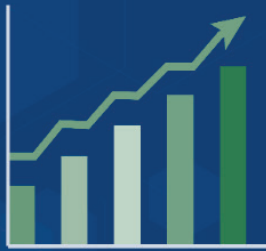


2023 | DATA YEAR RELEASE NOTES



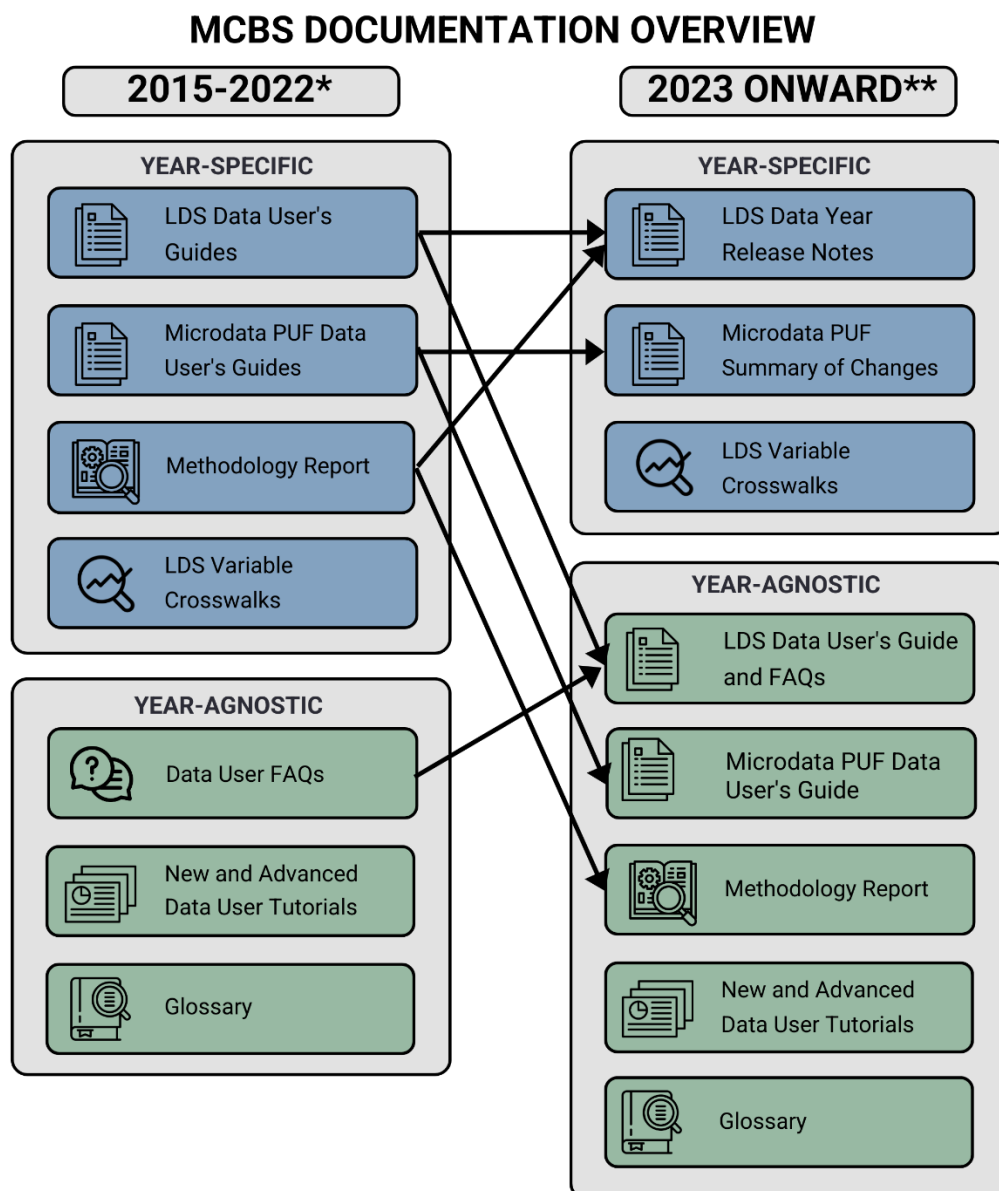
Centers for Medicare & Medicaid Services (CMS)
Office of Enterprise Data and Analytics (OEDA)

Version Control Log

Date	Version	Revisions
09/05/2024	1.0	Initial version published for 2023 Survey File - Early Release LDS.
02/13/2025	1.1	Updated version published to reflect re-released 2023 Survey File - Early Release LDS.
07/02/2025	1.2	Content added for 2023 Survey File LDS.
10/09/2025	1.3	Content added for 2023 Cost Supplement File LDS.

MCBS DOCUMENTATION CROSSWALK AND OVERVIEW

The Centers for Medicare & Medicaid Services (CMS) releases a comprehensive suite of documentation products to support researchers in using the Medicare Current Beneficiary Survey (MCBS). These products were consolidated beginning with the 2023 data year to separate the detailed background information on the MCBS from focused year-specific content that is most relevant to researchers. This section provides a concise overview of MCBS documentation products beginning with the 2015 data year, all available for download on the CMS MCBS website: <https://www.cms.gov/data-research/research/medicare-current-beneficiary-survey/data-documentation-codebooks>.



NOTES: The year-specific products are updated annually for each data year. The year-agnostic products are reviewed annually, but only updated as needed.

* For new researchers using the 2015-2022 MCBS LDS, the *Survey File LDS Data User's Guide* and *New User Tutorial* are the recommended starting points. See the CMS MCBS website for information on the pre-2015 MCBS documentation.

** Beginning with the 2023 MCBS LDS, the *LDS Data Year Release Notes* and *New User Tutorial* are the recommended starting points for new researchers.

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ACRONYM LIST

ACCESSCR	Survey File Access to Care segment
ACCSSMED	Survey File Access to Care, Medical Appointments segment
ACQ	Access to Care Questionnaire
ACS	American Community Survey
ADI	Area Deprivation Index
ADLs	Activities of Daily Living
ADMNUTLS	Survey File Administrative Utilization Summary segment
AHRQ	Agency for Healthcare Research and Quality
ANDA	Abbreviated New Drug Application
AR	Administrative Records
ASSIST	Survey File Assistance segment
BLA	Biologics License Application
BQ	Background Questionnaire
CAPI	Computer-Assisted Personal Interviewing
CCN	CMS Certification Number
CCW	CMS Chronic Conditions Warehouse
CENWGTS	Survey File Continuously enrolled weights
CHRNCDL	Survey File Chronic Conditions Flags segment
CHRNCOND	Survey File Chronic Conditions segment
CHRNPAIN	Survey File Chronic Pain segment
CMS	Centers for Medicare & Medicaid Services
CMQ	Cognitive Measures Questionnaire
COGNFUNC	Survey File Cognitive Measures segment
COVIDEXP	Survey File COVID-19 Experiences segment
COVIDTOP	Survey File COVID-19 Topical segment
CPS	Charge Payment Summary Questionnaire
CQ	Community Questionnaire
CS	Cost Supplement File
CSEVWGTS	Cost Supplement File Ever Enrolled weights
CSL2WGTS	Cost Supplement File Longitudinal weights (2-year)
CSL3WGTS	Cost Supplement File Longitudinal weights (3-year)
CSV	Comma-separated Values
CV	COVID-19 Beneficiary Questionnaire
CVQ	COVID-19 Questionnaire
DEMO	Survey File Demographics segment
DIABETES	Survey File Diabetes segment
DIQ	Demographics and Income Questionnaire
DME	Durable Medical Equipment
DU	Dental events
DUA	Data Use Agreement
DUE	Dental Utilization Events segment
DVH	Dental, Vision, and Hearing Care Utilization Questionnaire
EOBs	Explanation of Benefit Statements
ENS	Enumeration Summary Questionnaire
EPPE	Enterprise Privacy Policy Engine
ER	Survey File - Early Release
ERQ	Emergency Room Utilization Questionnaire
ERS	Economic Research Service

ER_ACCESSCR	Survey File - Early Release Access to Care segment
ER_ASSIST	Survey File - Early Release Assistance segment
ER_CHRNCOND	Survey File - Early Release Chronic Conditions segment
ER_COGNFUNC	Survey File - Early Release Cognitive Measures segment
ER_COVIDEXP	Survey File - Early Release COVID-19 Experiences segment
ER_DEMO	Survey File - Early Release Demographics segment
ER_DIABETES	Survey File - Early Release Diabetes segment
ER_EVRWGTS	Survey File - Early Release Ever enrolled weights
ER_FALLS	Survey File - Early Release Falls segment
ER_GENHLTH	Survey File - Early Release General Health segment
ER_HHCHAR	Survey File - Early Release Household Characteristics segment
ER_HISUMRY	Survey File - Early Release Health Insurance Summary segment
ER_MENTHLTH	Survey File - Early Release Mental Health segment
ER_MOBILITY	Survey File - Early Release Mobility segment
ER_NAGIDIS	Survey File - Early Release Nagi Disability segment
ER_NICOALCO	Survey File - Early Release Nicotine and Alcohol segment
ER_PNTACT	Survey File - Early Release Patient Activation segment
ER_PREVCARE	Survey File - Early Release Preventive Care segment
ER_SATWCARE	Survey File - Early Release Satisfaction with Care segment
ER_VISHEAR	Survey File - Early Release Vision and Hearing segment
ESRD	End-stage renal disease
EX	Expenditures Questionnaire
EVRWGTS	Survey File Ever enrolled weights
FA	Facility events
FACASMNT	Survey File Facility Assessments segment
FACCHAR	Survey File Facility Characteristics segment
FAE	Facility Events segment
FALLS	Survey File Falls segment
FC	COVID-19 Facility-Level Questionnaire
FDA	U.S. Food and Drug Administration
FDB	First Databank
FFACCVFL	Survey File COVID-19 Facility Facility-Level segment
FFS	Fee-for-Service
FI	Facility Instrument
FOODINS	Survey File Food Insecurity segment
FQ	Facility Questionnaire
GAD	Generalized Anxiety Disorder screening tool (GAD-2)
GENHLTH	Survey File General Health segment
HAQ	Housing Characteristics Questionnaire
HCPCS	Healthcare Common Procedure Coding System
HF	Home Health Friend events (formerly HHF)
HFQ	Health Status and Functioning Questionnaire
HH	Home Health events
HHCHAR	Survey File Household Characteristics segment
HHE	Home Health Events segment
HHQ	Home Health Utilization Questionnaire
HHS	Home Health Summary Questionnaire
HIQ	Health Insurance Questionnaire
HISUMRY	Survey File Health Insurance Summary segment
HITLINE	Survey File Health Insurance Timeline segment
HMO	Health Maintenance Organization

HP	Home Health Provider events (formerly HHP)
HS	Hospice events (formerly HP)
HS	Health Status Questionnaire
HU	Hearing events
HUE	Hearing Utilization Events segment
IADLs	Instrumental Activities of Daily Living
IAQ	Income and Assets Questionnaire
ID	Identification
IMQ	Survey File Immunization segment
IN	Health Insurance Questionnaire
INCASSET	Survey File Income and Assets segment
INQ	Introduction Questionnaire
INTERV	Survey File Interview Characteristics segment
IP	Inpatient Hospital events
IPE	Inpatient Hospital Events segment
IPQ	Inpatient Hospital Utilization Questionnaire
IRB	Institutional Review Board
IRQ	Interviewer Remarks Questionnaire
IU	Institutional events
IUE	Institutional Events segment
IUQ	Institutional Utilization Questionnaire
KNQ	Beneficiary Knowledge and Information Needs Questionnaire
LDS	Limited Data Set(s)
LNG2WGTS	Survey File Longitudinal weights (2-year)
LNG3WGTS	Survey File Longitudinal weights (3-year)
LNG4WGTS	Survey File Longitudinal weights (4-year)
MA	Medicare Advantage
MAPD	Medicare Advantage Part D Plan
MAPLANQX	Survey File Medicare Advantage Plan Questions segment
MBQ	Mobility of Beneficiaries Questionnaire
MCO	Managed Care Organization
MCBS	Medicare Current Beneficiary Survey
MCREPLNQ	Survey File Medicare Beneficiary Knowledge segment
MDS	Minimum Data Set
MDS3	Survey File Minimum Data Set segment
MENTHLTH	Survey File Mental Health segment
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003
MOBILITY	Survey File Mobility segment
MP	Medical Provider events
MPE	Medical Provider Events segment
MPQ	Medical Provider Utilization Questionnaire
MYENROLL	Survey File Multiple Year Enrollment segment
NAGIDIS	Survey File Nagi Disability segment
NDA	New Drug Application
NDC	National Drug Code
NICOALCO	Survey File Nicotine and Alcohol segment
NIR	Not-In-Round
Non PM	Non Prescription Medicine
NORC	NORC at the University of Chicago
NSQ	No Statement Charge Questionnaire
OASIS	Survey File Outcome and Assessment Information segment

OEDA	Office of Enterprise Data and Analytics
OM	Other Medical Expenses events
OMB	Office of Management and Budget
OMQ	Other Medical Expenses Utilization Questionnaire
OP	Outpatient Hospital events
OPE	Outpatient Hospital Events segment
OPQ	Outpatient Hospital Utilization Questionnaire
PAQ	Patient Activation Questionnaire
PDE	Part D Event
PDF	Portable Document Format
PDP	Prescription Drug Plan (or Part D Plan)
PHQ	Patient Health Questionnaire depression screening tool (PHQ-9)
PLT_PXWS	Physical Measures Pilot segment
PM	Prescription Medicine (or Prescribed Medicine events)
PME	Prescription Medicine Events segment
PMFORM	Prescribed Medicine Form
PMQ	Prescribed Medicine Utilization Questionnaire
PNTACT	Survey File Patient Activation segment
PREVCARE	Survey File Preventive Care segment
PS	Person Summary segment
PSQ	Post-Statement Charge Questionnaire
PUF	Public Use File
PVQ	Preventive Care Questionnaire
PXQ	Physical Measures Questionnaire
RESTMLN	Survey File Residence Timeline segment
RH	Residence History Questionnaire
RIC	Record Identification Code
RUCA	Rural-Urban Commuting Area
RXMED	Survey File RX Medications segment
RXQ	Drug Coverage Questionnaire
SAS	Statistical Analysis System
SATWCARE	Survey File Satisfaction with Care segment
SCF	Sample Control File
SCQ	Satisfaction with Care Questionnaire
SD	Separately Billing Doctor events
SF	Survey File
SL	Separately Billing Lab events
SNF	Skilled Nursing Facility
SS	Service Summary segment
STQ	Statement Cost Series Questionnaire
TELEMED	Survey File Telemedicine segment
TLQ	Telemedicine Questionnaire
US	Use of Health Services Questionnaire
USCARE	Usual Source of Care segment
USQ	Usual Source of Care Questionnaire
USU	Ultimate Sampling Unit
VA	Veterans Administration
VISHEAR	Survey File Vision and Hearing segment
VRDC	Virtual Research Data Center
VU	Vision events
VUE	Vision Utilization Events segment

1. INTRODUCTION

Medicare is the nation's health insurance program for persons 65 years and over and for persons younger than 65 years who have a qualifying disability. The Medicare Current Beneficiary Survey (MCBS) consists of a representative national sample of the Medicare population sponsored by the Centers for Medicare & Medicaid Services (CMS).¹ The MCBS is designed to aid CMS in administering, monitoring, and evaluating the Medicare program. A leading source of information on Medicare and its impact on beneficiaries, the MCBS provides important information on beneficiaries that is not otherwise collected through operational or administrative data on the Medicare program and plays an essential role in monitoring and evaluating beneficiary health status and health care policy. For more information, see the *Data User's Guides* and *Methodology Report*.

Beginning with the 2023 data year, CMS releases five sets of MCBS files annually, three Limited Data Sets (LDS)² and two Microdata Public Use Files (PUFs). Exhibit 1.1 provides an overview of the LDS releases: Survey File - Early Release, Survey File, and Cost Supplement File. The data within the LDS releases are organized into data segments, which are described in detail in the Data File Notes sections below.

Exhibit 1.1: Overview of 2023 MCBS Limited Data Sets

	Survey File - Early Release	Survey File	Cost Supplement File
File Contents	<ul style="list-style-type: none"> Timely data on key topics such as beneficiaries' socio-demographic information; self-reported health status, conditions, and functioning; disability; and access to and satisfaction with care 	<ul style="list-style-type: none"> Fall data released on the Survey File - Early Release as well as annualized data on topics such as health insurance coverage Data collected into the next calendar year to provide a complete picture of the beneficiaries' health and well-being Facility information, administrative records and assessment data, and Fee-for-Service (FFS) claims data 	<ul style="list-style-type: none"> Comprehensive accounting of beneficiaries' health care use, expenditures, and sources of payment Linked survey-reported and Medicare FFS and Part D claims data
Data Collection Timeframe	Fall only	Annualized	Annualized
Population Represented	Community only	Community and facility	Community and facility

¹ The MCBS is authorized by section 1875 (42 USC 139511) of the Social Security Act and is conducted by NORC at the University of Chicago for the U.S. Department of Health and Human Services. The OMB Number for this survey is 0938-0568.

² For the 2015 through 2022 data years, CMS released two MCBS LDS files annually, the Survey File and the Cost Supplement File. Beginning with the 2023 data year, CMS releases a subset of the Survey File LDS segments early via the Survey File - Early Release LDS in order to improve the timeliness of MCBS data. The Survey File LDS and Cost Supplement File LDS continue to be released annually.

	Survey File - Early Release	Survey File	Cost Supplement File
Weights Available	Cross-sectional ever enrolled Survey File - Early Release weights and select Topical weights	Cross-sectional ever enrolled, cross-sectional continuously enrolled, and longitudinal Survey File weights and Topical weights	Cross-sectional ever enrolled and longitudinal Cost Supplement File weights
Inclusion of Enrollment and Claims Data	Limited enrollment information; no FFS claims	Detailed enrollment information; five years of enrollment data; five years of FFS claims	No enrollment information; linked FFS and Medicare Part D claims
Supports Standalone Analysis?	Yes	Yes	No
Approximate Release Timeframe	Within nine months after the close of the calendar year	18 months after the close of the calendar year	Three months after the Survey File

Information on content and access to the MCBS Microdata PUFs, including codebooks and additional documentation, can be found at <https://www.cms.gov/data-research/statistics-trends-and-reports/mcbs-public-use-file>. Each PUF data release includes a *Data User's Guide* that is updated for each new data year to ensure that users have publicly available, easily searchable documentation on the data release.

For questions or suggestions on this document or other MCBS data-related questions, please email MCBS@cms.hhs.gov.

1.1 Contents of the Data Year Release Notes

The *2023 Data Year Release Notes* contain detailed information about the annual MCBS LDS releases. Data users can access this resource along with other data documentation at <https://www.cms.gov/data-research/research/medicare-current-beneficiary-survey/data-documentation-codebooks>. The *2023 Data Year Release Notes* is initially released to accompany the Survey File - Early Release LDS. This documentation is then updated and re-released for the Survey File LDS and again for the Cost Supplement File LDS (see the Version Control Log for information on the current version).

Here is an overview of the contents of the *2023 Data Year Release Notes*:

- Sections 2-3: These sections provide information on sampling, questionnaires, interviewing, data collection, and data releases for the 2023 data year.
- Section ER: This section provides specific information on the Survey File - Early Release LDS release, including a description of any changes and an overview of each segment included in the release.
- Section S: Once available, this section provides specific information on the Survey File LDS release, including a description of any changes and an overview of each segment included in the release.
- Section C: Once available, this section provides specific information on the Cost Supplement File LDS release, including a description of any changes and an overview of each segment included in the release.
- Appendix: This section provides reference information.

Please note the following terminology preferences for the MCBS used throughout this document:

- *Beneficiary* refers to a person receiving Medicare services who may or may not be participating in the MCBS.³ Beneficiary may also refer to an individual selected from the MCBS sample about whom the MCBS collects information.
- *Respondent* is the person who answers questions for the MCBS; this person can be the beneficiary, a proxy, or a staff member located at a facility where the beneficiary resides (i.e., the Facility respondent).
- The *data collection year* refers to the three rounds of data collection (winter, summer, and fall) that occur within the calendar year (e.g., Winter 2023, Summer 2023, and Fall 2023 for 2023).
- The *data year* refers to the data collected over the three years that are included in the LDS release (e.g., 2022, 2023, and 2024 for the 2023 LDS).

³ <https://www.cms.gov/Medicare/Medicare-General-Information/MedicareGenInfo/index.html>

2. 2023 DATA YEAR CONTENT

2.1 Questionnaires

The MCBS Community Questionnaire is administered to beneficiaries living in the community (i.e., not in a long-term care facility such as a nursing home) during the reference period covered by the MCBS interview and may be conducted with the beneficiary or a proxy. In addition to including data collected in the three rounds (winter, summer, and fall) administered during the calendar year, the 2023 MCBS LDS include some data collected in 2022 that are carried forward to fill in data for 2023 when questionnaire items are administered only once or when data are missing for the data year but valid values exist for the previous year. Some data collected in Winter and Summer 2024 are “pulled back” for inclusion in the 2023 LDS because the section’s reference period extends back to 2023. For guidance on analyzing data from these sections, see Section 3.4. The Facility Instrument is administered for beneficiaries living in facilities during the reference period covered by the MCBS interview and is conducted with staff members located at the facility. For more information on the MCBS Questionnaires, see the *Data User’s Guides* and *Methodology Report*. Additionally, descriptions of each of these questionnaire sections can be found in the *MCBS Questionnaire User Guide*: <https://www.cms.gov/data-research/research/medicare-current-beneficiary-survey/questionnaires>.

2.1.1 Core Community Questionnaire Sections

Exhibit 2.1.1 lists each Core section of the Community Questionnaire that contributes to the 2023 LDS.

Exhibit 2.1.1: 2023 Data Year MCBS Community Core Sections by Data File and Data Collection Schedule

Section Group	Abbr.	Section Name	LDS [§]	Data Collection Schedule
Socio-Demographics	IAQ	Income and Assets	SF	Summer 2024
	DIQ	Demographics/Income	ER, SF	Fall 2023, Baseline Interview
Health Insurance	HIQ	Health Insurance	ER, SF	All Seasons
Utilization*	DVH	Dental, Vision and Hearing Care Utilization	CS	All Seasons
	ERQ	Emergency Room Utilization	CS	All Seasons
	IPQ	Inpatient Hospital Utilization	CS	All Seasons
	OPQ	Outpatient Hospital Utilization	CS	All Seasons
	IUQ	Institutional Utilization	CS	All Seasons
	HHQ	Home Health Utilization	CS	All Seasons
	MPQ	Medical Provider Utilization	CS	All Seasons
	OMQ	Other Medical Expenses Utilization	CS	All Seasons
	PMQ	Prescribed Medicine Utilization	CS	All Seasons
Cost**	STQ	Statement Cost Series	CS	All Seasons
	PSQ	Post-Statement Charge	CS	All Seasons
	NSQ	No Statement Charge	CS	All Seasons
	CPS	Charge Payment Summary	CS	All Seasons

Section Group	Abbr.	Section Name	LDS [§]	Data Collection Schedule
Experiences with Care	ACQ	Access to Care	SF	Winter 2024
	SCQ	Satisfaction with Care	ER, SF	Fall 2023
	TLQ	Telemedicine	SF	Winter 2024
	USQ	Usual Source of Care	SF	Winter 2024
Health Status	HFQ	Health Status and Functioning	ER, SF	Fall 2023
	CMQ	Cognitive Measures	ER, SF	Fall 2023
	PXQ	Physical Measures	CS	Summer 2024

SOURCE: MCBS Community Questionnaire

*New respondents receiving the Baseline interview do not receive Core sections about health care utilization and costs; these sections are reserved for Continuing respondents. As such, in Fall 2023, only persons in the 2020, 2021, and 2022 Panels received the Core sections about health care utilization and health care costs.

[§]Limited Data Set (LDS) indicates the file where the questionnaire data appear (i.e., ER = Survey File - Early Release, SF = Survey File, CS = Cost Supplement File).

2.1.2 Topical Community Questionnaire Sections

Exhibit 2.1.2 lists each Topical section of the Community Questionnaire that contributes to the 2023 LDS.

Exhibit 2.1.2: 2023 Data Year MCBS Community Topical Sections by Data File and Data Collection Schedule

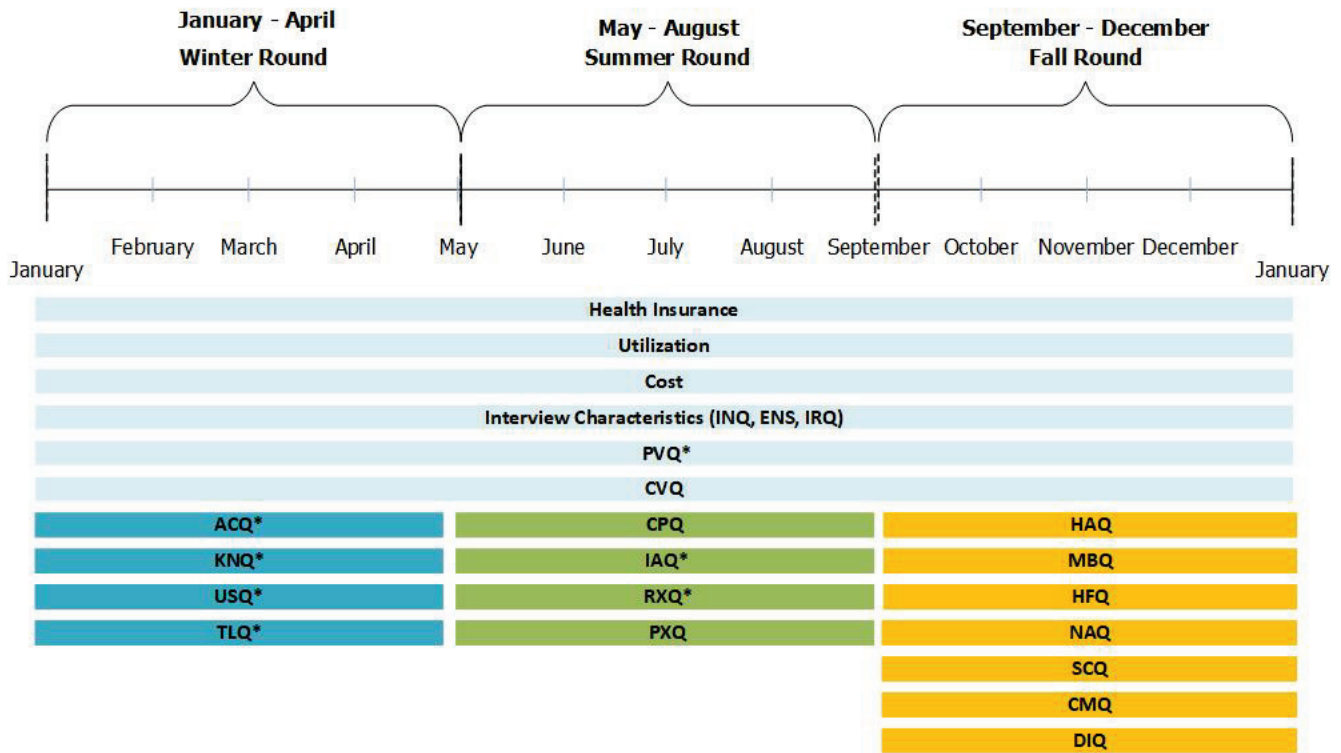
Section Group	Abbr.	Section Name	LDS [§]	Data Collection Schedule
Housing Characteristics	HAQ	Housing Characteristics	ER, SF	Fall 2023
Social Determinants of Health or Health Behaviors	CPQ	Chronic Pain	SF	Summer 2024
	MBQ	Mobility of Beneficiaries	ER, SF	Fall 2023
	NAQ	Nicotine and Alcohol Use	ER, SF	Fall 2023
	PVQ	Preventive Care	ER, SF	Fall 2023, Winter 2024, and Summer 2024
	IAQ	Food Insecurity items	SF	Summer 2024
COVID-19	CVQ	COVID-19	ER, SF	Fall 2023 and Winter 2024
Knowledge and Decision Making	KNQ	Beneficiary Knowledge and Information Needs	SF	Winter 2024
	RXQ	Drug Coverage	SF	Summer 2024

SOURCE: MCBS Community Questionnaire

[§]LDS indicates the file where the questionnaire data appear (i.e., ER = Survey File - Early Release, SF = Survey File, CS = Cost Supplement File).

2.1.3 Community Questionnaire Section Rotation within a Data Year

Exhibit 2.1.3 presents the MCBS Questionnaire section rotation schedule for 2023. The 2023 MCBS data releases reflect data collected from January 2023 through December 2023 and also include data collected in Winter and Summer 2024 rounds from questionnaire sections with a 2023 reference period.

Exhibit 2.1.3: 2023 Data Collection Year MCBS Community Questionnaire Section Rotation**Typical MCBS Data Collection Year**

*Fielded in 2024, but given the reference period is 2023, data are included in the 2023 LDS.

2.1.4 Facility Core Questionnaire Sections

Exhibit 2.1.4 lists each Core section of the Facility Instrument that contributes to the 2023 LDS.

Exhibit 2.1.4: 2023 Data Year MCBS Facility Core Sections by Data File and Data Collection Schedule

Section Group	Abbr.	Section Name	LDS [§]	Data Collection Schedule
Facility Characteristics	FQ	Facility Questionnaire	SF	All Seasons
Socio-Demographics	RH	Residence History	SF	All Seasons
	BQ	Background	SF	Fall 2023, Baseline Interview*
Health Insurance	IN	Health Insurance	SF	Fall 2023 [‡]
Utilization	US	Use of Health Services	CS	All Seasons
Cost	EX	Expenditures	CS	All Seasons
Health Status	HS	Health Status	SF	Fall 2023 [‡]

SOURCE: MCBS Facility Instrument

*The BQ section is also administered to Community-to-Facility Crossover cases each season.

[‡]The IN and HS sections are also administered to Community-to-Facility and Facility-to-Facility cases each season.

[§]Limited Data Set (LDS) indicates the file where the questionnaire data appears (i.e., SF = Survey File, CS = Cost Supplement File). Note, no Facility data are released on the 2023 Survey File - Early Release LDS.

2.1.5 Facility Topical Questionnaire Sections

Exhibit 2.1.5 lists the two Topical sections of the Facility Instrument that contribute to the 2023 LDS.

Exhibit 2.1.5: 2023 Data Year MCBS Facility Topical Sections by Data File and Data Collection Schedule

Section Group	Abbr.	Section Name	LDS [§]	Data Collection Schedule
COVID-19	CV	COVID-19 Beneficiary	SF	All Seasons
	FC*	COVID-19 Facility-Level	SF	Fall 2023*

*The FC section is also administered to Community-to-Facility and Facility-to-Facility crossover cases each season.

[§]Limited Data Set (LDS) indicates the file where the questionnaire data appear (i.e., SF = Survey File, CS = Cost Supplement File). Note, no Facility data are released on the 2023 Survey File - Early Release LDS.

2.2 Sampling

Drawn from a subset of Medicare enrollment data, the beneficiaries included in the 2023 MCBS LDS releases represent a random cross-section of all beneficiaries residing in the continental U.S. who were ever enrolled in either Part A or Part B of the Medicare program for any portion of 2023. A subset of these beneficiaries represents a random cross-section of all beneficiaries who were continuously enrolled from January 1, 2023 up to and including interviews conducted during Fall 2023. The MCBS uses a rotating panel sample design, so the 2023 MCBS LDS represent four separate MCBS panels identified by the year in which the panel was selected and first interviewed (i.e., the 2020, 2021, 2022, and 2023 Panels). The beneficiaries selected in Fall 2019 exited the study at the conclusion of the Winter 2023 round. See the *Data User's Guides* and *Methodology Report* for additional information on sampling.

2.2.1 Targeted Population and Sampling Strata

The targeted population for the MCBS consisted of persons enrolled in Medicare Part A or Part B as of December 31 of the applicable sampling year (e.g., 2023 for the 2023 Panel), and whose address in the Medicare files was in one of the 48 contiguous states (excludes Alaska and Hawaii) or the District of Columbia. Additionally, in the 2020, 2021, 2022, and 2023 Panels, beneficiaries residing within the U.S. who were Hispanic were oversampled to improve precision of estimates for this group. See the *MCBS Methodology Report* for more information about this oversample. Exhibit 2.2.1 displays the beneficiaries selected as part of the 2023 Panel, by age and ethnicity.

Exhibit 2.2.1: 2023 Panel of Selected Beneficiaries by Hispanic and Non-Hispanic Ethnicity Classification and Age Category*

Age Category as of 12/31/2023	TOTAL Sample Size	TOTAL Weighted	Hispanic Sample Size	Hispanic Weighted	Non-Hispanic Sample Size	Non-Hispanic Weighted
Under 45 years	1,186	1,567,767	131	187,568	1,055	1,380,199
45-64 years	1,266	6,113,271	171	613,954	1,095	5,499,318
65-69 years	2,968	17,997,989	358	1,429,313	2,610	16,568,675
70-74 years	2,189	15,505,622	269	1,227,722	1,920	14,277,900
75-79 years	2,297	11,966,216	282	884,148	2,015	11,082,068
80-84 years	2,476	7,424,851	304	591,724	2,172	6,833,127
85+ years	2,713	7,046,622	333	457,845	2,380	6,588,777
Total	15,095	67,622,339	1,848	5,392,273	13,247	62,230,065

SOURCE: Beneficiary age, race/ethnicity, and base weights were sourced from administrative data in the 2023 MCBS Internal Sample Control File.

2.2.2 Sample Selection

Exhibit 2.2.2 provides a brief summary of the number of selected beneficiaries and the inclusion criteria for the 2020 through 2023 Panels included in the 2023 MCBS LDS.

Exhibit 2.2.2: 2023 MCBS Sample Selection for the LDS Releases

Panel	# of Selected Beneficiaries	Previously Enrolled Beneficiaries Still Alive as of January 1 of Panel Year	Current-Year Enrollees
2020	15,952	Enrolled before 1/1/2020	Enrolled 1/1/2020 – 12/31/2020
2021	15,950	Enrolled before 1/1/2021	Enrolled 1/1/2021 – 12/31/2021
2022	17,139	Enrolled before 1/1/2022	Enrolled 1/1/2022 – 12/31/2022
2023	15,095	Enrolled before 1/1/2023	Enrolled 1/1/2023 – 12/31/2023

SOURCE: 2023 MCBS Internal Sample Control File

2.2.3 Completed Interviews

Exhibit 2.2.3 lists the number of completed interviews for the Fall 2023 Continuing (2020, 2021, and 2022) and Incoming (2023) Panels by age strata.

