

Medicare Current Beneficiary Survey
CY 1998 Access to Care

Public Use File Documentation

Introduction

The accompanying public use file is the eighth in a series of annual data releases relating to Medicare beneficiaries' access to care. The file consists of selected interview data from the ongoing Medicare Current Beneficiary Survey (MCBS), which were collected during Round 22 (September through December of 1998) or earlier rounds for some variables, for individuals in the continuing sample. These data are augmented with Medicare claims and administrative data for calendar year (CY) 1998.

Purposes of the Survey

The MCBS is a continuous, multi-purpose panel survey of a representative sample of the Medicare population, including both aged and disabled enrollees. The study is sponsored by the Centers for Medicare and Medicaid Services (CMS), is directed by that agency's Office of Strategic Planning, and maintains a close working relationship with CMS's Office of the Actuary. It is designed to support both the agency's and that office's functions. CMS's primary mission is administering the Medicare program (Health Insurance for the Aged and Disabled) and assisting the States in administering the Medicaid program (Grants to States for Medical Assistance Programs).

The Office of Strategic Planning is responsible for the following activities:

- monitor environmental issues to include accessibility, use, and costs of health care and analyze their impact on CMS programs and their implications for the national economy;
- measure the Agency's conformance with the requirements of the Government Performance and Results Act (GPRA);
- develop, design, and conduct research on health care programs, issues, trends, and their impacts on the beneficiary;
- provide technical advice and consultation to Agency components, governmental components, Congress, and outside organizations.

The Office of Actuary is responsible for the following activities:

- promulgating the premiums and deductible and coinsurance amounts associated with coverage or use of covered services;
- estimating the cost of covered benefits for Medicare and Medicaid for the budgetary exercise;
- estimating the cost of noncovered services in response to legislative initiatives;

- projecting the long term financial soundness of the health insurance trust funds.

Analysis of the National Health Accounts (current and projected national and personal health care expenditures) shows that in recent years there has been some slowing in the growth in health care expenditures. The decade from 1980 to 1990 experienced an average annual rate in the growth of national health expenditures of almost 11 percent. The average annual rate over the period of 1990 to 1998 slowed to 6.4 percent. However, health care spending continues to outpace the overall economy (as measured by the gross domestic product), which grows at an average rate of about 5 percent during the same time.

In addition, the share of the nation's total health care bill funded by the Federal, State and local governments through the Medicare and the Medicaid programs rose rapidly during the early part of this decade, from almost 27 percent in 1990 to 33.7 percent in 1998.

These trends, along with CMS's concerns about the quality of care beneficiaries are receiving, support the need for the collection of a wide variety of health related data. The MCBS is designed to aid in CMS's administration, monitoring, and evaluation of the Medicare and Medicaid programs. MCBS data enables CMS to do the following: monitor the impact, especially financial, of changes in the Medicare program on the beneficiary population and on the trust funds; develop reliable and current information on the use and cost of services not covered by Medicare (such as prescription drugs and long term care); develop reliable and current information on the sources of payment for costs of covered services not reimbursed by Medicare and of noncovered services; and analyze factors which are not available from claims or other administrative records but are thought to affect use and mix of services.

The MCBS primarily focuses on economic and beneficiary issues; in particular, health care use, expenditures and factors that affect use of care and the beneficiary's ability to pay. As a part of this focus, the MCBS collects a variety of information about demographic characteristics, health status and functioning, access to care, insurance coverage, financial resources, and potential family support. The longitudinal design of the MCBS allows analysis of the effects of changes in these factors on patterns of use over time.

The Design of the MCBS

Work on the MCBS has been done by CMS's Information and Methods Group through its contractor, Westat, Inc., a survey research firm with offices in Rockville, Maryland.

In its initial design, the MCBS was to serve as a traditional longitudinal survey of the Medicare population. There was no predetermined limit to the duration of time a beneficiary, once selected to participate, was to remain in the sample.

Fieldwork for Round 1 began in September 1991 and was completed in December 1991. Subsequent rounds, involving the re-interviewing of the same sample persons or appropriate proxy respondents, begin every four months. Interviews are conducted regardless of whether the sample person resides at home or in a long term care facility, using the questionnaire version (discussed later) appropriate to the setting.

Repeated Interviews. The MCBS is a longitudinal panel survey. Sample persons are interviewed three times a year over several years to form a continuous profile of each individual's personal health care experience. The MCBS is thus uniquely capable of tracing changes in coverage and other personal circumstances, and observing processes that occur over time, such as people leaving their homes and taking up residence in long term care facilities, or spending down their assets for medical care until they become eligible for Medicaid.

Sample. Respondents for the MCBS were sampled from the Medicare enrollment file to be representative of the Medicare population as a whole and by the following age groups: under 45, 45 to 64, 65 to 69, 70 to 74, 75 to 79, 80 to 84, and 85 and over. Because of interest in their special health care needs, the oldest old (85 and over) and the disabled (64 and under) were oversampled to permit more detailed analysis of these subpopulations. The sample size was designed to yield about 12,000 completed cases annually.

The sample was drawn from 107 primary sampling units (PSUs) or major geographic areas chosen to represent the nation, including the District of Columbia and Puerto Rico, with a second stage of initially 1,163 geographic clusters (later expanded to 1,366 in Round 4, 1,412 in Round 7, 1,443 in Round 10, 1,448 in Round 13, 1,468 in Round 16, 1,487 in Round 19, and 1,507 in Round 22) randomly drawn within those PSUs. The sample was annually supplemented during the September through December interview periods (that is, Round 4, Round 7, Round 10, Round 13, Round 16, Round 19, and Round 22) to account for attrition (deaths, disenrollments, refusals, etc.) and newly enrolled persons.

The set of beneficiaries reported on in the 1998 Access to Care File consists of a random cross-section of all beneficiaries who were enrolled in one or both parts of the Medicare program as of January 1, 1998 and were alive and enrolled at the time of interview during the 1998 fall round (September - December). Their names were drawn through the use of a fairly complex selection algorithm that involves five different panels.

The initial large panel of 15,411 beneficiaries was fielded in the fall of 1991. Smaller supplemental panels were added in the fall of 1992 and 1993. These supplementary panels afforded a chance of selection to beneficiaries who became entitled to either part A or Part B benefits during 1991 and 1992 in addition to maintaining adequate sample sizes in the face of death and sample attrition. At the time that the first panel was fielded, no definite decision had been made on how many years to interview sample beneficiaries.

In 1993, a decision was made phase out the 1991, 1992 and 1993 Panels after no more than 6 years of interviews and to limit future panels to four years of interviews. This meant that the new sample to be

selected for 1994 had to be designed like the 1991 Panel so that it could eventually replace it, rather than being narrowly focused as the 1992 and 1993 Panels were.

At the same time, a decision was made to increase the overall sample size in terms of interviews per year in order to allow the simultaneous interviewing of 4 panels, each starting with about 6,400 sample beneficiaries. In Round 10 (September-December 1994), we began implementation of the rotating panel process with the 1994 Panel. This group consisted of 6,390 beneficiaries, including a sample of those who became entitled during 1993 or on January 1, 1994. The following four bullets describe panel composition each year thereafter.

