100
% of MC Enrollees in Dental (Dups)	Count records with Dental Managed Care Plan months > 0, among records with with managed care combination (in any month) equal to 01 - 15, divide by total records with managed care combination (in any month) equal to 01 - 15, * 100
% of MC Enrollees in BHO (Dups)	Count records with Behavioral Managed Care Plan months > 0, among records with with managed care combination (in any month) equal to 01 - 15, divide by total records with managed care combination (in any month) equal to 01 - 15, * 100
% of MC Enrollees in Prenatal (Dups)	Count records with Prenatal/Delivery Managed Care Plan months > 0, among records with with managed care combination (in any month) equal to 01 - 15, divide by total records with managed care combination (in any month) equal to 01 - 15, * 100
% of MC Enrollees in LTC (Dups)	Count records with Long-Term Care Managed Care Plan months > 0, among records with with managed care combination (in any month) equal to 01 - 15, divide by total records with managed care combination (in any month) equal to 01 - 15, * 100
% of MC Enrollees in PACE (Dups)	Count records with All-Inclusive Care for the Elderly Managed Care Plan months > 0, among records with with managed care combination (in any month) equal to 01 - 15, divide by total records with managed care combination (in any month) equal to 01 - 15, * 100
% of MC Enrollees in PCCM (Dups)	Count records with Primary Care Case Management Plan months > 0, among records with with managed care combination (in any month) equal to 01 - 15, divide by total records with managed care combination (in any month) equal to 01 - 15, * 100
% of MC Enrollees in Other MC (Dups)	Count records with Other Managed Care Plan months > 0, among records with with managed care combination (in any month) equal to 01 - 15, divide by total records with managed care combination (in any month) equal to 01 - 15, * 100
% EDB Duals ever enrolled in HMO/HIOs	Count records with Comprehensive Managed Care Plan months > 0, among records with Medicare Crossover Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, divide by total records with Medicare Crossover 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 Health Plan months > 0 (excluding persons with Comprehensive Managed Care or Primary Care Case Management only), among records with Medicare Crossover Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, divide by total records with Medicare Crossover 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 > 0 and no other Pre-paid Health Plan, among records with Medicare Crossover Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, divide by total records with Medicare Crossover Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98, *100
TOTAL ENROLLEES IN JUNE	Count records with managed care combination (in June) > 0
June % HMO/HIO only (Code 1)	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 (Code 2)	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 (Code 3)	Count records with managed care combination (in June) equal to 3, divide by total records with managed care combination (in June) > 0, *100

Measure	Measure Description
June % PCCM only (Code 4)	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 (Code 5)	Count records with managed care combination (in June) equal to 5, divide by total records with managed care combination (in June) > 0, *100
June % HMO/HIO & Dental (Code 6)	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 (Code 7)	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 (Code 8)	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 (Code 9)	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 (Code 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 (Code 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 (Code 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 (Code 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 (Code 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 (Code 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 (Code 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 (Code 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 Cap 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	

Measure	Measure Description
PCCM	Sum Primary Care Case Management capitated payment amount
Ratio of Cap Claims to PME (person mo enroll) 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 months, Pre-paid Health Plan months, and Primary Care Case Management months
HMO/HIO	Number of Comprehensive Managed Care Plan claims, divide by Comprehensive Managed Care Plan months
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
Average Cap Payment for PME 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 months, Pre-paid Health Plan months, and Primary Care Case Management months
HMO/HIO	Comprehensive Managed Care Plan capitated payment amount, divide by Comprehensive Managed Care Plan months
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
Persons enrolled in PHP only or PHP/PCCM only	
Total Cap Payments	Among records with Pre-paid Health Plan months > 0 (excluding persons with Comprehensive Managed Care 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 Amt Paid	Among records with Pre-paid Health Plan months > 0 (excluding persons with Comprehensive Managed Care 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 or Primary Care Case Management only)
Persons enrolled in PCCM only	
Total Cap Payments	Among records with Primary Care Case Management > 0 and no other Pre-paid Health Plan, 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	

Measure	Measure Description
Persons ever enrolled in HMO/HIOs during year	
Count of Enrollees	Count records with Comprehensive Managed Care Plan months > 0
Aged	Count records with Comprehensive Managed Care Plan months > 0 and MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51
Disabled	Count records with Comprehensive Managed Care Plan months > 0 and MAX uniform eligibility code - most recent equal to 12, 22, 3A, 32, 42, or 52
Child	Count records with Comprehensive Managed Care Plan months > 0 and MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54
Adult	Count records with Comprehensive Managed Care Plan months > 0 and MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55
Total Ever Enrolled in HMO/HIO PYE	Number of Comprehensive Managed Care Plan months, divide by 12, sum over all records with Comprehensive Managed Care Plan months > 0
Total Cap Payments	Among records with Comprehensive Managed Care Plan months > 0, sum Comprehensive Managed Care Plan capitated payment amount, Pre-paid Health Plan capitated payment amount, and Primary Care Case Management capitated payment amount
Average Cap Payments	Among records with Comprehensive Managed Care Plan months > 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 Comprehensive Managed Care Plan months > 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 Comprehensive Managed Care Plan months > 0 and MAX uniform eligibility code - most recent equal to 12, 22, 3A, 32, 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 Comprehensive Managed Care Plan months > 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 Comprehensive Managed Care Plan months > 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 Comprehensive Managed Care Plan months > 0, sum total FFS payments
Average FFS Payments per enrollee	Among records with Comprehensive Managed Care Plan months > 0, sum total FFS payments, divide by number of records
Aged	Among records with Comprehensive Managed Care Plan months > 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