Exhibit 2.2.3: 2023 MCBS Fall Round Completed Interviews: Continuing and Incoming Panels

Age Category as of 12/31/2023	2020 Panel	2021 Panel	2022 Panel	2023 Panel	Total
Under 45 years	91	133	198	535	957
45-64 years	187	221	301	617	1,326
65-69 years	205	294	529	1,282	2,310
70-74 years	408	412	524	954	2,298
75-79 years	316	375	562	978	2,231
80-84 years	323	375	560	1,023	2,281
85+ years	380	415	640	1,136	2,571
Total	1,910	2,225	3,314	6,525	13,974

SOURCE: 2023 MCBS Internal Sample Control File

2.3 Interviewer Recruitment, Staffing, and Training

In 2023, most MCBS interviewers were experienced, having conducted interviews for at least a year or more. New interviewers were recruited to the project in Fall 2023 based on staffing needs and attrition.

The 2023 MCBS Training Program consisted of the following:

- Ahead of Summer 2023 data collection, NORC held an all staff in-person training on the administration of the Physical Measures (PXQ) section of the interview for all experienced interviewers actively working on the project. During this training, interviewers were prepared to collect the six physical measures asked about in the PXQ section: height, weight, balance, timed walk, chair stands, and grip strength. Experienced interviewers also received remote trainings ahead of the Winter and Fall rounds of data collection.
- New staff were onboarded and trained on the Baseline interview remotely in Fall 2023. This training included self-study modules in the learning management system, roundtable discussions with experienced interviewers and field managers, gaining cooperation role playing, and protocol demonstrations.

- Later in the Fall round, new staff were trained in-person on the Continuing interview. This 3.5-day training focused on the essential skills and protocols in the Continuing interview that require in-person instruction, such as correctly prompting for health events and purchases, organizing and abstracting from health and insurance documentation, and balancing complex caseloads.
- The select interviewers trained to administer the Facility interview received a short training focused on new content and round-specific reminders ahead of each round of data collection. A new cohort of experienced interviewers were trained to administer the Facility interview ahead of the Winter round.
- Formal trainings were supplemented with ad hoc additional training interventions, including weekly field memos, groups calls, and interviewer observations, referred to as “ride-alongs” or “call-alongs.”

2.4 Data Collection Schedule and Results

Exhibit 2.4.1 shows the data collection schedule for the 2023 calendar year.

Exhibit 2.4.1: 2023 MCBS Data Collection Schedule

Round	Start Date	End Date
Winter 2023 (Round 95)	January 9, 2023	April 23, 2023
Summer 2023 (Round 96)	May 3, 2023	August 6, 2023
Fall 2023 (Round 97)	July 17, 2023	December 31, 2023

Beneficiaries often require assistance in providing the detailed information needed to accurately respond to survey items, so during data collection, the beneficiary may designate a proxy to participate in the interview on their behalf or an assistant to provide help when responding to specific survey questions. Approximately 12-13 percent of interviews had proxy usage and approximately 9-10 percent of interviews had assistant usage. Additionally, the Community Questionnaire is programmed for administration in English or Spanish, while the Facility Instrument is available for administration in English. Approximately 5 percent of Community components were conducted in Spanish in 2023. For more information on proxy and assistant usage and interviewing languages, see the *MCBS Methodology Reports*.

An interview is complete once administration of all questionnaire sections to the respondent has concluded, the Interviewer Remarks Questionnaire (IRQ) is completed, and data are fully transmitted. Exhibit 2.4.2 provides the count of completed interviews by round and component for 2023. Exhibit 2.4.3 provides the ratio of completed interviews by interview mode.

Exhibit 2.4.2: 2023 Completed Interviews by Component

Round	Component	Completed Interviews	Mean Interview Duration (minutes)
Winter 2023	Community	10,769	67.1
	Facility	825	30.8
Summer 2023	Community	7,717	57.4
	Facility	639	24.3
Fall 2023	Community	13,417	72.1
	Facility	565	42.0

Exhibit 2.4.3: 2023 Completed Interviews by Interview Mode

Round	Component	Phone Interviews	In-Person Interviews
Winter 2023	Community	73%	27%
	Facility	94%	6%
Summer 2023	Community	82%	18%
	Facility	97%	3%
Fall 2023	Community	69%	31%
	Facility	94%	6%

2.5 Clearance

CMS maintains a current OMB clearance for the MCBS. For the 2023 MCBS, CMS received OMB approval on August 26, 2022 (OMB control number 0938-0568, expiration date 8/31/2025). The NORC IRB reviews and approves all MCBS data collection protocols, questionnaires, and respondent materials to ensure human subject protections are properly addressed before field data collection begins. The research protocol and consent procedures for MCBS data collection were first approved by NORC's IRB in July 2014, with subsequent changes to the protocol approved through amendments and annual renewal.

3. DATA USE GUIDANCE & DATA FILE DOCUMENTATION

3.1 Data Access

All requested LDS files require a signed LDS Data Use Agreement (DUA) between CMS and the data requestor to ensure that the data remain protected against unauthorized disclosure. Data users can submit an LDS request via a CMS DUA tracking system, the Enterprise Privacy Policy Engine or EPPE. EPPE can be used to initiate a new LDS DUA request or to amend/update an existing LDS DUA. Questions about LDS files or the process for requesting LDS files can be sent to datauseagreement@cms.hhs.gov. For additional information on data access and the DUA process, including instructions for accessing and using EPPE to make a request, data users can visit the CMS LDS website at <https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/limited-data-set-lds>.

Administrative processing fees for obtaining the LDS files are \$300 for the Survey File - Early Release alone, \$300 for the 2022 Survey File alone, and \$600 for the 2022 Survey File with the 2022 Cost Supplement File (the Cost Supplement File cannot be acquired separately or with the Survey File - Early Release). The processing of the DUA takes approximately six to eight weeks. Upon approval and payment, CMS releases the data within ten business days, depending on the size of the data request. Data users will receive the data on DVD or flash drive, or via the CMS Virtual Research Data Center (VRDC) for use with SAS® or other statistical software packages; each data release contains multiple files that are linkable through a key identification variable (BASEID).

3.2 Guidelines for Citation of Data Source

This communication was printed, published, or produced and disseminated at U.S. taxpayer expense. All material appearing in this document is in the public domain and may be reproduced or copied without permission; citation as to source, however, is appreciated. Accordingly, CMS requests that data users cite CMS and the MCBS as the data source in any publications or research based upon these data. Suggested citation formats are below.

Tables and Graphs: The suggested citation below all tables and graphs should read:

SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, [Data File, (e.g., Cost Supplement File Limited Data Set)], [Year].

Bibliography: The suggested citation for this document should read:

SOURCE: Centers for Medicare & Medicaid Services. [Year] *Medicare Current Beneficiary Survey Data Year Release Notes*. Retrieved from [ADD URL], [YEAR ACCESSED].

Survey Data: The suggested citation for the MCBS survey data files and other documentation should read:

SOURCE: Centers for Medicare & Medicaid Services. Medicare Current Beneficiary Survey, [Data File, (e.g., Cost Supplement File Limited Data Set)] data. Baltimore, MD: U.S. Department of Health and Human Services, [Year].

3.3 Data User Resources

CMS provides technical assistance to researchers interested in using MCBS data and provides free consultation to users interested in obtaining these data products and using these data in research. Users can email

MCBS@cms.hhs.gov with questions regarding obtaining or using the data. Exhibit 3.3.1 provides the links to MCBS documentation and other data user resources.

Exhibit 3.3.1: Table of Links to MCBS Documentation and Resources

MCBS Resources	Links
CMS MCBS website	https://www.cms.gov/data-research/research/medicare-current-beneficiary-survey
MCBS LDS file information	https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/limited-data-set-lds
MCBS Microdata PUFs	https://www.cms.gov/data-research/statistics-trends-and-reports/mcbs-public-use-file
CMS Chronic Conditions Warehouse (CCW)	https://www.ccwdata.org/web/guest/home/
MCBS Documentation: Data Year Release Notes, Data User's Guides, Methodology Reports, Codebooks, and LDS Variable Crosswalks	https://www.cms.gov/data-research/research/medicare-current-beneficiary-survey/data-documentation-codebooks
PUF Table Packages and Chartbook PDFs	https://www.cms.gov/data-research/research/medicare-current-beneficiary-survey/data-tables
Early Look, Data Briefs, Infographics, and Tutorials	https://www.cms.gov/data-research/research/medicare-current-beneficiary-survey/data-briefs-tutorials
Bibliography	https://www.cms.gov/data-research/research/medicare-current-beneficiary-survey/bibliography
Questionnaires and Questionnaire User Documentation	https://www.cms.gov/data-research/research/medicare-current-beneficiary-survey/questionnaires
MCBS Interactives – COVID-19 Data Tool, Survey File PUF Data Tool, and Financial Well-being Data Tool ⁴	https://mcbs-interactives.norc.org/
Chartbook ⁵	https://data.cms.gov/medicare-current-beneficiary-survey-mcbs

⁴ The MCBS Interactives consist of three data tools, the Financial Well-being Data Tool, the Survey File PUF Data Tool and the COVID-19 Data Tool. Each tool contains multiple interactive dashboards that allow users to sort and visualize data according to a variety of demographic and health-related factors.

⁵ Beginning with the release of 2021 MCBS data, the MCBS Chartbook website replaced the PDF version of the MCBS Chartbook that was updated and released annually on the CMS MCBS website to disseminate current estimates on the Medicare population. MCBS estimates from 2015 through 2020 can be found in both the online version of the MCBS Chartbook and the previous MCBS Chartbook PDFs at <https://www.cms.gov/data-research/research/medicare-current-beneficiary-survey/data-tables>.

3.4 Using the Data

3.4.1 Initial Interview Variables

Some questions are asked in only two scenarios: 1) it is the case's Baseline (initial) interview or 2) it is the first time the case has crossed to a new component (e.g., the case crosses from the Community component to the Facility component for the first time). These "initial interview variables" are not asked again during subsequent interviews because the responses are not likely to change. The 2023 LDS variables that have been processed this way are listed in Exhibit 3.4.1.

Exhibit 3.4.1: Initial Interview Variables in the 2023 LDS

Segment ¹	Topic	LDS Variable Name
ER_DEMO/DEMO	Date of Birth	D_DOB
ER_DEMO/DEMO	Hispanic Origin	HISPORIG; HISPORMA; HISPORPR; HISPORCU; HISPOROT
ER_DEMO/DEMO	Race	D_RACE2; RACEAA; RACEAS; RACENH; RACEWH; RACEAI
ER_DEMO/DEMO	Asian Race Subcategories	RACEASAI; RACEASCH; RACEASFI; RACEASJA; RACEASKO; RACEASVI; RACEASOT
ER_DEMO/DEMO	Pacific Islander Race Subcategories	RACEPIHA; RACEPIGU; RACEPISA; RACEPIOT
ER_DEMO/DEMO	Military Service	SPAFEVER; SPAFVIET; SPAFKORE; SPAFWWII; SPAFGULF; SPAFIRAF; SPAFPEAC; SPNGEVER; SPNGALL; SPNGDSBL; SPVARATE
ER_DEMO/DEMO	Number of Children	SPCHNLNM
ER_DEMO/DEMO	Limited English Proficiency	ENGWELL; ENGREAD; OTHRLANG; WHATLANG
ER_DEMO/DEMO	Education	SPDEGRCV
DEMO	Income	INCOME
ER_CHRNCOND/ CHRNCOND	Reason for Medicare Eligibility	EMHBP; EMMYOCAR; EMCHD; EMCFAIL; EMHRTCND; EMSTROKE; EMCSKIN; EMCANCER; EMARTERY; EMARTHRRH; EMARTOST; EMARTHOT; EMMENTAL; EMALZMER; EMDEMENT; EMDEPRSS; EMPSYCHO; EMOSTEOP; EMBRKHIP; EMPARKIN; EMEMPHYS; EMPPARAL; EMAMPUTE; EMDIABTS; EMOTHOS
ER_CHRNCOND	Number of Medications Taken for Blood Pressure	HYPEMANY
FACCHAR	Place of Residence before Facility Admission	BEFORADM
FACCHAR	Household Makeup before Facility Admission	D_LIVWTH

¹ Variables listed with more than one segment are released on both the Survey File - Early Release and Survey File.

3.4.2 Sort Order for Merging the LDS Segments

Sort order is important to understand when data users are merging segments within or across LDS releases. Most 2023 LDS segments are sorted by BASEID. However, some are sorted on other fields to create appropriate and unique sort keys for matching and merging the data, as shown in Exhibit 3.4.2.

Exhibit 3.4.2: Sort Order by Segment in the 2023 LDS

Segment(s)	LDS Release(s)	Sorted By
ER_ASSIST/ASSIST	Survey File - Early Release/Survey File	BASEID HLPNUM
FACCHAR	Survey File	BASEID RECADMN
HITLINE	Survey File	BASEID PLANTYPE PLANNUM
MDS3	Survey File	BASEID TRGT_DT A2300
OASIS	Survey File	BASEID HHASMTID

3.5 MCBS Rounds by Data Year and Season

Exhibit 3.5.1 lists the MCBS data collection rounds by year and by season.

Exhibit 3.5.1: MCBS Rounds by Data Year and Season through Fall 2024

Year	Winter	Summer	Fall
1991	n/a	n/a	1
1992	2	3	4
1993	5	6	7
1994	8	9	10
1995	11	12	13
1996	14	15	16
1997	17	18	19
1998	20	21	22
1999	23	24	25
2000	26	27	28
2001	29	30	31
2002	32	33	34
2003	35	36	37
2004	38	39	40
2005	41	42	43
2006	44	45	46
2007	47	48	49
2008	50	51	52
2009	53	54	55
2010	56	57	58
2011	59	60	61
2012	62	63	64
2013	65	66	67
2014	68	69	70

Year	Winter	Summer	Fall
2015	71/72	71/72	73
2016	74	75	76
2017	77	78	79
2018	80	81	82
2019	83	84	85
2020	86	87	88
2021	89	90	91
2022	92	93	94
2023	95	96	97
2024	98	99	100

2023 Survey File - Early Release LDS

ER1. SURVEY FILE - EARLY RELEASE LDS

The content of the MCBS LDS releases is governed by their central focus of serving as unique sources of information on beneficiaries' health and well-being that cannot be obtained through CMS administrative sources alone. For the 2023 data year, the Survey File - Early Release LDS contains data collected directly from Community respondents during the Fall data collection round and supplemented by some administrative data. The Survey File - Early Release is released approximately nine months after the end of data collection to allow for timely analysis. The Survey File - Early Release LDS includes beneficiaries who were alive, enrolled in Medicare, and completed a Community interview in fall 2023.

The following information is represented in the Survey File - Early Release LDS: beneficiary demographics; disability; health behaviors; health status, conditions, and functioning; household characteristics; mobility; patient activation; and access to and satisfaction with care. The file also contains select information on type of Medicare enrollment and preventive care as of the fall round. The following section contains detailed information about these data.

ER2. WHAT'S NEW FOR DATA YEAR 2023?

Below are the highlights and updates for the 2023 data year that pertain to the Survey File - Early Release LDS.

ER2.1 Sampling

There were no changes to sampling for the 2023 data year.

ER2.2 Questionnaires

Questionnaire content changes: There were a number of questionnaire sections that were revised in Fall 2023. Note that variable names referenced below are the questionnaire variable names. Data users can view the questionnaire for each data year along with the questionnaire variable names referenced below and question text on the MCBS website at <https://www.cms.gov/data-research/research/medicare-current-beneficiary-survey/questionnaires>.

Community Questionnaire

The MCBS introduced several Community Questionnaire updates in Fall 2023 to enhance survey content and data quality and improve interviewer and respondent experience. Changes include the addition of new items and updates to question text, response options, and respondent universes.

COVID-19 (CVQ)

A new response option was added to LONGCVD, which collects if the beneficiary had COVID-19 symptoms lasting three months or longer. The code list was updated to include a new "Not Applicable" response option to accommodate beneficiaries who were recently diagnosed (less than three months ago) with COVID-19.

Health Status and Functioning (HFQ)

In Fall 2023, two items (TEETHGUM and DRYMOUTH) adapted from the NHIS 2008 Oral Health Supplement⁶ and the World Health Organization Oral Health Survey⁷ were added to the Health Status and Function Questionnaire (HFQ) to assess the risk of disease for dry mouth symptoms and tooth sensitivity. Additionally, one item (TOOTHSEN) sourced from the 2019-2020 National Health and Nutrition Examination Survey (NHANES) was added to the HFQ to assess the overall oral health of the beneficiary's teeth and gums.

Preventive Care (PVQ)

Item HYSTEREC, which collects whether the beneficiary has ever had a hysterectomy, was moved to precede item PAPSMEAR, which collects if the beneficiary had a Pap smear in the prior year in Fall 2023. As a result of this change, the code list at the variable that collects the reason why the beneficiary has not had a recent Pap smear, PAPCODE, was updated to remove hysterectomy as a response option. To reflect the corresponding change in the universe of respondents at these items:

- HYSTEREC was renamed HYSTER
- PAPSMEAR was renamed PAPTEST
- PAPCODE was renamed PAPREASN

⁶ https://ftp.cdc.gov/pub/health_statistics/nchs/Dataset_Documentation/NHIS/2008/srvydesc.pdf

⁷ <https://www.who.int/publications/i/item/9789241548649>

- PAPNOTHS was renamed PAPOTHR

Facility Instrument

The MCBS introduced several Facility Instrument updates in Fall 2023 that included streamlining of the instrument and updates to question text and programming logic. However, given no Facility data are released on the Survey File - Early Release LDS, these changes will be documented in the *2023 Data Year Release Notes* for the Survey File LDS.

ER2.3 Data Collection

In Fall 2023, administrative data were used to prioritize enhanced outreach to Black, Asian, and Hispanic beneficiaries to increase their representation in the 2023 Panel data. These enhancements included a multi-lingual insert in the advance letter mailing that was included to facilitate conversation at the door and resolve possible language barriers quickly. Throughout data collection, interviewers concentrated on in-person contacting and interviewing, targeted field interviewer travel trips, and reminder letters sent via FedEx to prompt non responders who were presumed to be Black, Hispanic, and Asian.

ER2.4 Data Processing

The 2023 Survey File - Early Release is built from 16 analytic data files from Fall 2023 Community data collection, as well as some administrative data. These files are input into CMS processes that generate the final data files available to the public.

New and revised content:

For the 2023 Survey File - Early Release LDS, there are no new segments. The Survey File - Early Release LDS comprises a subset of the segments released on the annual Survey File LDS (i.e., all segments released on the Survey File - Early Release will also be released on the Survey File). To distinguish the Survey File - Early Release segments from the Survey File segments, the Early Release versions begin with the abbreviation "ER_." Notably, the 2023 Survey File - Early Release LDS provides abbreviated versions of three segments compared to prior Survey File LDS's: Demographics (DEMO), Health Insurance Summary (HISUMRY), and Preventive Care (PREVCARE). The complete, annualized versions of the DEMO and HISUMRY segments will be reprocessed and released on the 2023 Survey File LDS, while the Winter and Summer round data formerly included on the PREVCARE segment will be released on a new immunization segment beginning in 2023.

The 2023 questionnaire changes resulted in the following variables added to the release.

Exhibit ER2.4.1: 2023 MCBS Survey File - Early Release LDS Content Additions

Location	Questionnaire Section	Variable	Description
ER_CHRONCOND	HFQ	DRYMOUTH	HOW OFTEN SP HAVE DRY MOUTH
ER_CHRONCOND	HFQ	TEETHGUM	GENERAL ORAL, TEETH, AND GUM HEALTH OF SP
ER_CHRONCOND	HFQ	TOOTHSEN	HOW OFTEN SP HAVE TOOTH SENSITIVITY

Weighting:

For the inaugural 2023 Survey File - Early Release LDS release, three new sets of weights were developed to facilitate analysis of the data segments included in the release. The first weight is ER_EEYRSWGT, which can be used for all Survey File - Early Release data except the Patient Activation (ER_PNTACT) and Cognitive

Measures (ER_COGNFUNC) segments. For analysis of ER_PNTACT data, data users should use the weight ER_PNSEWT instead; this weight has been adjusted to account for non-proxy respondents to the Patient Activation (PAQ) section of the Satisfaction with Care Questionnaire (SCQ). For analysis of ER_COGNFUNC data, data users should use the weight ER_CGSEWT instead; this weight has been adjusted to account for non-proxy respondents to the Cognitive Measures Questionnaire (CMQ). All of these weights are accompanied by a set of 100 replicate weights for use in variance estimation. Each weight is representative of the same population: beneficiaries who were alive, enrolled in Medicare, and living in the community in the fall of 2023. More information on these new weights is available in section ER3.3.

Imputation:

There were no changes for the 2023 data year that affect the Survey File - Early Release LDS data.

ER3. DATA FILE CONTENTS

ER3.1 2023 MCBS Survey File - Early Release Segments

The 2023 Survey File - Early Release LDS contains over 1,100 variables across 20 segments. Exhibit ER3.1.1 displays each segment included in the Survey File - Early Release LDS including the **segment abbreviation**, **brief description**, and **information on weights or other special notes**.

The **Data Source** column describes the source of the data on the segment. The two possible sources for the Survey File - Early Release LDS are the Community Questionnaire (CQ) and Administrative Records (AR). Each LDS segment can have any combination of these sources. Data source reflects where the data came from, not where the beneficiary was living. For example, a beneficiary could have lived in both settings during the year, but the data for that beneficiary available on the ER_ASSIST segment came from their Community interview only.

The **Quex Section** column lists the specific questionnaire sources for the LDS segment. Please note that not all variables from the questionnaire are released on the segments. Some questionnaire items are combined or recoded to create the LDS variable. Data users will see these derived variables noted in the codebooks preceded with the character "D", such as D_OCDTYP.

Season indicates the round (winter, summer, fall, or all) and year when the questionnaire was administered.

Panel describes whether the questionnaire sections that provide the data for each segment are fielded for Baseline respondents (base), Continuing respondents (cont), or all panels (all). If the segment consists of administrative CMS data, then the cell indicates all panels are included.

Unit of Observation indicates what each row in the segment represents. For example, the ER_ASSIST segment provides multiple rows per BASEID for each person reported as helping the beneficiary in the data year.

A list of equivalent historic segments from the 1991-2013 data release structure is provided in section ER4.3.

Exhibit ER3.1.1: 2023 MCBS Survey File - Early Release Segments and Contents

Survey File - Early Release Segment (Abbrev)	Description	Data collection and special weights notes	Data Source	Quex Section	Season	Panel	Unit of Observation
Access to Care (ER_ACCESSCR)	Information on ability to obtain health care, delay of care related to costs, and reasons for not obtaining needed health care.		CQ	HFQ	Fall	All	Beneficiary
Assistance (ER_ASSIST)	Information on the person helping and type of assistance that the beneficiary with ADLs and IADLs.		CQ	ENS, HFQ	All (ENS) Fall (HFQ)	All	Helper by beneficiary

Survey File - Early Release Segment (Abbrev)	Description	Data collection and special weights notes	Data Source	Quex Section	Season	Panel	Unit of Observation
Chronic Conditions (ER_CHRNCOND)	Information on chronic and other diagnosed medical conditions.	Special non-response adjustment weights are included with this file.	CQ	HFQ, PVQ	Fall (HFQ, PVQ) ¹	All	Beneficiary
Cognitive Measures (ER_COGNFUNC)	Measures of cognitive functioning.		CQ	CMQ	Fall	All	Beneficiary
COVID-19 Experience (ER_COVIDEXP)	Information on COVID-19 vaccination, testing, diagnosis, symptoms, and prevention.		CQ	CVQ	Fall	All	Beneficiary
Demographics (ER_DEMO)	Select demographic information.		CQ, AR	ENS, DIQ, INQ	All (ENS, INQ) Fall (DIQ)	All (ENS, INQ) Base (DIQ)	Beneficiary
Diabetes (ER_DIABETES)	Information on diabetes management such as insulin usage.		CQ	HFQ	Fall	All	Beneficiary
Falls (ER_FALLS)	Information on injuries and attitudes about falls.		CQ	HFQ	Fall	All	Beneficiary
General Health (ER_GENHLTH)	Information on general health status and functioning such as height and weight.		CQ	HFQ	Fall	All	Beneficiary
Health Insurance Summary (ER_HISUMRY)	Select administrative information on the characteristics of insurance coverage.		AR	n/a	All	All	Beneficiary
Household Characteristics (ER_HHCHAR)	Information on household composition and home.		CQ	ENS, HAQ	Fall (ENS) Fall (HAQ)	All	Beneficiary
Mental Health (ER_MENTHLTH)	Information on mental health such as feelings of anxiety or depression.		CQ	HFQ	Fall	All	Beneficiary
Mobility (ER_MOBILITY)	Information on the use of available transportation options and whether health status affects their daily travel.		CQ	MBQ	Fall	All	Beneficiary
Nagi Disability (ER_NAGIDIS)	Information on difficulties with performance of activities of daily living.		CQ	HFQ	Fall	All	Beneficiary

Survey File - Early Release Segment (Abbrev)	Description	Data collection and special weights notes	Data Source	Quex Section	Season	Panel	Unit of Observation
Nicotine and Alcohol (ER_NICOALCO)	Information on the prevalence and frequency of alcohol and nicotine use.		CQ	NAQ	Fall	All	Beneficiary
Patient Activation (ER_PNTACT)	Information on the degree to which beneficiaries actively participate in their health care and decisions concerning care.	Special non-response adjustment weights are included with this file.	CQ	SCQ	Fall	All	Beneficiary
Preventive Care (ER_PREVCARE)	Information on preventive services such routine screening procedures.		CQ	HFQ, PVQ	Fall (HFQ, PVQ) ¹	All	Beneficiary
Satisfaction with Care (ER_SATWCARE)	Information on satisfaction with different aspects of health care.		CQ	SCQ	Fall	Cont. (MPQ, PMQ) Both (SCQ)	Beneficiary
Vision and Hearing (ER_VISHEAR)	Information on eye health and hearing status.		CQ	HFQ	Fall	All	Beneficiary
Survey File - Early Release Weights (ER_EVRWGTS)	The weights segment includes: general-purpose cross-sectional weights to represent the ever enrolled population and a series of replicate weights.		CQ	n/a	n/a	All	Beneficiary

1. PVQ is administered in rounds following the current data year given that the reference period is the prior year and data are included in the prior year data files. Fall round PVQ data are released on the Survey File - Early Release LDS, while winter and summer round PVQ data are released on the Survey File LDS.

ER3.2 Imputation

There are no imputation notes for the Survey File - Early Release LDS as the LDS does not include any imputed data.

ER3.3 Weights

Data users can merge segments within the 2023 Survey File - Early Release. This LDS file includes cross-sectional weights for the ever enrolled population based on preliminary enrollment data. Longitudinal weights are not available for these data, nor are cross-sectional weights for the continuously enrolled population.

The Survey File - Early Release cross-sectional weights represent the ever enrolled population of inference, which corresponds to the population of beneficiaries who were alive, enrolled, and living in the community as of fall 2023. The ever enrolled Survey File - Early Release weight is greater than zero for all beneficiaries in the

Survey File - Early Release. This weight segment is ER_EVRWGTS, and the name of the weight is ER_EEYRSWGT. The sum of this weight represents the population of beneficiaries who were entitled and enrolled in Medicare for at least one day at any time during the calendar year and still alive, enrolled, and living in the community in fall 2023.

ER3.3.1 Special Topical Segment Weights

The 2023 Survey File - Early Release LDS includes two segments with special non-response adjusted weights: ER_PNTACT and ER_COGNFUNC. ER_PNTACT includes select items from the Patient Activation Questionnaire (PAQ) section of SCQ that were fielded in Fall 2023 to only non-proxy respondents (i.e., beneficiary respondents). ER_COGNFUNC includes items from CMQ that were fielded in Fall 2023 to only non-proxy respondents. On the Survey File - Early Release LDS, ER_PNTACT and ER_COGNFUNC each offer one set of full-sample and replicate weights that correspond to the Survey File - Early Release ever enrolled population who were alive and living in the community in fall 2023 and can be used to conduct analyses of the Topical data as representing the ever enrolled population and in conjunction with other Survey File - Early Release data.

Exhibit ER3.3.1 summarizes the weights released on the 2023 Survey File - Early Release.

Exhibit ER3.3.1: 2023 MCBS Survey File - Early Release Summary of Weights

Limited Data Set	Description	Segment	Full-Sample Weight	Replicate Weights	Population
Survey File - Early Release	Ever Enrolled Cross-Sectional Weights	ER_EVRWGTS	ER_EEYRSWGT	ER_EEYRS1- ER_EEYRS100	Ever enrolled for at least one day at any time during 2023
Survey File - Early Release Topical Segment	CMQ Survey File - Early Release Ever Enrolled Weights	ER_COGNFUNC	ER_CGSEWT	ER_CGSE1- ER_CGSE100	Ever enrolled for at least one day at any time during 2023; includes Fall non-proxy adjustment
Survey File - Early Release Topical Segment	PAQ Survey File - Early Release Ever Enrolled Weights	ER_PNTACT	ER_PNSEWT	ER_PNSE1- ER_PNSE100	Ever enrolled for at least one day at any time during 2023; includes Fall non-proxy adjustment

ER4. DATA FILE NOTES

ER4.1 Survey File - Early Release Segment Information

Below is the information regarding each segment within the Survey File - Early Release, presented in alphabetical order. The notes have been organized into three main categories of information.

1. Core Content – a description of the main subject of the data.
2. Variable Definitions – definitions of derived variables and/or variables that require additional explanation regarding their construction. Note: The variables listed are not a comprehensive list of all variables in each segment. The Codebook provides information on all variables in each segment.
3. Special Notes – additional background information that data users may find helpful for constructing analyses.

ER4.2 Survey File - Early Release Segment Descriptions

ER4.2.1 Access to Care (ER_ACCESSCR)

ER4.2.1.1 Core Content

The Access to Care segment contains information from the HFQ section in the fall round. General questions are asked about the beneficiary's ability to access medical services. This segment also contains information on medical debt and the reasons beneficiaries cannot access the care they need.

ER4.2.1.2 Variable Definitions

Please see the Codebook for information regarding variables in this segment.

ER4.2.1.3 Special Notes

Respondents are asked why the beneficiary had trouble getting health care or scheduling a health care appointment in an open-ended format (e.g., "What were the reasons the doctor's office offered as an explanation for not scheduling an appointment with you?"). The respondents answer these questions in their own words, and interviewers select the response option(s) from a predefined code list that best matched the respondents' answer(s). These questions are select-all-that-apply so that respondents may provide multiple answers to each question, and each answer is stored in its own analytic variable.

If the respondent reports a reason that is not included in the predefined code list, the interviewer documents their response verbatim in an "other specify" variable that is not released. The "other specify" response is back coded as necessary into the predefined code list.

If the respondent reports that the beneficiary could not schedule an appointment because the doctor is not accepting new Medicare patients or the doctor does not accept Medicare at all, the respondent is then asked at variable OFFEXPLN whether the doctor's office explained why this is the case. If the doctor's office provided an explanation to the respondent, this explanation is recorded verbatim at OFFEXVB1 but not released.

ER4.2.2 Assistance (ER_ASSIST)

ER4.2.2.1 Core Content

The Assistance segment contains information on each person identified as helping the beneficiary with ADLs or IADLs, including the helper's age, relationship to the beneficiary, and the types of assistance that the beneficiary receives (e.g., assistance with dressing, shopping, eating) from each identified helper. The number of records in the Assistance segment reflects the number of persons identified as having assisted the beneficiary with one or more ADL or IADLs. Therefore, it is possible to have one, several, or no helper records per beneficiary.

ER4.2.2.2 Variable Definitions

Please see the Codebook for information regarding variables in this segment.

ER4.2.2.3 Special Notes

When a beneficiary has more than one helper, the variable HLPRMOST identifies which helper provides the beneficiary with the most help with daily activities. This variable contains missing values for helpers who were a beneficiary's only helper. If a beneficiary with multiple helpers has not indicated which helper provides the most help, then this variable contains missing data for each of the beneficiary's helpers.

Beginning in 2023, the code frame for the variable HLPREL (relationship to helper) aligns with the relationship code frame used by the ER HHCHAR segment.

Most ADL and IADL questions are asked in the HFQ section in the fall round. However, there is one variable, HLPRUSGO (the person who usually accompanies the beneficiary to their provider's office), that is asked in the winter round in the USQ section. As such, HLPRUSGO is not included in the Survey File - Early Release.

ER4.2.3 Chronic Conditions (ER_CHRNCOND)

ER4.2.3.1 Core Content

The Chronic Conditions segment contains information on whether the beneficiary has a series of chronic and other diagnosed medical conditions such as cancer, high blood pressure, and depression. If the respondent reports that the beneficiary has the condition, a series of follow-up questions is asked.

ER4.2.3.2 Variable Definitions

D_OCDTYP: This variable indicates type of diabetes and is derived from OCDDTYPE and DIAPRGNT. The OCDDTYPE categories for "Pre-diabetes" and "Borderline" diabetes are combined into one category for D_OCDTYP. Beneficiaries who answer "Yes" for DIAPRGNT, which is not released, are coded as "Gestational diabetes" for D_OCDTYP, unless they indicate for OCDDTYPE that they have Type 1 diabetes.

LOSTURIN: "More than once a week" is coded if the beneficiary cannot control urination at all. Leaking urine, especially when the person laughs, strains or coughs, does not qualify as incontinence.

ER4.2.3.3 Special Notes

The HFQ and PVQ sections ask respondents whether they have ever had any of a series of illnesses or conditions in the fall round. Their responses are coded affirmatively if the beneficiary had at some time been diagnosed with the condition, even if the condition had been corrected by time or treatment. The condition

must be reported by the respondent as diagnosed by a physician, not by the respondent. If the respondent is not sure about the definition of a condition, the interviewer offers no advice or information, but records the respondent's answer verbatim.

There are different versions of each illness/condition question depending on whether a respondent is in the Incoming Panel sample or Continuing sample. Incoming Panel sample respondents are asked if a doctor ever told them that they had a specific condition (e.g., hypertension). If the answer is "Yes", then the Incoming Panel respondent is asked if the doctor had told them in the past year that they had the condition.