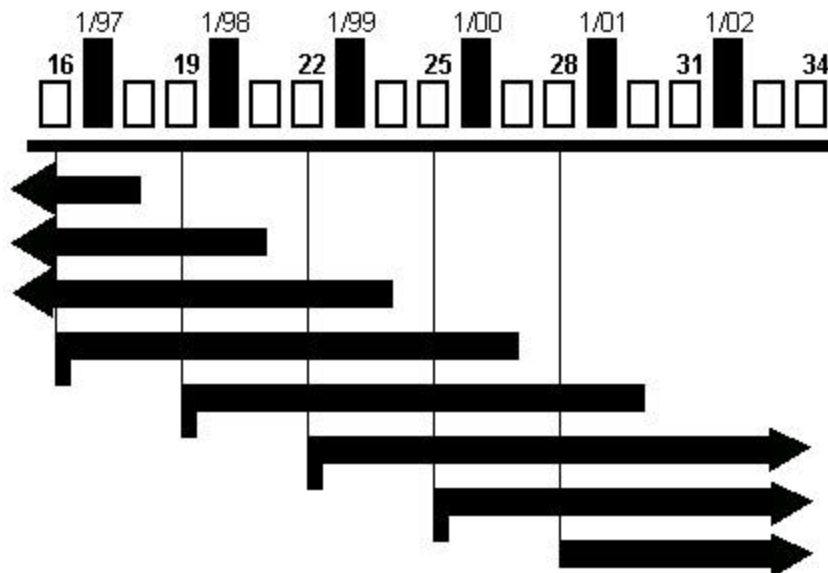
- In Round 13 (September-December 1995), we selected our second rotating panel, consisting of 6,349 beneficiaries, including a sample of those who became entitled during 1994 or on January 1, 1995. Like the first rotating panel (Round 10), all subsequent panels are designed to be representative of the continuing sample, for which it is designed to help ultimately replace.
- In Round 16 (September-December 1996), we selected our third rotating panel, consisting of 6,506 beneficiaries. Since HMO enrollees were not over sampled in the original MCBS sample design, the number of HMO enrollees included in the MCBS was small (about 1,249 in Round 13) relative to the analytic need. Only very large differences between HMO and FFS populations could be detected with respect to access, satisfaction, and health status. The sample was not large enough to examine specific subgroups of the managed care population, such as the very old, the disabled, or the chronically ill. Although the number of HMO respondents will eventually increase due to natural increases in this group in the Medicare population, the best time to learn more about Medicare's managed care program is while it is still evolving and amenable to change. As a result, an ORD/HMO special (one round only) supplement was added in Round 16, which expanded the total survey population by an additional 2,799 beneficiaries. 1,490 interviews were attempted in South California and South Florida combined. These additional interviews were distributed across these areas in such a way as to produce equal numbers of completed interviews in the total sample, among Medicare beneficiaries in HMOs with risk contracts and in fee for service, in each of the two areas. In addition, 1,309 interviews were attempted with beneficiaries enrolled under risk contracts only, and were spread over the remaining primary sampling units outside South California and South Florida, using the same criteria for selection as were employed for the existing sample.
- In Round 19 (September-December 1997), the rotating panel design was fully implemented with the selection of our fourth rotating panel, consisting of 6,599 beneficiaries. Again, the ORD/HMO special one round supplement was used to expand the total survey population by an additional 2,536 interviews. Approximately 2,089 interviews were attempted in Arizona and Philadelphia combined. The same methodology was used in selecting the special supplement as was employed in Round 16. Of the beneficiaries enrolled under risk contracts only -- outside of the two target areas, 447 interviews were conducted.
- In Round 22 (September-December 1998), the fifth rotating panel was selected, consisting of 6,450 beneficiaries. Again, the ORD/HMO special one round supplement was used to expand the total

survey population by an additional 5,162 interviews. Approximately 3,909 interviews were attempted in Denver, Minneapolis, and South Florida combined. The same methodology was used in selecting the special supplement as was employed in Round 19. Of the beneficiaries enrolled under risk contracts only -- outside of the three target areas, 1,253 interviews were attempted.

A rotating panel will be followed for 12 interviews. There are four panels active at any one time, and each panel has approximately 4,000 active sample persons. New panels will be introduced each year in the fall round and the panel being replaced will be retired the following summer.

Because of the overlap between the new panel and the retiring panel, the number of interviews we conduct in the September--December (Fall) round increases from 12,000 to 16,000. Figure I.1, while not drawn to scale, gives a visual display of the overlap that occurs during the simultaneous fielding of four panels in the fall round, and the ORD/HMO special one round supplement.

Figure I.1: Rotating Panel Overlap and ORD/HMO Special One Round Supplement



The retiring panel (about 4,000 individuals) has abbreviated questionnaires administered beginning in the January--April round and, if necessary, May--August (Summer) round to complete the collection of medical events occurring in the previous calendar year. These sample persons were then rotated out of the study. These individuals participated a maximum of four years (that is, a baseline interview, three complete years of utilization and expenditure data, and up to two interviews to "close out" events due to late arriving paperwork).

Each Fall round, under the rotating panel design, a new panel will be introduced and each Summer round a panel will be retired. Thus, a new panel was introduced in Round 22 and approximately 4,000 of the ongoing sample will be retired from the study by Round 24. This rotating panel sample design allows for both the eventual termination of participation in the study for individuals and for the completion of about 12,000 interviews for an ongoing study population.

As noted earlier, Figure I.1 shows the overlap that occurs during the simultaneous fielding of four panels in the fall round. It also shows the inclusion of a special-purpose one-time (that is, from the participant's viewpoint) supplemental sample that was added to the regular MCBS sample for the Round 22 interview period only. This supplement, consisting of 5,162 sample persons, yielded 4,215 completed Round 22 cases in three areas of high managed care penetration combined, evenly split between Medicare HMO and Medicare fee-for-service beneficiaries, and to increase the precision of the national risk HMO estimates. The analyses of additional respondents in selected localized regions will permit case studies of those important Medicare managed care markets.

The addition of more respondents in managed care increases the precision of national estimates of Medicare managed care enrollees and comparisons to fee-for-service enrollees. To achieve the precision desired, the MCBS needed an effective national managed care sample of about 2,500. Because of the oversampling in the high market penetration areas, we needed to draw more than 2,500 managed care respondents and in fact achieved 5,324 risk HMO cases overall. A description of how to use the weights for the regular and HMO supplemental samples is included in Section 3, "Notes on Using the Data."

Table I.1 shows the number of Round 22 respondents by oldest age attained in 1998. Differential sampling rates were used to obtain such large samples of the disabled and the oldest old.

Table I.1 Number of completes at Round 22 by age category	
Oldest age attained in 1998	Number of completes at Round 22
Total	20,889
Under 45	1,458
45 to 64	1,616
65 to 69	3,735
70 to 74	3,911
75 to 79	3,578
80 to 84	3,501
85 and older	3,090

Complex Sample Design. In order to maximize the precision of statistics, the sample was concentrated in about 1500 ZIP code clusters within 107 Metropolitan Statistical Areas and clusters of nonmetropolitan counties. Although this clustering increases the sample size that can be afforded for a given budget, the

precision is not as good as would be expected from a simple random sample of the same size (were such a sampling procedure feasible).

The differential sampling also has the effect of degrading precision compared to a simple random sample of the same size. Standard statistical packages, such as SAS, SPSS, S, and BMDP are not designed to control for both the clustering and for the differential sampling and will give seriously incorrect standard errors, confidence intervals and p-values. Two packages that will give correct estimates of precision and significance are SUDAAN⁷. See Section 5 for information on how to use these packages.

Nonresponse Bias Knowing that cumulative attrition can become very serious in a panel survey, a concerted effort is constantly made to keep response rates high at each round. After conducting 10 rounds of interviewing, approximately 67 percent of the survivors in the 1991 through 1995 Panels were still responding. (The other 33 percent dropped out of the survey after providing anywhere from 0 to 9 interviews.) See Table I.2 for a complete breakdown of cumulative response rates by panel for Rounds 13 through 22.

Table I.2 Cumulative Response Rates for Each Panel Through Ten Rounds of Data Collection

Cumulative Response Rates for Medicare Current Beneficiary Survey by Round								
	1991 Panel Response Rate (n=15,411)	1992 Panel Response Rate (n=2,410)	1993 Panel Response Rate (n=2,449)	1994 Panel Response Rate (n=6,390)	1995 Panel Response Rate (n=6,349)	1996 Panel Response Rate (n=6,506)	1997 Panel Response Rate (n=6,599)	1998 Panel Response Rate (n=6,450)
Round 13	64.1%	66.9%	69.7%	73.9%	83.1%			
Round 14	63.5%	66.3%	68.5%	72.4%	78.1%			
Round 15	62.9%	65.9%	67.6%	71.4%	76.6%			
Round 16	62.0%	65.2%	66.7%	70.0%	74.1%	83.4%		
Round 17	61.9%	64.6%	66.2%	69.2%	72.8%	79.2%		
Round 18	61.8%	64.6%	66.1%	68.4%	71.7%	77.3%		
Round 19				67.5%	70.6%	75.8%	83.6%	
Round 20				67.2%	69.8%	74.3%	79.2%	
Round 21				67.1%	69.4%	73.1%	77.1%	
Round 22					68.7%	71.9%	75.3%	83.3%

Although average cumulative nonresponse rates in this range are nontrivial; steps have been and continue to be taken to reduce the risk of nonresponse bias. First, at each round, data from administrative records and from prior rounds are used to contrast new nonrespondents with the continuing sample. Where systematic differences are noted, the survey sampling weights are adjusted to remove the bias. For this reason, it is critical that the survey sampling weights be used in all analyses. (This variable is called R22COWGT on the RIC X record format.)