Measure	Measure Description
Disabled	Among records with Comprehensive Managed Care Plan months > 0 and MAX uniform eligibility code - most recent equal to 12, 22, 3A, 32, 42, or 52, sum total FFS payments, divide by number of records
Child	Among records with Comprehensive Managed Care Plan months > 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 Comprehensive Managed Care Plan months > 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
Total FFS Payments by Type of Service	
IP	Among records with Comprehensive Managed Care Plan months > 0, sum total FFS payments (where MAX TOS = 01)
ILTC	Among records with Comprehensive Managed Care Plan months > 0, sum total FFS payments (where MAX TOS = 02, 04, 05, 07, 16)
Drug	Among records with Comprehensive Managed Care Plan months > 0, sum total FFS payments (where MAX TOS = 16)
All Other (excluding cap payments)	Among records with Comprehensive Managed Care Plan months > 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	Among records with Comprehensive Managed Care Plan months > 0, sum total FFS payments (where MAX TOS = 01), divide by number of records
ILTC	Among records with Comprehensive Managed Care Plan months > 0, sum total FFS payments (where MAX TOS = 02, 04, 05, 07, 16), divide by number of records
Drug	Among records with Comprehensive Managed Care Plan months > 0, sum total FFS payments (where MAX TOS = 16), divide by number of records
All Other (excluding cap payments)	Among records with Comprehensive Managed Care Plan months > 0, sum total FFS payments (where MAX TOS excludes 01, 02, 04, 05, 07, 16, 20, 21, 22), divide by number of records

Measure	Measure Description
FFS INFORMATION FOR NON-DUAL MEDICAID ENROLLEES (excludes EDB Duals, people ever enrolled in HMO/HIOs, with missing eligibility information, S-SCHIP only, FP Only, Aliens with restricted benefits only, and prescription drug only enrollees) ---- NOTE: S-SCHIP only, FP Only, and Aliens with restricted benefits were NOT excluded prior to 2001. Prescription drug only enrollees were NOT excluded prior to 2003.	**This section includes Full-Benefit EDB Non-Duals. EDB Non-Duals are defined as Medicare Crossover Code - Annual equal to 00, 01, 02, 03, 04, 05, 06, 07, 08, 09, or 99. This section excludes people with missing eligibility data switch equal to 1, ever enrolled in HMO/HIOs, S-SCHIP only, FP Only, Aliens with restricted benefits only, and prescription drug only enrollees. HMO/HIO enrollment is defined as Comprehensive Managed Care Plan months > 0. S-SCHIP only = 1, if SCHIP code equals 3 in at least one month and SCHIP code equals 1 or 2 in none of the months. FP Only = 1, if restricted benefits flag equals 6 in at least one month and restricted benefits flag equals 1, 2, 3, 4, 5, X, Y, or Z in none of the months. Aliens with only restricted benefits = 1, if restricted benefits flag equals 2 in at least one month and restricted benefits flag equals 1, 3, 4, 5, 6, X, Y, or Z in none of the months. Prescription drug only = 1, if restricted benefits flag equals X, Y, or Z in at least one month and restricted benefits flag equals 1, 2, 3, 4, 5, 6 in none of the months. The dataset is called BASE4.FFSND.**
Total Non-Dual FFS Enrollees	Count records
Total Non-Dual FFS Recipients	Count records with FFS claims > 0
Total Non-Dual FFS PYE	Number of months of enrollment, divide by 12, sum over all records with FFS claims > 0
MAX Aged Total	Count records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51
11: Aged, Cash	Count records with MAX uniform eligibility code - most recent equal to 11
21: Aged, MN	Count records with MAX uniform eligibility code - most recent equal to 21
31: Aged, Poverty	Count records with MAX uniform eligibility code - most recent equal to 31
41: Other Aged	Count records with MAX uniform eligibility code - most recent equal to 41
51: 1115 Aged	Count records with MAX uniform eligibility code - most recent equal to 51
MAX Disabled Total	Count records with MAX uniform eligibility code - most recent equal to 12, 22, 3A, 32, 42, or 52
12: Disabled, Cash	Count records with MAX uniform eligibility code - most recent equal to 12

Measure	Measure Description
22: Disabled, MN	Count records with MAX uniform eligibility code - most recent equal to 22
32: Disabled, Poverty	Count records with MAX uniform eligibility code - most recent equal to 32 or 3A
42: Other Disabled	Count records with MAX uniform eligibility code - most recent equal to 42
52: 1115 Disabled	Count records with MAX uniform eligibility code - most recent equal to 52
MAX Child Total	Count records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54
14: AFDC Child, Cash	Count records with MAX uniform eligibility code - most recent equal to 14
16: AFDC-U Child, Cash	Count records with MAX uniform eligibility code - most recent equal to 16
24: AFDC Child, MN	Count records with MAX uniform eligibility code - most recent equal to 24
34: Child Poverty	Count records with MAX uniform eligibility code - most recent equal to 34
44: Other Child	Count records with MAX uniform eligibility code - most recent equal to 44
48: Foster Care Child	Count records with MAX uniform eligibility code - most recent equal to 48
54: 1115 Child	Count records with MAX uniform eligibility code - most recent equal to 54
MAX Adult Total	Count records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55
15: AFDC Adult, Cash	Count records with MAX uniform eligibility code - most recent equal to 15
17: AFDC-U Adult, Cash	Count records with MAX uniform eligibility code - most recent equal to 17
25: AFDC Adult, MN	Count records with MAX uniform eligibility code - most recent equal to 25
35: Adult, Poverty	Count records with MAX uniform eligibility code - most recent equal to 35
45: Other Adult	