For illnesses or conditions that cannot change after diagnosis (e.g., Alzheimer's), once an affirmative response is given, respondents are not asked again. However, if a negative response is given, respondents are asked annually thereafter if they had that specific illness or condition in the past year.

For illnesses or conditions that can change after diagnosis or can be reoccurring, such as high blood pressure, respondents are asked annually thereafter if they were diagnosed with that illness or condition in the past year, irrespective of prior responses. All data for a beneficiary from the current survey year and all previous years are used to determine whether the beneficiary has ever been told by a doctor that they had a condition. The ER_CHRNCOND segment includes variables that indicate whether a beneficiary ever had specific conditions.

The "other specify" questions EMOS and EVROS are back coded as necessary into the "reason for Medicare eligibility" and "type of cancer" response options, respectively, but the verbatim text is not released.

As described in section ER2.2, the hysterectomy item was renamed to HYSTER in the questionnaire in Fall 2023 to reflect the change in the universe of respondents. However, the original variable name, HYSTEREC, is retained in the ER_CHRNCOND segment.

In 2023, three new variables were added to the ER_CHRNCOND segment: DRYMOUTH (how often beneficiary experiences dry mouth), TOOTHSEN (how often beneficiary experiences tooth sensitivity), and TEETHGUM (beneficiary's rating of their teeth and gum health).

ER4.2.4 Cognitive Measures (ER_COGNFUNC)

ER4.2.4.1 Core Content

The Cognitive Measures segment contains data on the beneficiary's cognitive abilities collected in the CMQ section administered in the fall rounds. The CMQ contains four cognitive measures, including backwards counting, date naming, object naming, and president/vice president naming.

ER4.2.4.2 Variable Definitions

Please see the Codebook for information regarding variables in this segment.

ER4.2.4.3 Special Notes

Special non-response adjustment weights are included in the file to account for survey non-response as these items are only asked of non-proxy respondents.

ER4.2.5 COVID-19 Experiences (ER_COVIDEXP)

ER4.2.5.1 Core Content

The COVID-19 Experiences segment contains information collected in the CVQ section during the fall round, and it includes data on COVID-19 vaccination, testing, diagnosis, symptoms, and prevention.

For the items collected in the CVQ section during the Winter round, see the COVID-19 Topical (COVIDTOP) segment on the Survey File.

ER4.2.5.1 Variable Definitions

Please see the Codebook for information regarding variables in this segment.

ER4.2.5.1 Special Notes

COVID-19 vaccine data are brought forward from the 2022 Survey File, but no other ER_COVIDEXP data are combined across interview rounds. The vaccine doses included in ER_COVIDEXP are those that were reported at or before the beneficiary's Fall 2023 interview.

The "other specify" question CVDOTHER is back coded as necessary into the "why beneficiary didn't seek medical care for coronavirus" response options, but the verbatim text is not released.

In Fall 2023, the code frame at LONGCVD, which collects if the beneficiary had any symptoms lasting three months or longer that they didn't have prior to having COVID-19, was updated to include a "Question does not apply" response for beneficiaries recently diagnosed with COVID-19 (less than three months).

ER4.2.6 Demographics (ER_DEMO)

ER4.2.6.1 Core Content

The Demographics segment released on the Survey File - Early Release (ER_DEMO) contains select demographic information collected in the survey as well as demographic information from Medicare Administrative enrollment data and constructed items of interest. Additional demographic data are provided on the Demographics segment released on the Survey File (DEMO).

ER4.2.6.2 Variable Definitions

ADI: The Area Deprivation Index (ADI) is an indicator of the socioeconomic deprivation of geographic areas and is intended for use in evaluating the relationship between socioeconomic factors and health. This index was originally developed using 17 markers of socioeconomic status from the 1990 Census data. The ADI dataset used in this data release was developed by Amy Kind, MD, PhD and her research team at the University of Wisconsin using the same indicators and 2020 Census block group-level data from the American Community Survey (ACS). This dataset contains national percentile rankings at the block group level from 1 to 100 as well as state decile rankings from 1 to 10. Raw ADI values are used to determine percentile and decile rankings. ADI values in the first percentile are the least disadvantaged, and those in the hundredth are the most disadvantaged.⁸

⁸ "2020 Area Deprivation Index v3.2," University of Wisconsin School of Medicine and Public Health, <https://www.neighborhoodatlas.medicine.wisc.edu/>.

The MCBS includes two ADI values for each beneficiary, a national-level percentile (ADINATNL) and a state-level decile (ADISTATE). Both rankings are based on the Census block group for the beneficiary's primary residence address. Beneficiaries have a value for each of these variables if their Census block group is found on the ADI dataset.

H_DOB, H_DOD, H_AGE, and D_STRAT: These four variables are related to the beneficiary's age. The "legal" dates of birth and death from Medicare and the Social Security Administration records are recorded as H_DOB and H_DOD, respectively. The variable H_AGE represents the "legal" age as of December 31, 2023, adjusted for date of death, if present. The variable D_STRAT groups the beneficiaries by various age categories using H_AGE. The date of birth, as reported during the Baseline interview, is recorded in ER_DEMO (D_DOB).

D_DOB: When the complete date of birth is entered (D_DOB) in the MCBS instrument, the CAPI questionnaire automatically calculates the person's age, which is then verified with the respondent. Despite this validation, the date of birth given by the respondent (D_DOB) does not always agree with the date of birth per CMS records (H_DOB). In these cases, the beneficiary is asked again in the next interview to provide a date of birth. Some recording errors are identified this way, but in most cases, beneficiaries provide the same date of birth both times they are asked. In some cases, proxies indicate that no one is exactly sure of the correct date of birth. In general, it is recommended that the variable (H_DOB) be used for analyses, since the CMS date of birth is used to select and stratify the sample.

D_RACE2: Race categories are self-reported by the respondent. Categories are not suggested by the interviewer, nor does the interviewer try to explain or define any of the groups. Ethnic groups such as Irish or Cuban are not recorded.

H_CENSUS: The Census division is performed through internal edits by matching the survey respondent's SSA State code to the appropriate Census region. The Census divisions are as follows:

- New England – Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
- Middle Atlantic – New Jersey, New York, Pennsylvania
- South Atlantic – Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia
- East North Central – Illinois, Indiana, Michigan, Ohio, Wisconsin
- West North Central – Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota
- East South Central – Alabama, Kentucky, Mississippi, Tennessee
- West South Central – Arkansas, Louisiana, Oklahoma, Texas
- Mountain – Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming
- Pacific – Alaska, California, Hawaii, Oregon, Washington

Urban/rural status variables: H_RUCA indicates overall urban/rural status. H_RUCA1 and H_RUCA2 indicate the primary and secondary RUCA codes, respectively (see Exhibits ER4.2.1 and ER4.2.2). This classification scheme provides an alternative to county-based systems for situations where more detailed geographic analysis is feasible. It identifies areas of emerging urban influence and areas where urban-rural classifications overlap, thus providing an exhaustive system of statistical areas for the country.

The ten whole numbers shown in Exhibit ER4.2.1 below refer to the primary, or single largest, commuting share. Metropolitan cores (code 1) are defined as Census tract equivalents of urbanized areas. Micropolitan and small town cores (codes 4 and 7, respectively) are tract equivalents of urban clusters. Tracts are included in urban cores if more than 30 percent of their population is in the urbanized area or urban cluster.

High commuting (codes 2, 5, and 8) means that the largest commuting share is at least 30 percent to a metropolitan, micropolitan, or small town core. Many micropolitan and small town cores themselves (and even a few metropolitan cores) have high enough out-commuting to other cores to be coded 2, 5, or 8; typically,

these areas are not job centers themselves but serve as bedroom communities for a nearby larger city. Low commuting (codes 3, 6, and 9) refers to cases where the single largest flow is to a core but is less than 30 percent. These codes identify "influence areas" of metro, micropolitan, and small town cores, respectively, and are similar in concept to the "nonmetropolitan adjacent" codes found in other Economic Research Service (ERS) classification schemes ([Rural-Urban Continuum Codes](#), [Urban Influence Codes](#)). The last of the general classification codes (10) identifies rural tracts where the primary flow is local or to another rural tract.

Exhibit ER4.2.1: Primary RUCA (H_RUCA1) Codes

Code	Classification description
1	Metropolitan area core: primary flow within an urbanized area (UA)
2	Metropolitan area high commuting: primary flow 30% or more to a UA
3	Metropolitan area low commuting: primary flow 10% to 30% to a UA
4	Micropolitan area core: primary flow within an urban cluster (UC) of 10,000 to 49,999 (large UC)
5	Micropolitan high commuting: primary flow 30% or more to a large UC
6	Micropolitan low commuting: primary flow 10% to 30% to a large UC
7	Small town core: primary flow within an urban cluster of 2,500 to 9,999 (small UC)
8	Small town high commuting: primary flow 30% or more to a small UC
9	Small town low commuting: primary flow 10% to 30% to a small UC
10	Rural areas: primary flow to a tract outside a UA or UC
99	Not coded: Census tract has zero population and no rural-urban identifier information

These ten codes offer a relatively straightforward and complete delineation of metropolitan and nonmetropolitan areas based on the size and direction of primary commuting flows. However, secondary flows may indicate other connections among rural and urban places. Thus, the primary RUCA codes are further subdivided to identify areas where classifications overlap, based on the size and direction of the secondary, or second largest, commuting flow (see Exhibit ER4.2.2). For example, 1.1 and 2.1 codes identify areas where the primary flow is within or to a metropolitan core, but another 30 percent or more commute to a larger metropolitan core. Similarly, 10.1, 10.2, and 10.3 identify rural tracts for which the primary commuting share is local, but more than 30 percent also commute to a nearby metropolitan, micropolitan, or small town core, respectively.

Exhibit ER4.2.2: Secondary RUCA (H_RUCA2) Codes

Code	Classification description
1 Metropolitan area core: primary flow within an urbanized area (UA)	
1.0	No additional code
1.1	Secondary flow 30% to 50% to a larger UA
2 Metropolitan area high commuting: primary flow 30% or more to a UA	
2.0	No additional code
2.1	Secondary flow 30% to 50% to a larger UA
3 Metropolitan area low commuting: primary flow 10% to 30% to a UA	
3.0	No additional code
4 Micropolitan area core: primary flow within an urban cluster (UC) of 10,000 to 49,999 (large UC)	
4.0	No additional code
4.1	Secondary flow 30% to 50% to a UA
5 Micropolitan high commuting: primary flow 30% or more to a large UC	
5.0	No additional code
5.1	Secondary flow 30% to 50% to a UA
6 Micropolitan low commuting: primary flow 10% to 30% to a large UC	
6.0	No additional code
7 Small town core: primary flow within an urban cluster of 2,500 to 9,999 (small UC)	
7.0	No additional code
7.1	Secondary flow 30% to 50% to a UA
7.2	Secondary flow 30% to 50% to a large UC
8 Small town high commuting: primary flow 30% or more to a small UC	
8.0	No additional code
8.1	Secondary flow 30% to 50% to a UA
8.2	Secondary flow 30% to 50% to a large UC
9 Small town low commuting: primary flow 10% to 30% to a small UC	
9.0	No additional code
10 Rural areas: primary flow to a tract outside a UA or UC	
10.0	No additional code
10.1	Secondary flow 30% to 50% to a UA
10.2	Secondary flow 30% to 50% to a large UC
10.3	Secondary flow 30% to 50% to a small UC
99 Not coded: Census tract has zero population and no rural-urban identifier information	

INT_TYPE: Provides the source for a beneficiary's residence status at the time of interview. In the Survey File - Early Release, all INT_TYPES are C, which means the respondent only lived in the community and only completed Community-administered survey instruments in each round. INT_TYPE on the Survey File - Early Release is created as follows: Beneficiaries are assigned an INT_TYPE if they completed or partially completed an interview in at least one round in 2023. INT_TYPE is also calculated for beneficiaries who completed an interview, but died or lost entitlement during the data year.

Note that in each data year, some differences by segment will exist (i.e., data may reflect a prior or future calendar year due to the specific questionnaire and reference period used to collect the information).

INT_TYPE is only constructed using survey-reported data for the benefit year and is not edited to account for data collected in a future or prior data year.

INT_TYPE is calculated on the benefit year, but data segments may reflect a prior or future calendar year due to the specific questionnaire and reference period used to collect the information. That is, the segment data is collected prior to or after the benefit year designation of INT_TYPE.

PANEL: Indicates the year of the beneficiary's Baseline interview.

ER4.2.6.3 Special Notes

ER_DEMO contains all demographic data from both the survey and from CMS administrative records, except for variables on income (INCOME_H, INCSRCE, INCOME, and IPR) and select variables related to the death of the beneficiary and their spouse/partner (D_DOD, SURVIVE, and SPSDTH). These variables will be released on DEMO in the Survey File.

The Department of Veterans Affairs (VA) disability rating collected at SPVARATE is a percentage and is expressed in multiples of ten; it refers to disabilities that are officially recognized by the government as service-related. If the VA finds that a Veteran has multiple disabilities, the VA uses a Combined Ratings Table to calculate a combined disability rating (see <https://www.benefits.va.gov/compensation/rates-index.asp#combined>).

ER4.2.7 Diabetes (ER_DIABETES)

ER4.2.7.1 Core Content

The Diabetes segment includes survey responses related to diabetes management. Only beneficiaries living in the community who indicated that they had ever been told they have non-gestational diabetes (variable D_OCDTYP in the Chronic Condition segment) are included in the Diabetes segment. This segment includes beneficiaries who indicated they had been diagnosed with any of these diabetic conditions: Type 1, Type 2, pre-diabetes/borderline diabetes, or other non-gestational type of diabetes.

ER4.2.7.2 Variable Definitions

Frequency of management variables: The Diabetes segment includes five pairs of items that describe the frequency of specific diabetes management behaviors. These behaviors are taking insulin, using an insulin pump, taking prescription or oral diabetes medications, testing blood glucose, and checking for foot sores. The frequency of each behavior is described by a pair of variables, with one set yielding the numeric frequency (variables D_INSFRQ, D_INSPMP, D_MEDFRQ, D_TSTFRQ, and D_SORFRQ, respectively). The other set of variables captures the corresponding frequency unit, with the exception of D_INSPMP (variables INSUUNIT, MEDSUNIT, TESTUNIT, and SOREUNIT, respectively).

ER4.2.7.3 Special Notes

The variables included in the Diabetes segment are centered on diabetes management. It should be noted there are other diabetes-related variables on other segments. For example, the Chronic Conditions segment stores variables relevant to diabetes diagnoses (e.g., OCBETES and D_OCDTYP). Variables related to diabetes risk and screening (e.g., DIAEVERT, DIARCNT, DIAAWARE, DIARISK, and DIASIGNS) appear in the ER_PREVCARE segment. The variable pertaining to diabetic retinopathy (RETINEVR) appears in the ER_VISHEAR segment.

ER4.2.8 Falls (ER_FALLS)

ER4.2.8.1 Core Content

The Falls segment contains responses related to injuries and attitudes related to falls.

ER4.2.8.2 Variable Definitions

Please see the Codebook for information regarding variables in this segment.

ER4.2.8.3 Special Notes

The “other specify” question FALOTHOS is back coded as necessary into the “type of injury from fall” response options, but the verbatim text is not released.

ER4.2.9 General Health (ER_GENHLTH)

ER4.2.9.1 Core Content

The General Health segment contains data regarding a beneficiary’s general health status and functioning such as height and weight.

ER4.2.9.2 Variable Definitions

BMI_CAT: BMI (Body Mass Index) was calculated using height and weight as-

$$(WEIGHT*703)/((HEIGHTFT*12+HEIGHTIN)*(HEIGHTFT*12+HEIGHTIN))$$

Then categorized as:

- 0 < BMI < 18.5 = 1
- 18.5 ≤ BMI < 25 = 2
- 25 ≤ BMI < 30 = 3
- 30 ≤ BMI < 40 = 4
- BMI ≥ 40 = 5

ER4.2.9.3 Special Notes

For height and weight information at HEIGHTFT, HEIGHTIN, and WEIGHT, the respondent is asked to recall or estimate, not to measure or weigh themselves. In the height measurement, fractions of an inch have been rounded: those one-half inch or more were rounded up to the next whole inch, those less than one-half inch were rounded down. In the weight measurement, fractions of a pound have been rounded: those one-half pound or more were rounded up to the next whole pound, those less than one-half pound were rounded down.

ER4.2.10 Health Insurance Summary (ER_HISUMRY)

ER4.2.10.1 Core Content

The Health Insurance Summary segment released on the Survey File - Early Release (ER_HISUMRY) contains a subset of information on administrative plans and their characteristics. Specifically, it includes flags for monthly enrollment, Part D, and dual eligibility status. Additional health insurance data are provided on the Health Insurance Summary segment released on the Survey File (HISUMRY).

There are important caveats to using premium information contained in ER_HISUMRY. For more details, see the notes below on the H_PDLS01-12: Low-Income Subsidy Indicator values.

ER4.2.10.2 Variable Definitions

H_DUAL01-12: The variables H_DUAL01-H_DUAL12 describe dual eligibility for each month based on state reporting requirements outlined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). These variables provide more detail regarding the type of Medicaid benefits the beneficiary is entitled to receive and are considered the most accurate source of information on enrollee status. Specific types of dual eligibility identified by these variables are as follows, where the applicable month is MM:

- Qualified Medicare Beneficiaries without other Medicaid (QMB-only) – These individuals are entitled to Medicare Part A, have an income of 100 percent of the Federal poverty level (FPL) or less, have resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for full Medicaid. Medicaid pays their Medicare Part A premiums, if any, Medicare Part B premiums, and to the extent consistent with the Medicaid State plan, Medicare deductibles, and coinsurance for Medicare services provided by Medicare providers. [Partial benefit; H_DUALMM=01]
- Qualified Medicare Beneficiaries plus full Medicaid (QMB-Plus) – These individuals are entitled to Medicare Part A, have an income of 100 percent FPL or less and resources that do not exceed twice the limit for SSI eligibility, and are eligible for full Medicaid benefits. Medicaid pays their Medicare Part A premiums, if any, Medicare Part B premiums, and, to the extent consistent with the Medicaid State plan, Medicare deductibles and coinsurance, and provides full Medicaid benefits. [Full benefit; H_DUALMM=02]
- Specified Low-Income Medicare Beneficiaries without other Medicaid (SLMB-only) – These individuals are entitled to Medicare Part A, have an income of greater than 100 percent FPL but less than 120 percent FPL, have resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for Medicaid. Medicaid pays their Medicare Part B premiums only. [Partial benefit; H_DUALMM=03]
- Specified Low-Income Medicare Beneficiaries plus full Medicaid (SLMB-Plus) – These individuals are entitled to Medicare Part A, have an income of greater than 100 percent FPL but less than 120 percent FPL, have resources that do not exceed twice the limit for SSI eligibility, and are eligible for full Medicaid benefits. Medicaid pays their Medicare Part B premiums and provides full Medicaid benefits. [Full benefit; H_DUALMM=04]
- Qualified Disabled and Working Individuals (QDWI) – These individuals lost their Medicare Part A benefits due to their return to work. They are eligible to purchase Medicare Part A benefits, have an income of 200 percent FPL or less, have resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for Medicaid. Medicaid pays the Medicare Part A premiums only. [Partial benefit; H_DUALMM=05]
- Qualifying Individuals (QI) – There is an annual cap on the amount of money available, which may limit the number of individuals in the group. These individuals are entitled to Medicare Part A, have an income of at least 120 percent FPL but less than 135 percent FPL, have resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for Medicaid. Medicaid pays their Medicare Part B premiums only. [Partial benefit; H_DUALMM=06]
- Other full benefit dually eligible/Medicaid Only Dually Eligibles (Non-QMB, -SLMB, -QDWI, -QI) – These individuals are entitled to Medicare Part A and/or Part B and are eligible for full Medicaid benefits. They are not eligible for Medicaid as a QMB, SLMB, QDWI, or QI. Medicaid provides full Medicaid benefits and pays for Medicaid services provided by Medicaid providers, but Medicaid will only pay for services also covered by Medicare if the Medicaid payment rate is higher than the amount paid by Medicare, and, within this limit, will only pay to the extent necessary to pay the beneficiary's Medicare cost sharing liability. Payment by Medicaid of Medicare Part B premiums is a state option. [Full benefit; H_DUALMM=08]

H_MAFF01-12: The MA flag variables are the most reliable indicators for monthly MA information. This information is sourced from the CMS administrative data.

H_OPMDCD: This variable provides a summary of annual Medicare-Medicaid dual eligibility based on the state Medicare Modernization Act (MMA) files.

Beneficiaries are assigned a dually eligible status if they are Medicaid eligible for at least one month. Specific eligibility (full, partial, or QMB) is determined by the beneficiary's status in the last month of eligibility for the year (for definitions, see option C below in Special Notes for HISUMRY for Full-benefit vs. Partial-benefit vs. QMB-only). QMB beneficiaries include Qualified Medicare Beneficiaries without other Medicaid (QMB-only). The "partial benefit" beneficiaries include: Specified Low-Income Medicare Beneficiaries without other Medicaid (SLMB-only), Qualified Disabled and Working Individuals (QDWI), and Qualifying Individuals (QI). The "full benefit" beneficiaries include: Qualified Medicare Beneficiaries plus full Medicaid (QMB-Plus), Specified Low-Income Medicare Beneficiaries (SLMB-Plus), and all other full benefit beneficiaries (Non-QMB, -SLMB, -QDWI, -QI).

H_PDLS01-12: Low-Income Subsidy Indicator values: When conducting data analysis with the variables H_PDLS01-12 from the 2013 and earlier files and the 2015 and later files, you will need to recode the 2015 and later data to the previous values. See the *2018 and 2019 Data User's Guides: Survey File* for recoding guidance. The eligible categories are beneficiaries who are deemed eligible, and these beneficiaries are automatically enrolled.

ER4.2.10.3 Special Notes

When describing dually eligible enrollees, users typically define and present analyses separately for two subgroups: full-benefit and partial-benefit. However, some users may wish to pull the QMB-only beneficiaries out of the partial-benefit group to create a third classification. Therefore, the H_DUAL01-H_DUAL12 variables may be used to group Medicare-Medicaid enrollees into one, two or three categories, as follows:

A. No delineation:

All Medicare-Medicaid (dually eligible) enrollees: H_DUAL01-H_DUAL12 in (01, 02, 03, 04, 05, 06, 08)

B. Full-benefit vs. Partial-benefit:

Partial-benefit: H_DUAL01-H_DUAL12 in (01, 03, 05, 06)

Full-benefit: H_DUAL01-H_DUAL12 in (02, 04, 08)

C. Full-benefit vs. Partial-benefit vs. QMB-only:

QMB-only: H_DUAL01-H_DUAL12 = 01

Partial-benefit (non-QMB): H_DUAL01-H_DUAL12 in (03, 05, 06)

Full-benefit: H_DUAL01-H_DUAL12 in (02, 04, 08)

For detailed information on how the HITLINE and ER_HISUMRY/HISUMRY segments differ from the previously released RICs (i.e., RICs 4 and A), see the *2018 and 2019 Data User's Guides: Survey File*.

ER4.2.11 Household Characteristics (ER_HHCHAR)

ER4.2.11.1 Core Content

The Household Characteristics segment includes beneficiaries who resided in a community setting as of their last complete interview and contains information about the beneficiary's household composition and residence. For each calendar year, this segment reflects the latest available data on the size of the household and the age and relationship of household members. Information about the beneficiary's physical residence is collected at the Baseline interview and updated as necessary.

ER4.2.11.2 Variable Definitions

D_HHTOT: Reflects the total number of people living in the household.

D_COMPHH: Reflects the composition of the household members.

D_SEXSPP: Indicates the sex when a spouse or partner is identified in D_COMPHH as a member of the household.

D_HHLT50 and D_HHGE50: Indicate the number of people in the household under the age of 50 and the number of people 50 years of age or above, respectively. These numbers may include the beneficiary.

D_HHLT18: Indicates the number of people under the age of 18 who are related to the beneficiary.

ER4.2.11.3 Special Notes

CMS defines a household as a group of individuals, either related or not, who live together and share one kitchen. This may be one person living alone, a head of household and relatives only, or a head of household living with relatives, boarders, and any other unrelated individual living under the same roof, sharing the same kitchen.

Household membership includes all persons who currently live at the household or who normally live there but are away temporarily. For example, unmarried students away at school or family members away receiving medical care are included. Visitors in the household who will be returning to a different home at the end of the visit are not included. Generally, if there is any question about the composition of the household, the respondent's response is accepted.

Because the date of birth is sometimes unknown (perhaps because a proxy provided the information), the sum of the variables "number under 50"/"number 50 or older" (D_HHLT50/D_HHGE50) may not equal the total number of people in the household (D_HHTOT).

Data on certain characteristics of the residence (e.g., number of levels) is collected during the Baseline interview and carried forward unless a beneficiary moved or had a Facility stay prior to returning to the Community. Information about other characteristics of the residence (e.g., availability of personal care services) is updated annually during the fall interview.

Only beneficiaries living in the community who are responding to a Continuing interview are in the universe for the question SPMOVED, "Has the SP moved since the last Fall Round data collection date?". For this reason, data users are encouraged to use the longitudinal weights (on the Survey File LDS) if they wish to utilize this variable in analysis. The reference period for this variable is going to be longer for beneficiaries whose last fall interview was in a facility and beneficiaries who missed the last fall interview.

The "other specify" questions DWELLOS and HCOMUNOS are back coded as necessary into the "description of beneficiary's housing" response options, but the verbatim text is not released.

Full date of birth is only collected for the beneficiary and their spouse or partner. Logic at variable EHHD0BDD hides the "day" field if the household member is anyone other than the beneficiary's partner or spouse.

ER4.2.12 Mental Health (ER_MENTHLTH)

ER4.2.12.1 Core Content

The Mental Health segment contains survey responses regarding the beneficiary's mental health such as feelings of anxiety or depression.

ER4.2.12.2 Variable Definitions

Please see the Codebook for information regarding variables in this segment.

ER4.2.12.3 Special Notes

Generalized Anxiety Disorder scale (GAD-2): Two items labeled with "GAD" comprise the GAD-2 scale, which is a screening tool for generalized anxiety.

Patient Health Questionnaire (PHQ-9): Items labeled with "PHQ" are taken from the PHQ-9, which is a screening tool for depression. The MCBS does not collect the ninth item on the PHQ-9, which asks about suicidal ideation, but does include the PHQ-9 follow-up question that asks about the overall difficulty caused by depression (ER_MENTHLTH item PHQPRDIF).

ER4.2.13 Mobility (ER_MOBILITY)

ER4.2.13.1 Core Content

The Mobility segment contains information on the beneficiary's use of available transportation options and whether the beneficiary's health affects their daily travel.

ER4.2.13.2 Variable Definitions

Please see the Codebook for information regarding variables in this segment.

ER4.2.13.3 Special Notes

N/A

ER4.2.14 Nagi Disability (ER_NAGIDIS)

ER4.2.14.1 Core Content

The Nagi Disability segment contains information on the beneficiary's difficulties with performing ADLs and IADLs, including which ADLs and IADLs the beneficiary has difficulty performing, how long the beneficiary has experienced these difficulties, whether the beneficiary has received any help or used supportive equipment to perform ADLs or IADLs, and the total number of persons who have helped the beneficiary, if applicable.

ER4.2.14.2 Variable Definitions

ADL and IADL measures: The MCBS asks respondents whether they have any difficulty performing 12 activities. Their answers about difficulty performing the IADLs (PRBTELE, PRBLHWK, PRBHHWK, PRBMEAL, PRBSHOP, and PRBBILS) and ADLs (HPPDBATH, HPPDDRES, HPPDEAT, HPPDCHAR, HPPDWALK, and HPPDPTOIL) reflect whether or not the beneficiary usually has difficulty and anticipates continued trouble with these tasks, even if a short-term injury made them temporarily difficult.

“Difficulty” in these questions has a qualified meaning. Only difficulties associated with a health or physical problem are considered. If a beneficiary only performed an activity with help from another person (including just needing to have the other person present while performing the activity), then that respondent is deemed to have difficulty with the activity.

Help from another person includes a range of helping behaviors. The concept encompasses personal assistance in physically doing the activity, instruction, supervision, and “standby” help. These questions are asked in the present tense; the difficulty may have been temporary or may be chronic. Vague or ambiguous answers, such as “Sometimes I have difficulty,” are coded “yes.”

D_ADLHNM: D_ADLHNM stores the number of persons helping the beneficiary with ADLs and/or IADLs. D_ADLHNM is derived by counting the number of helper rows for a BASEID.

D_MODTIM: The length of time the beneficiary spent doing moderate activities (e.g., golf, gardening) is collected in number of minutes/day, hours/day, hours/week, or hours/month. The length of time is stored in a continuous variable while the corresponding unit is stored in a categorical variable. These variables are used to derive D_MODTIM, the number of hours per week the beneficiary spent doing moderate activities.

D_MUSTIM: The length of time the beneficiary spent increasing muscle strength (e.g., lifting weights, yoga) is collected in number of minutes/day, hours/day, hours/week, or hours/month. The length of time is stored in a continuous variable while the corresponding unit is stored in a categorical variable. These variables are used to derive D_MUSTIM, the number of hours per week the beneficiary spent increasing muscle strength.

D_VIGTIM: The length of time the beneficiary spent doing vigorous activities (e.g., running, aerobics) is collected in number of minutes/day, hours/day, hours/week, or hours/month. The length of time is stored in a continuous variable while the corresponding unit is stored in a categorical variable. These variables are used to derive D_VIGTIM, the number of hours per week the beneficiary spent doing vigorous activities.

HPPDBATH: Beneficiaries who have difficulty bathing or showering without help met at least one of the following criteria:

- someone else washes at least one part of the body
- someone else helps the person get in or out of the tub or shower or helps get water for a sponge bath
- someone else gives verbal instruction, supervision, or stand-by help
- the person uses special equipment such as handrails or a seat in the shower stall
- the person never bathes at all (a highly unlikely possibility)
- the person receives no help, uses no special equipment or aids, but acknowledges having difficulty

HPPDDRES: Dressing is the overall complex behavior of getting clothes from closets and drawers and then putting the clothes on. Tying shoelaces and putting on socks or hose are not considered part of dressing. Special dressing equipment includes items such as button hooks, zipper pulls, long-handled shoe horns, tools for reaching, and any clothing made especially for accommodating a person's limitations in dressing, such as Velcro fasteners or snaps.

HPPDEAT: A person eats without help if he or she can get food from the plate into the mouth. A person who does not ingest food by mouth (that is, is fed by tube or intravenously) is not considered to eat at all. Special eating equipment includes such items as a special spoon that guides food into the mouth, a forked knife, a plate guard, or a hand splint.

PRBBILS: Managing money refers to the overall complex process of paying bills, handling simple cash transactions, and generally keeping track of money coming in and money going out. It does not include

managing investments, preparing tax forms, or handling other financial activities for which members of the general population often seek professional advice.

PRBLHWK and PRBHHWK: The distinction between light housework (PRBLHWK) and heavy housework (PRBHHWK) is made clear by examples. Washing dishes, straightening up and light cleaning represent light housework; scrubbing floors and washing windows represent heavy housework. The interviewer is not permitted to interpret the answer in light of the degree of cleanliness of the dwelling.

PRBMEAL: "Preparing meals" includes the overall complex behavior of cutting up, mixing, and cooking food. The amount of food prepared is not relevant, so long as it would be sufficient to sustain a person over time. Reheating food prepared by someone else does not qualify as "preparing meals."

PRBSHOP: Shopping for personal items means going to the store, selecting the items, and getting them home. Having someone accompany the beneficiary would qualify as help from another person.

PRBTELE: Using the telephone includes the overall complex behavior of obtaining a phone number, dialing the number, talking and listening, and answering the telephone.

ER4.2.14.3 Special Notes

Six global disability questions are released to comply with HHS guidance DISDECSN, DISWALK, DISBATH, and DISERRND on the ER_NAGIDIS segment. Variables DISHEAR and DISSEE are included on the ER_VISHEAR segment.

For beneficiaries with identified helpers, information about the persons responsible for assisting with the beneficiary's performance of ADLs and IADLs is found in the ER_ASSIST segment.

ER4.2.15 Nicotine and Alcohol (ER_NICOALCO)

ER4.2.15.1 Core Content

The Nicotine and Alcohol segment contains information on the prevalence and frequency of alcohol and nicotine use (including cigarettes, e-cigarettes, cigars, pipe tobacco, and smokeless tobacco).

ER4.2.15.2 Variable Definitions

Please see the Codebook for information regarding variables in this segment.

ER4.2.15.3 Special Notes

Affirmative responses indicating former or current use of inhaled tobacco products (cigar, cigarette, smokeless tobacco, pipe tobacco, and e-cigarettes) or alcohol are pulled forward to the current data year variables (i.e., CIGARONE, CIGAR50, CIG100, SMKLSONE, PIPEONE, ECIGONE, and ALCLIFE).

ER4.2.16 Patient Activation (ER_PNTACT)

ER4.2.16.1 Core Content

The Patient Activation segment contains data that can be used to assess the degree to which beneficiaries actively participate in their own health care and the decisions concerning their health care, measuring if beneficiaries receive information about their health and Medicare and if they understand the information in a way that makes it useful.

ER4.2.16.2 Variable Definitions

Please see the Codebook for information regarding variables in this segment.

ER4.2.16.3 Special Notes

Special non-response adjustment weights are included in the file to account for survey non-response as these items are only asked of non-proxy respondents.

ER4.2.17 Preventive Care (ER_PREVCARE)

ER4.2.17.1 Core Content

The Preventive Care segment provides data on the beneficiary's use of preventive services, including getting a mammogram, Pap smear, prostate screening, diabetes screening, colon cancer screening, blood pressure screening, and HIV testing.

ER4.2.17.2 Variable Definitions

Please see the Codebook for information regarding variables in this segment.

ER4.2.17.3 Special Notes

Certain PVQ items are collected only in the fall, including questions about getting a mammogram, Pap smear, prostate test, blood pressure screening, hysterectomy, and HIV testing, and are released on the Preventive Care segment. Other PVQ items are collected only in the summer (whether the beneficiary received a pneumonia shot or the shingles vaccine), while the seasonal flu vaccine items are asked in the winter and summer rounds; these items will be released on a new immunization segment in the 2023 Survey File LDS.

The "other specify" questions MAMNOTHS, PAPOTHR, and PRONOTHS are back coded as necessary into the reason(s) for not getting a mammogram, Pap smear, or prostate test respectively, but the verbatim text is not released.