Longitudinal Analyses. In addition to cross-sectional analyses of the Medicare population as of the fall of 1998, this PUF may be linked to PUFs from preceding years to enable longitudinal analyses. Special survey sampling weights are provided for the analysis of different time periods. Table I.3 shows the different possible periods that may be analyzed after linkage along with the panels involved, sample sizes, and the appropriate weight. (It should be noted that the longitudinal files are not appropriate for doing certain types of analyses, such as mortality, disenrollment or characteristics of nonrespondents. If an analyst is interested specifically in analyzing such topics using the MCBS, they will need additional data.)

Table I.3 Possible longitudinal analyses using CY 1998 Access to Care

Period	Targeted last possible “accretion” (that is, new entitlement) date	Earliest possible loss of entitlement	Rounds Interviewed	Sample Size	Weight
Fall 1995 to fall 1998	1/1/95	fall 98	R13, R16, R19, R22	11,611	R223P
Fall 1995 to fall 1998	1/1/96	fall 98	R16, R19, R22	7,263	R222P
Fall 1995 to fall 1998	1/1/97	fall 98	R19, R22	3,313	R22NRWGT

The Community Interview. Sample persons in the community (or appropriate proxy respondents) are interviewed using computer-assisted personal interviewing (CAPI) survey instruments installed on notebook-size portable computers. The CAPI program automatically guides the interviewer through the questions, records the answers, and compares them to edit specifications, thereby increasing the output of timely, clear, and high quality data. CAPI guides the interviewer through complex skip patterns and inserts follow-up questions where certain data were missing from the previous round’s interview. When the interview is completed, CAPI allows the interviewer to transmit the data by telephone to the home office computer.

These interviews yield a series of complementary data over time for each sample person on utilization of health services, medical care expenditures, health insurance coverage, sources of payment (public and private, including out-of-pocket payments), health status and functioning, and a variety of demographic and behavioral information (such as income, assets, living arrangements, family supports, and quality of life). Additionally, an access to care supplement is asked once a year in the September--December round. An effort is made to interview the sampled person directly, but in case this person is unable to answer the questions, he or she is asked to designate a proxy respondent, usually a family member or close acquaintance. In Round 22, roughly 10 percent of the community interviews were done with proxies.

The Facility Interview. The MCBS conducts interviews for persons in long-term care facilities using a similar, but shortened instrument. A long-term care facility is defined as having three or more beds and providing long-term care services throughout the facility or in a separately identifiable unit. Types of facilities currently participating in the survey include nursing homes, retirement homes, domiciliary or personal care facilities, distinct long-term units in a hospital complex, mental health facilities and centers, assisted and foster care homes, and institutions for the mentally retarded and developmentally disabled.

If an institutionalized person returns to the community, a community interview is conducted. If he or she spent part of the reference period in the community and part in an institution, a separate interview is conducted for each period of time. Because of this, a beneficiary can be followed in and out of facilities, and a continuous record is maintained regardless of the location of the respondent.

The initial contact for the institutional interview is always with the facility administrator. Interviews are then conducted with the staff designated by the director as the most appropriate to answer each section of the questionnaire. It was decided early in the design of the study not to attempt interviews with the sample person or family members. The facility interview does not include attitudinal or other subjective items. The facility instruments include:

- (1) The Facility Screener - This instrument gathers information on the facility to determine the facility type. It is asked during the initial interview;
- (2) The Baseline Questionnaire - Gathers information on the health status, insurance coverage, residence history, and demographic items on supplemental sample beneficiaries in a facility setting and new admissions from the continuing sample. Selected information from this questionnaire is updated annually for continuing sample persons using an abbreviated version, The Facility Component Supplement to the Core Questionnaire; and
- (3) The Facility Core Questionnaire - Collects information on facility utilization, charge and payment information. This questionnaire is asked in every round but the initial one.

Data Linkage. MCBS interview data have been augmented with selected individual person-level administrative data (for example, buy-in status for Medicaid and Medicare capitation payments for managed care plan membership) and fee-for-service claims for Medicare-covered services. The addition of these data greatly enhances the analytic power of the survey-reported data alone. This results in a database which combines data that can only be obtained from personal interviews (survey data) with Medicare administrative data and Medicare claims data. All personal identifying information is removed to ensure confidentiality.

Design of the Access to Care Public Use File

The Access to Care Public Use File is designed to provide early release of MCBS data related to Medicare beneficiaries' access to care. Rapid release of access data is achieved by omitting survey reported utilization and expenditure data. The claims information, while limited to program payments for covered services, third party payments for some Medicare secondary payer situations, and potential beneficiary liability, allows significant analysis of the impact of program changes on the beneficiary. This process eliminates the need for imputation of missing cost and payment variables and bypasses the reconciliation of the utilization and expenditure data collected in the survey with Medicare claims data.

The content of the Access to Care Public Use File is governed by its central focus. In addition to questions from the access supplement concerning access to care, satisfaction with care and usual source of care, the file contains demographic and health insurance data and data on health status and functioning. To facilitate analysis, the information collected in the survey is augmented with data on the use and program cost of Medicare services from Medicare claims data.

Contents of this Documentation

The rest of this manual contains detailed information about this public use file and specific background information intended to make the data more understandable. The sections are described below.

Section 1: Technical description of the public use file specifications and the structure of the public use file. It also provides a brief description and count of each of the record types in this file.

Section 2: Codebook of the file variables. This codebook is organized by record type and contains the question number (for data collected in the survey), and variable name, description and location in the record. Codes or possible values and value labels are also supplied. Frequencies for most variables (those with fewer than 120 distinct values) are also included in the codebook, as are notes concerning when variables are inapplicable (that is, questions were not asked due to skip patterns in the CAPI program). An index of variables is also included at the end of the codebook.

Variables in the CMS bill records are documented slightly differently. Record layouts are provided and are cross-walked to CMS data dictionary names. The data dictionary supplies a full explanation of all the variables and their various values.

Section 3: Notes on how individual variables were collected.

Section 4: Hard copy versions of the questionnaires used in Round 22. The questionnaires have been annotated with variable names to associate the questions with the codebook.

Section 5: A general description of the MCBS sample design, estimation procedures and projections. A brief discussion of response rates is also included. This section concludes with a comparison of the MCBS projections to CMS control figures.

References

Centers for Medicare and Medicaid Services, Office of the Actuary, unpublished 1998 data from the National Health Accounts.

Medicare Current Beneficiary Survey CY 1998 Access to Care

Public Use File Structure

File specifications

The MCBS Calendar Year 1998 Access to Care PUF consists of a series of 50 separate datasets or files. Twenty-five of these datasets contain data on the MCBS sample persons; these files are the data files. The other 25 datasets contain SAS7 code (SAS input statements, formats and labels) to facilitate the use of the data files by users who have access to a SAS mainframe environment. These are the README files.

Figure 1.1 shows file specifications such as file names, record counts and the associated README file names.

Summary of the Data

The 25 data files represent completed Round 22 interviews with a sample of 20,889 Medicare beneficiaries, and supplemental information from CMS's Medicare files. Of these cases, 19,650 beneficiaries had community interviews and 1,239 beneficiaries had facility interviews.

Using the Data

All datasets are standard “flat” files to allow for processing with a wide variety of operating systems and programming languages. The datasets can be divided into two subject matter groups, files related to MCBS survey data with related Medicare administrative variables and files related to Medicare bill data.

There are 18 data files containing survey data and related summary administrative variables. For each of these files there is a “README” file which includes a SAS INPUT statement, a PROC FORMAT to interpret the coded fields, LABELs which provide more information about the variable than would be possible in an 8-character name, and a FORMAT statement which associates the code interpretations with the appropriate variables.