Measure	Measure Description
55: 1115 Adult	Count records with MAX uniform eligibility code - most recent equal to 55
# Non-Dual FFS Enrollees w/ MSIS Dual Code/No EDB Confirmation	Count records with Medicare Crossover Code - Annual equal to 01, 02, 03, 04, 05, 06, 07, 08, or 09
Total FFS Medicaid Amt Paid	Sum total FFS payments
Average FFS Medicaid Amt Paid per Non-Dual FFS Enrollee	Sum total FFS payments, divide by total record count
Avg FFS Medicaid Amt Paid per Non-Dual FFS Recipient (User of any service)	Sum total FFS payments, divide by total record count with FFS claims > 0
AVG FFS MEDICAID AMT PD/NON-DUAL FFS ENROLLEE BY MAX ELIG GRP	
All 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
11: Aged, Cash	Among records with MAX uniform eligibility code - most recent equal to 11, sum total FFS payments, divide by total record count
21: Aged, MN	Among records with MAX uniform eligibility code - most recent equal to 21, sum total FFS payments, divide by total record count
31: Aged, Poverty	Among records with MAX uniform eligibility code - most recent equal to 31, sum total FFS payments, divide by total record count
41: Other Aged	Among records with MAX uniform eligibility code - most recent equal to 41, sum total FFS payments, divide by total record count
51: 1115 Aged	Among records with MAX uniform eligibility code - most recent equal to 51, sum total FFS payments, divide by total record count
All Disabled	Among records with MAX uniform eligibility code - most recent equal to 12, 22, 3A, 32, 42, or 52, sum total FFS payments, divide by total record count
12: Disabled, Cash	Among records with MAX uniform eligibility code - most recent equal to 12, sum total FFS payments, divide by total record count
22: Disabled, MN	Among records with MAX uniform eligibility code - most recent equal to 22, sum total FFS payments, divide by total record count
32: Disabled, Poverty	Among records with MAX uniform eligibility code - most recent equal to 32 or 3A, sum total FFS payments, divide by total record count
42: Other Disabled	Among records with MAX uniform eligibility code - most recent equal to 42, sum total FFS payments, divide by total record count
52: 1115 Disabled	Among records with MAX uniform eligibility code - most recent equal to 52, sum total FFS payments, divide by total record count

Measure	Measure Description
All 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
14: AFDC Child, Cash	Among records with MAX uniform eligibility code - most recent equal to 14, sum total FFS payments, divide by total record count
16: AFDC-U Child,Cash	Among records with MAX uniform eligibility code - most recent equal to 16, sum total FFS payments, divide by total record count
24: AFDC Child, MN	Among records with MAX uniform eligibility code - most recent equal to 24, sum total FFS payments, divide by total record count
34: Child, Poverty	Among records with MAX uniform eligibility code - most recent equal to 34, sum total FFS payments, divide by total record count
44: Other Child	Among records with MAX uniform eligibility code - most recent equal to 44, sum total FFS payments, divide by total record count
48: Foster Care Child	Among records with MAX uniform eligibility code - most recent equal to 48, sum total FFS payments, divide by total record count
54: 1115 Child	Among records with MAX uniform eligibility code - most recent equal to 54, sum total FFS payments, divide by total record count
All 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
15: AFDC Adult, Cash	Among records with MAX uniform eligibility code - most recent equal to 15, sum total FFS payments, divide by total record count
17: AFDC-U Adult, Cash	Among records with MAX uniform eligibility code - most recent equal to 17, sum total FFS payments, divide by total record count
25: AFDC Adult, MN	Among records with MAX uniform eligibility code - most recent equal to 25, sum total FFS payments, divide by total record count
35: Adult, Poverty	Among records with MAX uniform eligibility code - most recent equal to 35, sum total FFS payments, divide by total record count
45: Other Adult	Among records with MAX uniform eligibility code - most recent equal to 45, sum total FFS payments, divide by total record count
55: 1115 Adult	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 TOS	
IP: Total Medicaid Paid (TOS 01)	Sum total FFS payments (where MAX TOS = 01)
IP: Number of Users	

Measure	Measure Description
IP: Average Medicaid Pd 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: Average 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 (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 Pd 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 < 21: Total Medicaid Paid (TOS 04)	Sum total FFS payments (where MAX TOS = 04)
IP Psych < 21: Number of Users	Count records with number of FFS claims (where MAX TOS = 04) > 0
IP Psych<21 :Avg Medicaid Pd 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 Pd (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 Pd 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 (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 Pd 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 (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 Pd 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 (TOS 09)	