As described in ER2.2, the Pap smear items were renamed in the questionnaire in Fall 2023 to reflect the change in the universe of respondents. The variable names were changed as follows in the ER_PREVCARE segment. Note, the variable PAPNHYST (no Pap because beneficiary had a hysterectomy) was dropped as a result of the questionnaire change.

- | | | |
|----------------------|----------------------|----------------------|
| ■ PAPSMEAR → PAPTEST | ■ PAPNREC → PAPREC | ■ PAPNHEAR → PAPHEAR |
| ■ PAPNNEED → PAPNEED | ■ PAPNLIKE → PAPLIKE | ■ PAPNAPPT → PAPAPP |
| ■ PAPNANUL → PAPANU | ■ PAPNLOCA → PAPLOC | ■ PAPNILL → PAPILL |
| ■ PAPNGET → PAPCAN | ■ PAPNMISS → PAPMISS | ■ PAPNOTHR → PAPOTH |
| ■ PAPNRISK → PAPRISK | ■ PAPNCOST → PAPCOST | |
| ■ PAPNPRES → PAPPRES | ■ PAPNFEAR → PAPFEAR | |

ER4.2.18 Satisfaction with Care (ER_SATWCARE)

ER4.2.18.1 Core Content

The Satisfaction with Care segment contains data from the SCQ section on satisfaction with different aspects of medical care, such as cost and the information provided by the beneficiary's medical care provider. The questions about satisfaction with care represent the respondent's general opinion of all medical care received in the year preceding the interview.

ER4.2.18.2 Variable Definitions

Please see the Codebook for information regarding variables in this segment.

ER4.2.18.3 Special Notes

N/A

ER4.2.19 Vision and Hearing (ER_VISHEAR)

ER4.2.19.1 Core Content

The Vision and Hearing segment contains information on the beneficiary's eye health and hearing status.

ER4.2.19.2 Variable Definitions

Please see the Codebook for information regarding variables in this segment.

ER4.2.19.3 Special Notes

The "other specify" question EDOCTYOS is back coded as necessary into a variable (EDOCTYPE) capturing the type of doctor the beneficiary saw at their last eye exam, but the verbatim text is not released.

Six global disability questions are released to comply with HHS guidance. DISHEAR and DISSEE are included on the ER_VISHEAR segment. Variables DISDECSN, DISWALK, DISBATH, and DISERRND are included on the ER_NAGIDIS segment.

ER4.2.20 Weights

For information about the ever enrolled cross-sectional weights available in the Survey File - Early Release LDS and obtaining weighted estimates using these files, please see section ER3.3.

For discussion on how the weights files were created, please refer to the prior *MCBS Methodology Reports*, which can be found on the CMS website at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Codebooks>.

ER4.3 2023 MCBS Survey File - Early Release LDS Segment Crosswalk

Exhibit ER4.3.1 crosswalks the 2023 Survey File - Early Release LDS segments against their historic RIC segments counterparts (as released prior to data year 2015).

Exhibit ER4.3.1: 2023 MCBS Survey File - Early Release LDS Segment Crosswalk

Survey File - Early Release Segment	Segment Abbrev	Historic RIC Segment
Access to Care	ER_ACCESSCR	3
Assistance	ER_ASSIST	2H
Chronic Conditions	ER_CHRNCOND	2, 2P
Cognitive Measures	ER_COGNFUNC	N/A
COVID-19 Experiences	ER_COVIDEXP	N/A
Demographics	ER_DEMO	1, 9, A, K

Survey File - Early Release Segment	Segment Abbrev	Historic RIC Segment
Diabetes	ER_DIABETES	N/A
Falls	ER_FALLS	2, 2P
General Health	ER_GENHLTH	2
Health Insurance Summary	ER_HISUMRY	4, A
Household Characteristics	ER_HHCHAR	5
Mental Health	ER_MENTHLTH	N/A
Mobility	ER_MOBILITY	N/A
Nagi Disability	ER_NAGIDIS	2, 2H, 2P
Nicotine and Alcohol	ER_NICOALCO	2, 2P
Patient Activation	ER_PNTACT	PA
Preventive Care	ER_PREVCARE	2, 2P
Satisfaction with Care	ER_SATWCARE	3
Vision and Hearing	ER_VISHEAR	2
Survey File - Early Release Weights	ER_EVRWGTS	N/A

2023 Survey File LDS

SF1. SURVEY FILE LDS

The content of the MCBS LDS releases is governed by their central focus of serving as unique sources of information on beneficiaries' health and well-being that cannot be obtained through CMS administrative sources alone. For the 2023 data year, the Survey File LDS contains survey-reported data for Community and Facility beneficiaries, administrative records, facility information, assessment data, and Fee-for-Service (FFS) claims data. The Survey File is released approximately 11 months after the end of data collection and represents a random cross-section of all beneficiaries who were ever enrolled in either Part A or Part B of the Medicare program for any portion of 2023.

The following information is represented in the Survey File LDS: beneficiary demographics; chronic pain; COVID-19; disability; facility information and assessments; food insecurity; health behaviors; health status, conditions, and functioning; health insurance coverage and plan information; household characteristics; income and assets; Medicare knowledge; mobility; nicotine and alcohol use; patient activation; preventive care and immunizations; RX medications; access to and satisfaction with care; telemedicine; and usual source of care.

SF2. WHAT'S NEW FOR DATA YEAR 2023?

Below are the highlights and updates for the 2023 data year that pertain to the Survey File LDS.

SF2.1 Sampling

There were no changes to sampling for the 2023 data year.

SF2.2 Questionnaires

Questionnaire content changes: There were a number of questionnaire sections that were revised in 2023. Note that variable names referenced below are the questionnaire variable names. Data users can view the *Questionnaire User Guide* and the questionnaires for each data year, including the questionnaire variable names referenced below and question text, on the MCBS website at <https://www.cms.gov/data-research/research/medicare-current-beneficiary-survey/questionnaires>.

Community Questionnaire

The MCBS introduced several Community Questionnaire updates to enhance survey content and data quality and improve interviewer and respondent experience. Changes include the addition of new items and updates to question text, response options, and respondent universes.

Descriptions of the Fall 2023 changes to the **COVID-19 (CVQ)**, **Health Status and Functioning (HFQ)**, and **Preventive Care (PVQ)** questionnaire sections can be found above in Section ER2.2, as these changes affect both the 2023 Survey File and the 2023 Survey File - Early Release. Section SF2.2 documents additional changes that *only* pertain to the 2023 Survey File.

COVID-19 (CVQ)

In Winter 2024, modifications were made to the COVID-19 Questionnaire (CVQ) to ensure the section remained policy relevant while minimizing respondent burden:

- The administration schedule of CVQ was changed to field the section once per year in the Winter rather than every round. To accommodate the new annual administration schedule, reference periods were updated throughout the section to refer to the previous year rather than “since the date of the last interview.” Since the reference period refers to the previous year, these data are included in the 2023 data year release even though they were administered in Winter 2024.
- Several content updates were made to make items more applicable and less burdensome for administration:
 - ▶ Vaccination: Rather than collecting details such as vaccine date, manufacturer, and vaccine site for each COVID-19 vaccine dose, the revised CVQ asks for the total number of COVID-19 vaccine doses received by the beneficiary and whether they received a dose in the last year for an overall metric for vaccine uptake.
 - ▶ Testing: Previously, CVQ collected information on COVID-19 at-home tests and antibody tests separately. In Winter 2024, the testing series was consolidated to reduce the number of questions and follow-up items about testing details. The beneficiary is first asked if they have been tested for COVID-19 in the last year. If yes, they are asked which type of test they received (e.g., via nasal swab, at-home test, or blood test) and the test result. If they tested positive, they are asked about their symptoms.
 - ▶ Prevention: The revised CVQ asks how often the beneficiary masks in public.

Health Insurance (HIQ)

In Winter 2023, several updates were made to improve the Health Insurance Questionnaire (HIQ). The purpose of these changes was three-fold:

Align collection of health insurance information across different plan types:

- For Medicare Advantage, Medicare Prescription Drug Plan (MPDP), Medicaid, TRICARE, public plans, and private plans, several question sequences were updated to collect beginning (COVBEGMM/COVBEGYY) and ending (COVENDMM/COVENDYY) dates for plan coverage.
- To accommodate this change, two new variables were added to pathways collecting information about Medicare Advantage and MPDP pathways:
 - ▶ COVTIME, which asks whether the beneficiary had coverage the “whole time” or “part of the time” during the reference period.
 - ▶ CURRCOV, which asks whether the beneficiary was covered during the current round.
- For MPDP plans, the questionnaire previously collected whether the plan was current via a different variable than for other plan types (PDPCURR instead of COVNOW/CURRCOV). In Winter 2023, the variable name was updated to CURRCOV to align with other plan types.
- Previously, the questionnaire collected information about specific services and items (e.g., prescription drugs, eye care, dental care, etc.) covered by the beneficiary’s plan via 12 separate items. These questions were replaced with one check-all item to capture the services provided by Medicare Advantage (MHMOCVR/ MHMOCVOS), TRICARE (TRICOV/TRICOVOS), public plans (PUBCOV/ PUBCOVOS), and private plans (PRIVSERV/ PRIVSVOS). The check-all item is administered for newly entered plans and annually in the fall for current, existing plans. The list of services collected was also expanded to include behavioral health care (e.g., counseling, psychotherapy, mental health and substance use disorder services, etc.), hearing care, and other services. The item that previously asked if a plan covered visits to a doctor and lab work was replaced by two separate items.

Reduce respondent burden by discontinuing collection of detailed information with limited analytic utility:

- It was determined that the exact day that health insurance coverage began or ended is not needed, so only the month and year are now collected. Therefore, all instances of COVBEGDD and COVENDDD were removed.
- Prior to Winter 2023, beneficiaries with existing plans were asked whether the plan was still current the “whole time” or “part of the time” during the reference period (COVTIME) and then asked if the beneficiary was now covered by the same plan (COVNOW). In Winter 2023, it was determined that those who reported their plan was covered “the whole time” at COVTIME did not need to be asked COVNOW because it can be inferred that the beneficiary is now covered by the same plan. The variable was renamed CURRCOV because the item universe changed to exclude existing plans at COVNOW.
- The administration schedule for items PPRVGET and PPRVGOS, which collect how the beneficiary obtained their private insurance coverage, was updated from annual to once per plan since this information should not change over time. The variables were renamed PRIVOBTN and PRIVOBOS, respectively, to accommodate the change in universe at these items.

Improve quality of information collected:

- Prior to Winter 2023, the exact dollar amount spent on insurance coverage was collected at MIPPAMT for Medicare Advantage plans and MHMOUNT for private plans. In Winter 2023, range follow-up items were added to the Medicare Advantage and private plan series to accommodate respondents who do not provide an exact dollar amount.

Income and Assets (IAQ)

In Summer 2024, one item (SNAPBNFT) from the American Community Survey⁹ on Supplemental Nutrition Assistance Program (SNAP) participation was added to the Income and Assets Questionnaire (IAQ).

Telemedicine (TLQ)

In the Telemedicine Questionnaire (TLQ), items TELMEDUS and TELMEDT4 ask if the beneficiary had an appointment with a doctor by telephone or video and, if yes, whether it was a telephone appointment, video appointment, or both. In Winter 2024, the universe of respondents who receive these items was updated so that all beneficiaries receive these items rather than only those who report a usual source of care in the Usual Source of Care Questionnaire (USQ). TELMEDUS and TELMEDT4 were renamed TELAPPT and TELAPPT1 to accommodate the change.

Two items were removed from TLQ in Winter 2024. TELMEDDU collected if the beneficiary's usual provider offered a telephone or video appointment to replace a regularly scheduled appointment. If the beneficiary reported yes, TELMEDT3 asked whether the provider offered a telephone appointment, video appointment, or both. Both items were removed in Winter 2024 due to their redundancy with similar items in TLQ.

Usual Source of Care (USQ)

Two updates were made to the Usual Source of Care Questionnaire (USQ) in Winter 2024:

- Item INNOVATE, which collected if the beneficiary's health care provider is associated with an innovative care initiative, was removed from USQ in Winter 2024 due to high levels of item non-response.
- The series on the beneficiary's experiences with medical staff at their usual provider's office was transformed into a grid format with a simplified code frame to reduce administration time and respondent confusion. Because this change slightly modified the meaning of each item in the series, variables OSUPTODT, OSTLKCR, and OSNOINFO were renamed OSUPTDAT, OSTALKCR, and OSKNWINF.

Facility Instrument

The MCBS introduced several Facility Instrument updates in 2023 that included streamlining the instrument and updates to question text and programming logic.

Background Questionnaire (BQ)

In Fall 2023, the "COLLEGE GRADUATE" response option at BQ9-EDLEVELF, which collects the beneficiary's highest level of education in the Background Questionnaire (BQ) section, was replaced with "ASSOCIATE'S DEGREE" and "BACHELOR'S DEGREE" to align with a similar question in the Community Questionnaire's Demographics and Income Questionnaire (DIQ) section.

COVID-19 Beneficiary (CV)

In July 2022, the U.S. Food and Drug Administration (FDA) granted emergency use authorization for the COVID-19 vaccine Novavax. In Winter 2023, the question text and response options at CV8-VACNME were updated to include Novavax, which aligns with the Community Questionnaire's CVQ section.

⁹ United States Census Bureau, "The American Community Survey 2020 Questionnaire," <https://www2.census.gov/programs-surveys/acs/methodology/questionnaires/2020/quest20.pdf>

Health Status (HS)

There were two updates made to the Health Status (HS) section in Fall 2023:

- Item HA43B-PAPSMEAR, which asks if the beneficiary has had a pap smear test, is now administered after confirming whether the beneficiary has had a hysterectomy (HA43C-HYSTEREC or HA43D- EVERHYST). HA43B-PAPSMEAR was renamed to HA43O-PAPTEST due to this change in respondent universe. In addition, the routing logic was updated to skip over HA43O-PAPTEST if it was reported that the beneficiary has had a hysterectomy. This routing is in alignment with the Community Questionnaire's PVQ section.
- The "COLLEGE GRADUATE" response option at HA51B- HEDULEV, which collects the beneficiary's highest level of education if it has not already been reported in BQ, was replaced with "ASSOCIATE'S DEGREE" and "BACHELOR'S DEGREE" to better align with the Community Questionnaire and updates made to the BQ section.

Use of Health Services (US)

Two items were updated in the Use of Health Services (US) section in Summer 2023 due to outdated terminology:

- At item US40-USEEQUIP, which collects supplies, equipment, or other types of medical services the beneficiary received, response options "DISPOSABLE DIAPERS" and "CLOTH DIAPERS" were replaced with a new response option, "INCONTINENCE BRIEFS", to address Facility respondents' concerns that the term "diapers" was outdated and/or demeaning to beneficiaries.
- Item US43-MSRESTR, which collects if the beneficiary received restraints, was removed as some Facility respondents had concerns about the legality of this service and expressed offense when asked this item. As a result of this change, the previous item, US43-MSTUBE, was re-routed to US43-MSINJECT instead of US43-MSRESTR.

SF2.3 Data Collection

In Fall 2023, the MCBS data collection protocols were modified to increase the representation of Black, Asian, and Hispanic beneficiaries in the 2023 Panel data. These changes affect both the 2023 Survey File and the 2023 Survey File - Early Release and are described above in Section ER2.2. There were no other changes that pertain to just the 2023 Survey File.

SF2.4 Data Processing

The 2023 Survey File release is built from files encompassing Community and Facility data collection from five rounds of data (Winter 2023, Summer 2023, Fall 2023, Winter 2024, and Summer 2024), as well as administrative data.

Comparison between the 2023 Survey File - Early Release and 2023 Survey File:

Early versions of a subset of the Survey File LDS segments were released on the 2023 Survey File - Early Release LDS. Relative to the 2023 Survey File - Early Release LDS, the 2023 Survey File LDS provides complete, annualized versions of the Demographics (DEMO) and Health Insurance Summary (HISUMRY) segments. The remaining segments provided on both LDS's are the same across releases except for minor changes to data counts due to case eligibility and data editing during the Survey File LDS processing. The Survey File LDS also includes segments not available from the 2023 Survey File - Early Release LDS.

Comparison between the 2022 Survey File and 2023 Survey File:

The following segments changed between the 2022 Survey File and the 2023 Survey File:

- The new Immunization (IMQ) segment contains the Winter and Summer round data formerly included on the Preventive Care (PREVCARE) segment beginning in 2023.
- The COVID-19 Facility Facility-Level Supplement (FFACCVFL) segment was retired beginning in 2023.
- All COVID-19 related information collected in Winter 2024 onward is stored on the COVID-19 Topical (COVIDTOP) segment to reflect the change in the administration schedule of the CVQ section.
- The Outcome and Assessment Information Set (OASIS) segment is released with all variables except those containing PII, and some variable names may differ from previous years. Users should refer to the accompanying record layout (data dictionary) for detailed variable information. A variable crosswalk is also available that compares the 2022 and 2023 variables names.

The 2023 questionnaire changes resulted in the following variables added to the 2023 Survey File release. Please note, some of these variables were also added to the 2023 Survey File - Early Release. See Exhibit ER2.4.1 for more information.

Exhibit SF2.4.1: 2023 MCBS Survey File LDS Content Additions

Location	Questionnaire Section	Variable	Description
COVIDTOP	CVQ	D_FCEMASK	HOW OFTEN SP WEARS A FACE MASK
COVIDTOP	CVQ	D_NOIMMU	REASON NO VAX: IMMUNE FROM PRIOR DOSES
COVIDTOP	CVQ	D_NOREQ	REASON NO VAX: NOT REQUIRED FOR WORK
COVIDTOP	CVQ	D_NOWORR	REASON NO VAX: NOT WORRIED ABOUT COVID-19
COVIDTOP	CVQ	D_NOYET	REASON NO VAX: PLANS TO BUT NOT YET
COVIDTOP	CVQ	D_TSTBLD	SP RECEIVED ANTIBODY BLOOD TEST
COVIDTOP	CVQ	D_TSTHOM	SP RECEIVED AT-HOME COVID-19 TEST
COVIDTOP	CVQ	D_TSTSWB	SP RECEIVED NASAL OR THROAT SWAB BY HEALTH CARE PROFESSIONAL
COVIDTOP	CVQ	D_PYRDOS	AT LEAST ONE COVID-19 VACCINE IN THE LAST YEAR
CHRNCOND	HFQ	DRYMOUTH	HOW OFTEN SP HAVE DRY MOUTH
CHRNCOND	HFQ	TEETHGUM	GENERAL ORAL, TEETH, AND GUM HEALTH OF SP
CHRNCOND	HFQ	TOOTHSEN	HOW OFTEN SP HAVE TOOTH SENSITIVITY
DEMO	DIQ	RELGPREF	RELIGIOUS PREFERENCE OF SP
DEMO	DIQ	SEXORINT	SP SEXUAL ORIENTATION OF SP
FBENCVFL	CV	FPRVYRDS	SP RECEIVED AT LEAST ONE COVID-19 VACCINE DOSE IN LAST YEAR
FOODINS	IAQ	SNAPBNFT	DID SP RECEIVE FOOD STAMPS OR SNAP BENEFITS IN THE LAST 12 MONTHS
HITLINE	HIQ	COVBEH	PLAN COVERS BEHAVIORAL HEALTH
HITLINE	HIQ	COVDENT	PLAN COVERS DENTAL CARE
HITLINE	HIQ	COVDOC	PLAN COVERS DOCTOR VISITS
HITLINE	HIQ	COVHEAR	PLAN COVERS HEARING CARE
HITLINE	HIQ	COVINP	PLAN COVERS INPATIENT HOSPITAL CARE
HITLINE	HIQ	COVLAB	PLAN COVERS LAB WORK
HITLINE	HIQ	COVNURS	PLAN COVERS NURSING HOME OR LONG-TERM CARE
HITLINE	HIQ	COVOTH	PLAN COVERS OTHER SERVICES

Location	Questionnaire Section	Variable	Description
HITLINE	HIQ	COVPMED	PLAN COVERS PRESCRIBED MEDICINES
HITLINE	HIQ	COVVIS	PLAN COVERS OPTICAL OR VISION CARE
HITLINE	HIQ	D_PAYSP	MIP PAY ANY PREMIUM FOR PLAN
HITLINE	HIQ	D_PAYSP_I	IMPUTATION FLAG FOR D_PAYSP
MAPLANQX	HIQ	MADVBEH	MA PLAN COVERS BEHAVIORAL HEALTH
MAPLANQX	HIQ	MADVDOC	MA PLAN COVERS HCP VISIT
MAPLANQX	HIQ	MADVHEAR	MA PLAN COVERS HEARING CARE
MAPLANQX	HIQ	MADVINTPT	MA PLAN COVERS INPATIENT STAY
MAPLANQX	HIQ	MADVLAB	MA PLAN COVERS LAB WORK
MAPLANQX	HIQ	MADVOTH	MA PLAN COVERS OTHER HEALTH CARE
MAPLANQX	HIQ	MADVPAI_I	IMPUTATION FLAG FOR MADVPAY
MAPLANQX	HIQ	MAMONPRM	MONTHLY AMOUNT PAID FOR MA COVERAGE
MAPLANQX	HIQ	MAMONPRM_I	IMPUTATION FLAG FOR MAMONPRM
SATWCARE	SCQ	AGEEQTY	SP TREATED UNFAIRLY DUE TO AGE
SATWCARE	SCQ	CULTEQTY	SP TREATED UNFAIRLY DUE TO CULTURE OR RELIGION
SATWCARE	SCQ	DISEQTY	SP TREATED UNFAIRLY DUE TO DISABILITY
SATWCARE	SCQ	HISTEQTY	SP TREATED UNFAIRLY DUE TO MEDICAL HISTORY
SATWCARE	SCQ	LANGEQTY	SP TREATED UNFAIRLY DUE TO LANGUAGE OR ACCENT
SATWCARE	SCQ	RCEQTY	SP TREATED UNFAIRLY DUE TO RACE
SATWCARE	SCQ	SEXEQTY	SP TREATED UNFAIRLY DUE TO SEXUAL ORIENTATION
TELEMED	TLQ	TELAPPT	SP HAD TELEMEDICINE VISIT IN LAST 12 MONTHS
TELEMED	TLQ	TELAPPT1	WHAT KIND OF TELEMEDICINE APPOINTMENT IN LAST 12 MONTHS
USCARE	USQ	OSUPTDAT	HOW OFTEN STAFF WAS UP TO DATE
USCARE	USQ	OSTALKCR	HOW OFTEN STAFF TALKED ABOUT CARE
USCARE	USQ	OSKNWINF	HOW OFTEN STAFF KNEW ABOUT MEDICAL HISTORY

Weighting:

Special Topical weights have been provided for several years for the Patient Activation items from SCQ that are collected in the Fall round for the Patient Activation segment (PNTACT). Beginning in 2023, these weights are also applied to the Cognitive Measures Questionnaire (CMQ) items that are collected in the Fall round for the Cognitive Measures segment (COGNFUNC). The weights adjust for the exclusion of proxy respondents and apply to both sets of items. There are no new sets of weights being calculated for 2023.

Imputation and Data Processing:

For the 2023 Survey File, the protocols for imputing incomplete information on **insurance premiums** that contribute to the HITLINE (private plans) and MAPLANQX (Medicare Advantage plans) segments were enhanced to include imputation of both premium probe questions and premium amounts.

Looking ahead, the processing of health insurance data will be further expanded and improved for the MCBS beginning in 2024 to take advantage of the redesign of HIQ. Guidance on bridging the 2023 and 2024 health insurance data will be provided to data users in the 2024 MCBS LDS documentation.

The 2023 Income and Assets imputation added the response to the SNAP benefit question from IAQ (SNAPBNFT) to the set of variables used to impute the amount of monthly rent (HOMERENT). SNAPBNFT joined the existing variables low-income status of home, metropolitan status, census division, and a calculated measure of poverty as the imputation cell selection variables.

SF3. DATA FILE CONTENTS

SF3.1 2023 Sampling and Medicare Population Covered by the 2023 MCBS Data

The 2023 LDS's represent four separate MCBS panels identified by the year in which the panel was selected and first interviewed (i.e., the 2020, 2021, 2022, and 2023 Panels). Exhibit SF3.1.1 shows the composition of each of the four panels included in the 2023 data files.

Exhibit SF3.1.1: 2023 MCBS Composition of Panels Contributing to the LDS Data Files

Data Year (Fall)	Number of Beneficiaries Selected
2020	15,952
2021	15,950
2022	17,139
2023	15,077

Exhibit SF3.1.2 presents the aggregated estimates of the size of the two Medicare populations overall and by sex and race.¹⁰ Exhibits SF3.1.3 and SF3.1.4 present estimates of the size of the continuously enrolled and ever enrolled Medicare populations by race and age (as of December 31, 2023) for male and female beneficiaries.

Exhibit SF3.1.2: 2023 Total Estimated Number of Medicare Beneficiaries by Sex and Race*

Group	Subgroup	Continuously Enrolled	Ever Enrolled
Overall Total		62,236,481	67,402,060
Sex	Male Total	28,498,339	30,670,036
	Female Total	33,738,142	36,732,024
Race	White non-Hispanic Total	45,143,258	47,387,476
	Black non-Hispanic Total	6,674,595	6,965,128
	Hispanic Total	5,292,474	5,447,427
	Other Total [†]	5,126,154	7,602,030

SOURCE: Beneficiary race/ethnicity were sourced from administrative data in the Sample Control File and the weights were sourced from the 2023 Survey File.

* Weighted counts may not sum to the total of beneficiaries living in the community in the U.S. due to missingness.

[†]The "Other" race category includes other single races not of Hispanic origin, Two or More Races, or Unknown Races.

¹⁰ Hispanic origin and race are two separate and distinct categories. Persons of Hispanic origin may be of any race or combination of races. Hispanic origin includes persons of Mexican, Puerto Rican, Cuban, Central and South American, or Spanish origin. For the MCBS, responses to beneficiary race and ethnicity questions are reported by the respondent. More than one race may be reported. For conciseness, the text, tables, and figures in this document use shorter versions of the terms for race and Hispanic or Latino origin specified in the Office of Management and Budget 1997 Standards for Data on Race and Ethnicity. Beneficiaries reported as White and not of Hispanic origin were coded as White non-Hispanic; beneficiaries reported as Black/African American and not of Hispanic origin were coded as Black non-Hispanic; beneficiaries reported as Hispanic, Latino/Latina, or of Spanish origin, regardless of their race, were coded as Hispanic. The "Other" race category includes other single races not of Hispanic origin (including American Indian or Alaska Native, Asian, Native Hawaiian or Other Pacific Islander), Two or More Races, or Unknown Races.

Exhibit SF3.1.3: 2023 Estimated Number of Male Medicare Beneficiaries by Race and Age*

Race	Age as of 12/31/2023	Continuously Enrolled	Ever Enrolled
White non-Hispanic	<45	435,481	458,455
	45-64	1,707,899	1,730,469
	65-69	4,733,009	5,240,931
	70-74	5,549,088	5,556,742
	75-79	4,098,430	4,190,906
	80-84	2,576,955	2,644,652
	85+	1,978,938	2,252,802
Black non-Hispanic	<45	155,462	167,005
	45-64	563,675	559,780
	65-69	682,564	736,228
	70-74	556,065	578,934
	75-79	369,254	390,120
	80-84	233,119	241,799
	85+	147,136	159,177
Hispanic	<45	102,808	110,425
	45-64	304,427	325,861
	65-69	562,397	583,292
	70-74	487,420	493,232
	75-79	342,821	349,515
	80-84	208,219	200,030
	85+	137,450	153,896
Other[†]	<45	131,396	157,774
	45-64	190,972	325,549
	65-69	953,542	1,746,727
	70-74	539,369	564,918
	75-79	495,135	497,189
	80-84	147,738	147,002
	85+	107,570	106,624

SOURCE: Beneficiary age and race/ethnicity were sourced from administrative data in the Sample Control File and the weights were sourced from the 2023 Survey File.

* Weighted counts may not sum to the total of beneficiaries living in the community in the U.S. due to missingness.

[†]The "Other" race category includes other single races not of Hispanic origin, Two or More Races, or Unknown Races.

Exhibit SF3.1.4: 2023 Estimated Number of Female Medicare Beneficiaries by Race and Age*

Race	Age as of 12/31/2023	Continuously Enrolled	Ever Enrolled
White non-Hispanic	<45	330,113	355,184
	45-64	1,664,592	1,705,469
	65-69	5,010,577	5,496,569
	70-74	6,083,051	6,226,281
	75-79	4,712,303	4,812,256
	80-84	3,254,225	3,332,936
	85+	3,008,599	3,383,823
Black non-Hispanic	<45	119,040	124,272
	45-64	622,650	597,764
	65-69	932,478	1,024,419
	70-74	898,370	925,569
	75-79	638,661	636,940
	80-84	396,857	390,224
	85+	359,262	432,895
Hispanic	<45	69,076	70,707
	45-64	371,251	360,373
	65-69	836,614	912,826
	70-74	734,830	730,372
	75-79	519,826	512,946
	80-84	317,738	315,134
	85+	297,598	328,818
Other[†]	<45	91,467	146,678
	45-64	200,830	309,294
	65-69	950,323	2,221,299
	70-74	537,014	555,997
	75-79	403,090	421,431
	80-84	165,597	171,269
	85+	212,112	230,279

SOURCE: Beneficiary age and race/ethnicity were sourced from administrative data in the Sample Control File and the weights were sourced from the 2023 Survey File.

*Weighted counts may not sum to the total of beneficiaries living in the community in the U.S. due to missingness.

[†]The "Other" race category includes other single races not of Hispanic origin, Two or More Races, or Unknown Races.

SF3.2 2023 MCBS Survey File Segments

The 2023 Survey File LDS contains 46 segments. Exhibit SF3.2.1 displays each segment included in the Survey File LDS including the **segment abbreviation**, **brief description**, and **information on weights or other special notes**.

The **Data Source** column describes the source of the data on the segment. The three possible sources for the Survey File LDS are the Community Questionnaire (CQ), Facility Instrument (FI), and Administrative Records

(AR). Each LDS segment can have any combination of these sources. Data source reflects where the data came from, not where the beneficiary was living. For example, a beneficiary could have lived in both settings during the year, but the data for that beneficiary available on the ACCESSCR segment came from their Community interview only.

The **Quex Section** column lists the specific questionnaire sources for the LDS segment. Please note that not all variables from the questionnaire are released on the segments. Some questionnaire items are combined or recoded to create the LDS variable. Data users will see these derived variables noted in the codebooks preceded with the character "D", such as D_OCDTYP.

Season indicates the round (winter, summer, fall, or all) and year when the questionnaire was administered.

Panel describes whether the questionnaire sections that provide the data for each segment are fielded for Baseline respondents (base), Continuing respondents (cont), or all panels (all). If the segment consists of administrative CMS data, then the cell indicates all panels are included.

Unit of Observation indicates what each row in the segment represents. For example, the ASSIST segment provides multiple rows per BASEID for each person reported as helping the beneficiary in the data year.

A list of equivalent historic segments from the 1991-2013 data release structure is provided in section SF4.3.