Figure 1.1: File organization		
File name	Record Counts	
MCBS.readme.rick		
MCBS.readme.rica2		
MCBS.readme.ric1		
MCBS.readme.ric2		
MCBS.readme.ric2f		
MCBS.readme.ric3		
MCBS.readme.ric4		
MCBS.readme.ric5		
MCBS.readme.ric6		
MCBS.readme.ric7		
MCBS.readme.ric8		
MCBS.readme.rich		
MCBS.readme.ricbk		
MCBS.readme.ricbn		
MCBS.readme.ricx		
MCBS.readme.ricx4		
MCBS.readme.ricx3		
MCBS.readme.ricx2		
MCBS.rick	20,889	RECFM=FB,LRECL=17,BLKSIZE=9010
MCBS.rica2	20,889	RECFM=FB,LRECL=595,BLKSIZE=8925
MCBS.ric1	20,889	RECFM=FB,LRECL=83,BLKSIZE=8300
MCBS.ric2	19,650	RECFM=FB,LRECL=379,BLKSIZE=8717
MCBS.ric2f	1,239	RECFM=FB,LRECL=507,BLKSIZE=8619
MCBS.ric3	19,650	RECFM=FB,LRECL=530,BLKSIZE=7420
MCBS.ric4	20,889	RECFM=FB,LRECL=174,BLKSIZE=8178
MCBS.ric5	19,650	RECFM=FB,LRECL=87,BLKSIZE=8613
MCBS.ric6	1,239	RECFM=FB,LRECL=45,BLKSIZE=9045
MCBS.ric7	1,239	RECFM=FB,LRECL=99,BLKSIZE=9009
MCBS.ric8	20,889	RECFM=FB,LRECL=65,BLKSIZE=7475
MCBS.rich	5,874	RECFM=FB,LRECL=65,BLKSIZE=7475
MCBS.ricbk	14,679	RECFM=FB,LRECL=1092,BLKSIZE=8736
MCBS.ricbn	14,096	RECFM=FB,LRECL=214,BLKSIZE=8988
MCBS.ricx	20,889	RECFM=FB,LRECL=859,BLKSIZE=8590
MCBS.ricx4	16,674	RECFM=FB,LRECL=852,BLKSIZE=8520
MCBS.ricx3	16,674	RECFM=FB,LRECL=852,BLKSIZE=8520
MCBS.ricx2	16,674	RECFM=FB,LRECL=852,BLKSIZE=8520
access98.readme.inp		
access98.readme.snf		
access98.readme.hsp		
access98.readme.hha		
access98.readme.otp		
access98.readme.phy	5,635	RECFM=VB, LRECL=11080, BLKSIZE=32760
access98.readme.dme	1,381	
access98.billrec.inp	289	
access98.billrec.snf	6,111	
access98.billrec.hsp		52,813
access98.billrec.hha	265,957	
access98.billrec.otp	17,599	
access98.billrec.phy		
access98.billrec.dme		

As an illustration of the structure of the README files, Figure 1.2 is a copy of the README file for the Survey Enumeration record, RIC5.