Measure	Measure Description
Dental: Number of Users	Count records with number of FFS claims (where MAX TOS = 09) > 0
Dental: Avg Medicaid Pd 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 Pd (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 Pd 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
OPD: Total Medicaid Paid (TOS 11)	Sum total FFS payments (where MAX TOS = 11)
OPD Number of Users	Count records with number of FFS claims (where MAX TOS = 11) > 0
OPD: Avg Medicaid Pd 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 (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 Pd 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
HH: Total Medicaid Paid (TOS 13)	Sum total FFS payments (where MAX TOS = 13)
HH: Number of Users	Count records with number of FFS claims (where MAX TOS = 13) > 0
HH: Avg Medicaid Pd 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 (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 Pd 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 (TOS 16)	

Measure	Measure Description
Drugs: Number of Users	Count records with number of FFS claims (where MAX TOS = 16) > 0
Drugs: Avg Medicaid Pd 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 (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 Pd 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 (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 Pd 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
PCS: Total Medicaid Paid (TOS 30)	Sum total FFS payments (where MAX TOS = 30)
PCS: Number of Users	Count records with number of FFS claims (where MAX TOS = 30) > 0
PCS: Avg Medicaid Pd 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
Target Case Management: Total Medicaid Pd (TOS 31)	Sum total FFS payments (where MAX TOS = 31)
Target Case Management: Number of Users	Count records with number of FFS claims (where MAX TOS = 31) > 0
Target Case Management: Avg Medicaid Pd 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
Rehab Services: Total Medicaid Pd (TOS 33)	Sum total FFS payments (where MAX TOS = 33)
Rehab Services: Number of Users	Count records with number of FFS claims (where MAX TOS = 33) > 0
Rehab Services: Avg Medicaid Pd 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/Hear: Total Medicaid Paid (TOS 34)	

Measure	Measure Description
PT/OT/Speech/Hear: Number of Users	Count records with number of FFS claims (where MAX TOS = 34) > 0
PT/OT/Speech/Hear: Avg Medicaid Pd 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 (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 Pd 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
DME: Total Medicaid Paid (TOS 51)	Sum total FFS payments (where MAX TOS = 51)
DME: Number of Users	Count records with number of FFS claims (where MAX TOS = 51) > 0
DME: Avg Medicaid Pd 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 (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 Pd 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 (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 Pd 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 (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 Pd 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

Measure	Measure Description
Inpatient Hospital (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, 3A, 32, 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 (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, 3A, 32, 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 (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, 3A, 32, 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	

Measure	Measure Description
Disabled	Among records with MAX uniform eligibility code - most recent equal to 12, 22, 3A, 32, 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
% OF NON-DUAL FFS ENROLLEES WITH CLAIMS BY SELECTED MAX TOS	
% Non-Dual FFS Enrollees with IP Claims (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, 3A, 32, 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 (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, 3A, 32, 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/enroll 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 (TOS=16)	

Measure	Measure Description
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, 3A, 32, 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, 3A, 32, 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
Disabled	Among records with MAX uniform eligibility code - most recent equal to 12, 22, 3A, 32, 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, 3A, 32, 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	

Measure	Measure Description
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 Delivery	Count records with delivery code equal to 1, divide by total record count, *100
FFS EXPENDITURES AND USERS BY MAX PGM TYPE	
FP: Total Medicaid Paid (Program 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: Average Medicaid Pd 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 (Program 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 Pd 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 (Program 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 Pd 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 Pd (Program 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 Pd per User	Sum total Medicaid payments (where Program Type = 5), divide by total record count with number of claims (where Program Type = 5) > 0
Waiver: Total Medicaid Paid (Program Types 6 and 7)	Sum total Medicaid payments (where Program Type = 6 or 7)
Waiver: Number of Users	Count records with number of claims (where Program Type = 6 or 7) > 0
Waiver: Avg Medicaid Pd 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

Measure	Measure Description
FFS INFORMATION FOR DUAL MEDICAID ENROLLEES (excludes non-EDB duals, duals ever enrolled in HMO/ HIOs, duals with only restricted benefits, duals with missing eligibility information, and prescription drug only enrollees)---NOTE: non-EDB duals and duals with restricted benefits were not excluded in the past. Prescription drug only enrollees were NOT excluded prior to 2003.	**This section includes Full-Benefit EDB Duals. EDB Duals are defined as Medicare Crossover Code - Annual equal to 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98. This section excludes people with missing eligibility data switch equal to 1, ever enrolled in HMO/HIOs, S-SCHIP only, FP Only, Aliens with restricted benefits only, duals with restricted benefits only, and prescription drug only enrollees. HMO/HIO enrollment is defined as Comprehensive Managed Care Plan months > 0. S-SCHIP only = 1, if SCHIP code equals 3 in at least one month and SCHIP code equals 1 or 2 in none of the months. FP Only = 1, if restricted benefits flag equals 6 in at least one month and restricted benefits flag equals 1, 2, 3, 4, 5, X, Y, or Z in none of the months. Aliens with only restricted benefits = 1, if restricted benefits flag equals 2 in at least one month and restricted benefits flag equals 1, 3, 4, 5, 6, X, Y, or Z in none of the months. Duals with restricted benefits only = 1, if restricted benefits flag equals 3 in at least one month and restricted benefits flag equals 1, 2, 4, 5, 6, X, Y, or Z in none of the months and Medicare Crossover Code - Annual equals 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98. Prescription drug only = 1, if restricted benefits flag equals X, Y, or Z in at least one month and restricted benefits flag equals 1, 2, 3, 4, 5, 6 in none of the months. The dataset is called BASE5.FFSD.**
Total EDB Dual FFS Enrollees	Count records
Number of EDB Dual FFS Recipients	Count records with FFS claims > 0
Total EDB Dual FFS PYE	Number of months of enrollment, divide by 12, sum over all records with FFS claims > 0
% EDB Only Dual (code 50)	Count records with Medicare Crossover Code - Annual equal to 50, divide by total record count, *100
% QMB Only (Code 51)	Count records with Medicare Crossover Code - Annual equal to 51, divide by total record count, *100
% QMB Plus (Code 52)	Count records with Medicare Crossover Code - Annual equal to 52, divide by total record count, *100
% SLMB Only (Code 53)	Count records with Medicare Crossover Code - Annual equal to 53, divide by total record count, *100
% SLMB Plus (Code 54)	Count records with Medicare Crossover Code - Annual equal to 54, divide by total record count, *100
% QDWI (Code 55)	Count records with Medicare Crossover Code - Annual equal to 55, divide by total record count, *100
% QI 1 (Code 56)	