Exhibit SF3.2.1: 2023 MCBS Survey File Segments and Contents

Survey File Segment (Abbrev)	Description	Data collection and special weights notes	Data Source *	Quex Section	Season	Panel **	Unit of Observation
Access to Care (ACCESSCR)	Information on ability to obtain health care, delay of care related to costs, and reasons for not obtaining needed health care.		CQ	HFQ	Fall	All	Beneficiary
Access to Care Medicare Appointments (ACCSSMED)	Information on medical and dental visit experiences and forgone medical, dental, vision, hearing, and mental health care and prescription medicines.	The data collected in Winter 2024 are released with the 2023 Survey File given that the reference period is 2023. Special non-response adjustment weights are included with this file.	CQ	ACQ, DVH, MPQ, PMQ	Winter (ACQ) ³ All (DVH, MPQ, PMQ)	Cont.	Beneficiary
Administrative Utilization Summary (ADMNUTLS)	Summarized administrative information on Medicare, program expenditures, and utilization.		AR	n/a (Admin data)	n/a	All	Beneficiary

Survey File Segment (Abbrev)	Description	Data collection and special weights notes	Data Source *	Quex Section	Season	Panel **	Unit of Observation
Assistance (ASSIST)	Information on the person helping and type of assistance that the beneficiary with ADLs and IADLs receives.		CQ	ENS, HFQ	All (ENS) Fall (HFQ)	All	Helper by beneficiary
Chronic Conditions (CHRNCOND)	Information on chronic and other diagnosed medical conditions.		CQ	HFQ, PVQ	Fall (HFQ, PVQ) ³	All	Beneficiary
Chronic Conditions Flags (CHRNCDL)	FFS Chronic Condition Flag Records and FFS Chronic and other Disabling Flag records from administrative data sources.		AR	n/a (Admin data)	n/a	n/a	Beneficiary
Chronic Pain (CHRNPAIN)	Information on experiences with chronic pain and non-medication related chronic pain management techniques.	The data collected in Summer 2024 are released with the 2023 Survey File given that the reference period is 2023. Special non-response adjustment weights are included with this file.	CQ	CPQ	Summer	Cont.	Beneficiary
Cognitive Measures (COGNFUNC)	Measures of cognitive functioning.	Special non-response adjustment weights are included with this file.	CQ	CMQ	Fall	All	Beneficiary
COVID-19 Topical (COVIDTOP)	Information on COVID-19 vaccination, testing, diagnosis, symptoms, and prevention.	The data collected in Winter are released with the 2023 Survey File given that the reference period is 2023. Special non-response adjustment weights are included with this file.	CQ	CVQ	Winter	All	Beneficiary

Survey File Segment (Abbrev)	Description	Data collection and special weights notes	Data Source *	Quex Section	Season	Panel **	Unit of Observation
COVID-19 Experience (COVIDEXP)	Information on COVID-19 vaccination, testing, diagnosis, symptoms, and prevention.		CQ	CVQ	Fall	All	Beneficiary
Demographics (DEMO)	Demographic information.		CQ, FI, AR	ENS, DIQ, INQ, BQ, RH	All (ENS, INQ, RH) Fall ¹ (DIQ, BQ)	All (ENS, INQ, BQ, RH) Base (DIQ)	Beneficiary
Diabetes (DIABETES)	Information on diabetes management such as insulin usage.		CQ	HFQ	Fall	All	Beneficiary
Facility Assessments (FACASMNT)	Assessment information conducted while the beneficiary was living in a Medicare approved or non-Medicare approved facility.		FI, AR	HS	Fall ²	All	Beneficiary
Facility Characteristics (FACCHAR)	Primarily information from the Facility Questionnaire with Skilled Nursing Facility (SNF) stay information for beneficiaries living in the community and in facilities incorporated.		FI, AR	BQ, FQ, RH	Fall ¹ (BQ) All (FQ, RH)	All	Facility by beneficiary
Falls (FALLS)	Information on injuries and attitudes about falls.		CQ	HFQ	Fall	All	Beneficiary
Food Insecurity (FOODINS)	Information on access to sufficient food.	The data collected in Summer 2024 are released with the 2023 Survey File given that the reference period is 2023. Special non-response adjustment weights are included with this file.	CQ	IAQ	Summer	Cont.	Beneficiary
General Health (GENHLTH)	Information on general health status and functioning such as height and weight.		CQ	HFQ	Fall	All	Beneficiary

Survey File Segment (Abbrev)	Description	Data collection and special weights notes	Data Source *	Quex Section	Season	Panel **	Unit of Observation
Health Insurance Summary (HISUMRY)	Administrative information on the characteristics of insurance coverage.		CQ, AR	HIQ	All	All	Beneficiary
Health Insurance Timeline (HITLINE)	Information on insurance plans and the coverage eligibility timeline as well as information regarding premiums and covered services.		CQ, FI, AR	CPS, ENS, HIQ, NSQ, STQ, IN	All (CPS, HIQ, NSQ, STQ) Fall ² (IN)	Cont. (CPS, NSQ, STQ) Both (HIQ)	Plan type by beneficiary
Household Characteristics (HHCHAR)	Information on household composition and home.		CQ	ENS, HAQ	All (ENS) Fall (HAQ)	All	Beneficiary
Immunization (IMQ)	Information on beneficiary immunizations.		CQ	PVQ	Summer, Winter ³	All	Beneficiary
Income and Assets (INCASSET)	Information on income and assets.	The data collected in Summer 2024 are released with the 2023 Survey File given that the reference period is 2023. Special non-response adjustment weights are included with this file.	CQ	IAQ	Summer ³	Cont.	Beneficiary
Interview Characteristics (INTERV)	Information on interview characteristics.		CQ, FI	END, ENS, INQ, IRQ	All	All	Interview by beneficiary
MA Plan Questions (MAPLANQX)	Information on covered services for beneficiaries enrolled in Medicare Part C.		CQ, AR	HIQ	All	All	Beneficiary

Survey File Segment (Abbrev)	Description	Data collection and special weights notes	Data Source *	Quex Section	Season	Panel **	Unit of Observation
Medicare Plan Beneficiary Knowledge (MCREPLNQ)	Information on experiences with the Medicare open enrollment period and knowledge about Medicare-covered expenses.	The data collected in Winter 2024 are released with the 2023 Survey File given that the reference period is 2023. Special non-response adjustment weights are included with this file.	CQ	KNQ	Winter ³	Cont.	Beneficiary
Minimum Data Set (MDS3)	Assessment information conducted while the beneficiary was living in an approved Medicare facility.		AR	n/a (Admin data)	n/a	n/a	Assessment by beneficiary
Mental Health (MENTHLTH)	Information on mental health such as feelings of anxiety or depression.		CQ	HFQ	Fall	All	Beneficiary
Mobility (MOBILITY)	Information on the use of available transportation options and whether health status affects their daily travel.		CQ	MBQ	Fall	All	Beneficiary
Multiple Year Enrollment (MYENROLL)	Up to five years of beneficiary enrollment information with monthly flags related to Part D and LIS enrollment, dual eligibility status, and type of Medicare coverage.		AR	n/a (Admin data)	n/a	All	Beneficiary
Nagi Disability (NAGIDIS)	Information on difficulties with performance of activities of daily living.		CQ	HFQ	Fall	All	Beneficiary
Nicotine and Alcohol (NICOALCO)	Information on the prevalence and frequency of alcohol and nicotine use.		CQ	NAQ	Fall	All	Beneficiary
Outcome and Assessment Information (OASIS)	Assessment information conducted while the beneficiary was receiving home health services.		AR	n/a (Admin data)	n/a	n/a	Assessment by beneficiary

Survey File Segment (Abbrev)	Description	Data collection and special weights notes	Data Source *	Quex Section	Season	Panel **	Unit of Observation
Patient Activation (PNTACT)	Information on the degree to which beneficiaries actively participate in their health care and decisions concerning care.	Special non-response adjustment weights are included with this file.	CQ	SCQ	Fall	All	Beneficiary
Preventive Care (PREVCARE)	Information on preventive services such as routine screening procedures.		CQ	HFQ, PVQ	Fall (HFQ) Fall (PVQ) ³	All	Beneficiary
Residence Timeline (RESTMLN)	Information on where the beneficiary lived over the course of the year.		CQ, FI	HHQ, IPQ, IUQ	All	Cont.	Beneficiary
RX Medications (RXMED)	Information on prescription medication access and satisfaction with and knowledge about Medicare Part D.	The data collected in Summer 2024 are released with the 2023 Survey File given that the reference period is 2023. Special non-response adjustment weights are included with this file.	CQ	RXQ	Summer ³	Cont.	Beneficiary
Satisfaction with Care (SATWCARE)	Information on satisfaction with different aspects of health care.		CQ	SCQ	Fall	Cont. (MPQ, PMQ) Both (SCQ)	Beneficiary
Telemedicine (TELEMED)	Information on telemedicine visit availability and usage.	The data collected in Winter 2024 are released with the 2023 Survey File given that the reference period is 2023. Special non-response adjustment weights are included with this file.	CQ	TLQ	Winter ³	Cont.	Beneficiary

Survey File Segment (Abbrev)	Description	Data collection and special weights notes	Data Source *	Quex Section	Season	Panel **	Unit of Observation
Usual Source of Care (USCARE)	Information on where and how the beneficiary typically seeks medical care.	The data collected in Winter 2024 are released with the 2023 Survey File given that the reference period is 2023. Special non-response adjustment weights are included with this file.	CQ	USQ	Winter ³	Cont.	Beneficiary
Vision and Hearing (VISHEAR)	Information on eye health and hearing status.		CQ	HFQ	Fall	All	Beneficiary
Survey File Weights (CENWGTS) (EVRWGTS) (LNG2WGTS) (LNG3WGTS) (LNG4WGTS)	The weights segments include longitudinal weights for the continuously enrolled population, general-purpose cross-sectional weights, a series of replicate weights, and weights to represent the ever enrolled population.		CQ, FI	n/a	n/a	All	Beneficiary
COVID-19 Facility Beneficiary-Level (FBENCVFL)	Information on COVID-19 diagnosis, testing, and care received by beneficiaries living in a facility during the fall of 2023 and winter of 2024.		FI	CV	Fall, Winter	All	Beneficiary
Fee-for-Service Claims (FFS)	Abbreviated FFS claims data. Additional claims-like data will be included as they become available in subsequent years (e.g., Encounter Data, Medicaid claims data).		AR	n/a (Admin data)	n/a	All	Beneficiary

* = Data source describes the source of the data on the segment. The three possible sources are the Community Questionnaire (CQ), Facility Instrument (FI), and Administrative Records (AR). Each LDS segment can have any combination of these sources. Data source reflects where the data came from, not where the beneficiary was living. For example, a beneficiary could have lived in both settings during the year but the data for that beneficiary available on the ACCESSCR segment came from their Community interview only.

** = Panel describes whether the questionnaire sections that provide the data for each segment are fielded for baseline respondents, continuing respondents, or both.

1. The BQ section is also administered to Community-to-Facility Crossover cases each season.
2. The FC, IN, and HS sections are also administered each season to Community-to-Facility cases, Facility-to-Facility cases, and for beneficiaries living in a Facility whose last interview was a Community interview and who completed a Facility interview in a prior round.
3. These sections are administered in rounds following the current data year given that the reference period is the prior year and data are included in the prior year data files.

SF3.3 Imputation

For the 2023 Survey File, imputation occurs for 1) missing data on beneficiaries' **income and assets** that contribute to the INCASSET segment and 2) incomplete information on **insurance premiums** that contributes to the HITLINE (private plans) and MAPLANQX (Medicare Advantage plans) segments. For more information on the imputation that occurs for each LDS, see the *MCBS Data User's Guide*. For a detailed description of the MCBS imputation procedures, see the *MCBS Methodology Report*.

If needed, "probe" variables, which indicate whether the beneficiary paid a premium or additional cost, are imputed. Reported premium values are converted into monthly amounts and monthly values are imputed for beneficiaries who did not report a premium amount.

SF3.4 Weights

The data user may choose to conduct analyses of final Survey File data alone or in combination with Cost Supplement File data. The Survey File weights are for analysis of Survey File data only; data users cannot use the Survey File weights with Cost Supplement File data. Users who want to analyze Survey File data along with cost and utilization data in the Cost Supplement File should use the provided Cost Supplement File weights. Survey File - Early Release data should not be combined with the Survey File or Cost Supplement File data.

Two types of general weights are provided for the 2023 Survey File LDS, **cross-sectional weights** and **longitudinal weights**. Two sets of cross-sectional weights are provided representing the ever enrolled population (EVRWGTS) and the continuously enrolled population (CENWGTS). Three sets of longitudinal weights are provided representing the two-year (LNG2WGTS), three-year (LNG3WGTS), and four-year (LNG4WGTS) continuously enrolled populations. For more information on the weights available for each LDS, see the *MCBS Data User's Guide*. For a detailed description of the MCBS weighting procedures, see the *MCBS Methodology Report*.

Exhibit SF3.4.1 summarizes the general weights released on the 2023 Survey File.

Exhibit SF3.4.1: 2023 MCBS Survey File General Weights

Limited Data Set	Description	Segment	Full-Sample Weight	Replicate Weights	Population
Survey File	Continuously Enrolled Cross-Sectional Weights	CENWGTS	CEYRSWGT	CEYRS001-CEYRS100	Continuously enrolled from 1/1/2023 through the fall of 2023
Survey File	Ever Enrolled Cross-Sectional Weights	EVRWGTS	EEYRSWGT	EEYRS001-EEYRS100	Ever enrolled for at least one day at any time during 2023
Survey File	Continuously Enrolled Two-Year Longitudinal Weights	LNG2WGTS	L2YRSWGT	L2YRS001-L2YRS100	Continuously enrolled from 1/1/2022 through the fall of 2023

Limited Data Set	Description	Segment	Full-Sample Weight	Replicate Weights	Population
Survey File	Continuously Enrolled Three-Year Longitudinal Weights	LNG3WGTS	L3YRSWGT	L3YRS001-L3YRS100	Continuously enrolled from 1/1/2021 through the fall of 2023
Survey File	Continuously Enrolled Four-Year Longitudinal Weights	LNG4WGTS	L4YRSWGT	L4YRS001-L4YRS100	Continuously enrolled from 1/1/2020 through the fall of 2023

SF3.4.1 Special Topical Segment Weights

There are 11 2023 Survey File LDS segments that have special non-response adjusted weights: ACCSMED, CHRNPAIN, COGNFUNC, COVIDTOP, FOODINS, INCASSET, MCREPLNQ, PNTACT, RXMED, TELMED, and USCARE. These segments are referred to as Topical segments because most of them were traditionally sourced from the Topical questionnaire sections. **To generate estimates using these Topical segment data, on their own or merged with another Survey File segment, always use the special full-sample and replicate weights included in the Topical segment.** Do not use the weights that appear in the separate weight segments (CENWGTS, EVRWGTS).

The questionnaire sections (or specific items within questionnaire sections) that are weighted separately are fielded in the winter and summer rounds following the data year, and/or are not administered to proxy respondents. Exhibit SF3.4.2 crosswalks these questionnaire sections and their corresponding Topical segments.

Exhibit SF3.4.2: Crosswalk of 2023 Questionnaire Sections and LDS Segments with Topical Weights

Questionnaire Section	Questionnaire Type	Data Collection Round	Topical LDS Segment
Access to Care (ACQ)	Core	Winter 2024	ACCSMED
Cognitive Measures (CMQ)*	Core	Fall 2023	COGNFUNC
Chronic Pain (CPQ)*	Topical	Summer 2024	CHRNPAIN
COVID-19 (CVQ)	Topical	Winter 2024	COVIDTOP
Income and Assets (IAQ)	Core	Summer 2024	INCASSET
Income and Assets (IAQ) – Food Insecurity items	Topical	Summer 2024	FOODINS
Knowledge and Decision Making (KNQ)	Topical	Winter 2024	MCREPLNQ
Satisfaction with Care (SCQ) – Patient Activation items*	Core	Fall 2023	PNTACT
Drug Coverage (RXQ)	Topical	Summer 2024	RXMED
Telemedicine (TLQ)	Core	Winter 2024	TELEMED
Usual Source of Care (USQ)	Core	Winter 2024	USCARE

*CMQ, CPQ, and the Patient Activation items in SCQ are only administered to non-proxy respondents.

Exhibit SF3.4.3 summarizes the Topical weights released on the 2023 Survey File. See the codebooks for the names of the full-sample and replicate weights for each Topical segment.

Exhibit SF3.4.3: 2023 MCBS Survey File Topical Weights

Limited Data Set	Description	Segments	Population
Survey File Topical Section	Non-Proxy Adjustment – Survey File Ever Enrolled	PNTACT, COGNFUNC	Ever enrolled for at least one day at any time during 2023
Survey File Topical Section	Non-Proxy Adjustment – Survey File Continuously Enrolled	PNTACT, COGNFUNC	Continuously enrolled from 1/1/2023 through the fall of 2024
Survey File Topical Section	Non-Proxy Adjustment – Cost Supplement File Ever Enrolled	PNTACT, COGNFUNC	Ever enrolled for at least one day at any time during 2023
Survey File Topical Section	Winter Nonresponse Adjustment – Survey File Ever Enrolled	MCREPLNQ, ACCSSMED, USCARE, TELEMED, COVIDTOP	Ever enrolled in 2023 and still alive, entitled, and not living in a facility in Winter 2024
Survey File Topical Section	Winter Nonresponse Adjustment – Survey File Continuously Enrolled	MCREPLNQ, ACCSSMED, USCARE, TELEMED, COVIDTOP	Continuously enrolled in 2023 and still alive, entitled, and not living in a facility in Winter 2024
Survey File Topical Section	Winter Nonresponse Adjustment – Cost Supplement File Ever Enrolled	MCREPLNQ, ACCSSMED, USCARE, TELEMED, COVIDTOP	Ever enrolled in 2023 and still alive, entitled, and not living in a facility in Winter 2024
Survey File Topical Section	Summer Nonresponse Adjustment – Survey File Ever Enrolled	INCASSET, FOODINS, RXMED	Ever enrolled in 2023 and still alive, entitled, and not living in a facility in Summer 2024
Survey File Topical Section	Summer Nonresponse Adjustment – Survey File Continuously Enrolled	INCASSET, FOODINS, RXMED	Continuously enrolled in 2023 and still alive, entitled, and not living in a facility in Summer 2024
Survey File Topical Section	Summer Nonresponse Adjustment– Cost Supplement File Ever Enrolled	INCASSET, FOODINS, RXMED	Ever enrolled in 2023 and still alive, entitled, and not living in a facility in Summer 2024
Survey File Topical Section	Non-Proxy and Summer Nonresponse Adjustment – Survey File Ever Enrolled	CHRNPAIN	Ever enrolled in 2023 and still alive, entitled, and not living in a facility in Summer 2024
Survey File Topical Section	Non-Proxy and Summer Nonresponse Adjustment – Survey File Continuously Enrolled	CHRNPAIN	Continuously enrolled in 2023 and still alive, entitled, and not living in a facility in Summer 2024
Survey File Topical Section	Non-Proxy and Summer Nonresponse Adjustment – Cost Supplement File Ever Enrolled	CHRNPAIN	Ever enrolled in 2023 and still alive, entitled, and not living in a facility in Summer 2024

SF4. DATA FILE NOTES

SF4.1 Survey File Segment Information

This section provides information regarding each segment within the Survey File in alphabetical order. The notes have been organized into three main categories of information.

1. Core Content – a description of the main subject of the data.
2. Variable Definitions – definitions of derived variables and/or variables that require additional explanation regarding their construction. Note: The variables listed are not a comprehensive list of all variables in each segment. The Codebook provides information on all variables in each segment.
3. Special Notes – additional background information that data users may find helpful for constructing analyses.

SF4.2 Survey File Segment Descriptions

SF4.2.1 Access to Care (ACCESSCR)

There are no notable differences in this segment between the 2023 Survey File (ACCESSCR) and the 2023 Survey File - Early Release (ER_ACCESSCR). Please see Section ER4.2.1 for relevant notes on this segment.

SF4.2.2 Access to Care, Medical Appointments (ACCSSMED)

SF4.2.2.1 Core Content

The Access to Care, Medical Appointments segment contains information from the ACQ section and the emergency room, outpatient, medical provider, dental, vision, and hearing, and prescription medicine utilization sections asked in the winter round following the year of interest. General questions are asked about the beneficiary's access to all types of medical services and prescription medicines, the reasons for their visits, and the reasons for any forgone care or prescription medicines.

SF4.2.2.2 Variable Definitions

Please see the Codebook for information regarding variables in this segment.

SF4.2.2.3 Special Notes

Respondents are asked why the beneficiary did or did not receive different types of medical services or prescription medicines in an open-ended format (e.g., "What was the reason you saw the doctor?"). The respondents answer these questions in their own words, and interviewers select the response option(s) from a predefined code list that best matched the respondents' answer(s). These questions are select-all-that-apply so that respondents may provide multiple answers to each question, and each answer is stored in its own analytic variable.

If the respondent reports a reason that is not included in the predefined code list, the interviewer documents their response verbatim in an "other specify" variable that is not released. The "other specify" response is back coded as necessary into the predefined code list.

Special non-response adjustment weights are included in the file to account for survey non-response from the fall to the winter data collection period. Note that counts of cases with positive Topical weights may vary within the data year and may change across years due to response rates, sample sizes, and fielding methods. The Topical weights account for these changes. Please see Section SF3.4.1 for information on using Topical weights.

SF4.2.3 Administrative Utilization Summary (ADMNUTLS)

SF4.2.3.1 Core Content

The Administrative Utilization Summary segment contains information on Medicare program expenditures and utilization taken directly from the Medicare Administrative enrollment data.

SF4.2.3.2 Variable Definitions

Except as noted otherwise, the variables in this segment are derived from summarizing data from CMS' Medicare Administrative enrollment data and the Medicare Administrative utilization and payment records. Administrative data available as of December 31, 2023 were summarized to create these data items.

H_HHASW: One or more home health agency (HHA) visits in the calendar year is indicated by a 1. This is triggered by a value (greater than zero) found in the home health visits field (H_HHVIS). Otherwise, the value for H_HHASW is 2.

H_HOSSW: One or more hospice bills in the calendar year is indicated by a 1. This is triggered by a value (greater than zero) found in the hospice Medicare payments (H_HOSPMT) field or the hospice stays (H_HOSSTY) field. Otherwise, the value for H_HOSSW is 2.

H_INPSW: One or more inpatient discharges in the calendar year is indicated by a 1. This is triggered by a value (greater than zero) found in the acute inpatient stays (H_ACTSTY) field or the other inpatient stays (H_OIPSTY) field. Otherwise, the value for H_INPSW is 2.

H_OUTSW: One or more outpatient visits in the calendar year is indicated by a 1. This is triggered by a value (greater than zero) found in the hospital outpatient visits (H_HOPVIS) field or hospital outpatient emergency room visits (H_HOP_ER) field. Otherwise, the value for H_OUTSW is 2.

H_PBSW: One or more Part B claims in the calendar year is indicated by a 1. This is triggered by a value (greater than zero) found in any of the following fields: H_PHYPMT, H_PHYEVT, H_PB_DEV, H_PB_DRG, H_PB_OTH, H_PB_OEV, H_DMEEVT, H_DMEPMT, H_TSTEVT, H_TSTPMT, H_ANEVT, H_ANEPMT, H_ASCEVT, H_ASCPMT, H_DIAEVT, H_DIAPMT, H_EMEVT, H_EMPMT, H_IMG EVT, H_IMG PMT, and H_PTBRMB. Otherwise, the value for H_PBSW is 2.

H_SNFSW: One or more skilled nursing facility (SNF) admissions in the calendar year is indicated by a 1. This is triggered by a value (greater than zero) found in any of the following fields: H_SNFPMT, H_SNFSY, H_SNFDAY. Otherwise, the value for H_SNFSW is 2.

H_PTARMB: Total Part A reimbursement in the calendar year. It is a sum of calendar year reimbursements for HHA Part A, Hospice, Inpatient, and SNF. The CLM_PMT_AMT field is selected for each claim type in preparing this calculation. The CLM_VAL_CD = "64" is used to determine HHA Part A.

H_PTBRMB: Total Part B reimbursement in the calendar year. It is a sum of calendar year reimbursements for HHA Part B, Physician, and Outpatient. The CLM_PMT_AMT field is selected for each claim type in preparing

this calculation. The CLM_VAL_CD = "65" is used to determine HHA Part B. "Physician" as noted in the "sum" statement above consisted of BCARRIER_CLAIMS and DME_CLAIMS.

H_ACTPMT: Acute Inpatient Medicare Payments is the sum of the Medicare claim payment amounts (CLM_PMT_AMT from each source claim) in the acute inpatient hospital setting in the calendar year. To obtain the total acute hospital Medicare payments, take this variable and add in the annual per diem payment amount (H_ACTMPT + H_ACTPRD).

H_ACTPRD: Acute Inpatient Hospital Pass-thru Per Diem Payments is the sum of all the pass-through per diem payment amounts (CLM_PASS_THRU_PER_DIEM_AMT from each source claim) in the acute inpatient hospital setting for the calendar year. Medicare payments are designed to include certain "pass-through" expenses such as capital-related costs, direct medical education costs, kidney acquisition costs for hospitals that are renal transplant centers, and bad debts. This variable is the sum of all the daily payments for pass-through expenses. It is not included in the Medicare Payment amount (H_ACTPMT). To determine the total Medicare payments for acute hospitalizations for the beneficiary, this field must be added to the total Medicare payment amount for acute inpatient hospitalizations (H_ACTPMT+ H_ACTPRD).

H_ACTSTY: Acute Inpatient Stays is the count of acute inpatient hospital stays (unique admissions, which may span more than one facility) for the calendar year. An acute inpatient stay is defined as a set of one or more consecutive acute inpatient hospital claims where the beneficiary is only discharged on the most recent claim in the set. If a beneficiary is transferred to a different provider, the acute stay is continued even if there is a discharge date on the claim from which the beneficiary was transferred.

H_ACTDAY: Acute Inpatient Medicare Covered Days is the count of Medicare covered days in the acute inpatient hospital setting for the calendar year.

H_ACTBPT: Acute Inpatient Beneficiary Payments is the sum of Medicare coinsurance and deductible payments in the acute inpatient hospital setting for the calendar year. The total acute hospitalization beneficiary payments are calculated as the sum of the beneficiary deductible amount and coinsurance amount for all acute inpatient claims where the CLM_PMT_AMT >= 0.

H_IP_ER: Inpatient Emergency Room Visits is the count of emergency department (ED) claims in the inpatient setting for the year. The revenue center codes indicating emergency room use were 0450, 0451, 0452, 0456, and 0459.

H_OIPPMT: Other Inpatient Hospital Medicare Payments is the sum of the Medicare claim payment amounts (CLM_PMT_AMT from each source claim) in the other inpatient (OIP) settings for the calendar year. To obtain the total OIP Medicare payments, take this variable and add in the annual per diem payment amount (H_OIPPMT + H_OIPPRD). These OIP claims are a subset of the IP claims consisting of data from IP settings such as long-term care hospitals, inpatient psychiatric facilities, inpatient rehabilitation facilities, and other types of IP facilities such as children's hospitals or cancer centers.

H_OIPPRD: Other Inpatient Pass-thru Per Diem Payments is the sum of all the pass-through per diem payment amounts (CLM_PASS_THRU_PER_DIEM_AMT from each source claim) in the OIP setting for the calendar year. This variable is the sum of all the daily payments for pass-through expenses. It is not included in the Medicare payment amount (H_OIPPMT). To determine the total Medicare payments for other non-acute hospitalizations for the beneficiary, this field must be added to the total Medicare payment amount for other hospitalizations (H_OIPPMT + H_OIPPRD).

H_OIPSTY: Other Inpatient Stays is the count of hospital stays (unique admissions, which may span more than one facility) in the non-acute inpatient setting for the calendar year. A non-acute inpatient stay is defined as a

set of one or more consecutive non-acute inpatient claims where the beneficiary is only discharged on the most recent claim in the set.

H_OIPDAY: Other Inpatient Hospital Covered Days is the count of covered days in the non-acute inpatient hospital setting for the calendar year. This variable equals the sum of the CLM_UTLZTN_DAY_CNT variables on the source claims.

H_OIPBPT: Other Inpatient Beneficiary Payments is the sum of Medicare coinsurance and deductible payments in the nonacute inpatient hospital setting for the year. The total OIP beneficiary payments are calculated as the sum of NCH_BENE_IP_DDCTBL_AMT and NCH_BENE_PTA_COINSRNC_LBLTY_AM for all relevant claims where the CLM_PMT_AMT ≥ 0 .

H_SNFPMT: SNF Medicare Payments is the total Medicare payments in the SNF setting for the calendar year.

H_SNFSTY: SNF Stays is the count of SNF stays (unique admissions, which may span more than one facility) for the calendar year. A SNF stay is defined as a set of one or more consecutive SNF claims where the beneficiary is only discharged on the most recent claim in the set.

H_SNFDAY: SNF Medicare Covered Days is the count of Medicare covered days in the SNF setting for the calendar year. This variable equals the sum of the CLM_UTLZTN_DAY_CNT variables on the source claims.

H_SNFBPT: Skilled Nursing Facility Beneficiary Payments is the sum of Medicare coinsurance and deductible payments in the SNF setting for the calendar year. The total beneficiary payment is calculated as the sum of the beneficiary deductible amount and coinsurance amount (variables NCH_BENE_IP_DDCTBL_AMT and NCH_BENE_PTA_COINSRNC_LBLTY_AM) for all SNF claims where the CLM_PMT_AMT ≥ 0 .

H_HOSPMT: Hospice Medicare Payments is the total Medicare payments in the hospice (HOS) setting for the calendar year.

H_HOSSTY: Hospice Stays is the count of stays (unique admissions, which may span more than one facility) in the HOS setting for the calendar year. A HOS stay is defined as a set of one or more consecutive hospice claims where the beneficiary is only discharged on the most recent claim in the set.

H_HOSDAY: Hospice Medicare Covered Days is the count of Medicare covered days in the HOS setting for the calendar year. This variable equals the sum of the CLM_UTLZTN_DAY_CNT variables on the source claims.

H_HHPMT: Home Health Medicare Payments is the total Medicare payments in the home health (HH) setting for the calendar year.

H_HHVIS: Home Health Visits is the count of HH visits for the calendar year.

H_HOPPMT: Hospital Outpatient Medicare Payments is the total Medicare payments in the hospital outpatient (HOP) setting for the calendar year.

H_HOPVIS: Hospital Outpatient Visits is the count of unique revenue center dates (as a proxy for visits) in the HOP setting for the calendar year.

H_HOP_ER: Hospital Outpatient Emergency Room Visits is the count of unique emergency department revenue center dates (as a proxy for an ED visit) in the HOP claims for the calendar year. Revenue center codes indicating emergency room use are 0450, 0451, 0452, 0456, or 0459.

H_HOPBPT: Hospital Outpatient Beneficiary Payments is the sum of Medicare coinsurance and deductible payments in the HOP setting for the calendar year. The total beneficiary payment is calculated as the sum of the beneficiary deductible amount and coinsurance amount (variables REV_CNTR_CASH_DDCTBLE_AMT and REV_CNTR_COINSRNC_WGE_ADJSTD_C) for all HOP claims where the CLM_PMT_AMT >= 0.

H_PB_DRG: Part B Drug Medicare Payments is the total Medicare payments for Part B drugs for the calendar year. Part B drug claims are a subset of the claims in the Part B Carrier and DME claims.

H_PB_DEV: Part B Drug Events is the count of events in the Part B drug setting for the calendar year. An event is defined as each line item that contains the relevant service.

H_BPTDRG: Part B Drug Beneficiary Payments is the sum of coinsurance and deductible payments for Part B drugs for the calendar year. The total beneficiary payments are calculated as the sum of LINE_COINSRNC_AMT + LINE_BENE_PTB_DDCTBL_AMT for the relevant lines. The Part B drug claims are identified by BETOS codes (CCW variable BETOS_CD with values of "D1G", "O1D", "O1E", "O1G", "I1E", or "I1F").

H_EMPMT: Evaluation and Management Medicare Payments is the total Medicare payments for the Part B evaluation and management (E&M) services for a given year. E&M claims are a subset of the claims in the Part B Carrier and DME claims and a subset of physician claims.

H_EMEVT: E&M Events is the count of events for the Part B E&M services for the calendar year. An event is defined as each line item that contains the relevant service.

H_EMBPT: Evaluation and Management Beneficiary Payments is the sum of coinsurance and deductible payments for the Part B E&M services for the calendar year. The total beneficiary payments are calculated as the sum of LINE_COINSRNC_AMT and LINE_BENE_PTB_DDCTBL_AMT for the relevant lines. E&M claims are a subset of the claims in the Part B Carrier and DME data files and a subset of physician claims. The E&M claims are defined as those with a line BETOS code (BETOS_CD) where the first digit = "M" (but is not M1A or M1B – which are categorized as physician office care in this file – see PHYS_MDCR_PMT).

H_PHYPMT: Part B Physician Medicare Payments is the total Medicare payments for the Part B physician office services (PHYS) for the calendar year. PHYS claims are a subset of the claims in the Part B Carrier and DME claims and a subset of physician evaluation and management claims (note that E&M are tabulated separately).

H_PHYEVT: Part B Physician Events is the count of events for Part B PHYS for the calendar year. An event is defined as each line item that contains the relevant service.

H_PHYBPT: Part B Physician Beneficiary Payments is the sum of coinsurance and deductible payments for the Part B PHYS for the calendar year. The total beneficiary payments are calculated as the sum of LINE_COINSRNC_AMT and LINE_BENE_PTB_DDCTBL_AMT for the relevant lines. The PHYS claims are defined as those with a line BETOS code (BETOS_CD) where the first three digits = M1A or M1B (the remainder of physician services which occur in different settings appear in EM_MDCR_PMT).

H_OPRPMT: Other Procedures Medicare Payments is the total Medicare payments for services considered Part B other procedures (i.e., not anesthesia or dialysis) for the calendar year. Claims for other procedures are a subset of the claims and a subset of procedures in the Part B Carrier claims.

H_OPREVT: Other Procedures Events is the count of events for Part B other procedures for the calendar year. An event is defined as each line item that contains the relevant service. Claims for other procedures are a subset of the claims in the Part B Carrier claims.

H_OPRBPT: Other Procedures Beneficiary Payments is the sum of coinsurance and deductible payments for services considered Part B other procedures for the calendar year. The total beneficiary payments are calculated as the sum of `LINE_COINSRNC_AMT` and `LINE_BENE_PTB_DDCTBL_AMT` for the relevant lines. Claims for other procedures are a subset of the claims in the Part B Carrier data file. These other procedure claims are defined as those with a line `BETOS` code (`BETOS_CD`) where the first 2 digits are ("P1", "P2", "P3", "P4", "P5", "P6", "P7", or "P8").

H_DMEPMT: Durable Medical Equipment Medicare Payments is the total Medicare payments for Part B durable medical equipment (DME) for the calendar year. Claims for DME are a subset of the claims in the Part B Carrier and DME claims.

H_DMEEVT: Durable Medical Equipment Events is the count of events in the Part B DME for the calendar year. An event is defined as each line item that contains the relevant service.

H_DMEBPT: Durable Medical Equipment Beneficiary Payments is the total Medicare payments for Part B DME for the calendar year.

H_PB_OTH: Other Part B Carrier Medicare Payments is the total Medicare payments from Part B Carrier and DME claims which appear in specific settings for the calendar year. Claims for other carrier/DME claims are a subset of the claims in the Part B Carrier and DME claims. Types of services which may have been summarized in this other carrier category (OTH) include ambulance, chiropractor, chemotherapy, vision, hearing and speech services, etc.

H_PB_OEV: Other Part B Carrier Events is the count of events in the Part B other setting for the calendar year, which includes Part B Carrier and DME claims which appear in specific settings for the year. An event is defined as each line item that contains the relevant service.

H_BPTOTH: Other Part B Carrier Beneficiary Payments is the sum of coinsurance and deductible payments from Part B Carrier and DME claims for the calendar year, which appear in settings other than the 10 specific categories in this segment. The total beneficiary payments are calculated as the sum of `LINE_COINSRNC_AMT` and `LINE_BENE_PTB_DDCTBL_AMT` for the relevant lines.

H_PTDPMT: Part D Medicare Payments is the dollar amount that the Part D plan covered for all covered drugs for the calendar year. The variable is calculated as the sum of the plan payments for covered Prescription Drug Events (PDEs) (`CVRD_D_PLAN_PD_AMT`) and the low-income cost sharing subsidy amount (`LICS_AMT`) during the year.

H_PTDEVT: Part D Events is the count of events for Part D drugs for the calendar year (i.e., a unique count of the `PDE_IDs`). An event is a dispensed (filled) drug prescription that appears on the source PDE claims.

H_PTDBPT: Part D Beneficiary Payments is the dollar amount that the beneficiary paid for all PDEs for the calendar year, without being reimbursed by a third party. The amount includes all copayments, coinsurance, deductible, or other patient payment amounts, and comes directly from the source PDEs.

H_PTDTOT: Part D Total Prescription Costs is the gross drug cost (`TOT_RX_CST_AMT` on the source claims) of all Part D drugs for the calendar year. This value includes the ingredient cost, dispensing fee, sales tax (if applicable), and vaccine administration fee.

H_ASCEVT: Ambulatory Surgery Center Events is the count of events in the Part B ambulatory surgery center (ASC) setting for the calendar year. An event is defined as each line item that contains an ambulatory surgery center service.

H_ASCBPT: Ambulatory Surgery Center Beneficiary Payments is the sum of coinsurance and deductible payments in the Part B ASC setting for the calendar year. The total beneficiary payment is calculated as the sum of the `LINE_COINSRNC_AMT` and `LINE_BENE_PTB_DDCTBL_AMT` for all relevant lines. ASC claims are a subset of the claims in the Part B Carrier data file. The ASC claims are identified by the claim lines where the `LINE_CMS_TYPE_SRVC_CD` = "F".