Figure 1.2: Text of a Typical README file
(MCBS.README.RIC5 Illustrated)

```

INPUT  @1    RIC      $1.
        @2    FILEYR   $2.
        @4    BASEID   $8.
        @12   D_HHTOT   2.
        @14   D_HHREL   2.
        @16   D_HHUNRL  2.
        @18   D_HHCOMP  2.
        @20   D_HHLT50  2.
        @22   D_HHGE50  2.;

PROC FORMAT;
VALUE HHCDFMT . = 'INAPPLICABLE'
              -8 = 'DONT KNOW'
              1 = 'NO ONE'
              2 = 'SPOUSE ONLY'
              3 = 'SPOUSE & OTHERS'
              4 = 'CHILDREN ONLY'
              5 = 'CHILDREN & OTHERS'
              6 = 'OTHERS ONLY'
              7 = 'NON RELATIVE';

VALUE PEOPLE 0 = 'NO ONE'
              1 = 'ONE PERSON'
              2 = 'TWO PEOPLE'
              .
              .
              .
              22 = 'TWENTY TWO PEOPLE';

VALUE $FIYRFMT . = 'MISSING'
              '98' = 'FILEYR' ;

VALUE $RICFMT . = 'MISSING'
              '5' = 'RIC' ;

VALUE $BASEID ' ' = 'MISSING'
              '00000000' - '99999999' = 'RECORD IDENTIFICATION #' ;

COMMENT USE THIS TO SET LABELS ON THIS FILE;

LABEL
      RIC      = 'RIC CODE FOR SURVEY ENUMERATION CODE'
      FILEYR   = 'YY REFERENCE YEAR OF RECORD'
      BASEID   = 'UNIQUE IDENTIFICATION NUMBER'
      D_HHTOT  = 'TOTAL NUMBER OF PEOPLE IN HH'
      D_HHREL  = 'NO. IN HH RELATED TO SP (INCLUDING SP)'
      D_HHUNRL = 'TOTAL NO. PEOPLE IN HH UNRELATED TO SP'
      D_HHCOMP = 'HOUSEHOLD COMPOSITION CODE'
      D_HHLT50 = 'NUMBER IN HH UNDER 50 (MAY INCLUDE SP)'
      D_HHGE50 = 'NO. IN HH 50 AND OVER (MAY INCLUDE SP)';

FORMAT  RIC      $RICFMT.
        FILEYR   $FIYRFMT.
        BASEID   $BASEID.
        D_HHTOT  PEOPLE.
        D_HHREL  PEOPLE.
        D_HHUNRL PEOPLE.
        D_HHCOMP HHCDFMT.
        D_HHLT50 PEOPLE.
        D_HHGE50 PEOPLE.;

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Structure of the MCBS public use file(s)

As mentioned above, the data files can be divided into two subject matter groups: files containing survey data with related Medicare administrative variables and files containing Medicare bill data.

There are 18 data files in the survey and administrative summary data group:

- o Key
- o Administrative Identification
- o Survey Identification
- o Survey Health Status and Functioning (Community only)
- o Survey Health Status and Functioning (Facility only)
- o Survey Access to Care
- o Survey Health Insurance
- o Survey Enumeration
- o Survey Facility Residence History
- o Survey Facility Identification
- o Survey Interview
- o Survey HMO Supplement
- o Survey BK Supplement (Beneficiary Knowledge)
- o Survey BN Supplement (Beneficiary Information Needs)
- o Survey Cross-Sectional Weights
- o Survey Longitudinal Weights (for individuals from the Round 13 Panel who completed Round 13, Round 16, Round 19, and Round 22 interviews)
- o Survey Longitudinal Weights (for individuals from the Round 13 or Round 16 panel who completed Round 16, Round 19, and Round 22 interviews)
- o Survey Longitudinal Weights (for individuals from the Round 13, Round 16, or Round 19 panel who completed Round 19 and Round 22 interviews)

There are seven types of Medicare bill records in the detailed utilization portion of the file:

- o Inpatient hospital
- o Skilled nursing facility
- o Hospice
- o Home health
- o Outpatient
- o Physician/supplier (Part B)
- o Durable medical equipment

Section 1: File Structure

The bill records represent services provided during calendar year 1998 and processed by CMS in conjunction with our administrative functions. To facilitate analysis, the Administrative Identification record contains a summary of the utilization that these bills present in detail.

Figure 1.3 The number of records present on each of the data files for community and facility sample respondents

Data files	Community respondents	Facility respondents
RIC K - Key record	1 per respondent	1 per respondent
RIC A - Administrative Identification	1 per respondent	1 per respondent
RIC 1 - Survey Identification	1 per respondent	1 per respondent
RIC 2 - Survey Health Status and Functioning (community)	1 per respondent	none
RIC 2f - Survey Health Status and Functioning (facility)	none	1 per respondent
RIC 3 - Survey Access to Care	1 per respondent	none
RIC 4 - Survey Health Insurance	1 per respondent	1 per respondent
RIC 5 - Survey Enumeration	1 per respondent	none
RIC 6 - Survey Facility Residence History	none	1 per respondent
RIC 7 - Survey Facility Identification	none	1 per respondent
RIC 8 - Survey Interview	1 per respondent	1 per respondent
RIC H - Survey HMO Supplement	1 per respondent	1 per respondent
RIC BK - Survey Supplement (Beneficiary Knowledge)	1 per respondent	none
RIC BN - Survey Supplement (Beneficiary Information Needs)	1 per respondent	none
RIC X - Survey Cross-sectional Weights	1 per respondent	1 per respondent
RIC X4 - Survey R13/16/19/22 Longitudinal Weights	1 per respondent	1 per respondent
RIC X3 - Survey R16/19/22 Longitudinal Weights	1 per respondent	1 per respondent
RIC X2 - Survey R19/22 Longitudinal Weights	1 per respondent	1 per respondent
Hospital bills *	1, several, or none per respondent	
Skilled nursing facility bills *	1, several, or none per respondent	
Hospice bills *	1, several, or none per respondent	
Home health bills *	1, several, or none per respondent	
Outpatient bills *	1, several, or none per respondent	
Physician/supplier bills *	1, several, or none per respondent	
Durable medical equipment bills *	1, several, or none per respondent	

* *These bills are summarized in the Administrative Identification record (RIC A), but are provided for more detailed analysis. If the sample person used Medicare benefits, there will be one or many bills, of one or many types, depending on what types of services were used. If the sample person used no Medicare benefits of a certain type, there will be no bills of that type. If the sample person used no Medicare benefits at all, there will be no bills. The RIC A summary provides information about how many services of each type will be found in the bill record files.*

Section 1: File Structure

All MCBS public use records begin with the same three variables: a record identification code (RIC), the version of the RIC (VERSION) and a unique number that identifies the person who was sampled (BASEID). These elements serve to identify the type of record and to provide a link to other types of records. To obtain complete survey information for an individual, an analyst must link together records for that individual from the various data files using the variable BASEID. In Round 22, none of the sample people has a record on every data file. The above Figure 1.3 provides an overview of the presence of data records on the various data files for community and facility respondents.

The tables that follow Figure 1.3 describe all of the types of records in this release. Table 1.A describes the survey and administrative records; Table 1.B describes the bill records.

Table 1.A – File Overviews**Survey and Administrative Summary Data Files**

File: KEY

RIC: K

Number of Records: 20,889 - 1 for each person who completed an interview

Description: The BASEID key identifies the person interviewed. It is an 8-digit element, consisting of a unique, randomly assigned 7-digit number concatenated with a single-digit checkdigit.

In addition to the BASEID, the KEY file contains the type of interview conducted and other variables for classifying the beneficiary.

File: ADMINISTRATIVE IDENTIFICATION

RIC: A

Number of records: 20,889 - 1 for each person who completed an interview

Description: The ADMINISTRATIVE IDENTIFICATION file contains information about the sample person from administrative records maintained by the Health Care Financing Administration. It contains basic demographic information (date of birth, sex), insurance information (Medicare entitlement, Medicaid eligibility, HMO enrollment), and summarizes the sample person's Medicare utilization for 1998.

Table 1.A – File Overviews**Survey and Administrative Summary Data Files**

File: SURVEY IDENTIFICATION

RIC: 1

Number of records: 20,889 - 1 for each person who completed an interview

Description: The SURVEY IDENTIFICATION file contains demographic information collected in the survey. To some extent, it parallels the demographic information provided in the ADMINISTRATIVE IDENTIFICATION file (date of birth and sex, for example). Demographic information that is not available in the CMS records, such as education, income and military service, are also present.

File: SURVEY HEALTH STATUS AND FUNCTIONING

RIC: 2 and 2F

Number of Records: 19,650 and 1,239 respectively - 1 for each person who completed an interview

Description: The SURVEY HEALTH STATUS AND FUNCTIONING file contains information about the sample person's health, including: self-reported height and weight, a self-assessment of vision and hearing, use of preventive measures such as immunizations and mammograms, avoidable risk factors such as smoking, and a history of medical conditions. Standard measures - activities of daily living (ADLs) and instrumental activities of daily living (IADLs) - also appear in this file.

NOTE: Part of the process of converting the facility instrument from a "paper and pencil" format to a Computer Assisted Personal Interviewing (CAPI) format in 1997 was to adapt applicable questions from the facility instrument to the Resident Assessment Instrument (RAI) format. As a result of the format changes and question adaptations to the facility instrument, the RIC 2 was divided into two separate RICs (RIC 2 and RIC 2F). Those beneficiaries residing in the community have been recorded in the RIC 2. Beneficiaries residing in the facility environment have been recorded in the RIC 2F. Further discussion on the RAI and CAPI conversion and its impact on the RIC 2 can be found in Section 3: Notes on Using the Data.

File: SURVEY ACCESS TO CARE

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Table 1.A – File Overviews**Survey and Administrative Summary Data Files**

RIC: 3

Number of Records: 19,650 - 1 for each community person who completed an interview

Description: The ACCESS TO CARE file contains information from the Access to Care and Satisfaction with Care sections of the questionnaire. Sample people were asked general questions about their use of all types of medical services in 1998 and about their usual source of medical care. This file also contains the sample people's assessment of the quality of the medical care that they are receiving.

File: SURVEY HEALTH INSURANCE

RIC: 4

Number of Records: 20,889 - 1 for each person who completed an interview

Description: The SURVEY HEALTH INSURANCE file summarizes current health insurance information provided by the sample people.

NOTE: One derived variable, the summary insurance indicator, D_SUMINS, indicates the variety and number of current policies reported by the sample person. Medicaid coverage and details of other types of coverage are also included. To limit the size of the RIC 4 record, only 5 private health insurance policies are detailed. For individuals in the sample that had more than 5 private health insurance policies, the total in the summary indicator is correct, but the number of plans detailed is less than the total. After a comparison of two MCBS files revealed a deviation in the number of health insurance policies held by the survey population, the editing procedures in the Access to Care RIC 4 were changed to include only those health insurance plans that the survey participant is currently enrolled with.