Measure	Measure Description
% QI 2 (Code 57)	Count records with Medicare Crossover Code - Annual equal to 57, divide by total record count, *100
% Other Type Dual (Code 58)	Count records with Medicare Crossover Code - Annual equal to 58, divide by total record count, *100
% Dual Type Unknown (Code 59)	Count records with Medicare Crossover Code - Annual equal to 59, divide by total record count, *100
MAX Aged EDB Dual FFS Total	Count records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51
11: Aged, Cash	Count records with MAX uniform eligibility code - most recent equal to 11
21: Aged, MN	Count records with MAX uniform eligibility code - most recent equal to 21
31: Aged, Poverty	Count records with MAX uniform eligibility code - most recent equal to 31
41: Other Aged	Count records with MAX uniform eligibility code - most recent equal to 41
51: 1115 Aged	Count records with MAX uniform eligibility code - most recent equal to 51
MAX Disabled EDB Dual FFS Total	Count records with MAX uniform eligibility code - most recent equal to 12, 22, 3A, 32, 42, or 52
12: Disabled, Cash	Count records with MAX uniform eligibility code - most recent equal to 12
22: Disabled, MN	Count records with MAX uniform eligibility code - most recent equal to 22
32: Disabled, Poverty	Count records with MAX uniform eligibility code - most recent equal to 32 or 3A
42: Other Disabled	Count records with MAX uniform eligibility code - most recent equal to 42
52: 1115 Disabled	Count records with MAX uniform eligibility code - most recent equal to 52
Total FFS Medicaid Amt Paid	Sum total FFS payments
Average FFS Medicaid Amt Paid per FFS Dual	Sum total FFS payments, divide by total record count
Average FFS Medicaid Amt Paid per FFS Dual Recipient (User of any service)	

Measure	Measure Description
AVG FFS MEDICAID AMT PD/FFS DUAL BY MAX ELIGIBILITY GROUP	
All 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
11: Aged, Cash	Among records with MAX uniform eligibility code - most recent equal to 11, sum total FFS payments, divide by total record count
21: Aged, MN	Among records with MAX uniform eligibility code - most recent equal to 21, sum total FFS payments, divide by total record count
31: Aged, Poverty	Among records with MAX uniform eligibility code - most recent equal to 31, sum total FFS payments, divide by total record count
41: Other Aged	Among records with MAX uniform eligibility code - most recent equal to 41, sum total FFS payments, divide by total record count
51: 1115 Aged	Among records with MAX uniform eligibility code - most recent equal to 51, sum total FFS payments, divide by total record count
All Disabled	Among records with MAX uniform eligibility code - most recent equal to 12, 22, 3A, 32, 42, or 52, sum total FFS payments, divide by total record count
12: Disabled, Cash	Among records with MAX uniform eligibility code - most recent equal to 12, sum total FFS payments, divide by total record count
22: Disabled, MN	Among records with MAX uniform eligibility code - most recent equal to 22, sum total FFS payments, divide by total record count
32: Disabled, Poverty	Among records with MAX uniform eligibility code - most recent equal to 32 or 3A, sum total FFS payments, divide by total record count
42: Other Disabled	Among records with MAX uniform eligibility code - most recent equal to 42, sum total FFS payments, divide by total record count
52: 1115 Disabled	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 TOS	
IP: Total Medicaid Paid (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: Average Medicaid Pd 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: Average Medicaid Covered Days Per User	

Measure	Measure Description
MH Aged: Total Medicaid Paid (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 Pd 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 < 21: Total Medicaid Paid (TOS 04)	Sum total FFS payments (where MAX TOS = 04)
IP Psych < 21: Number of Users	Count records with number of FFS claims (where MAX TOS = 04) > 0
IP Psych<21 :Avg Medicaid Pd 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 Pd (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 Pd 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 (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 Pd 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 (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 Pd 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 (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 Pd per User	

Measure	Measure Description
Other Practitioner: Total Medicaid Pd (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 Pd 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
OPD: Total Medicaid Paid (TOS 11)	Sum total FFS payments (where MAX TOS = 11)
OPD Number of Users	Count records with number of FFS claims (where MAX TOS = 11) > 0
OPD: Avg Medicaid Pd 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 (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 Pd 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
HH: Total Medicaid Paid (TOS 13)	Sum total FFS payments (where MAX TOS = 13)
HH: Number of Users	Count records with number of FFS claims (where MAX TOS = 13) > 0
HH: Avg Medicaid Pd 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 (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 Pd 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 (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 Pd per User	