H_ANEPMT: Anesthesia Medicare Payments is the total Medicare payments for Part B anesthesia services (ANES) for the calendar year. Anesthesia claims are a subset of the claims and a subset of procedures in the Part B Carrier claims.

H_ANEVT: Anesthesia Events is the count of events for Part B ANES for the calendar year. An event is defined as each line item that contains the relevant service.

H_ANEBPT: Anesthesia Beneficiary Payments is the sum of coinsurance and deductible payments for Part B ANES for the calendar year. The total beneficiary payments are calculated as the sum of `LINE_COINSRNC_AMT` and `LINE_BENE_PTB_DDCTBL_AMT` for the relevant lines. ANES claims are a subset of the claims and a subset of procedures in the Part B Carrier data file. ANES claims are defined as those with a line BETOS code (`BETOS_CD`) where the first 2 digits = "P0" and the `CARR_LINE_MTUS_CD` = "2".

H_DIAPMT: Dialysis Medicare Payments is the total Medicare payments for Part B dialysis services (primarily the professional component since treatments are covered in hospital outpatient) for the calendar year. Dialysis claims are a subset of the claims and a subset of procedures in the Part B Carrier claims.

H_DIAEVT: Dialysis Events is the total Medicare payments for Part B dialysis services for the calendar year. An event is defined as each line item that contains the relevant service.

H_DIABPT: Dialysis Beneficiary Payments is the total Medicare payments for Part B dialysis services for the calendar year. The total beneficiary payments are calculated as the sum of `LINE_COINSRNC_AMT` and `LINE_BENE_PTB_DDCTBL_AMT` for the relevant lines.

H_IMGPMT: Imaging Medicare Payments is the total Medicare payments for imaging services (IMG) for the calendar year. Claims for imaging procedures are a subset of the claims and a subset of procedures in the Part B Carrier and DME claims.

H_IMGEVT: Imaging Events is the count of events for IMG for the calendar year. An event is defined as each line item that contains the relevant service.

H_IMGBPT: Imaging Beneficiary Payments is the sum of coinsurance and deductible payments for IMG for the calendar year. The total beneficiary payments are calculated as the sum of `LINE_COINSRNC_AMT` and `LINE_BENE_PTB_DDCTBL_AMT` for the relevant lines. These IMG claims are defined as those with a line BETOS code (`BETOS_CD`) where the first digit = I (except for "I1E", or "I1F" – which are considered Part B drugs).

H_TSTPMT: Tests Medicare Payments is the total Medicare payments for Part B tests for the calendar year. Claims for tests are a subset of the claims in the Part B Carrier claims.

H_TSTEVT: Tests Events is the count of events for Part B tests for the calendar year. An event is defined as each line item that contains the relevant service. Claims for tests are a subset of the claims in the Part B Carrier claims.

H_TSTBPT: Tests Beneficiary Payments is the sum of coinsurance and deductible payments for Part B tests for the calendar year.

H_PTDFIL: Part D prescribing events (PDE) consist of highly variable days' supply of the medication. This derived variable creates a standard 30 days' supply of a filled Part D prescription and counts this as a "fill." The Part D fill count does not indicate the number of different drugs the person is using, only the total months covered by a medication (e.g., if a patient is receiving a full year supply of a medication, whether this occurs in one transaction or 12 monthly transactions, the fill count = 12; if the patient is taking three such medications, the fill count = 36).

H_READMT: Acute Inpatient Hospital Readmissions is the count of hospital readmissions in the acute inpatient setting for the calendar year. The original admission must have been in the year of the data file, but it is possible for the readmission claim to have occurred in January of the following year. A beneficiary is considered to be readmitted when they have an acute inpatient stay with a discharge status that is not expired or left against medical advice within 30 days of a previous acute inpatient stay with a discharge status that is also not expired or left against medical advice.

SF4.3.3.3 Special Notes

For easier comparison of groups of beneficiaries by the number and cost of medical services they have received, the Administrative Utilization Summary includes a summary of all Medicare bills and claims for calendar year 2023, as received and processed by CMS through December 2024 for the 2023 benefit year.

The utilization summary represents services rendered and reimbursed under Medicare FFS in the calendar year 2023. If a beneficiary used no Medicare services at all or was a member of a coordinated or managed care plan that does not submit claims to a fiscal intermediary or carrier, all program payment summary variables will be null. If the beneficiary used no services of a particular type (e.g., inpatient hospitalization), the variables relating to those benefits will be null.

For additional information on administrative data items, please see the Master Beneficiary Summary – Cost and Use Segment Data Dictionary Codebook: <https://www.ccwdata.org/web/guest/data-dictionaries>.

SF4.2.4 Assistance (ASSIST)

There is one notable difference in this segment between the 2023 Survey File (ASSIST) and the 2023 Survey File - Early Release (ER_ASSIST). HLPRUSGO (the person who usually accompanies the beneficiary to their provider's office) is asked in the winter round in the USQ section. As such, HLPRUSGO is included on ASSIST, but not on ER_ASSIST. Please see Section ER4.2.2 for other relevant notes on this segment.

SF4.2.5 Chronic Conditions (CHRNCOND)

There are no notable differences in this segment between the 2023 Survey File (CHRNCOND) and the 2023 Survey File - Early Release (ER_CHRNCOND). Please see Section ER4.2.3 for relevant notes on this segment.

SF4.2.6 Chronic Conditions Flags (CHRNCDL)

SF4.2.6.1 Core Content

The Chronic Conditions Flags segment contains chronic and other disabling conditions flags from administrative FFS records from the CCW. The CCW summarizes beneficiaries' FFS claims for the calendar year and indicates whether a claim for a particular condition met criteria for inclusion. This segment also provides the first year the beneficiary met the criteria for having that chronic condition. Variables are included for those conditions related to the self-reported information included in the MCBS instrument and are not inclusive of all chronic and disabling conditions available.

SF4.2.6.2 Variable Definitions

The end of year indicator flags require beneficiaries to satisfy both claims criteria (a minimum number/type of claims that have the proper diagnosis codes and occurred within a specified time period) and coverage criteria (FFS Part A and Part B coverage during the entire specified time period). Each flag is also created using details about the specific condition that must be met for inclusion.

Indicators have the following values:

- 0 = Beneficiary did not meet claims criteria or have sufficient FFS coverage
- 1 = Beneficiary met claims criteria but did not have sufficient FFS coverage
- 2 = Beneficiary did not meet claims criteria but had sufficient FFS coverage
- 3 = Beneficiary met claims criteria and had sufficient FFS coverage

The ever indicator variables for the conditions show the date when the beneficiary first met the criteria for the chronic or disabling condition. The variable is missing for beneficiaries that have never had the condition. The earliest possible date for anyone is January 1, 2016. If the beneficiary became eligible for Medicare after that, the earliest possible date will be some time after their coverage start date.

SF4.2.6.3 Special Notes

The end of year indicator flags criteria was developed after reviewing validated algorithms from the research literature and criteria used by other federal data sources. Please visit the CCW website for more detailed information on the criteria: <https://www.ccwdata.org/web/guest/condition-categories>.

Beginning with the 2022 Survey File, the CHRNCDFL flags only reflect ICD-10 codes, rather than ICD-9 and ICD-10 codes as in previous years. As such, diagnoses made before 2016 are no longer reflected in the flags.

SF4.2.7 Chronic Pain (CHRNPAIN)

SF4.2.7.1 Core Content

The Chronic Pain segment contains data on beneficiaries' experiences with chronic pain and chronic pain management techniques collected in the CPQ section administered the summer following the year of interest. The CPQ collects information related to frequency and severity of chronic pain, location of chronic pain (e.g., hips, knees, or feet), and use of pain management techniques (e.g., massage).

SF4.2.7.2 Variable Definitions

Please see the Codebook for information regarding variables in this segment.

SF4.2.7.3 Special Notes

The CPQ uses a three-month reference period; thus, the items administered in Summer 2024 (Round 99) asked beneficiaries about pain experienced in 2024. However, because the CPQ is administered to beneficiaries who were ever enrolled in Medicare in 2023 and are still enrolled in 2024, the CPQ data are released with the 2023 Survey File.

Special non-response adjustment weights are included in the file to account for survey non-response from the fall to the summer data collection period. This includes Survey File ever enrolled and continuously enrolled weights, as well as Cost Supplement ever enrolled weights. Note that counts of cases with positive Topical weights may vary within the data year and may change across years due to response rates, sample sizes, and

fielding methods. The Topical weights account for these changes. Please see Section SF3.4.1 for information on using Topical weights.

SF4.2.8 Cognitive Measures (COGNFUNC)

There are no notable differences in the variables included on this segment between the 2023 Survey File (COGNFUNC) and the 2023 Survey File - Early Release (ER_COGNFUNC), but there are differences in the special non-response adjustment weights. ER_CONGFUNC includes one set of weights that represent the Survey File - Early Release ever enrolled population, while COGNFUNC includes three sets of weights that represent the Survey File ever enrolled, Survey File continuously enrolled, and Cost Supplement File ever enrolled populations. Please see Section ER4.2.4 for other relevant notes on this segment and Section SF3.4.1 for information on using Topical weights.

SF4.2.9 COVID-19 Experiences (COVIDEXP)

There are no notable differences in this segment between the 2023 Survey File (COVIDEXP) and the 2023 Survey File - Early Release (ER_COVIDEXP). Please see Section ER4.2.5 for relevant notes on this segment.

SF4.2.10 COVID-19 Topical (COVIDTOP)

SF4.2.10.1 Core Content

The Community COVID-19 Topical segment contains information collected in the CVQ section during the Winter 2024 round. This timing is a change from the 2022 Survey File, for which the COVIDTOP represented data collected in Summer 2023. These data include information about COVID-19 vaccination, testing, diagnosis, symptoms, and treatment, as well as persistent symptoms of long COVID-19.

SF4.2.10.2 Variable Definitions

Please see the Codebook for information regarding variables in this segment.

SF4.2.10.3 Special Notes

In 2023, 8 new variables were added to the COVIDTOP segment resulting from the changes to the CVQ section, including:

- D_FCEMASK (how often the beneficiary wears a facemask in public)
- D_PYRDOS (at least one COVID-19 vaccine in the last year)
- D_TSTBLD (received antibody blood test)
- D_TSTHOM (received at-home COVID-19 test)
- D_TSTSWB (received nasal or throat swab by a health care professional)

The remaining variables store reasons why the beneficiary did not receive the COVID-19 vaccine: D_NODRR (doctor did not recommend it), D_NOEFFE (side effects with other doses), NOELIGI (not yet eligible), D_NOHADC (already had COVID-19), D_NOIMMU (enough immunity from prior doses), D_NOREQ (not required by work or school), D_NOWORR (not worried about COVID-19), D_NOYET (plans to but has not yet), and D_NOOTH (other). Of these, D_NOYET, D_NOIMMU, D_NOWORR, and D_NOREQ are new in the 2023 Survey File.

Beginning with data collected in Winter 2024, two variables previously on the COVID-19 Experiences (COVIDEXP) segment are included on COVIDTOP: ONEDOSE (ever had a COVID-19 vaccine dose) and CVDOS (number of COVID-19 vaccine doses).

The “other specify” variable NOVACOS (why the beneficiary did not receive COVID-19 vaccine) is back coded as necessary, but the verbatim text is not released.

Special non-response adjustment weights are included in the file to account for survey non-response from the fall to the winter data collection period. This includes Survey File ever enrolled and continuously enrolled weights, as well as Cost Supplement ever enrolled weights. Note that counts of cases with positive Topical weights may vary within the data year and may change across years due to response rates, sample sizes, and fielding methods. The Topical weights account for these changes. Please see Section SF3.4.1 for information on using Topical weights.

SF4.2.11 Demographics (DEMO)

SF4.2.11.1 Core Content

The Demographics segment released on the Survey File (DEMO) contains demographic information collected in the survey as well as demographic information from Medicare administrative enrollment data and constructed items of interest. This section documents notable differences in this segment between the 2023 Survey File (DEMO) and the 2023 Survey File - Early Release (ER_DEMO), including variables that are only released on DEMO. Please see Section ER4.2.6 for other relevant notes on this segment.

SF4.2.11.2 Variable Definitions

D_DOD: Date of death provided by proxy respondents. In general, it is recommended that both the survey-reported (D_DOD) and administrative (H_DOD) variables be used for analyses.

INCOME: Income represents the best source or estimate of income during the year of interest. Data gathered in fall and summer interviews represent the most detailed data and are used when available. For individuals who did not complete the fall interview (that is, Continuing Panel people unavailable for their fall interview), the most recent information available is used. It should be noted that the variable INCOME includes income from all sources, such as pension, Social Security, and retirement benefits, for the beneficiary and spouse/partner. In some cases, the respondent will not or cannot provide specific information but did say the income is above or below \$25,000.

INT_TYPE: Provides the source for a beneficiary’s residence status at the time of interview, and the types of interviews conducted with C = Community, F = Facility, and B = Both. INT_TYPE is defined as:

- C = respondent only resided in the community and only completed Community-administered survey instruments in each round
- F = respondent only resided in a facility and only completed Facility-administered survey instruments in each round
- B = respondents completed instruments in both settings across the rounds

Beneficiaries are assigned an INT_TYPE if they completed or partially completed an interview in at least one round in 2023. INT_TYPE is also calculated for beneficiaries who completed an interview, but died or lost entitlement during the data year.

Note that in each data year, some differences by segment will exist (i.e., data may reflect a prior or future calendar year due to the specific questionnaire and reference period used to collect the information). INT_TYPE is only constructed using survey-reported data for the benefit year and is not edited to account for data collected in a future or prior data year.

For example, there may be beneficiaries living in facilities (INT_TYPE = F) that appear on the 2023 segments that include 2023 non-response adjustments: ACCSSMED, CHRNPAIN, COVIDTOP, FOODINS, INCASSET, MCREPLNQ, RXMED, TELEMED, and USCARE. The MCBS would expect these segments to only include beneficiaries with INT_TYPE = C or B because these segments contain data from survey-reported instruments only asked of beneficiaries that reside in the community. However, because the data for these segments is collected in 2024, beneficiaries may have moved from a facility in 2023 to the community in 2024 at the time these data segments were collected.

Alternatively, data may be pulled forward from a prior data collection year. For example, a beneficiary in 2022 that answered affirmative to the question, “Have you ever had a hysterectomy?”, a survey item that is asked of beneficiaries in the Community Questionnaire, will have that answer pulled forward to the 2023 data segment even if the beneficiary currently resides in a facility in 2023, and thus they would show an INT_TYPE = F.

IPR: Indicates the income-to-poverty ratio (IPR). The Census Bureau determines who is “poor” by comparing an individual or household’s income to a set of dollar-value thresholds that are intended to represent the amount of income needed to meet basic needs and are adjusted for family size and composition. A family will be designated as “poor” or “not poor” depending on whether their income is at or below or above this set threshold in a given year. In addition, the Census Bureau provides another way to describe a person’s economic well-being by gauging how close to or far from the poverty threshold a family’s income rests using an IPR. IPRs, income divided by the appropriate poverty threshold, are used to normalize incomes across family types and provide context for a better understanding of the depth of poverty (or lack thereof) of a family. The IPR is a useful analytic tool that can help MCBS users to easily identify the percentage of Medicare beneficiaries living in deep poverty, below poverty, or “near” poverty (usually defined as less than 125 percent of the poverty level); or how health care access and use may differ across different thresholds of interest. Note that the MCBS IPR is calculated only for household sizes of one (beneficiary living alone or in a facility) or two (beneficiary living with a spouse/partner only) as the Income and Asset information is collected only from the beneficiary and the beneficiary’s spouse/partner. Medicare beneficiaries have slightly different poverty level indices used for program eligibility. The IPR uses the Medicare poverty thresholds for calculation but can be unformatted to create other thresholds.

SF4.2.11.3 Special Notes

Compared to ER_DEMO, DEMO also contains variables on income (INCOME_H, INCSRCE, INCOME, and IPR) and select variables related to the death of the beneficiary and their spouse/partner (D_DOD, SURVIVE, and SPSDTH). Additionally, all INT_TYPES = C on ER_DEMO, while INT_TYPES = C, B, or F on DEMO. DEMO includes beneficiaries living either in a community or in a facility setting, while ER_DEMO only includes beneficiaries living in the community at the time of their Fall 2023 interview.

SF4.2.12 Diabetes (DIABETES)

There are no notable differences in this segment between the 2023 Survey File (DIABETES) and the 2023 Survey File - Early Release (ER_DIABETES). Please see Section ER4.2.7 for relevant notes on this segment.

SF4.2.13 Facility Assessments (FACASMNT)

SF4.2.13.1 Core Content

CMS designed the MDS instrument to collect information regarding the health status and functioning of nursing home residents. The MDS is administered to anyone residing in a certified nursing home, regardless of payer.

About half of MCBS beneficiaries living in a facility at the time of their interview live in certified nursing homes. For this reason, the MCBS Facility instrument has been designed to mirror parts of the MDS instrument.

SF4.2.13.2 Variable Definitions

D_HYST: Beneficiary ever had a hysterectomy. This variable is set to 1 if there was ever a “yes” response to the Facility variables EVERHYST or HYSTEREC. D_PNEU: Beneficiary ever had a pneumonia shot. This variable is set to 1 if there was ever a “yes” response to the Facility variable PNEUSHOT. Otherwise, it is set to the most recent value of Facility variable PNEUSHOT.

D_SMOKE: This variable is set to:

- 1 if there was ever a “yes” response to the facility variable EVRSMOKE, otherwise
- .D if there was ever a “don’t know” response to the facility variable EVRSMOKE, otherwise
- The most recent value of Facility variable EVRSMOKE

SF4.2.13.3 Special Notes

As described in SF2.2, the Pap smear items were renamed in the HS questionnaire in Fall 2023 to reflect the change in the universe of respondents. As such, the variable PAPSMEAR (beneficiary had a Pap smear in the last year) was renamed to PAPTEST in the 2023 FACASMNT.

Special Notes Regarding the Integration of MDS Data with FACASMNT

For beneficiaries for which the facility respondent reported a CCN, more than half of the variables in FACASMNT are skipped during data collection. The survey-reported data are later merged with MDS administrative data in data processing using the BASEID and CCN. Specifically, MDS data from the Nursing Home Comprehensive and Quarterly assessments are integrated with the FACASMNT data using the following data matching protocol:

- If there is an MDS record with an assessment date exactly matching the survey-reported assessment date, this MDS record is used.
- Otherwise, if there is an MDS assessment within 90 days of the survey-reported assessment date, the identified MDS record is used.
- If there is no survey-reported assessment date and there is an MDS assessment within 90 days of the survey reference date, this MDS record is used.
- If no MDS assessments meet these criteria, the survey record is unable to be matched to the administrative data, and the skipped variables are not populated during data processing and thus remain missing on FACASMNT.

FACASMNT data match outcomes for 2023 are detailed in Exhibit SF4.2.13.3a.

Exhibit SF4.2.13.3a: FACASMNT Administrative Data Match Outcomes

Match Type	Record Count
MDS record identified via an exact date match between the survey-reported assessment date and MDS assessment date	408
MDS record identified via a non-exact date match between the survey-reported assessment date and MDS assessment date	46
MDS record identified via the survey reference date	16
No match found	23

A flag variable, D_SOURCE, indicates whether the FACASMNT record has been populated for qualifying variables using the MDS.

Since the MCBS Facility Instrument has been designed to mirror the MDS, the MDS data used is mostly comparable to the survey-reported data, but there are minor differences in the handling of item non-response and missing data. As the MDS data is administrative, values of .R (refuse to answer) and .D (don't know the answer) are not possible for these records. The MDS administrative data uses a dash, "-", to signify a missing value, while the survey-reported data use a period, ".". Values of "-" have been converted to "." in the FACASMNT segment to maintain the same convention as survey-reported data, but "-" values remain intact in the MDS3 segment.

The FACASMNT variables that may be populated during data processing using MDS data are indicated in the table below.

Exhibit SF4.2.13.3b: FACASMNT Variables Populated with Administrative Data

Variable Names			
AFIBDYS	CSNAMFAC	MENTDOWN	PHQSYCON
ALZHMR	CTBLADDC	MENTEPIL	PHQSYDEP
ANEMIA	CTBOWELC	MENTOTHN	PHQSYINT
ANXIETY	CVATIAST	MENTOTHO	PHQSYMOM
APHASIA	DEHYD	MENTSUM	PHQSYSES
ARTHRIT	DELUS	MOLCANE	PHQSYSLP
ASTHCOPD	DEMENT	MOLPROS	PHQSYSUI
BPH	DEPRESS	MOLWCHR	PHQSYTEM
BRAININJ	DIABMRN	MOLWLKR	PHQSYTIR
BSAYSOT	DVTPEPTE	NUROBLAD	PSYCOTIC
BSEFACT	GERDULC	OBURPATH	PTSD
BSELFCA	HALLUC	ORTHHYPO	PVDPAD
BSELFILL	HARTFAIL	OSTEOP	QUADPLEG
BSNOEVAL	HCHEAID	OTHFRAC	RENLESRD
BSNOTOT	HCHECOND	PARAPLEG	RESPFAIL
BSOFTWAN	HCUNCOND	PARKNSON	SCHIZOPH
BSOTHACT	HCUNDOTH	PFBATHNG	SCLEROS
BSOTHENV	HEIGHT	PFDRSSNG	SEIZEPIL
BSOTHILL	HEMIPLA	PFEATING	SOCACITY
BSVERBOT	HIPFRAC	PFLOCOMO	SOCHEW
BSWDANGR	HUNTDIS	PFTOILET	SOCOUGH
BSWOTACT	HYPERKAL	PFTRNSFR	SODENT
CANCER	HYPETENS	PHQINTRO	SOGUMS
CATGLAUC	HYPONMIA	PHQSCORE	SOHOLD
CERPALS	HYPRLIPI	PHQSFQAP	SOLOSS
CIRROSIS	INFHPPTS	PHQSFQCO	SOPAIN
COLCROHN	INFMDRO	PHQSFQDE	SOTEETH
COMATOSE	INFNEU	PHQSFQIN	SOTISSUE

Variable Names

CORARTDS	INFSEPT	PHQSFQMO	THYROID
CSCURSEA	INFTBRC	PHQSFQSE	TOURETTE
CSDECIS	INFURNRY	PHQSFQSL	VISAPPL
CSINNH	INFWND	PHQSFQSU	VISION
CSLOCROM	MALNUTRI	PHQSFQTE	WEIGHT
CSMEMLT	MANICDEP	PHQSFQTI	
CSMEMST	MENTAUTI	PHQSYAPT	

As of October 1, 2023, the Minimum Data Set (MDS) 3.0 transitioned from version 1.17.2 to version 1.18.11. This update may significantly impact the specifications of certain quality measures. Users should be aware of the following implications for the FACASMNT segment:

- There may be increased instances of missing values for variables that were discontinued in the new version.
- Potential data gaps could occur during the transition period as systems and processes adjust to the new specifications.
- New variables will be integrated into the dataset at a later stage.

Additionally, the CCW reports an increase in the number of records that cannot be assigned a CCW BENE_ID due to a source system change. Between 20- percent and 30 percent of MDS assessment records are missing a CCW BENE_ID beginning in spring 2023. These records are not included in the standard MDS SAS datasets in the VRDC.

What is the difference between the MDS3 and FACASMNT segments?

FACASMNT rows populated with MDS data can be linked to the corresponding MDS3 rows using the unique key BASEID, TRGT_DT, and A2300.

See the exhibit below for key differences between the segment sources, population, reference period, and unit of observation.

Exhibit SF4.2.13.3c: Differences between FACASMNT and MDS3 Data

Data Type	Facility Assessment (FACASMNT)	Minimum Data Set (MDS3)
Source	Blended administrative (MDS) and survey-reported (facility staff may pull information from electronic health records or systems to answer the survey questions)	Administrative (MDS)
Population	Represents all Facility residents, not just residents in nursing homes	Represents all residents of nursing homes certified to participate in Medicare or Medicaid only
Reference period	Throughout the year	Could be multiple assessments during the year, time periods may differ based on individual experiences
Unit of observation	One per beneficiary	One per beneficiary per assessment

What is the difference between FACASMNT and similar Community segments?

Many of the variables on the FACASMNT segment are similar to variables available on the Survey File segments containing data from the Community interview. The exhibit below summarizes the topics that are available on FACASMNT that have similar content on a Community segment. However, in order to combine Community and Facility data together for analysis, some variables may need to be recoded to account for differences in response categories between Community and Facility variables. See the Advanced Tutorial on Using Community and Facility Data for more information about combining Community and Facility data.

For information on using flu shot data in analyses, please see PREVCARE.

Exhibit SF4.2.13.3d: LDS Segments with Similar Topics for Community and Facility Interviews

Topic	Segments with Community Data	Segments with Facility Data	Segments with Data for All Beneficiaries
Health Status	GENHLTH FALLS CHRNCOND MENTHLTH OASIS	FACASMNT MDS3	
Preventive Care	PREVCARE	FACASMNT	
Functional Status & Assistance with Long-Term Care Needs	ASSIST NAGIDIS OASIS MOBILITY	FACASMNT MDS3	
Demographics and Socio-Economic Status	INCASSET		DEMO
Health Insurance Coverage			HISUMRY HITLINE ADMNUTLS

SF4.2.14 Facility Characteristics (FACCHAR)

SF4.2.14.1 Core Content

The Facility Characteristics segment is constructed using data from the Facility Questionnaire, which provides information about survey-collected facility stays, and the administrative Provider of Service (POS) file, which provides facility characteristics pertaining to SNF stays.

For a beneficiary in the current year's population file, any facility stay within a round from the current file year, as well as from the following winter round, provided that it has an admission date that falls within the current file year, is included in the file. The inclusion of these winter round records is meant to capture any stays which began after the conclusion of the fall round for a given file year. Selected data from the POS file is also included for any SNF stay occurring during the file year for beneficiaries on the finder file.

SF4.2.14.2 Variable Definitions

Please see the Codebook for information regarding variables in this segment.

SF4.2.14.3 Special Notes

Special Notes regarding the Integration of CASPER Data with FACCHAR

For beneficiaries for which the facility respondent reported a CCN, 12 variables in FACCHAR are skipped during data collection. The survey-reported data are later merged with CASPER administrative data during data processing using the CCN. The values in the CCN questionnaire lookup tool are derived from CASPER, ensuring that matching administrative data will be available during data processing.

For some variables, data from CASPER are not directly comparable to the survey-reported items. FMRBEDS, PCHBED, and HDLICBED cannot be substituted using CASPER during data processing and thus remain missing on FACCHAR.

Services provided by the facility are derived from multiple CASPER variables.

- BATHHELP: If more than one resident needs help from staff for bathing or more than one resident completely depends on staff for bathing, then the facility is classified as providing help with bathing.
- DRESHHELP: If more than one resident needs help from staff for dressing or more than one resident completely depends on staff for dressing, then the facility is classified as providing help with dressing.
- EATHELP: If more than one resident needs help from staff for eating or more than one resident completely depends on staff for eating, then the facility is classified as providing help with eating.
- NORMCARE: The facility is classified as providing nursing or medical care if more than one resident receives any of the following types of care: a catheter, radiation therapy, chemotherapy, dialysis, intravenous therapy, respiratory treatment, tracheostomy care, ostomy care, suctioning, injections, or tube feedings.
- SUPRMEDI: The facility is classified providing supervision over medications if more than one resident receives any of the following types of medications: psychoactive, antipsychotic, antianxiety, antidepressant, hypnotic, antibiotics, or pain management.

SF4.2.15 Falls (FALLS)

There are no notable differences in this segment between the 2023 Survey File (FALLS) and the 2023 Survey File - Early Release (ER_FALLS). Please see Section ER4.2.8 for relevant notes on this segment.

SF4.2.16 Food Insecurity (FOODINS)

SF4.2.16.1 Core Content

The Food Insecurity segment contains information regarding the beneficiary's access to sufficient food. These questions are part of the IAQ and are based upon the USDA ERS Six-Item Short Form of the Food Security Survey Module found at <https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/survey-tools> as well as one item from the American Community Survey on SNAP participation.

SF4.2.16.2 Variable Definitions

Please see the Codebook for information regarding variables in this segment.

SF4.2.16.3 Special Notes

This questionnaire is administered the summer following the year of interest. The food insecurity section for the reference year 2023 was asked in the summer of 2024. Special non-response adjustment weights are included in the file to account for survey non-response from the fall to the summer data collection period. Note

that counts of cases with positive Topical weights may vary within the data year and may change across years due to response rates, sample sizes, and fielding methods. The Topical weights account for these changes. Please see Section SF3.4.1 for information on using Topical weights.

In 2023, a new variable, SNAPBNFT (received benefits from the Food Stamp Program or SNAP [Supplemental Nutrition Assistance Program] in the last 12 months) was added to the FOODINS segment.

SF4.2.17 General Health (GENHLTH)

There are no notable differences in this segment between the 2023 Survey File (GENHLTH) and the 2023 Survey File - Early Release (ER_GENHLTH). Please see Section ER4.2.9 for relevant notes on this segment.

SF4.2.18 Health Insurance Summary (HISUMRY)

SF4.2.18.1 Core Content

The Health Insurance Summary segment released on the Survey File contains information on administrative plans and their characteristics. Specifically, it includes flags for monthly enrollment and dual eligibility status and information on premiums, co-pays, deductibles, and capitated payments. The file also includes EST_TPRM, which is the sum of premiums for Parts A, B, C, and D and premiums for other plans (private coverage purchased directly from an insurance company, etc.). This section documents notable differences in this segment between the 2023 Survey File (HISUMRY) and the 2023 Survey File - Early Release (ER_HISUMRY), including variables that are only released on HISUMRY. Please see Section ER4.2.10 for other relevant notes on this segment. In addition, HISUMRY includes data for beneficiaries living either in a community or in a facility setting, while ER_HISUMRY only includes data for beneficiaries living in the community.

SF4.2.18.2 Variable Definitions

H_DOT: Medicare entitlement end date from the Medicare Administrative data. If the date is beyond the calendar year, it is shown as missing.

H_EGWP01-H_EGWP12: Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP) Indicator: If the plan is an EGWP, then the value is 1, else the value is 2. An EGWP is not open to general enrollment but is offered through an employer group.

H_ESREND: Ending date of ESRD period. If the date is beyond the calendar year, then it is shown as missing.

H_GHPSW: Some MCBS beneficiaries belong to Medicare managed care plans. CMS derives variables that describe this Medicare managed care membership (H_GHPSW and H_MAFF01-MAFF12). The variable (H_GHPSW) should be used only when there is an indication that the enrollee was a member of a Medicare managed care plan at some time during 2023, and this information is needed for analysis. The monthly variables (H_MAFF01-H_MAFF12) can be used for analyzing membership at specific points in time. The variables will indicate either "FF" (Original Medicare/Fee for Service), "MA" (Medicare Advantage/Other Medicare Capitated Payment Plans), or "NO" (No Entitlement). The H_GHPSW variable is derived from the Health Maintenance Organization (HMO) Coverage Months variable in the administrative data. This variable indicates participation in a group health organization, also known as HMO, managed care participation, or Medicare Advantage/Medicare Part C.

H_MAFF01-12: The MA flag variables are the most reliable indicators for monthly MA information. This information is sourced from the CMS administrative data. The H_ENT variables were used to determine if the individual did not have Medicare entitlement. This information factored into the "No Entitlement" category in the MA flag monthly variables. The monthly entitlement variables can be found on the HITLINE segment.

H_DOE and H_DOT on the HISUMRY file provide Medicare entitlement start and end dates for the beneficiary. Because the administrative source of this information has changed, H_ENT variables cannot be used to crosswalk to the MA flag variables. However, H_ENT can be used to determine Part A and Part B eligibility among FFS beneficiaries in files prior to 2015.

H_MAPMT: Total MA A/B Payment – annual amount from Medicare Advantage Prescription Drug (MARx) data.

H_MCSW: State buy-in is tracked by CMS and used as a general proxy for Medicaid participation. CMS derived H_MCSW using its administrative enrollment data.

H_DDED01-12: The monthly values reflect the annual Part D deductible amount charged by the plan that the beneficiary was enrolled in that month.

H_PDPY01-12: The monthly values reflect the monthly Part D capitation payment and are sourced from the Medicare Advantage/Prescription Drug System. The capitation payments provided to MA and Medicare Advantage Prescription Drug (MAPD) sponsors are calculated and paid monthly.

H_PLPY01-12: The monthly values reflect the Medicare capitation payment for MA Parts A/B and are sourced from the Medicare Advantage/Prescription Drug System. The capitation payments provided to MA and MAPD sponsors are calculated and paid monthly.

H_PRPY01-04: Primary Payer codes are summarized from the FFS claims. These codes indicate that some other payer besides Medicare covered at least some portion of the charges. Additional detail can be found under NCH_PRMRY_PYR_CD, <https://www2.ccwdata.org/documents/10280/19022436/codebook-ffs-claims.pdf>

H_PTAPRM: Total Part A Premium paid in calendar year (CY) – This is for beneficiaries who purchased Part A by paying a monthly premium. Note that this variable will have a relatively small number of beneficiaries.

H_PTBPRM: Total Part B Premium paid in CY – This includes all Part B beneficiaries (a large number; a premium is always paid by either the beneficiary or a third party). NOTE: The MCBS shows no Part B premium paid if the beneficiary belongs to a managed care plan in which the plan pays the entirety of the premium. In this scenario, the plan paid the entirety of the beneficiary's premium, so the process shows no premium paid.

H_PTDAMT: PTD Total Payment – annual amount from the MARx data.

EST_TPRM: This variable is the sum of all premiums reported prorated by the number of months of coverage for each plan. The variable name emphasizes that the total is an estimate since complete information on the amount that a beneficiary paid may not be available for all plans. For Part A, B, C, and D plans, the premium reflects the total paid, either by the beneficiary or a third party on their behalf. Starting with 2022, premium information for private plans was imputed for beneficiaries who did not provide a response. Starting with 2023, information on premium probes was also imputed for beneficiaries who did not provide an answer. This may affect the total value of EST_TPRM for some records. The Part C portion is based on premiums reported to CMS, and it is important to note that this information may not be available, as in the case of plans obtained through a beneficiary's employer. Additionally for Part C, the EST_TPRM is based on the administrative premiums only (administrative and survey-reported data are not reconciled). Due to the availability of premium data, it is important to note that EST_TPRM is an estimate.