File: SURVEY ENUMERATION

Table 1.A – File Overviews**Survey and Administrative Summary Data Files**

RIC: 5

Number of Records: 19,650 - 1 for each person who completed a community interview

Description: The ENUMERATION file contains information about the sample person's household. It reflects the size of the household, and the age and relationship of the people in it.

File: SURVEY FACILITY RESIDENCE HISTORY

RIC: 6

Number of Records: 1,239 - 1 for each person who completed a facility interview

Description: The FACILITY RESIDENCE HISTORY file summarizes the sample person's stay(s) in the facility, providing information about the admission and some limited information about the sample person's living arrangement prior to admission.

NOTE: In converting the MCBS Facility questionnaire to CAPI, full advantage was taken of the work done by the Agency for Health Care Policy and Research in its development of the CAPI protocol for the National Nursing Home Expenditure Survey (NNHES). The NNHES closely resembles the MCBS facility questionnaire in design and content. Adaptation was done carefully to insure both the continuity of the MCBS data and their comparability with NNHES. Consequently, both the RIC 6 and RIC 7 were modified. A more complete discussion of these modifications can be found in Section 3: Notes on Using the Data.

File: SURVEY FACILITY IDENTIFICATION

RIC: 7

Table 1.A – File Overviews**Survey and Administrative Summary Data Files**

Number of Records: 1,239 - 1 for each sample person interviewed in a facility

Description: The FACILITY IDENTIFICATION file provides general characteristics of the institutions, most of the information from the facility screener. In several cases, more than one sample person resided in the same facility. In these cases the RIC 7 records are redundant (containing all of the same information), and differ only in the BASEID.

File: SURVEY INTERVIEW

RIC: 8

Number of Records: 20,889 - 1 for each person who completed an interview

Description: The SURVEY INTERVIEW file summarizes the characteristics of the interview, including type of questionnaire, duration, and whether or not the interview was conducted with a proxy respondent.

File: SURVEY HMO SUPPLEMENT

RIC: H

Number of Records: 5,874 - 1 for each sample person

Description: The HMO SUPPLEMENT file augments information from the Access to Care and Satisfaction with Care sections of the questionnaire. Sample people who were currently enrolled in a State licensed HMO at the time of the interview were asked general questions about their health plans, to include access to and satisfaction with medical services in 1998. This file also contains the sample people's assessment of the quality of the medical care that they are receiving, types of additional coverage offered, and any out of pocket costs associated with the health plan.

File: SURVEY BK SUPPLEMENT (Beneficiary Knowledge)

RIC: BK

Table 1.A – File Overviews

Survey and Administrative Summary Data Files

Number of Records: 14,679 - 1 for each sample person

Description: The BK Supplement provides the opportunity to quantify many of CMS's Strategic Plan objectives. Specifically, to involve the beneficiaries in defining their health care needs by aggregating and using data for continuous policy and process improvement, to assess outreach by the Medicare program and general knowledge of the Medicare program (services and health care choices) by the beneficiaries.

NOTE: The BK Supplement was conducted in the January through April 1999 interview period. As a result, there is a discrepancy in the number of records. This record count variance is attributed to the absence of the HMO “one time only” supplement, the retiring of a panel, and natural attrition.

File: SURVEY BN SUPPLEMENT (Beneficiary Information Needs)

RIC: BN

Number of Records: 14,096 - 1 for each sample person

Description: The BN Supplement (much like the BK Supplement) provides the opportunity to quantify many of CMS's Strategic Plan objectives. Specifically, to obtain an understanding as to how beneficiaries receive information about their benefits and about developments in the Medicare program.

NOTE: The BN Supplement was conducted in the May through August 1999 interview period. As a result, there is a discrepancy in the number of records. This record count variance is attributed to the absence of the HMO “one time only” supplement, the retiring of a panel, and natural attrition.

File: SURVEY CROSS-SECTIONAL WEIGHTS

RIC: X

Number of Records: 20,889 - 1 for each sample person

Table 1.A – File Overviews**Survey and Administrative Summary Data Files**

Description: The CROSS-SECTIONAL WEIGHTS file provides cross-sectional weights, including general-purpose weights and a series of replicate weights.

File: SURVEY R13/16/19/22 LONGITUDINAL WEIGHTS

RIC: X4

Number of Records: 16,674 - 1 non-zero weight for each individual from the 13 sample who completed Round 13, Round 16, Round 19, and Round 22 interviews (5,063); missing value (“.”) for all others (11,611).

Description: The LONGITUDINAL WEIGHTS file provides longitudinal weights, including general-purpose weights and a series of replicate weights.

NOTE: The missing 4,215 records (RIC X4, X3, and X2) constitute a one time over sample of HMO enrolled Medicare beneficiaries.

File: SURVEY R16/19/22 LONGITUDINAL WEIGHTS

RIC: X3

Number of Records: 16,674 - 1 non-zero weight for each individual from the Round 13 or Round 16 samples who completed Round 16, Round 19, and Round 22 interviews (9,411); missing value (“.”) for all others (7,263).

Description: The LONGITUDINAL WEIGHTS file provides longitudinal weights, including general-purpose weights and a series of replicate weights.

File: SURVEY R19/22 LONGITUDINAL WEIGHTS

RIC: X2

Table 1.A – File Overviews**Survey and Administrative Summary Data Files**

Number of Records: 16,674 - 1 non-zero weight for each individual from the Round 13, Round 16, or Round 19 samples who completed Round 19 and Round 22 interviews (13,361); missing value (“.”) for all others (3,313).

Description: The LONGITUDINAL WEIGHTS file provides longitudinal weights, including general-purpose weights and a series of replicate weights.

Table 1.B – File Overviews
Medicare Utilization Summary Files

File: HOSPITAL BILLS

RIC: INP

Number of Records: 5,577

Description: Inpatient hospital bills for the MCBS population. These include bills from short stay general hospitals, and long-term hospitals such as psychiatric and TB hospitals. Different provider types are distinguishable. Generally, there is one bill for each stay. Some hospitals, particularly the long-term facilities, may bill on a cyclical basis and several bills may constitute a single hospitalization.

File: SKILLED NURSING FACILITY BILLS

RIC: SNF

Number of Records: 1,339

Description: Skilled-nursing facility bills for the MCBS population. These include Christian Science facilities and other skilled nursing facilities. Different provider types are distinguishable. Generally, several bills constitute a period of institutionalization.

File: HOSPICE BILLS

RIC: HSP

Number of Records: 284

Description: Hospice bills for the MCBS population. Billing practices vary by provider in that some hospices bill on a cycle (e.g. monthly) so that several bills constitute a period of hospice care; others submit a series of “final” bills.

Table 1.B – File Overviews
Medicare Utilization Summary Files

File: HOME HEALTH BILLS

RIC: HHA

Number of Records: 6,074

Description: Home health bills for the MCBS population. Home health agencies generally bill on a cycle, e.g., monthly.

File: OUTPATIENT BILLS

RIC: OTP

Number of Records: 52,116

Description: Outpatient hospital bills for the MCBS population. These bills are generally for Part B services that are delivered through the outpatient department of a hospital (traditionally, a Part A provider).

File: PHYSICIAN/SUPPLIER BILLS

RIC: PHY

Number of Records: 265,959

Description: Medicare Part B (physician, other practitioners, and suppliers other than DME-- see RIC M below for DME) claims for the MCBS population. These records reflect services such as doctor visits, laboratory tests, X-rays and other types of radiological tests, surgeries, and inoculations.

File: DURABLE MEDICAL EQUIPMENT BILLS

Table 1.B – File Overviews**Medicare Utilization Summary Files**

RIC: DME

Number of Records: 17,188

Description: Medicare DME Part B claims for the MCBS population. These records reflect claims for DME rentals and purchases.

Medicare Current Beneficiary Survey CY 1998 Access to Care

Codebook

This public use release consists of two parts: 1) a summary segment, which contains all of the survey information and summary data from CMS's administrative and claims files, and 2) a bill segment, which contains itemized bill records from CMS's National Claims History (NCH) database.

The first part of this section includes frequency tables for all of the variables in the summary segment. The second part of this section documents the variables (without frequencies) in the bill detail records.

SUMMARY SEGMENT

Using the tables

The following tables list the variables in each of the records, give their physical location in the record, list their possible values and relate them to the questionnaires or to source CMS files.

The first part of the Medicare Current Beneficiary Survey public use file (that is, the survey and CMS summary data) is made up of 18 different types of records. The name of the record type being described is identified by name on the second line. The RIC or record identification code with the record type being described is shown on the third line on the right of the page under the page number. This will enable more rapid access to particular parts of the codebook.

Variable - This column contains the variable names that we have associated with the SAS version of our data files. Since SAS limits variable names to 8 characters, these names are not always immediately meaningful. You can change them to more informative names, but the names in the tables were used to annotate the copies of the questionnaires.

Certain conventions apply to the SAS variable names. All variables that are preceded by the characters "D_", such as D_SMPTYP are derived variables. The variables did not come directly from the survey data, but compiled from several survey variables. Variables preceded by the characters "H_" come from CMS source files.

Col (Column) - This column locates the variable physically in the record.

Len (Length) - This column describes the length of the field of the variable.

Fmt (Format) Name - This column identifies the format name associated with the variable in the SAS README file for this variable's RIC.

Frequency - This column shows unweighted frequency counts of values or recodes for each variable.

Ques # - The column headed “Ques #” contains a reference to the questionnaire for direct variables, or to the source of derived variables. For example, the “Ques #” entry that accompanies the variable ERVISIT in the Access to Care record is “AC1.” The first question in the Access to Care portion of the community questionnaire is the one referenced.

Table 2.1 lists the abbreviations that may appear in this column when a section of the questionnaire is referenced.

This column will be blank for variables that relate to neither the questionnaire nor to CMS source files. These variables, such as the record identification code (variable name is RIC), are usually ones that we created to manage the data and the file.