Measure	Measure Description
Other Services: Total Medicaid Paid (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 Pd 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 (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 Pd 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
PCS: Total Medicaid Paid (TOS 30)	Sum total FFS payments (where MAX TOS = 30)
PCS: Number of Users	Count records with number of FFS claims (where MAX TOS = 30) > 0
PCS: Avg Medicaid Pd 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
Target Case Management: Total Medicaid Pd (TOS 31)	Sum total FFS payments (where MAX TOS = 31)
Target Case Management: Number of Users	Count records with number of FFS claims (where MAX TOS = 31) > 0
Target Case Management: Avg Medicaid Pd 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
Rehab Services: Total Medicaid Pd (TOS 33)	Sum total FFS payments (where MAX TOS = 33)
Rehab Services: Number of Users	Count records with number of FFS claims (where MAX TOS = 33) > 0
Rehab Services: Avg Medicaid Pd 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/Hear: Total Medicaid Paid (TOS 34)	Sum total FFS payments (where MAX TOS = 34)
PT/OT/Speech/Hear: Number of Users	Count records with number of FFS claims (where MAX TOS = 34) > 0
PT/OT/Speech/Hear: Avg Medicaid Pd per User	

Measure	Measure Description
Hospice: Total Medicaid Paid (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 Pd 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
DME: Total Medicaid Paid (TOS 51)	Sum total FFS payments (where MAX TOS = 51)
DME: Number of Users	Count records with number of FFS claims (where MAX TOS = 51) > 0
DME: Avg Medicaid Pd 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 (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 Pd 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 (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 Pd 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 (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 Pd 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
AVG FFS MEDICAID AMT PD/FFS DUAL BY SELECTED TYPE OF SERVICE	
Inpatient Hospital (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	

Measure	Measure Description
Disabled	Among records with MAX uniform eligibility code - most recent equal to 12, 22, 3A, 32, 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 (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, 3A, 32, 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 (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, 3A, 32, 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, 3A, 32, 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
% OF FFS DUALS WITH CLAIMS BY SELECTED TYPE OF SERVICE	
% FFS Duals with IP Claims (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, 3A, 32, 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 (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	

Measure	Measure Description
% FFS Duals with Drug Claims (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, 3A, 32, 42, or 52, sum total record count with total FFS claims (where MAX TOS = 16) > 0, divide by total record count, *100
% 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, 3A, 32, 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 (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, 3A, 32, 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 (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, 3A, 32, 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
FFS EXPENDITURES AND USERS BY MAX PROGRAM TYPE	
FP: Total Medicaid Paid (Program 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: Average Medicaid Pd 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 (Program Type 3)	Sum total Medicaid payments (where Program Type = 3)
RHC: Number of Users	

Measure	Measure Description
RHC: Avg Medicaid Pd 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 (Program 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 Pd 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 Pd (Program 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 Pd per User	Sum total Medicaid payments (where Program Type = 5), divide by total record count with number of claims (where Program Type = 5) > 0
Waiver: Total Medicaid Paid (Program Types 6 and 7)	Sum total Medicaid payments (where Program Type = 6 or 7)
Waiver: Number of Users	Count records with number of claims (where Program Type = 6 or 7) > 0
Waiver: Avg Medicaid Pd 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 INFORMATION FOR TOTAL MEDICAID ENROLLEES (excludes people ever enrolled in HMO/HIOs, with missing eligibility information, S-SCHIP only, FP Only, Aliens with only restricted benefits, duals with restricted benefits only, and prescription drug only enrollees) ---- NOTE: S-SCHIP 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.	**This section includes Full-Benefit Enrollees. This section excludes people with missing eligibility data switch equal to 1, ever enrolled in HMO/HIOs, S-SCHIP only, FP Only, Aliens with restricted benefits only, duals with restricted benefits only, and prescription drug only enrollees. HMO/HIO enrollment is defined as Comprehensive Managed Care Plan months > 0. S-SCHIP only = 1, if SCHIP code equals 3 in at least one month and SCHIP code equals 1 or 2 in none of the months. FP Only = 1, if restricted benefits flag equals 6 in at least one month and restricted benefits flag equals 1, 2, 3, 4, 5, X, Y, or Z in none of the months. Aliens with only restricted benefits = 1, if restricted benefits flag equals 2 in at least one month and restricted benefits flag equals 1, 3, 4, 5, 6, X, Y, or Z in none of the months. Duals with restricted benefits only = 1, if restricted benefits flag equals 3 in at least one month and restricted benefits flag equals 1, 2, 4, 5, 6, X, Y, or Z in none of the months and Medicare Crossover Code - Annual equals 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, or 98. Prescription drug only = 1, if restricted benefits flag equals X, Y, or Z in at least one month and restricted benefits flag equals 1, 2, 3, 4, 5, 6 in none of the months. The dataset is called BASE6.FFST.**
Total FFS Enrollees	