Payment Model Participation Flags

There are three variables that indicate the payment model for each plan.

- H_PRGID: CMS Prog ID – Payment Model

- H_PRGID2: 2nd CMS Prog ID – Payment Model
- H_PRGID3: 3rd CMS Prog ID – Payment Model

H_PRGID2 and H_PRGID3 are only populated if the beneficiary has multiple program IDs. Variables are designated as single, 2nd, or 3rd based on the start/end dates of the entries in the source data (earliest start date, next=2, etc.). Start dates are prior to 12/31/YR and end dates may be after 1/1/YR where “YR” = data year.

SF4.2.18.3 Special Notes

N/A

SF4.2.19 Health Insurance Timeline (HITLINE)

SF4.2.19.1 Core Content

The Health Insurance Timeline segment contains one record for each plan a beneficiary has and includes information on type of insurance coverage, monthly eligibility/enrollment, coverage start and end dates, and the source information for the coverage. For all plans that a beneficiary has, both administrative and survey reported are included on the file. However, starting with 2021, survey reports of Medicare Advantage (MA) enrollment with no corresponding record of MA enrollment in administrative data have been excluded. In addition, HITLINE contains detailed information on plans for which no administrative data are available. These plans are reported in the survey only and include different types of private plans, Tricare, coverage for certain medical events through the Department of Veteran’s Affairs for beneficiaries living in a facility, and public plans that do not fall under either Medicare or Medicaid. For these survey-only plans, the file includes flags indicating types of services covered, and, for private plans, information on plan policyholder and premiums paid. All plans reported in a Community setting also have a unique plan identifier, PLANNUM. This identifier can generally be used to link plans across multiple years, though exceptions may occur if steps are taken to correct data issues.

Prior to the HIQ redesign, information on coverage details was only available for private plans. Starting with 2023, HITLINE also contains coverage details for public plans that do not fall under either Medicare or Medicaid and Tricare. Information on services covered by each plan has also been standardized across plan types and expanded to include additional services such as behavioral health and hearing care. Coverage information for survey-reported MA plans is available in the MAPLANQX segment.

Some plans ended before the Fall interview when additional information on covered services was collected. For this reason, these plans may have certain variables populated with a .N.

The questionnaire does not ask whether a given plan offers ‘comprehensive’ coverage. Data users can construct their own definition of comprehensive coverage and consult individual coverage flags for different services to determine if a plan meets their criteria for being a comprehensive plan.

SF4.2.19.2 Variable Definitions

SRCCOV01-12: Indicates the source of coverage information for the plan for a given month in the calendar year: CMS Administrative Data, Survey Data, or Both Administrative and Survey Data.

COV01-12: Indicates if the beneficiary was covered by this plan for a given month in the calendar year.

S_DVH: Indicates whether plan was a dental, a vision, or a hearing plan.

S_OTHPLN: Indicates whether plan is a specialty plan that only covers specific services (such as long-term care, coverage for cancer/dread disease, etc.).

S_HMOPPO: Indicates whether beneficiary's private plan is an HMO/PPO. Obtained from the HIQ variable PPRVHMO.

S_PHREL: The relationship of the policyholder to the beneficiary. Responses from the HIQ variable PERS_MIPNUM are combined with beneficiary's household roster information to determine the policyholder's relationship to the beneficiary.

S_OBTNP: Indicates how the main insured person obtained their private policy (e.g., self-purchased, current or former employer, etc.). Obtained from the HIQ variable PPRVGET. Starting with 2023, the first reported value of PPRVGET is used to determine the value of S_OBTNP.

S_COVNM: The number of people covered by each private plan. Obtained from the HIQ variable PRVNMCOV.

Information on COVDOC – COVOTH was obtained from PRIVSERV, PUBCOV, or TRICOV, depending on the coverage type.

COVDOC: Indicates if beneficiary's plan covers visits to a doctor.

COVLAB: Indicates if beneficiary's plan covers lab work.

S_MSCOV: Indicates if beneficiary's plan covers visits to a doctor or other professional or lab work. Obtained from the pre-HIQ redesign variable PRVMSCOV. Prior to the HIQ redesign, information on whether each plan covered visits to a doctor or lab work was collected via a single item. This information, when available for a plan, was pulled forward to provide more complete information on the coverage provided by each plan (since some plans ended before new plan details, including plan coverage of doctor's visits and lab work, were collected). This variable is provided for 2023 only and will be removed starting with 2024 HITLINE.

COVPMED: Indicates whether beneficiary's plan covers prescription medications.

COVINP: Indicates whether beneficiary's plan covers inpatient hospital stays.

COVNURS: Indicates whether beneficiary's plan covers nursing home or long-term care.

COVDENT: Indicates whether beneficiary's plan provides dental coverage.

COVVIS: Indicates whether beneficiary's plan provides vision coverage.

COVHEAR: Indicates whether beneficiary's plan provides hearing coverage.

COVBEH: Indicates whether beneficiary's plan covers behavioral health services.

COVOTH: Indicates whether beneficiary's plan covers other services.

S_TRIRX: Specifies where Tricare members obtain prescription drugs. This is obtained from the HIQ variable TRIMEDS.

D_PAYSP: Indicates whether the main insured person (MIP) pays any part of the insurance premium. This variable was renamed from S_PAYSP to D_PAYSP in the 2023 HITLINE to reflect that probe information is now being imputed where the respondent did not provide a response. This is obtained from the HIQ variable MIPPINS.

D_PAYSP_I: Imputation flag for D_PAYSP.

D_PREMMON: Monthly cost of private health insurance plan premiums. A premium amount was recorded even if the respondent did not directly pay the premium (for example, if a son or daughter paid the premium). This variable was derived from the HIQ variable MIPPAMT. For family plans, the reported amount reflects the total premium paid for the plan. Reported premiums were converted to monthly values. The redesigned HIQ collects premium range information for cases where a beneficiary reported paying a premium but did not provide an exact amount. This information was utilized, where available, to impute a more accurate premium value. For beneficiaries who did not provide complete premium information or were imputed to pay a premium, premium information was imputed.

D_PREMN_I: Imputation flag for D_PREMMON.

S_PAYOTH: Indicates whether anyone else, such as an employer or a union, helped to pay any portion of the premium. Obtained from the HIQ variable MHMOCOST.

S_PAYWHO: Indicates who paid a portion of the total cost of the premium. Obtained from the HIQ variable MHMOWHO.

D_FCLTYF: Indicates whether a plan was reported in a Facility setting. Facility interviews are not conducted with the beneficiary but rather with facility staff who may have little information on coverage type and plan details. D_FCLTYF indicates which plans were reported in a Facility setting and thus have limited detailed information about them available. Beneficiaries who transition between community and facility settings may have a plan reported in each setting. However, due to the nature of the Facility interview, it is not possible to ascertain whether these would reference the same plan.

SF4.2.19.3 Special Notes

The HITLINE segment has one record for every plan reported for a beneficiary. Individuals covered for the entire year by a plan will have a BEGDATE of 010120XX and an ENDDATE of 123120XX to indicate a full year's coverage. BEGDATE is set for all plans using the month when a plan was first reported. For example, if someone had coverage January – March and June – November, BEGDATE will reflect that coverage started in January. Most plans have an ENDDATE as well. The only plans with missing ENDDATE are plans where coverage ended and then started again. For plans where survey and administrative data are combined, BEGDATE and ENDDATE are set using all available coverage information. Data users can reference SRCCOV01-SRCCOV12 flags to identify whether coverage information for a given month came from administrative records, a survey report, or both.

Eligibility for Tricare can be lost. Due to this fact, data users should pay attention to the appropriate coverage indicators (i.e., PLANTYPE, COV01-COV12).

SF4.2.20 Household Characteristics (HHCHAR)

There are no notable differences in this segment between the 2023 Survey File (HHCHAR) and the 2023 Survey File - Early Release (ER_HHCHAR). Please see Section ER4.2.11 for relevant notes on this segment.

SF4.2.21 Immunization (IMQ)

SF4.2.21.1 Core Content

The Immunization segment provides data on the beneficiary's flu, pneumonia, and shingles vaccinations.

SF4.2.21.2 Variable Definitions

Please see the codebook for information regarding variables in this segment.

SF4.2.21.3 Special Notes

The IMQ segment contains 29 variables previously released on the PREVCARE segment in the 2022 Survey File and earlier: FLUAGNST, FLUBEFOR, FLUCAUSE, FLUCOST, FLUCOVID, FLUDOCNO, FLUHIRSK, FLUHLTH, FLULOCAT, FLUMAIN, FLUMISS, FLUNEED, FLUNFIND, FLUOTHER, FLUPRVNT, FLUREACT, FLUSERI, FLUSHOT, FLUSICK, FLUSIDE, FLUSITE, FLUTIME, FLUTRUST, FLUVACC, FLUVALUE, PNEUSHOT, SHINGVAC, VACAVAIL, and VACPAID.

Please note, the Immunization Questionnaire (IMQ) was fielded to Community respondents beginning in Winter 2025 to collect data on immunization-related items that were previously collected by PVQ. While the LDS segment and questionnaire section use the same acronym (IMQ), they do not align one-for-one (e.g., the IMQ segment contains data from other Community questionnaire sections).

The “other specify” questions FLUOTHOS, and FLUSITOS are back coded as necessary into the reason(s) for not getting a flu shot or where they got their flu shot, respectively, but the verbatim text is not released.

How do I find out what proportion of Medicare beneficiaries received a flu shot in a given calendar year? Flu shot data are available for both Community and Facility components, but data collection and processing methods are different, and the variables are located on different segments in the Survey File LDS. To estimate prevalence of flu shots in a given flu season, data users need the prior data year (e.g., 2022) Survey File for beneficiaries living in the community and the current data year (e.g., 2023) Survey File for beneficiaries living in a facility. Note that the response categories of the FLUSHOT variables are similar across the two components (Yes/No), but the coding values associated with the Yes/No categories in the LDS files are different. For community, Yes = 1 and No = 2, but for facility Yes = 1 and No = 0. In addition, the reference periods differ between the Community and Facility components. Therefore, users need both the prior and current data year Survey File LDS's to estimate the flu shot prevalence for all Medicare beneficiaries for a given flu season.

Exhibit SF4.2.21.3a: Segment, Questionnaire, and Variable Information for Analyses of 2023-2024 Flu Shot Data

Component	Variable Location	Variable Label	Data Collection Timing
Community	FLUSHOT ON IMQ	FLU SHOT FOR LAST WINTER	PVQ in Winter and Summer 2024 and included in 2023 Survey File
Facility	FLUSHOT on FACASMNT	SP HAD A FLU SHOT IN THE PAST YEAR?	HS in Fall 2023 and included in 2023 Survey File

SF4.2.22 Income and Assets (INCASSET)

SF4.2.22.1 Core Content

This segment contains data on a beneficiary's reported income and assets.

SF4.2.22.2 Variable Definitions

Please see the Codebook for information regarding variables in this segment.

SF4.2.22.3 Special Notes

In the IAQ, for a few income questions the reference period is the previous calendar year. That is, these income questions are asked in the summer of 2024 about income earned in 2023.

Example: "Now I want to ask about your [and spouse's or partner's] total income for last year, that is, for the calendar year ending in December [CURRENT YEAR - 1], before any federal or state taxes were taken out."

Other items ask about income earned in the current calendar year.

Example: "You told me earlier that you have job-related pension plans. In all, how much was received from these pension plans in the last month, before any federal or state taxes were taken out (for the month of [CURRENT MONTH - 1])?"

For assets, there are three different timeframes referenced in the IAQ:

1. How much of an asset was received or withdrawn in the last month.
 - a. Example: "Is your mortgage paid off or are monthly mortgage payments still being made?"
2. How much is currently in certain accounts.
 - a. Example: "This next question is a bit different. You mentioned that you have retirement accounts. In total, about how much is currently in all of these retirement accounts?"
3. How much altogether was received or withdrawn in the last year.
 - a. Example: "Now thinking about all of last year, that is calendar year [CURRENT YEAR - 1], how much altogether did you receive or withdraw from all of these retirement accounts?"

The difference in reference periods between income and assets items is due to the nature of the information collected (i.e., respondent recall is facilitated when asking about a bank account balance from the last month versus four months ago), and many assets are relatively stable in value (e.g., housing).

Special non-response adjustment weights are included in the file to account for survey non-response from the fall to the summer data collection period. Note that counts of cases with positive Topical weights may vary within the data year and may change across years due to response rates, sample sizes, and fielding methods. The Topical weights account for these changes. Please see Section SF3.4.1 for information on using Topical weights.

The MCBS imputes income when income data are missing. Data are first imputed whether or not an income source (such as Social Security) exists. If the income source exists, then the amount earned is imputed next. Imputation is performed using the hot deck imputation method, and a flag is created for each imputed variable indicating whether or not the corresponding value is imputed.

The "other specify" questions LUMPSUMO and OPYSCHED are back coded as necessary into the "form of lump payment" and "other payment schedule" response options, respectively, but the verbatim text is not released.

SF4.2.23 Interview Characteristics (INTERV)

SF4.2.23.1 Core Content

The Interview Characteristics segment summarizes interview characteristics, such as the type of interview and whether a proxy is used.

SF4.2.23.2 Variable Definitions

Please see the Codebook for information regarding variables in this segment.

SF4.2.23.3 Special Notes

Some beneficiaries have more than one interview in a round if they have moved from a community to facility setting within the reference period, or vice versa. To avoid duplication of data, the information in this file represents the last interview conducted with the respondent in each given round. INTERVU indicates which type of interview (Community or Facility) was conducted.

TOTLINTV indicates the total number of interviews conducted with the beneficiary in the year.

SF4.2.24 Medicare Advantage Plan Questions (MAPLANQX)

SF4.2.24.1 Core Content

The MA Plan Questions segment contains survey-reported information on types of coverage included and premiums paid for beneficiaries enrolled in Medicare Part C. Although the segment includes all beneficiaries enrolled in an MA plan (based on administrative enrollment data), only respondents who reported having an MA in the survey will have coverage details populated with non-missing values. All other respondents will have the values set to the missing value of .N.

HIQ redesign modified the questionnaire to collect end dates for MA plans, which eliminated the ambiguity over whether a particular plan was active during the reference period. HIQ redesign also expanded information collected on services covered by each plan. These changes and other improvements made by the HIQ redesign may affect distributions of some variables in 2023 MAPLANQX.

SF4.2.24.2 Variable Definitions

D_MADV: This variable is derived from administrative data and set to 1 if the beneficiary was covered by an MA plan for at least one month out of the calendar year. All beneficiaries included in the MA Plan Questions segment have D_MADV set to 1.

YDISNROL: Reason beneficiary disenrolled from MA or switched their MA plan.

MADVXR, MADVDOC, MADVLAB, MADVINPT, MADVNH, MADVDENT, MADVEYE, MADVHEAR, MADVBEH, and MADVOTH were derived from the HIQ item MHMOCVR and indicate services covered by the beneficiary's MA plan.

MADVPAY and MAMONPRM: Indicate whether there was an additional cost associated with the MA plan (not including the cost of the Medicare Part B premium) and monthly amount paid. These variables are derived from HIQ items MHMOPAY and MHMOAMT. Starting with 2022, information on premium amount is imputed for beneficiaries who do not provide an amount. Starting with 2023, MADVPAY is also imputed for beneficiaries who do not provide a response. Moreover, information about premium range is used for beneficiaries who do not provide exact premium information. MADVPAY_I and MAMONPRM_I are imputation flags associated with MADVPAY and MAMONPRM and allow data users to identify whether premium information was imputed and the imputation method used.

MA payment variables (MADVOCOST and MADVWHO): Indicate whether someone helped pay the additional cost associated with the MA plan. These variables are derived from the HIQ items MHMOPAY, MHMOCOST, and MHMOWHO.

MADVRS: The number of years the beneficiary has been enrolled in MA. This variable is derived from the HIQ item HMONUMYR.

RECMADV: Indicates whether the respondent recommends the MA plan to family/friends. This variable is derived from the HIQ item RECMHMO.

SF4.2.24.3 Special Notes

If the respondent reports a payer or a unit of payment that is not included in the predefined code list, the interviewer documents their response verbatim in an “other specify” variable that is not released. The “other specify” response is back coded as necessary into the predefined code list.

SF4.2.25 Medicare Plan Beneficiary Knowledge (MCREPLNQ)

SF4.2.25.1 Core Content

The Medicare Plan Beneficiary Knowledge segment contains information from the KNQ section related to the beneficiary’s knowledge about the Medicare open enrollment period and Medicare-covered expenses. The KNQ is administered the winter following the year of interest.

The data collected in this segment support evaluation of the impact of existing education initiatives by CMS. The KNQ section helps refine future CMS education initiatives by asking about information that beneficiaries may need, preferred sources for this information, and beneficiaries’ access to insurance information. This data also presents the knowledge beneficiaries have gained from CMS publications.

SF4.2.25.2 Variable Definitions

KVSTSITE: This variable collects whether the respondent has ever visited the official website for Medicare information. If the respondent has previously answered “yes” to this question, the “yes” response is pulled forward to the current data year.

KCPHINFO: This variable collects whether the respondent has ever called 1-800-MEDICARE. If the respondent has previously answered “yes” to this question, the “yes” response is pulled forward to the current data year.

SF4.2.25.3 Special Notes

Special non-response adjustment weights are included in the file to account for survey non-response from the fall to the winter data collection period. Note that counts of cases with positive Topical weights may vary within the data year and may change across years due to response rates, sample sizes, and fielding methods. The Topical weights account for these changes. Please see Section SF3.4.1 for information on using Topical weights.

SF4.2.26 Minimum Data Set (MDS3)

SF4.2.26.1 Core Content

The Minimum Data Set is health assessment information collected while the beneficiary was in an approved Medicare Facility. For more information regarding the MDS and the changes in version 3.0, please consult <https://www.cms.gov/medicare/quality/nursing-home-improvement>.

SF4.2.26.2 Variable Definitions

Please see the Codebook for information regarding variables in this segment.

SF4.2.26.3 Special Notes

MDS3 administrative data records are included for any beneficiary having such a record in the year of interest. There are beneficiaries living in the community (DEMO segment INT_TYPE = C) that appear in the MDS segment. CMS includes MDS data for all MCBS beneficiaries regardless of the INT_TYPE, which is determined by the type of survey instrument completed.

The transition to MDS 3.0 version 1.18.11, effective October 1, 2023, introduces several changes that may affect data continuity and analysis:

- Users may observe missing data for variables that were removed or restructured in the new version.
- The introduction of new variables will occur in phases, and these may not be immediately available in all datasets.
- Analysts should exercise caution when comparing data across the transition period, as variable definitions and availability may differ.

Furthermore, due to a source system change, a portion of records from spring 2023 onward are missing CCW BENE_IDs, making them unavailable in standard VRDC datasets.

For information on the difference between the MDS and FACASMNT data and how the two segments can be linked, please see the FACASMNT section above.

SF4.2.27 Mental Health (MENTHLTH)

There are no notable differences in this segment between the 2023 Survey File (MENTHLTH) and the 2023 Survey File - Early Release (ER_MENTHLTH). Please see Section ER4.2.12 for relevant notes on this segment.

SF4.2.28 Mobility (MOBILITY)

There are no notable differences in this segment between the 2023 Survey File (MOBILITY) and the 2023 Survey File - Early Release (ER_MOBILITY). Please see Section ER4.2.13 for relevant notes on this segment.

SF4.2.29 Multiple Year Enrollment (MYENROLL)

SF4.2.29.1 Core Content

The Multiple Year Enrollment segment combines five years of enrollment information for the current year MCBS beneficiary population. This allows users to view multiple years of enrollment information in one file.

SF4.2.29.2 Variable Definitions

ENROLYR: Indicates the enrollment data year.

H_MAFF01-12: These MA flag variables are the most reliable indicators for monthly MA information. This information is sourced from CMS administrative data.

PTA_MONS: Indicates the number of months the beneficiary had Medicare Part A Hospital Insurance (HI) coverage.

PTB_MONS: Indicates the number of months the beneficiary had Medicare Part B Supplemental Medical Insurance (SMI) coverage.

H_PTD01-12: These Part D plan flags indicate whether there was Medicare Part D coverage for the month.

H_DUAL01-12: These variables indicate the dual eligibility code by month.

H_PDLS01-12: These variables indicate the Low Income Subsidy (LIS) Indicator by month.

SF4.2.29.3 Special Notes

N/A

SF4.2.30 Nagi Disability (NAGIDIS)

There are no notable differences in this segment between the 2023 Survey File (NAGIDIS) and the 2023 Survey File - Early Release (ER_NAGIDIS). Please see Section ER4.2.14 for relevant notes on this segment.

SF4.2.31 Nicotine and Alcohol (NICOALCO)

There are no notable differences in this segment between the 2023 Survey File (NICOALCO) and the 2023 Survey File - Early Release (ER_NICOALCO). Please see Section ER4.2.15 for relevant notes on this segment.

SF4.2.32 Outcome and Assessment Information (OASIS)

SF4.2.32.1 Core Content

The Outcome and Assessment Information segment contains assessment information conducted while the beneficiary was receiving home health services.

For more information regarding OASIS, please consult <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits>.

SF4.2.32.2 Variable Definitions

Starting with the 2023 data year, the OASIS segment is released with all variables except those containing PII. Each release includes a record layout (or data dictionary) sourced from ResDAC. Please note that some variable names have changed. For more information about the variables in this segment, please refer to the record layout.

SF4.2.32.3 Special Notes

Given the changes between the 2022 and 2023 OASIS segments, a variable crosswalk is also made available to users that compares the variable names.

All home health records are included for MCBS respondents for the year of interest.

SF4.2.33 Patient Activation (PNTACT)

There are no notable differences in the variables included on this segment between the 2023 Survey File (PNTACT) and the 2023 Survey File - Early Release (ER_PNTACT), but there are differences in the special non-response adjustment weights. ER_PNTACT includes one set of weights that represent the Survey File - Early

Release ever enrolled population, while PNTACT includes three sets of weights that represent the Survey File ever enrolled, Survey File continuously enrolled, and Cost Supplement File ever enrolled populations. Please see Section ER4.2.16 for other relevant notes on this segment and Section SF3.4.1 for information on using Topical weights.

SF4.2.34 Preventive Care (PREVCARE)

There are no notable differences in this segment between the 2023 Survey File (PREVCARE) and the 2023 Survey File - Early Release (ER_PREVCARE). Please see Section ER4.2.17 for relevant notes on this segment.

See the Immunization segment for information on the Winter and Summer round items on flu, pneumonia, and shingles vaccination formerly included in PREVCARE.

SF4.2.35 Residence Timeline (RESTMLN)

SF4.2.35.1 Core Content

The Residence Timeline segment provides a timeline of each MCBS setting type in which a beneficiary resides over the portion of the year in which they are enrolled in Medicare, as well as any periods associated with FFS inpatient, SNF, or hospice events.

SF4.2.35.2 Variable Definitions

D_BEG1: Represents the beneficiary's first date of Medicare eligibility within the file year.

D_CODE1: Either identifies a residential setting or for a small number of cases, contains the code "N". The latter only occurs for some Facility respondents who are new to the MCBS survey but were enrolled in Medicare prior to the start of the year. The first interview that these beneficiaries receive only covers back to the date of admission into the facility in which they currently reside. If they were admitted into their current facility after the 1st of the year, it will result in the setting code on their first situation (D_CODE1) having a value of "N".

SF4.2.35.3 Special Notes

Residential situations are overwritten by all claim events which overlap them, with two exceptions. Hospice events do not overwrite residential situations as this type of utilization is less indicative of a change in setting as it is a change in the level of care being received. These events should instead be considered as occurring concurrently with the beneficiary's identified residential situation. Also, a beneficiary's initial residential status is not overwritten, even when overlapped completely by a claim of any type, in order to provide context as to their original living situation at the start of their timeline.

The total number of setting changes is equal to the sum of MCBS residential status changes (D_NUMRES) and the number of the events corresponding to the above mentioned claim types (D_NUMEVT). Each transition is identified with a code representing the type of setting along with begin and end dates.

The number of variables in the series D_CODEn, D_BEGn, and D_ENDn will correspond to the maximum number of settings in a given year (calculated as D_NUMSIT + D_NUMEVT). At a minimum, each beneficiary has information pertaining to their setting at the beginning of their eligibility period within the year. Residential status situations do not have end dates populated to illustrate that these extend through any claim events which follow until a change in residential status occurs.

SF4.2.36 RX Medications (RXMED)

SF4.2.36.1 Core Content

The RX Medications segment augments information from the ACQ and SCQ sections of the questionnaire with information specific to prescription drug coverage collected in the RXQ section. The RXQ covers topics related to knowledge about and experience with Medicare Part D enrollment, options considered when choosing prescription drug coverage, access to prescription drugs, and satisfaction with current prescription drug coverage.

SF4.2.36.2 Variable Definitions

Please see the Codebook for information regarding variables in this segment.

SF4.2.36.3 Special Notes

This questionnaire is administered the summer following the year of interest. The RXQ questions for the reference year 2023 were asked in the summer of 2024. Special non-response adjustment weights are included in the file to account for survey non-response from the fall to the summer data collection period. Note that counts of cases with positive Topical weights may vary within the data year and may change across years due to response rates, sample sizes, and fielding methods. The Topical weights account for these changes. Please see Section SF3.4.1 for information on using Topical weights.

The “other specify” questions PDNOOS and PDNTOS are back coded as necessary into the reason(s) for not using the current coverage response options and the reason(s) for not being enrolled response options, respectively, but the verbatim text is not released.

HIQ section of the questionnaire drives routing for some of the items in RXQ. With the full implementation of HIQ redesign in 2023, users will notice a decrease in the number of observations with missing values.

SF4.2.37 Satisfaction with Care (SATWCARE)

There are no notable differences in this segment between the 2023 Survey File (SATWCARE) and the 2023 Survey File - Early Release (ER_SATWCARE). Please see Section ER4.2.18 for relevant notes on this segment.

SF4.2.38 Telemedicine (TELEMED)

SF4.2.38.1 Core Content

The Telemedicine segment contains data from TLQ about the availability of telemedicine visits and the beneficiary’s use of telemedicine visits.

SF4.2.38.2 Variable Definitions

Please see the Codebook for information regarding variables in this segment.

SF4.2.38.3 Special Notes

Due to the questionnaire changes described in SF2.2, the variables TELMEDDU (beneficiary’s usual provider offered a telephone or video appointment) and TELMEDT3 (provider offered telephone, video, or both) were removed from the TELEMED segment in 2023. Additionally, the variables TELMEDUS and TELMEDT4 were

renamed TELAPPT (provider offered telemedicine appointment in last 12 months) and TELAPPT1 (type of telemedicine appointment) in 2023 to reflect the change in the universe of respondents.

This questionnaire is administered the winter following the year of interest. Special non-response adjustment weights are included in the file to account for survey non-response from the fall to the winter data collection period. Note that counts of cases with positive Topical weights may vary within the data year and may change across years due to response rates, sample sizes, and fielding methods. The Topical weights account for these changes. Please see Section SF3.4.1 for information on using Topical weights.

SF4.2.39 Usual Source of Care (USCARE)

SF4.2.39.1 Core Content

The Usual Source of Care segment contains data from USQ on where and how the beneficiary typically seeks medical care.

SF4.2.39.2 Variable Definitions

Please see the Codebook for information regarding variables in this segment.

SF4.2.39.3 Special Notes

As a result of the questionnaire changes described in SF2.2, the variable INNOVATE (beneficiary's health care provider is associated with an innovative care initiative) was removed from the USCARE segment in 2023. Additionally, the OSUPTODT, OSTLKCR, and OSNOINFO items on beneficiary's experience with their provider's staff were renamed OSUPTDAT, OSTALKCR, and OSKNWINF in 2023 to reflect the change in the universe of respondents.

Several "other specify" variables are back coded as necessary into response options, but the verbatim text is not released. Back coded "other specify" variables include PVSPEC (provider specialty), LANGPREF (the language in which the beneficiary prefers to receive medical care), GETUSOS (how beneficiary normally gets to their provider), ACCOTHOS (why someone accompanies the beneficiary to their appointments), PLACEKND (the kind of place the beneficiary goes for medical care), and USWHYNAV (why the beneficiary's usual doctor is not available).

This questionnaire is administered the winter following the year of interest. Special non-response adjustment weights are included in the file to account for survey non-response from the fall to the winter data collection period. Note that counts of cases with positive Topical weights may vary within the data year and may change across years due to response rates, sample sizes, and fielding methods. The Topical weights account for these changes. Please see Section SF3.4.1 for information on using Topical weights.

SF4.2.40 Vision and Hearing (VISHEAR)

There are no notable differences in this segment between the 2023 Survey File (VISHEAR) and the 2023 Survey File - Early Release (ER_VISHEAR). Please see Section ER4.2.19 for relevant notes on this segment.

SF4.2.41 COVID-19 Facility Beneficiary-Level (FBENCVFL)

SF4.2.41.1 Core Content

The COVID-19 Facility Beneficiary-Level segment contains information collected in the CV section in Fall 2023 and Winter 2024, including COVID-19 vaccination, diagnosis, testing, and care received by different types of health care providers.

SF4.2.41.2 Variable Definitions

Please see the Codebook for information regarding variables in this segment.

SF4.2.41.3 Special Notes

This segment combines data from the Fall 2023 and Winter 2024 rounds, including recorded doses of COVID-19 vaccines. Many of the variables on the FBENCVFL segment are similar to variables available on the Survey File segments containing Community data from the COVID-19 Questionnaire.

In 2023, FPRVYRDS (COVID-19 vaccine dose in past year) was added to the FBENCVFL segment, and the variables FVACDATM, FVACDATY, FVACNME, and FVACSITE were removed.

SF4.2.42 Weights

For information about the ever enrolled and continuously enrolled cross-sectional weights and two-year, three-year, and four-year longitudinal weights available in the Survey File LDS and obtaining weighted estimates using these files, please see Section SF3.4. For discussion on how the weights files were created, please refer to the prior *MCBS Methodology Reports*, which can be found on the CMS website at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Codebooks>.

SF4.3 2023 MCBS Survey File LDS Segment Crosswalk

Exhibit SF4.3.1 crosswalks the 2023 Survey File LDS segments against their historic RIC segments counterparts (as released prior to data year 2015).

Exhibit SF4.3.1: 2023 MCBS Survey File LDS Segment Crosswalk

Survey File Segment	Segment Abbrev	Historic RIC Segment
Access to Care	ACCESSCR	3
Access to Care, Medical Appointments	ACCSSMED	3
Administrative Utilization Summary	ADMNUTLS	A
Assistance	ASSIST	2H
Chronic Conditions	CHRNCOND	2, 2P
Chronic Conditions Flags	CHRNCDL	N/A
Chronic Pain	CHRNPAIN	N/A
Cognitive Measures	COGNFUNC	N/A
COVID-19 Topical	COVIDTOP	N/A
COVID-19 Experiences	COVIDEXP	N/A
Demographics	DEMO	1, 9, A, K

Survey File Segment	Segment Abbrev	Historic RIC Segment
Diabetes	DIABETES	N/A
Facility Assessments	FACASMNT	2F
Facility Characteristics	FACCHAR	7, 7S
Falls	FALLS	2, 2P
Food Insecurity	FOODINS	N/A
General Health	GENHLTH	2
Health Insurance Summary	HISUMRY	4, A
Health Insurance Timeline	HITLINE	4, A
Household (HH) Characteristics	HHCHAR	5
Immunization	IMQ	N/A
Income and Assets	INCASSET	1, Income Asset
Interview Characteristics	INTERV	4, 8, 9, K
Medicare Advantage (MA) Plan Questions	MAPLANQX	H
Medicare Plan Beneficiary Knowledge	MCREPLNQ	KN
Minimum Data Set	MDS3	MDS, 10
Mental Health	MENTHLTH	N/A
Mobility	MOBILITY	N/A
Multiple Year Enrollment	MYENROLL	N/A
Nagi Disability	NAGIDIS	2, 2H, 2P
Nicotine and Alcohol	NICOALCO	2, 2P
Outcome and Assessment Information	OASIS	OAS, 10
Patient Activation	PNTACT	PA
Preventive Care	PREVCARE	2, 2P
RX Medications	RXMED	RX
Residence Timeline	RESTMLN	6, 9, A, K
Satisfaction with Care	SATWCARE	3
Telemedicine	TELEMED	N/A
Usual Source of Care	USCARE	2, 3
Vision and Hearing	VISHEAR	2
Weights	CENWGTS EVRWGTS LNG2WGTS LNG3WGTS LNG4WGTS	X, XE, X3, X4
COVID-19 Facility Beneficiary-Level	FBENCVFL	N/A
Fee-for-Service Claims	FFS	Research Claims

2023 Cost Supplement File LDS

CS1. COST SUPPLEMENT FILE LDS

The content of the MCBS LDS releases is governed by their central focus of serving as unique sources of information on beneficiaries' health and well-being that cannot be obtained through CMS administrative sources alone. For the 2023 data year, the Cost Supplement File LDS contains cost and utilization data that can be linked to the MCBS Survey File to conduct analyses on beneficiaries' health care costs and utilization. The 2023 Cost Supplement File also contains physical measures data collected from a subset of beneficiaries living in the community. In general, the Cost Supplement File is released 12 to 15 months after data collection has ended and final administrative and claims data for that calendar year become available. CMS releases the Cost Supplement File approximately three months after the Survey File. The Survey File is typically released in the summer, and the Cost Supplement File is typically released in the fall. The 2023 Cost Supplement File represents a random cross-section of all beneficiaries who were ever enrolled in either Part A or Part B of the Medicare program for any portion of 2023.

The MCBS Cost Supplement File links Medicare claims to survey-reported events and aims to provide complete expenditure and source of payment data on all health care services, including those not covered by Medicare. The Cost Supplement File provides a comprehensive picture of health services received, amounts paid, and sources of payment. The Cost Supplement File undergoes a careful reconciliation process to separately identify and flag health care services reported from: 1) the survey alone, 2) the Medicare Fee-for-Service (FFS) and Part D claims data alone, and 3) both sources. Survey-reported data include information on the cost and utilization of all types of medical services, including those not covered by Medicare and payments by supplementary health insurance and Medicare Part C/Medicare Advantage (MA). Medicare claims data include cost and utilization information on inpatient hospitalizations, outpatient hospital care, physician services, home health care, durable medical equipment, skilled nursing home services, hospice care, and prescription drugs. The Cost Supplement File data on utilization and expenditures are provided at three different levels of summarization: Event-level, Service Summary (SS) level, and Person Summary (PS) level. Please see the *MCBS Data User's Guide* for more information on this structure.