Ty (Type) - This column identifies the type of variable, that is, numeric (N) or character (C).

Label (Variable label and codes) - In the first line under this column, you will find an explanation of the variable which describes it more explicitly than would be possible in only 8 letters. These labels are available in README files, if you wish to use them in creating SAS data sets.

For coded variables all of the possible values of the variable appear in lines beneath that explanation. Associated with each possible value (in the column labeled “Frequency”) is a count of the number of times that the variable had that value, and, under the column labeled “Label,” a short format expanding on the coded value. Formats are also available in the README files.

Certain conventions were used in coding all variables to distinguish between questions that beneficiaries would not, or could not, answer, and questions that were not asked. These conventional codes are: “.” or “-1” if the question was not applicable; “-7” if the respondent refused to answer; “-8” if the respondent didn’t know the answer; and “-9” if the answer could not be ascertained from the response. With derived variables, a “ ” (blank) or “.” mean that the variable could not be derived because one or more of the component parts was not available.

Many questions were posed to elicit simple “Yes” or “No” answers, or to limit responses to one choice from a list of categories. In these cases, the responses are “Yes” or “No,” or one of the codes from the list. In other questions, the respondent was given a list of items to choose from, and all of the responses were recorded. In these cases, each of the responses is coded “Indicated” or “Not indicated.”

If a beneficiary responded with an answer that was not on the list of possible choices, it was recorded verbatim. All of the verbatim responses were reviewed and categorized. New codes were

added to the original list of options to accommodate narratives that appeared frequently. For this reason, the list of possible values for some variables may not exactly match the questionnaire.

Inapplicable - Each variable is followed by a statement that describes when a question was not asked, resulting in a missing variable. Questions were not asked when the response to a prior question or other information gathered earlier in the interview, would make them inappropriate. For example, if the sample person said he has never smoked (community component, question HS16), he would not be asked if he smokes now (question HS17).

The codebook for the various survey and summary RICs is followed by a Variable Name Index that lists sequentially all variables in the codebook, source of information, pertinent RIC, and page within the codebook.

Table 2.1: Abbreviations Used to Identify Sections of the Questionnaires

Community Questionnaire

IN	Introduction
EN	Enumeration
HI	Health Insurance
AC	Access to Care
HS	Health Status and Functioning
SC	Satisfaction with Care
US	Usual Source of Care
DI	Demographics/Income
CL	Closing

Facility Questionnaire (Screener)

FQ

Facility Baseline Questionnaire

A	Demographics/Income
B	Residence History
C	Health Status and Functioning
D	Health Insurance
L	Tracing and Closing

BILL DETAIL SEGMENT

Using the tables

The tables in the bill detail section describe the Medicare utilization files included on the public use file. There are two sets of tables; they must be considered together in order to interpret the data in this segment.

FILE DESCRIPTIONS FOR MEDICARE CLAIMS - These record layouts correspond to the seven Medicare utilization files on the public use tape(s). The inpatient hospital and SNF bill files are described in the same record layout even though they are in separate datasets.

NCH No. - The number associated with each variable in the public use file bill records and CMS's Data Dictionary (discussed below). The NCH No. can be used to crosswalk from the bill record to the more detailed description in the dictionary.

Variable - The name we have assigned to the data element (variable). Names may be up to eight characters long and are mnemonic. The variable name links the record layout to the remainder of the bill detail documentation. This name is also the name that we have supplied in the "README" SAS INPUT statement and labels.

Type - The format of the data element, or variable. Singly occurring data fields may be numeric, character or packed-decimal.

Group items may appear more than once, depending on the information that is present in the bill. For example, if several surgical procedures were reported on the bill, each of them would appear as a separate group item. One surgical procedure would translate to a single group item. A counter shows how many of each trailer type are present. For example, the number of ICD-9-CM procedure code groups present on the claim would be indicated by the counter PROCCNT.

Length - The number of bytes physically occupied by the variable in the record.

Format - How the data should be interpreted. For example, date fields may be read as eight characters, interpreted as CCYYMMDD (two-digit century, followed by two-digit year of the century, followed by two-digit month, followed by the two-digit day of the month).

Description - A more complete explanation of what the variable contains. These descriptions can be assigned to variables with the SAS LABEL code that is provided in the "README" file.

DATA DICTIONARY - These tables are maintained by CMS to describe their internal records. They contain standard definitions of the variables in this file and values for all coded variables. Some of the variables referenced in this dictionary do not appear in this

file. We have deleted some fields to protect the privacy of those who are participating in the survey.

Note: CMS has released a new version of the Medicare claims. This new version (H) incorporates federally mandated changes to the structure and content of the Medicare claims found in version G. It is important to look closely at the different readme files for each of the claim records before attempting to merge the Medicare claims data with MCBS data.

Medicare Current Beneficiary Survey

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Notes on Using the Data

In an undertaking of this nature and magnitude, there are bound to be questions about how terms are defined operationally and how field procedures affect the data collection process. We have included this section to address those questions.

This section is a collection of information about various data fields present in this public use release. We have not attempted to present information on every survey data field; rather, we concentrated our efforts on data fields where we have something useful to introduce. We start with information which is relevant across the board (global information). We follow that with specific information on individual data fields, presented in the same sequence as the data fields appear in the codebook.

Global Information

Missing Values

Various negative values are used to indicate missing data. For instance, for survey collected data, a value of -1 indicates that the variable is inapplicable. A variable is generally inapplicable because the question is not appropriate, for example, a question about hysterectomy when the respondent is a male. In this file, the value -1 has been replaced with SAS7 standard missing values (“ ” or blank for character and “.” for numeric). Other missing value codes used in the survey (-7 for “refused,” -8 for “don’t know,” and -9 for “not ascertained”) were not changed.

Dates

The CMS derived date of birth and death include century indicators and are in the format CCYYMMDD (2-digit century, 2-digit year, 2-digit month and 2-digit day). Due to the manner in which the responses were given, these dates must be evaluated in parts because one or more of the parts may be missing. For example, a vague response about a particular date (such as, “I know it was in June of last year, but I’m not sure of the exact day”) would be coded “199606-8” (A19” for the century, “96” for the year, “09” for June, and the code “-8” for “Don’t know” for the day).

Narratives

Respondents were asked a number of open-ended questions. The respondents answered these questions in their own words, and interviewers recorded the responses verbatim. The interviewer was prohibited from paraphrasing or summarizing the respondents' answers. However, this public use release does not contain narratives. Instead, we have supplied codes that summarize the answer. Often there will be more than one code because the answer included several specific topics.

Specific variables - Key Record (RIC K)

There are 20,889 key records, one for each individual who completed an interview (19,650 community interviews **INTERVU**="C" and 1,239 facility interviews **INTERVU**="F").

The facility interview was conducted whenever the sample person was residing in a facility: 1) that contains three or more beds, 2) that is classified by the administrator as providing long-term care, and 3) whose physical structure allows long-term care residents of the facility to be separately identified from those of the institution as a whole. This broad definition allows analysis beyond traditional views of long-term care, that is, nursing home and related care homes having three or more beds and providing either skilled nursing, or rehabilitative or personal care (other than supervision). Analysts can narrow or extend the focus of their studies of facility care by using information from the Survey Facility Identification Record. This record is present for each sample person for whom a facility questionnaire was administered.

Some sample people had more than one interview in this round. This release is a mix of people who joined the survey in: Round 13 (**D_SMPTYP**="95"), Round 16 (**D_SMPTYP**="96"), Round 19 (**D_SMPTYP**="97"), and Round 22 (**D_SMPTYP**="98"). Interviews are conducted for the continuing panels (that is, the Round 13, Round 16, and Round 19 panels) in as many settings as necessary, to create a seamless view of the entire round. Only one interview--facility or community--conducted with the new (Round 22) panel, depending on the situation in which we locate them. In the total group of 20,889 respondents with a Round 22 interview, the great majority had one, and only one, interview.

To avoid duplication of data, the records in this file represent only the last interview in Round 22: 19,650 community and 1,239 facility interviews.

This record contains a special-purpose variable, **SURVIVE**. The Round 22 MCBS data are not suited for making estimates of the "ever enrolled" 1998 Medicare population because the sample does not include beneficiaries new to Medicare in 1998 nor those who died during the year prior to the fall round. For the same reason, point-in-time estimates are also inappropriate. However, an

Section 3: Notes on Using the Data

adjustment has been done to account for persons newly enrolled on January 1, 1998. It is appropriate, therefore, to use the Round 22 data to approximate the “always enrolled” 1998 Medicare population, that is, those beneficiaries who were alive and enrolled on or before January 1, 1998 and were still alive and enrolled on January 1, 1999. We estimate this population at 36.5 million beneficiaries. This group can be separated from the entire group of Round 22 interviews by selecting only beneficiaries who were enrolled before 1998 and survived until 1999 (**SURVIVE**=“Y”).