Measure	Measure Description
# FFS Recipients	Count records with FFS claims > 0
% 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, 3A, 32, 42, or 52, divide by total records with MAX uniform eligibility code - most recent equal to 12, 22, 3A, 32, 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 PYE	Number of months of enrollment, divide by 12, sum over all records with FFS claims > 0
MAX Aged Total	Count records with MAX uniform eligibility code - most recent equal to 11, 21, 31, 41, or 51
11: Aged, Cash	Count records with MAX uniform eligibility code - most recent equal to 11
21: Aged, MN	Count records with MAX uniform eligibility code - most recent equal to 21
31: Aged, Poverty	Count records with MAX uniform eligibility code - most recent equal to 31
41: Other Aged	Count records with MAX uniform eligibility code - most recent equal to 41
51: 1115 Aged	Count records with MAX uniform eligibility code - most recent equal to 51
MAX Disabled Total	Count records with MAX uniform eligibility code - most recent equal to 12, 22, 3A, 32, 42, or 52
12: Disabled, Cash	Count records with MAX uniform eligibility code - most recent equal to 12
22: Disabled, MN	Count records with MAX uniform eligibility code - most recent equal to 22
32: Disabled, Poverty	Count records with MAX uniform eligibility code - most recent equal to 32 or 3A
42: Other Disabled	Count records with MAX uniform eligibility code - most recent equal to 42

Measure	Measure Description
52: 1115 Disabled	Count records with MAX uniform eligibility code - most recent equal to 52
MAX Child Total	Count records with MAX uniform eligibility code - most recent equal to 14, 16, 24, 34, 44, 48, or 54
14: AFDC Child, Cash	Count records with MAX uniform eligibility code - most recent equal to 14
16: AFDC-U Child, Cash	Count records with MAX uniform eligibility code - most recent equal to 16
24: AFDC Child, MN	Count records with MAX uniform eligibility code - most recent equal to 24
34: Child Poverty	Count records with MAX uniform eligibility code - most recent equal to 34
44: Other Child	Count records with MAX uniform eligibility code - most recent equal to 44
48: Foster Care Child	Count records with MAX uniform eligibility code - most recent equal to 48
54: 1115 Child	Count records with MAX uniform eligibility code - most recent equal to 54
MAX Adult Total	Count records with MAX uniform eligibility code - most recent equal to 15, 17, 25, 35, 45, or 55
15: AFDC Adult, Cash	Count records with MAX uniform eligibility code - most recent equal to 15
17: AFDC-U Adult, Cash	Count records with MAX uniform eligibility code - most recent equal to 17
25: AFDC Adult, MN	Count records with MAX uniform eligibility code - most recent equal to 25
35: Adult, Poverty	Count records with MAX uniform eligibility code - most recent equal to 35
45: Other Adult	Count records with MAX uniform eligibility code - most recent equal to 45
55: 1115 Adult	Count records with MAX uniform eligibility code - most recent equal to 55
Total FFS Medicaid Amt Paid	Sum total FFS payments
Average FFS Medicaid Amt Paid per FFS Enrollee	

Measure	Measure Description
Average FFS Medicaid Amt Paid per FFS Recipient (User of any svc)	Sum total FFS payments, divide by total record count with FFS claims > 0
AVG FFS MEDICAID AMT PD/FFS ENROLLEE BY MAX ELIGIBILITY GROUP	
All 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
11: Aged, Cash	Among records MAX uniform eligibility code - most recent equal to 11, sum total FFS payments, divide by total record count
21: Aged, MN	Among records MAX uniform eligibility code - most recent equal to 21, sum total FFS payments, divide by total record count
31: Aged, Poverty	Among records MAX uniform eligibility code - most recent equal to 31, sum total FFS payments, divide by total record count
41: Other Aged	Among records MAX uniform eligibility code - most recent equal to 41, sum total FFS payments, divide by total record count
51: 1115 Aged	Among records MAX uniform eligibility code - most recent equal to 51, sum total FFS payments, divide by total record count
All Disabled	Among records with MAX uniform eligibility code - most recent equal to 12, 22, 3A, 32, 42, or 52, sum total FFS payments, divide by total record count
12: Disabled, Cash	Among records with MAX uniform eligibility code - most recent equal to 12, sum total FFS payments, divide by total record count
22: Disabled, MN	Among records with MAX uniform eligibility code - most recent equal to 22, sum total FFS payments, divide by total record count
32: Disabled, Poverty	Among records with MAX uniform eligibility code - most recent equal to 32 or 3A, sum total FFS payments, divide by total record count
42: Other Disabled	Among records with MAX uniform eligibility code - most recent equal to 42, sum total FFS payments, divide by total record count
52: 1115 Disabled	Among records with MAX uniform eligibility code - most recent equal to 52, sum total FFS payments, divide by total record count
All 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
14: AFDC Child, Cash	Among records with MAX uniform eligibility code - most recent equal to 14, sum total FFS payments, divide by total record count
16: AFDC-U Child,Cash	Among records with MAX uniform eligibility code - most recent equal to 16, sum total FFS payments, divide by total record count
24: AFDC Child, MN	Among records with MAX uniform eligibility code - most recent equal to 24, sum total FFS payments, divide by total record count