CS2. WHAT'S NEW FOR DATA YEAR 2023?

Below are the highlights and updates for the 2023 data year that pertain to the Cost Supplement File LDS.

CS2.1 Sampling

There were no changes to sampling for the 2023 data year.

CS2.2 Questionnaires

Questionnaire content changes: There were several questionnaire sections revised in 2023. Note that variable names referenced below are the questionnaire variable names. Data users can view the *Questionnaire User Guide* and the questionnaires for each data year, including the questionnaire variable names referenced below and question text, on the MCBS website at <https://www.cms.gov/data-research/research/medicare-current-beneficiary-survey/questionnaires>.

Community Questionnaire

The MCBS introduced several Community Questionnaire updates to enhance survey content and data quality and improve interviewer and respondent experience. Changes include the addition of new items and updates to question text, response options, and respondent universes.

Descriptions of the Fall 2023 changes to the **Health Insurance Questionnaire (HIQ)** are found in Section SF2.2, as these changes affect both the 2023 Survey File and the 2023 Cost Supplement File. This section documents additional changes that *only* pertain to the 2023 Cost Supplement File.

Cost Series (STQ, NSQ, CPS)

In Winter 2023, several updates were made to improve HIQ. These changes aligned collection of health insurance information across different plan types, reduced respondent burden by discontinuing collection of information with little analytic utility, and improved the quality of information collected. These changes are described in Section SF2.2 for the 2023 Survey File.

To coincide with the changes made to HIQ in Winter 2023, the Statement Questionnaire (STQ), No Statement Questionnaire (NSQ), and Cost Payment Summary (CPS) were updated so that new plans entered in the cost series follow the same revised flow as new plans entered in the modified HIQ section. Items that asked about the beneficiary's current Medicare Advantage (MA) or Medicare Prescription Drug Program (MPDP) coverage were removed from STQ (STSOPCURR1 and STSOPCURR2), NSQ (NSSOPCURR1 and NSSOPCURR2), and CPS (CPSOPCURR and CPSOPCURR2), as that information is now collected via the COVTIME item in HIQ.

At the start of wide-scale MCBS telephone interviewing in 2020, a skip mechanism was added throughout the cost series to allow interviewers to route out of the cost series at various points in situations of respondent burden or fatigue. This skip mechanism was removed in Summer 2023 due to its limited use and increased availability of in-person and hybrid interviewing.

Facility Instrument

The MCBS introduced some Facility Instrument updates in 2023 that included changes to response options and item removal.

Use of Health Services (US)

In Summer 2023, two updates were made to improve medical terminology used in the Use of Health Services (US) section. At item US40-USEEQUIP, which collects supplies, equipment, or other types of medical services the beneficiary received, the response options "DISPOSABLE DIAPERS" and "CLOTH DIAPERS" were replaced with a new response option, "INCONTINENCE BRIEFS." Additionally, item US43-MSRESTR, which collected if the beneficiary received restraints, was removed.

CS2.3 Data Collection

In Fall 2023, the MCBS data collection protocols were modified to increase the representation of Black, Asian, and Hispanic beneficiaries in the 2023 Panel data. These changes affect all three 2023 MCBS LDS's and are described above in Section ER2.3. There were no other changes that pertain to just the 2023 Cost Supplement File.

CS2.4 Data Processing

The 2023 Cost Supplement File release is built from files encompassing Community and Facility data collection from five rounds of data (Winter 2023, Summer 2023, Fall 2023, Winter 2024, and Summer 2024), as well as administrative and claims data.

New and revised content:

For the 2023 Cost Supplement File LDS, the MCBS created the following new segment:

- HHE contains event-level data on home health provider and home health friend events.

Additionally, two hospice variables in the PS segment were renamed for the 2023 data year: HSAEVNTS was renamed from HPAEVNTS and PAMTHS was renamed from PAMTHP.

Outside of these updates, the 2023 questionnaire changes resulted in the following variables added to or deleted from the 2023 Cost Supplement File release.

Exhibit CS2.4.1: 2023 MCBS Cost Supplement File LDS Content Additions

Location	Questionnaire Section	Variable	Description
FAE	US	INCNTBRF	DID SP RECEIVE INCONTINENCE BRIEFS?

Exhibit CS2.4.2: 2023 MCBS Cost Supplement File LDS Content Deletions

Location	Questionnaire Section	Variable	Description
FAE	US	CLOTHDPR	DID SP RECEIVE CLOTH DIAPERS?
FAE	US	DIAPRSUP	DID SP RECEIVE DISPOSABLE DIAPERS?
FAE	US	RESTRAIN	DID SP HAVE RESTRAINTS?
SS	HHQ	HHETYPE	HOME HEALTH EVENT TYPE

Weighting:

There were no changes to weights for the 2023 data year that affect the Cost Supplement File LDS data.

Imputation:

The 2023 prescription medicine (PM) imputation caps imputed out-of-pocket payment amounts at \$105 for insulin prescriptions. This threshold is equivalent to three times the \$35 maximum monthly out-of-pocket payment for insulin as specified in the Inflation Reduction Act of 2022. Beneficiaries often obtain a three-month supply of medications within a single purchase, thus the \$105 imputation threshold.

For information on imputation changes relevant to the 2023 Survey File, including enhancements to the insurance premium imputation and processing of health insurance data, see Section SF2.4.

CS3. DATA FILE CONTENTS

CS3.1 2023 MCBS Cost Supplement File Segments

The 2023 Cost Supplement File LDS contains 16 segments. Exhibit CS3.2.1 displays each segment included in the Cost Supplement File LDS including the **segment abbreviation**, **brief description**, and **information on weights or other special notes**.

The **Data Source** column describes the source of the data on the segment. The three possible sources for the Cost Supplement File LDS are the Community Questionnaire (CQ), Facility Instrument (FI), and Administrative Records (AR). Each LDS segment can have any combination of these sources. Data source reflects where the data came from, not where the beneficiary was living. For example, a beneficiary could have lived in both settings during the year, but the data for that beneficiary available on the PLT_PXWS segment came from their Community interview only.

The **Quex Section** column lists the specific questionnaire sources for the LDS segment. Please note that not all variables from the questionnaire are released on the segments. Some questionnaire items are combined or recoded to create the LDS variable. Data users will see these derived variables noted in the codebooks preceded with the character "D", such as D_BEGYY.

Season indicates the round (winter, summer, fall, or all) and year when the questionnaire was administered.

Panel describes whether the questionnaire sections that provide the data for each segment are fielded for Baseline respondents (base), Continuing respondents (cont), or all panels (all). If the segment consists of administrative CMS data, then the cell indicates all panels are included.

Unit of Observation indicates what each row in the segment represents. For example, the DUE segment provides multiple rows per BASEID for each dental event in the data year.

A list of equivalent historic segments from the 1991-2013 data release structure is provided in section CS4.6.

Exhibit CS3.1.1: 2023 MCBS Cost Supplement File Segments and Contents

Cost Supplement File Segment (Abbrev)	Description	Data collection and special weights notes	Data Source*	Quex Section	Season	Panel **	Unit of Observation
Dental Utilization Events (DUE)	Contains individual dental events reported during a Community interview or created from Medicare claims data.		CQ, AR	DVH	All	All	One record per beneficiary per event (defined as a single visit to the dentist)
Facility Events (FAE)	Contains individual facility events reported during a Facility interview.	There is one record for each stay that occurred at least partly in the data year.	FI, AR	RH, US, EX	All	All	One record per beneficiary per stay in a long-term care facility

Cost Supplement File Segment (Abbrev)	Description	Data collection and special weights notes	Data Source*	Quex Section	Season	Panel **	Unit of Observation
Hearing Utilization Events (HUE)	Contains individual hearing care events reported during a Community interview or created from Medicare claims data.		CQ, AR	DVH, US	All	All	One record per beneficiary per event (defined as a single visit to a hearing care provider)
Home Health Events (HHE)	Contains individual home health care events reported during a Community interview or created from Medicare claims data.		CQ, AR	HHQ	All	All	One record per beneficiary per event (defined as a separate visit or service for a survey-reported home health event)
Inpatient Hospital Events (IPE)	Contains individual inpatient hospital events reported during a Community interview or created from Medicare claims data.		CQ, AR	IUQ, IPQ, ERQ, OPQ	All	All	One record per beneficiary per admission
Institutional Events (IUE)	Contains individual short-term facility (usually skilled nursing facility) stays that were reported during a Community interview or created from Medicare claims data.		CQ, AR	IUQ, IPQ	All	All	One record per beneficiary per admission
Medical Provider Events (MPE)	Contains individual events for a variety of medical services, equipment, and supplies reported during a Community interview or created from Medicare claims data.		CQ, AR	ERQ, IPQ, MPQ, OMQ, OPQ	All	All	One record per beneficiary per event, defined as a separate visit, procedure, service, or a supplied item for a survey-reported event
Outpatient Hospital Events (OPE)	Contains individual outpatient hospital events reported during a Community interview or created from Medicare claims data.		CQ, AR	OPQ	All	All	One record per beneficiary per event (defined as a single outpatient visit)

Cost Supplement File Segment (Abbrev)	Description	Data collection and special weights notes	Data Source*	Quex Section	Season	Panel **	Unit of Observation
Prescribed Medicine Events (PME)	Contains individual outpatient prescribed medicine events reported during a Community interview or created from Medicare claims data.		CQ, AR	PMQ, DVH, ERQ, IPQ, OPQ, MPQ	All	All	One record per beneficiary per prescribed medicine (defined as a single prescribed medicine)
Vision Utilization Events (VUE)	Contains individual vision care events reported during a Community interview or created from Medicare claims data.		CQ, AR	DVH, US	All	All	One record per beneficiary per event (defined as a single visit to a vision care provider)
Person Summary (PS)	Summarization of utilization and expenditures by type of service and summarization of expenditures by payer.		CQ, FI, AR	All utilization including US	All	All	One record per beneficiary
Service Summary (SS)	Summarization of the 10 individual event files, along with one record for hospice utilization, yielding a total of 11 summary records per beneficiary.		CQ, FI, AR	All utilization including US	All	All	11 records per beneficiary
Cost Supplement Ever Enrolled Weights (CSEVWGTS)	Contains cross-sectional full-sample and replicate weights representing the 2023 ever enrolled population.		CQ/FI	N/A	All	All	One record per beneficiary

Cost Supplement File Segment (Abbrev)	Description	Data collection and special weights notes	Data Source*	Quex Section	Season	Panel **	Unit of Observation
Cost Supplement Longitudinal Weights (CSL2WGTS CSL3WGTS)	Contains longitudinal full -sample and replicate weights for the multi-year ever enrolled populations. The CSL2WGTS file includes the two-year longitudinal weights for the population ever enrolled at any time during both 2022 and 2023. The CSL3WGTS file includes the three-year longitudinal weights for the population ever enrolled at any time during 2021, 2022, and 2023.		CQ/FI	N/A	All	All	One record per beneficiary
Physical Measures Pilot (PLT_PXWS)	Information about the beneficiary's physical measures such as weight, height, balance, and grip strength.	There are no weights for this segment.	CQ	PXQ	Summer	Cont.	Beneficiary

* = Data source describes the source of the data on the segment. The three possible sources are the Community Questionnaire (CQ), Facility Instrument (FI), and Administrative Records (AR). Each LDS segment can have any combination of these sources.

** = Panel describes whether the questionnaire sections that provide the data for each segment are fielded for baseline respondents, continuing respondents, or both.

CS3.2 Imputation

As displayed in Exhibit CS3.2.1,¹¹ imputation occurs across three levels for the 2023 Cost Supplement File. In the first level, **payment amounts for individual sources of payment** (such as Medicare or private insurance) are imputed. These imputed values are reflected in the event-level data. In the second level, an **MA Encounter Data Ratio Adjustment** accounts for medical events that were not reported by survey respondents who were covered by MA. This adjustment is applied in the outpatient, inpatient, institutional, home health, and medical procedure LDS segments. In the third level, a **part-year ratio adjustment** is applied to account for reference period gaps within the calendar year which are usually caused by Not-In-Round (NIR).¹² For more information on the imputation that occurs for each LDS, see the *MCBS Data User's Guide*. For a detailed description of the MCBS imputation procedures, see the *MCBS Methodology Report*.

¹¹ Imputation does not apply for the physical measures data released on the 2023 PLT_PXWS segment; as such, this segment is excluded from Exhibit CS3.2.1.

¹² Not-In-Round refers to cases in which the respondent was not available to be interviewed within the round's time frame.

Exhibit CS3.2.1: Summary of Event-Level Imputation for LDS Segments

Event-Level LDS Segment	Level 1	Level 2	Level 3
	Imputation of Payments	MA Encounter Ratio Adjustment (New for 2019)	Part Year Ratio Adjustment
DUE			
FAE*	(FSF)		(FSF)
HHE			
Hospice [†]	Not Imputed	Not Imputed	Not Imputed
HUE			
IPE			
IUE			
MPE			
OPE			
PME			
VUE			

Event Level Data
 Service Level Summary
Person Level Summary

* Imputation in the Facility Stay File (FSF) occurs via a separate, simpler process.

† The MCBS adds Hospice administrative data to the files but does not conduct imputation.

CS3.3 Weights

The data user can conduct analyses of final Cost Supplement File data in combination with Survey File data. Users who want to analyze Survey File data along with cost and utilization data in the Cost Supplement File should use the provided Cost Supplement File weights. Survey File - Early Release data should not be combined with the Survey File or Cost Supplement File data.

Two types of general weights are provided for the 2023 Cost Supplement File LDS, **cross-sectional weights** and **longitudinal weights**. One set of cross-sectional weights is provided representing the ever enrolled population (CSEVWGTS). Two sets of longitudinal weights are provided representing the two-year (CSL2WGTS) and three-year (CSL3WGTS) ever enrolled populations who provided utilization and cost data each year. For more information on the weights available for each LDS, see the *MCBS Data User's Guide*. For a detailed description of the MCBS weighting procedures, see the *MCBS Methodology Report*.

Exhibit CS3.3.1 summarizes the general weights released on the 2023 Cost Supplement File.

Exhibit CS3.3.1: 2023 MCBS Cost Supplement File General Weights

Limited Data Set	Description	Segment	Full-Sample Weight	Replicate Weights	Population
Cost Supplement File	Ever Enrolled Cross-Sectional Weights	CSEVWGTS	CSEVRWGT	CSEVR001-CSEVR100	Ever enrolled for at least one day at any time during 2023
Cost Supplement File	Two-Year Longitudinal Weights	CSL2WGTS	CSL2YWGT	CSL2Y001-CSL2Y100	Enrolled at any time during both 2022 and 2023
Cost Supplement File	Three-Year Longitudinal Weights	CSL3WGTS	CSL3YWGT	CSL3Y001-CSL3Y100	Enrolled at any time during each of 2021, 2022, and 2023

CS3.4 Response Rates

Exhibit CS3.4.1 displays the 2023 Survey File and 2023 Cost Supplement File unconditional and conditional response rates by panel for the ever enrolled and continuously enrolled populations. Additional information, including details on how these rates are calculated, can be found in Section 8 of the *MCBS Methodology Report*: <https://www.cms.gov/data-research/research/medicare-current-beneficiary-survey/data-documentation-codebooks>.

Exhibit CS3.4.1: 2023 MCBS Survey File and Cost Supplement File Annual Response Rates

Panel	Survey File				Cost Supplement File	
	Unconditional Response Rate		Conditional Response Rate		Unconditional Response Rate	Conditional Response Rate
	Ever Enrolled	Continuously Enrolled	Ever Enrolled	Continuously Enrolled	Ever Enrolled	Ever Enrolled
2020	12.8%	12.8%	82.6%	80.3%	14.6%	82.1%
2021	14.9%	14.7%	75.4%	72.0%	16.3%	74.8%
2022	20.9%	20.2%	57.1%	54.2%	21.8%	57.1%
2023	45.1%	43.6%	45.1%	43.6%	39.7%	39.7%
Overall	23.0%	22.6%	55.0%	52.7%	18.1%	65.6%

SOURCE: 2023 MCBS Internal Sample Control File

CS4. DATA FILE NOTES

CS4.1 Cost Supplement File Segment Information

This section provides information regarding each segment within the Cost Supplement File in alphabetical order. The notes have been organized into three main categories of information.

1. Core Content – a description of the main subject of the data.
2. Variable Definitions – definitions of derived variables and/or variables that require additional explanation regarding their construction. Note: The variables listed are not a comprehensive list of all variables in each segment. The Codebook provides information on all variables in each segment.
3. Special Notes – additional background information that data users may find helpful for constructing analyses.

CS4.2 Cost Supplement File Event-Level Segment Descriptions

CS4.2.1 Dental Utilization Events (DUE)

CS4.2.1.1 Core Content

The Dental Utilization Events segment contains individual dental events for the MCBS population. The unit of observation is a single visit to the dentist, at which time a variety of services, including cleaning, x-rays, and an exam might be rendered. Most of the information on this segment is survey-reported from the Community Questionnaire. There is no survey-reported information from the Facility Instrument on this segment.

Medicare does not cover most dental procedures or supplies, like cleanings, fillings, dentures, or other dental devices. Medicare Part A will pay for certain dental services that are delivered in the hospital. The few claims that are used in this segment are from Part A claims for qualifying procedures.

CS4.2.1.2 Variable Definitions

Please see the Codebook for information regarding variables in this segment.

CS4.2.1.3 Special Notes

N/A

CS4.2.2 Facility Events (FAE)

CS4.2.2.1 Core Content

The Facility Events segment includes individual facility events for the MCBS population recorded during a Facility interview. There is one record for each stay that occurred at least partly in the data year (i.e., the stay begins, ends, or continues through the calendar year). The unit of measurement of facility services is a “stay” in a nursing home or other long-term care facility. Stays are measured in terms of days of residence in that facility. If a person is still in the facility at the end of 2023, the stay is not complete, but all data through the end of 2023 are included.

CS4.2.2.2 Variable Definitions

AMTUCARE: The amount paid by Medicare to the facility that is not included in any of the other Event records. For instance, most doctor visits that occurred while the person was in the facility and were paid for by Medicare FFS are in the MPE segment; however, if the facility reported an amount received by Medicare that exceeded the total Medicare amounts on the Event segments, then the Medicare amount reported by the facility that is in excess of the other events' Medicare amounts is reported here.

AMTTOT: The sum of the five facility payer types (AMTUCARE, AMTCAID, AMTPRVU, AMTOOP, AMTOTH). Note that according to the above explanation of AMTUCARE, this amount is not duplicated in the other Event segments.

AMTOTH: Given the definition of TOTCARE, AMTOTH is the total amount paid for the person while in the facility by other payers (i.e., payments not attributed to Medicare, Medicaid, or other private payers). In the case of missing information where imputed amounts are needed, AMTOTH could contain either the total payment amount or the additional amount by which payment amounts were increased.

REFBEGYY, REFBEGMM, REFBEGDD: The earliest date in the calendar year when the beneficiary was in the facility.

REFENDYY, REFENDMM, REFENDDD: The last date in the calendar year when the beneficiary was in the facility.

TOTCARE: The total amount paid by Medicare FFS while the person was in the facility, which includes all Medicare amounts from other Event segments that occurred during the person's facility stay. Additionally, it includes any amount reported by the facility that is in excess of the other events' Medicare amounts (AMTUCARE).

TOTALL: The sum of TOTCARE, AMTCAID, AMTPRVU, AMTOOP, AMTOTH.

CS4.2.2.3 Special Notes

Stays are defined as any period of time when the beneficiary lived in a facility for one or more days and had complete Facility interview data. New stays are generated for a beneficiary whenever they move to a new facility and complete an interview with the new facility. If the beneficiary left the facility for a period greater than 30 days and returned to the facility, a separate stay record was created.

CS4.2.3 Hearing Utilization Events (HUE)

CS4.2.3.1 Core Content

This segment contains individual hearing events for the MCBS population. The unit of observation is a single visit to a hearing care provider, such as an ear and nose throat doctor or audiologist. A variety of services may be rendered during a hearing event, including a hearing exam, a hearing aid fitting, repair, or purchase, or hearing rehabilitative services. Note that any hearing aid purchases are classified as OM events rather than HU events, similar to durable medical equipment purchases. Only the HU visits themselves are assigned an HU event type. The majority of the information on this segment is survey-reported from the Community Questionnaire. There is no survey-reported information from the Facility Instrument on this segment.

Medicare does not cover most hearing procedures or supplies, like hearing exams or hearing aids. Medicare Part A will pay for certain hearing services that are delivered in the hospital. The few claims that are used on this segment are from Part A claims for qualifying procedures.

CS4.2.3.2 Variable Definitions

Please see the Codebook for information regarding variables in this segment.

CS4.2.3.3 Special Notes

N/A

CS4.2.4 Home Health Events (HHE)

CS4.2.4.1 Core Content

This segment contains individual home health care events reported during a Community interview or created from Medicare claims data. The unit of observation of home health visits is a separate visit or service for a survey-reported home health event. Home health events can be home health friend (HF) or home health provider (HP) events.

CS4.2.4.2 Variable Definitions

Please see the Codebook for information regarding variables in this segment.

CS4.2.4.3 Special Notes

Beginning with 2023, event-level home health data are made available in the Cost Supplement File in this new segment. Summarized home health data continue to be available in the SS and PS segments.

CS4.2.5 Inpatient Hospital Events (IPE)

CS4.2.5.1 Core Content

The Inpatient Hospital Events segment contains individual inpatient hospital events for the MCBS population that are reported during a Community interview or created from Medicare claims data. The unit of observation of inpatient hospital services is a single admission. If the beneficiary was still hospitalized at the end of the year, the inpatient event record is not complete, but all data through the end of 2023 are present.

CS4.2.5.2 Variable Definitions

Please see the Codebook for information regarding variables in this segment.

CS4.2.5.3 Special Notes

Note that only the principal diagnosis code, PRINDIAG, is included in the IPE and IUE segments, and the principal procedure code, PRCDRCD1, is only included in the IPE segment. Please consult the CMS claims included in the Survey File LDS for any additional diagnosis or procedure codes associated with the event records. Please note that research claims only include FFS events.

CS4.2.6 Institutional Events (IUE)

CS4.2.6.1 Core Content

The Institutional Events segment contains individual short-term facility (usually SNF) stays for the MCBS population that are reported during a Community interview or created from Medicare claims data. The unit of

observation is a single admission. If the beneficiary was still in the institution at the end of the year, the institutional event is not complete, but all data for 2023 are present.

CS4.2.6.2 Variable Definitions

Please see the Codebook for information regarding variables in this segment.

CS4.2.6.3 Special Notes

Note that the IPE and IUE segments report only the principal diagnosis code, PRINDIAG. Please consult the CMS claims included in the Survey File LDS for any additional diagnosis or procedure codes associated with the event records. Please note that research claims only include FFS events.

CS4.2.7 Medical Provider Events (MPE)

CS4.2.7.1 Core Content

The Medical Provider Events segment contains individual events for a variety of medical services, equipment, and supplies reported during a Community interview or created from Medicare claims data and Medicare Part D claims data. The unit of observation is a separate visit, procedure, service, or a supplied item for a survey-reported event. For Medicare claim-only events, it may represent 1) single or multiple visits; 2) single or multiple procedures; 3) single or multiple services; or 4) single or multiple supplies, depending on the number of items pulled together on the bill.

MPE is a combination of medical provider events collected in the Community Questionnaire: medical provider (MP), separately billing doctor (SD), separately billing lab (SL), and other medical expenses (OM).

CS4.2.7.2 Variable Definitions

Please see the Codebook for information regarding variables in this segment.

CS4.2.7.3 Special Notes

The EVNTTYPE variable distinguishes between the different event types. The classifications of EVNTTYPEs are determined by how the respondent reported the event during the survey. For example, a respondent may report an MP event type and total costs associated with it. This may match a Medicare claim with a line-item cost for the physician visit and a line-item cost for a lab service. In this case, there would not be an SL event.

When an event matches a Medicare claim or Medicare Part D claim, efforts are made to preserve some of the cost classifications that the claims line items explain through the Healthcare Common Procedure Coding System (HCPCS) code. These groupings are found in several variables:

- PAMTMED (physician costs)
- PAMTSURG (surgical costs)
- PAMTLABX (laboratory and x-ray costs)
- PAMTOM (other medical costs such as durable medical equipment [DME])
- PAMTPM (prescribed medicine costs)

The costs above reflect total reimbursements and sum to AMTTOT. These variables will only have data for matched survey events and claim-only events.

CS4.2.8 Outpatient Hospital Events (OPE)

CS4.2.8.1 Core Content

The Outpatient Hospital Events segment contains individual outpatient hospital events for the MCBS population reported during a Community interview or created from Medicare claims data. The unit of observation is a separate visit to any part of the outpatient department for a survey-reported event. For Medicare claim-only events, it may represent 1) a single visit; 2) multiple procedures or services within one visit; or 3) multiple visits billed together.

CS4.2.8.2 Variable Definitions

Please see the Codebook for information regarding variables in this segment.

CS4.2.8.3 Special Notes

The primary diagnosis code, PRINDIAG, is present on the file. For any other additional diagnosis codes associated with an event, please consult the CMS claims included in the Survey File LDS. Please note that research claims only include Medicare FFS events.

CS4.2.9 Prescribed Medicine Events (PME)

CS4.2.9.1 Core Content

The Prescribed Medicine Events segment contains individual outpatient prescribed medicine events for the MCBS population reported during a Community interview or created from Medicare Part D claims data. The unit of observation is a single purchase/fill of a single drug in a single container. The segment also contains the names of the prescribed medicines, the form, and unit of strength.

CS4.2.9.2 Variable Definitions

Please see the Codebook for information regarding variables in this segment.

CS4.2.9.3 Special Notes

Some of the variables in this record are only applicable in certain situations during the interview. The following variable is only applicable when the form of the medication is a pill or a patch:

- TABNUM Number of tablets/patches in the container

The following questions are asked of the respondent when the medication's dosage form is not a pill, a patch, or a suppository:

- AMTUNIT Amount unit
- AMTNUM Amount number
- SUPPNUM Inapplicable unless the dosage form is a suppository

Often, drug characteristics are imputed to assist in assigning pricing data. The imputed dosage form was only imputed when there was no match between what was reported and the possible dosage forms found in First Databank (FDB) or if the form was missing. The value of PMFORM (Prescribed Medicine Form, which is the type of medicine prescribed, such as pills, liquid, injection, etc.) was also changed when the imputed dosage form was present. The imputed strength and the amount number were imputed using various criteria and

contributed to determining a unit price only. The presence of imputed amounts is identified via flags on this segment.

The following variables are unadjusted totals for the beneficiary. These totals only partially account for any gap days (days not covered by interview). While survey data was not available, Part D administrative claim amounts were included, thus any interview gap period would be partially covered by these Prescription Drug Event (PDE) administrative claims.

■ AMTTOT	Amount paid by all payers
■ AMTCARE	Amount paid by Medicare FFS/Part D
■ AMTCAID	Amount paid by Medicaid
■ AMTHMOP	Amount paid by private MCO/HMO
■ AMTMADV	Amount paid by Medicare MCO/HMO
■ AMTPRVE	Amount paid by insurance - employer sponsored
■ AMTPRVI	Amount paid by insurance - self purchased
■ AMTPRVU	Amount paid by private insurance (Unknown Purchase)
■ AMTOOP	Amount paid out of pocket
■ AMTDISC	Discounted amount
■ AMTOTH	Amount paid by other sources, including VA

Part B drug information: A small number of Part B drugs are collected as survey-reported data in the PME. However, the data added from claims are only from Part D. There are no survey-reported drugs administered by a physician matched from the Part B administrative claims data.

In order to determine whether a drug is brand name or generic, data users can compare the FDB FDB_BN field with the FDB_GNN field. If these fields differ, then it is potentially a brand name drug (or at least has a trademarked name).

Data users can also use the PDE National Drug Code (NDC) and use an external drug information database (like FDB) to determine brand vs. generic status of the drug.

If data users do not have a drug database, they could use the Food and Drug Administration's NDC SPL Data Elements File. CMS uses this for the Manufacturer drug discount program to determine what products are not eligible for the Manufacturer discount. Based on the Marketing category, drugs can be classified as follows:

Brand: NDA (New Drug Application), NDA authorized generic, BLA (Biologics License Application)
 Generic: ANDA (Abbreviated New Drug Application)

CS4.2.10 Vision Utilization Events (VUE)

CS4.2.10.1 Core Content

The Vision Utilization Events segment contains individual vision events for the MCBS population. The unit of observation is a single visit to a vision care provider, such as an optometrist or an optician. A variety of services may be rendered during a vision event, including a vision exam, a contact lens fitting or purchase, an eye glass frame fitting or purchase, and different kinds of surgeries (e.g., cataract, corneal, etc.). Note that any vision purchases (e.g., contacts, eyeglasses, etc.) are classified as OM events rather than VU events, similar to durable medical equipment purchases. Only the VU visits themselves are assigned a VU event type. The majority of the information on this segment is survey-reported from the Community Questionnaire. There is no survey-reported information from the Facility Instrument on this segment.

Medicare does not cover most vision procedures or supplies, like eye exams or contact lenses. Medicare Part A will pay for certain vision services that are delivered in the hospital. The few claims that are used on this segment are from Part A claims for qualifying procedures.

CS4.2.10.2 Variable Definitions

Please see the Codebook for information regarding variables in this segment.

CS4.2.10.3 Special Notes

N/A

CS4.3 Cost Supplement File Summary-Level Segment Descriptions

CS4.3.1 Service Summary (SS)

CS4.3.1.1 Core Content

The Service Summary segment provides a summary of the 10 individual event files along with hospice utilization, yielding a total of 11 summary records per person.

CS4.3.1.2 Variable Definitions

Please see the Codebook for information regarding variables in this segment.

CS4.3.1.3 Special Notes

For every person, there are 11 records: one record for each of the 10 event types, plus an additional record for hospice services, which are not present at the event-level. The records are identifiable by the EVNTTYPE variable:

- DU - Dental
- FA - Facility
- HH - Home health
- HS - Hospice
- HU - Hearing
- IP - Inpatient hospital
- IU - Institutional
- MP - Medical provider
- OP - Outpatient hospital
- PM - Prescribed medicine
- VU - Vision

Beginning in 2023, the event type abbreviation for hospice services changed from 'HP' to 'HS' to avoid confusion with the home health provider events (which use 'HP'). Researchers should note this change when conducting multi-year analyses with MCBS hospice data.

When linking event-level Non PM data to service-level data, any survey-reported event that specified traditional Medicare as a payer and was not matched to an FFS Medicare claim was excluded from the Type of Service summary. The analysis showed that either 1) the survey event's monies are bundled with a Medicare claim that already matched another survey event or 2) the respondent was incorrect in reporting Medicare as a payer.

CS4.3.2 Person Summary (PS)

CS4.3.2.1 Core Content

The Person Summary segment provides a summarization of utilization and expenditures by type of service and a summarization of expenditures by payer, yielding one record per person.

CS4.3.2.2 Variable Definitions

Please see the Codebook for information regarding variables in this segment.

CS4.3.2.3 Special Notes

For home health services, respondents report home health utilization in terms of 1 event = 1 visit. However, Medicare pays for and tracks home health utilization in terms of 15-minute increments. On the PS record, home health data report one visit per event, but aggregate the total payment made for the visit.

CS4.4 Weights Segment Description

For information about the ever enrolled cross-sectional weights and two-year and three-year longitudinal weights available in the Cost Supplement File LDS and obtaining weighted estimates using these files, please see Section CS3.4. For discussion on how the weights files were created, please refer to the *MCBS Methodology Report*, which can be found on the CMS website at <https://www.cms.gov/data-research/research/medicare-current-beneficiary-survey/data-documentation-codebooks>.

CS4.5 Physical Measures Pilot Segment Description

CS4.5.1 Physical Measures Pilot (PLT_PXWS)

CS4.5.1.1 Core Content

The Physical Measures Pilot segment contains PXQ data about the beneficiary's physical measures such as weight, height, balance, and grip strength.

CS4.5.1.2 Variable Definitions

Please see the Codebook for information regarding variables in this segment.

CS4.5.1.3 Special Notes

The 2023 Cost Supplement File only contains Summer 2024 pilot physical measures data.

There are no weights that can be used with the PLT_PXWS segment because it was fielded for a non-random subset of beneficiaries and the data cannot be weighted to represent a national population.

Several "other specify" variables are back coded as necessary into response options, but the verbatim text is not released. Back coded "other specify" variables include: HGTREAS (reason why respondent could not complete height measurement), WGTREAS (reason why respondent could not complete weight measurement), BALRS1R (reason why respondent could not complete first balance test), BALRS2R (reason why respondent could not complete second balance test), BALRS3R (reason why respondent could not complete third balance test), WLKRS1R (reason why respondent could not complete first walking measure), WLKRS2R (reason why respondent could not complete second walking measure), SGCHRSR (reason why respondent could not

complete chair stand), RPCHRSR (reason why respondent could not complete repeated chair stand), RHDREASN (reason why respondent cannot complete grip strength test for right hand), and LHDREASN (reason why respondent cannot complete grip strength test for left hand).

CS4.6 2023 MCBS Cost Supplement File LDS Segment Crosswalk

Exhibit CS4.6.1 crosswalks the 2023 Cost Supplement File LDS segments against their historic RIC segments counterparts (as released prior to data year 2015).

Exhibit CS4.6.1: 2023 MCBS Cost Supplement File LDS Segment Crosswalk

Cost Supplement Segment	Segment Abbrev	Historic RIC Segment
Dental Utilization Events	DUE	DUE
Facility Events	FAE	FAE
Hearing Utilization Events	HUE	N/A
Home Health Events	HHE	N/A
Inpatient Hospital Events	IPE	IPE
Institutional Events	IUE	IUE
Medical Provider Events	MPE	MPE
Outpatient Hospital Events	OPE	OPE
Prescribed Medicine Events	PME	PME
Vision Utilization Events	VUE	N/A
Person Summary	PS	PS
Service Summary	SS	SS
Cost Supplement Ever Enrolled Weights	CSEVWGTS	X
Cost Supplement Longitudinal Weights	CSL2WGTS CSL3WGTS	N/A
Physical Measures Pilot	PLT_PXWS	N/A

APPENDIX A. REFERENCES

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