Measure	Measure Description
34: Child, Poverty	Among records with MAX uniform eligibility code - most recent equal to 34, sum total FFS payments, divide by total record count
44: Other Child	Among records with MAX uniform eligibility code - most recent equal to 44, sum total FFS payments, divide by total record count
48: Foster Care Child	Among records with MAX uniform eligibility code - most recent equal to 48, sum total FFS payments, divide by total record count
54: 1115 Child	Among records with MAX uniform eligibility code - most recent equal to 54, sum total FFS payments, divide by total record count
All 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
15: AFDC Adult, Cash	Among records with MAX uniform eligibility code - most recent equal to 15, sum total FFS payments, divide by total record count
17: AFDC-U Adult, Cash	Among records with MAX uniform eligibility code - most recent equal to 17, sum total FFS payments, divide by total record count
25: AFDC Adult, MN	Among records with MAX uniform eligibility code - most recent equal to 25, sum total FFS payments, divide by total record count
35: Adult, Poverty	Among records with MAX uniform eligibility code - most recent equal to 35, sum total FFS payments, divide by total record count
45: Other Adult	Among records with MAX uniform eligibility code - most recent equal to 45, sum total FFS payments, divide by total record count
55: 1115 Adult	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 TOS	
IP: Total Medicaid Paid (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: Average Medicaid Pd 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: Average 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 (TOS 02)	Sum total FFS payments (where MAX TOS = 02)
MH Aged: Number of Users	

Measure	Measure Description
MH Aged: Avg Medicaid Pd 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 < 21: Total Medicaid Paid (TOS 04)	Sum total FFS payments (where MAX TOS = 04)
IP Psych < 21: Number of Users	Count records with number of FFS claims (where MAX TOS = 04) > 0
IP Psych<21 :Avg Medicaid Pd 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 Pd (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 Pd 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 (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 Pd 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 (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 Pd 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 (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 Pd 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 Pd (TOS 10)	Sum total FFS payments (where MAX TOS = 10)
Other Practitioner: Number of Users	

Measure	Measure Description
Other Practitioner: Avg Medicaid Pd 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
OPD: Total Medicaid Paid (TOS 11)	Sum total FFS payments (where MAX TOS = 11)
OPD Number of Users	Count records with number of FFS claims (where MAX TOS = 11) > 0
OPD: Avg Medicaid Pd 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 (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 Pd 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
HH: Total Medicaid Paid (TOS 13)	Sum total FFS payments (where MAX TOS = 13)
HH: Number of Users	Count records with number of FFS claims (where MAX TOS = 13) > 0
HH: Avg Medicaid Pd 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 (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 Pd 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 (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 Pd 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 (TOS 19)	Sum total FFS payments (where MAX TOS = 19)
Other Services: Number of Users	

Measure	Measure Description
Other Services: Avg Medicaid Pd 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 (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 Pd 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
PCS: Total Medicaid Paid (TOS 30)	Sum total FFS payments (where MAX TOS = 30)
PCS: Number of Users	Count records with number of FFS claims (where MAX TOS = 30) > 0
PCS: Avg Medicaid Pd 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
Target Case Management: Total Medicaid Pd (TOS 31)	Sum total FFS payments (where MAX TOS = 31)
Target Case Management: Number of Users	Count records with number of FFS claims (where MAX TOS = 31) > 0
Target Case Management: Avg Medicaid Pd 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
Rehab Services: Total Medicaid Pd (TOS 33)	Sum total FFS payments (where MAX TOS = 33)
Rehab Services: Number of Users	Count records with number of FFS claims (where MAX TOS = 33) > 0
Rehab Services: Avg Medicaid Pd 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/Hear: Total Medicaid Paid (TOS 34)	Sum total FFS payments (where MAX TOS = 34)
PT/OT/Speech/Hear: Number of Users	Count records with number of FFS claims (where MAX TOS = 34) > 0
PT/OT/Speech/Hear: Avg Medicaid Pd 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 (TOS 35)	Sum total FFS payments (where MAX TOS = 35)
Hospice: Number of Users	

Measure	Measure Description
Hospice: Avg Medicaid Pd 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
DME: Total Medicaid Paid (TOS 51)	Sum total FFS payments (where MAX TOS = 51)
DME: Number of Users	Count records with number of FFS claims (where MAX TOS = 51) > 0
DME: Avg Medicaid Pd 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 (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 Pd 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 (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 Pd 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 (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 Pd 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
AVG FFS MEDICAID AMT PD/FFS ENROLLEE BY SELECTED MAX TOS	
Inpatient Hospital (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, 3A, 32, 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	

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 = 01), divide by total record count with total FFS claims (where MAX TOS = 01) > 0
ILTC (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, 3A, 32, 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 (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, 3A, 32, 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, 3A, 32, 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	

Measure	Measure Description
% OF FFS ENROLLEES WITH CLAIMS BY SELECTED MAX TYPE OF SERVICE	
% FFS Enrollees with IP Claims (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, 3A, 32, 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
% FFS Enrollees with ILTC Claims (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, 3A, 32, 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 (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, 3A, 32, 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	

Measure	Measure Description
Disabled	Among records with MAX uniform eligibility code - most recent equal to 12, 22, 3A, 32, 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 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, 3A, 32, 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, 3A, 32, 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
FFS EXPENDITURES AND USERS BY MAX PGM TYPE	
FP: Total Medicaid Paid (Program 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: Average Medicaid Pd 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 (Program Type 3)	

Measure	Measure Description
RHC: Number of Users	Count records with number of claims (where Program Type = 3) > 0
RHC: Avg Medicaid Pd 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 (Program 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 Pd 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 Pd (Program 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 Pd per User	Sum total Medicaid payments (where Program Type = 5), divide by total record count with number of claims (where Program Type = 5) > 0
Waiver: Total Medicaid Paid (Program Types 6 and 7)	Sum total Medicaid payments (where Program Type = 6 or 7)
Waiver: Number of Users	Count records with number of claims (where Program Type = 6 or 7) > 0
Waiver: Avg Medicaid Pd 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