Administrative Identification Record (RIC A)

Except as noted otherwise, the variables in this record were derived from CMS's Medicare enrollment database. History records were searched to establish the beneficiary's status (for example, age, age, residence, and type of beneficiary) as of December 31, 1998.

Four variables relating to the sample person's age are provided. Date of birth as reported by the respondent during the initial interview is recorded in the RIC 1 - Survey Identification record (**D_DOB**). Legal date of birth from the Medicare - Social Security Administration records is recorded in the Administrative Identification Record (**H_DOB**). Note that starting with the 1996 data, this is the SSA legal date of birth, which is the first day of the birth month, unless the sample person was born on the first of the month, in which case the legal birth date is the first day of the previous month. The variable **H_AGE** represents the sample person's legal age as of December 31, 1998. The variable **H_STRAT** groups the sample persons by **H_AGE**. The variables **H_DOB**, **H_AGE**, and **H_STRAT** appear in the Administrative Identification record.

Because of privacy issues several variables were changed or deleted from the public use file (PUF) version of the 1997 RIC A. These changes were continued in the 1998 file. The (**H_DOB**) date of birth change to legal date of birth was mentioned above. The date of death (**H_DOD**) has been changed to the last day of the death month. The **H_CENSUS** census region code has been deleted from the PUF version. The hospice periods (**H_HSBEG1 - 4** and **H_HSEND1 - 4**) and the latest End Stage Renal Disease (ESRD) period dates (**H_ESRBEG** and **H_ESREND**) have been eliminated from the PUF version.

As of July 1, 1998, approximately 5.2 million enrollees or 13 percent of the Medicare population had their Part B and/or Part A premiums paid by a State agency (for the entire year an estimated 5.8 million persons ever-enrolled had their premium paid for at least one month). This process, called State buy-in, is tracked by CMS and is used as a general proxy for Medicaid participation. The variables that describe this participation (**H_MCSW** and **H_MCDE01 -H_MCDE12**) were derived through a match with CMS's enrollment database. The variable **H_MCSW** can be used when only an indication that the enrollee was a “buy-in” at some time during

Section 3: Notes on Using the Data

1996 is needed for analysis. The monthly variables **H_MCDE01 - H_MCDE12** can be used for analyzing Medicaid eligibility at specific points in time.

Section 3: Notes on Using the Data

Membership in Medicare managed care plans has been increasing faster than the overall Medicare population. During 1998 managed care enrollees increased from 6.0 million in January to 6.8 million in December. As of the mid-point of the calendar year, July 1, approximately 6.5 million or 17 percent of the Medicare population received Medicare benefits through coordinated care organizations such as an HMO, which contracts directly with CMS to provide those services. Some of the beneficiaries in the MCBS sample belong to such organizations. The variables that describe this membership (**H_GHPSW** and **H_PLTP01 - H_PLTP12**) were derived through a match with CMS's enrollment database. The variable **H_GHPSW** can be used when only an indication that the enrollee was a member of a Medicare managed care plan at some time during 1998 is needed for analysis. The monthly variables **H_PLTP01 - H_PLTP12** can be used for analyzing membership at specific points in time.

Utilization Summary

For easier comparison of groups of people by the number and cost of medical services they have received, the Administrative Identification Record also includes a summary of all Medicare bills and claims for calendar year 1998, as received and processed by CMS through July 1999. (See the variables in the Administrative Identification Record from **H_LATDCH** to the end). In response to heightened privacy awareness, individual bill records are not supplied as part of the public use release. Researchers who wish to study individual Medicare bills in detail (i.e., the HOSPITAL BILL, the SNF BILL, the HOSPICE BILL, the HOME HEALTH BILL, the OUTPATIENT BILL, the PHYSICIAN/SUPPLIER BILL and the DURABLE MEDICAL EQUIPMENT BILL), will need to obtain the analytic release of the RIC A.

The utilization summary represents services rendered and reimbursed under fee-for-service in calendar year 1998. If a beneficiary used no Medicare services at all or was a member of a coordinated or managed care plan (such as a risk HMO) that does not submit claims to a fiscal intermediary or carrier, all program payment summary variables will be empty. If the beneficiary used no services of a particular type (for example, inpatient hospitalization), the variables relating to those benefits will be empty. Empty variables are zero-filled, except as noted in the next paragraphs.

The variables pertaining to deductibles: **H_LATLOS**, the Part A deductible, **H_INPDED**; Part B deductible, **H_PTBDDED**, and the blood pints deductible, **H_BLDDED**, have been eliminated. This information was not consistently available from CMS's present files. An approximation can be derived from the individual bill records.

The variables pertaining to special coverage (lifetime reserve days, **H_LRDAY**, and psychiatric days, **H_PSYDAY**) have been eliminated. They had been blank in previous releases of Access to Care data, as they did not offer a useful history of utilization.

Utilization summary

Adjustment bills Initial claims submitted by fiscal intermediaries and carriers for services rendered and paid for by Medicare may be modified by later transactions that result in additional submittal of information relevant to payment or utilization for a given event. There are two types of Part A (institutional) adjustment transactions: credit-debit pairs, and cancel-only credit transactions.

Both types of transactions cancel out a bill that was processed earlier (the credit bill exactly matches the earlier bill, which can be viewed as an initial debit). The difference between them lies in how (or if) a new debit transaction is applied to show the correct utilization. If the adjustment consists of a credit-debit pair, the new debit is applied immediately because it is submitted as the “debit” half of the pair. If the adjustment is a cancel-only transaction, the debit may be processed at a later date through a separate bill. In some cases, as when the original bill was completely in error, the cancel-only transaction simply serves to “erase” a mistake, and no new debit would be submitted. For this file, the adjustment processing removes the original debit and the credit which cancels it out, leaving only the final, corrected debit.

[NOTE: A few rare cases of credit bills with no prior debit may be in this file; these records can be dropped from analysis because they are, in effect, canceling out something of which CMS has no record.]

For Part B claims, we summarized only accepted claims (process code is “A”), or adjusted claims if the adjustment concerned money (process code either “R” or “S” and allowed charges greater than \$0). If the claim disposition code (DISPCD) was “03” or “63” (indicating a credit), both the credit and the matching debit were deleted.

Individual fields After adjustments were processed, the bills were summarized following the rules set forth below.

Inpatient hospital bills

Utilization is summarized by admissions, days, charges, covered charges, reimbursement amount, coinsurance days, and coinsurance amount. Admissions (**H_INPSTY**) were totaled by sorting the bills in chronological order, and counting the first admission in each sequence. Total covered days (**H_INPDAY**) were summed from **COVDAY** in the bill. Total coinsurance days (**H_INPCDY**) were summed from **COINDAY**. Total bill charges and non-covered charges were selected from the revenue center trailer coded “0001”; total charges were summed as **H_INPCHG** and covered charges (total charges less non-covered charges) were summed as **H_INPCCH**. Coinsurance amounts (**H_INPCAM**) were summed from **COINAMTA** in the bill. Reimbursement (**H_INPRMB**) is the sum of **PROVPAY**, organ acquisition costs (if any) and “pass through” amounts. Organ acquisition costs were accumulated from revenue center trailers when the second

Section 3: Notes on Using the Data

and third positions of the code were “81”. Pass through amounts were calculated by multiplying covered days (**COVDAY** in the bill record) by the pass through per diem (**PTDIEM** in the bill record).

Skilled nursing facility

Utilization is summarized by admissions, days, charges, covered charges, reimbursement amount, coinsurance days and coinsurance amount. Admissions (**H_SNFSTY**) were totaled by sorting the bills in chronological order, and counting the first admission in each sequence. Total covered days (**H_SNFDAY**) were summed from **COVDAY** in the bill. Total coinsurance days (**H_SNFCDY**) were summed from **COINDAY**. Total bill charges and non-covered charges were selected from the revenue center trailer coded “0001”; total charges were summed as **H_SNFCCHG** and covered charges (total charges less non-covered charges) were summed as **H_SNFCCH**. Total coinsurance amounts (**H_SNFCAM**) were summed from **COINAMTA** in the bill. Total reimbursement (**H_SNFRMB**) is the sum of **PROVPAY**.

Home Health

Utilization is summarized by visits, visit charges, and other (that is, nonvisit) charges. If the second and third positions of the revenue center code were 42, 43, 44, 47, 55, 56, 57, or 58, then the units in the trailer (visits) were added to total visits (**H_HHAVST**) and the charges were accumulated as total covered visit charges (**H_HHACCH**). If the revenue center codes did not indicate visits, the charges were accumulated as other HHA charges (**H_HHACHO**). Total home health reimbursement (**H_HHARMB**) was summed from the variable **PROVPAY**.

Hospice

Utilization is summarized by days, covered charges and reimbursement amount. Covered hospice days (**H_HSDAYS**) were summed from the bill variable **COVDAY**. Covered charges were selected from the revenue center trailer coded “0001” and summed as **H_HSTCHG**. Total hospice reimbursement (**H_HSREIM**) was summed from the variable **PROVPAY**.

Outpatient

Section 3: Notes on Using the Data

Utilization is summarized by bills, covered charges and reimbursement amount. Total bills were counted as **H_OUTBIL**. Total covered charges were selected from the revenue center trailer coded “0001” and summed as **H_OUTCHG**. Total outpatient reimbursement (**H_OUTRMB**) was summed from the variable **PROVPAY**.

Part B (Carrier) claims

Utilization is summarized by number of claims, number of line items, submitted and allowed charges, reimbursement, office visits and office visit charges. All claims and individual line items (there can be up to 13 per claim) were counted and summed as (**H_PMTCLM**) and (**H_PMTLIN**). Submitted charges and allowed charges (**H_PMTTCH**) and (**H_PMTCHG**) were summed from **SUBCRG** and **ALLOWCRG** in the bill. Total reimbursement for Part B claims (**H_PMTRMB**) was summed from the variable **PAYAMT** in the bill.

Office visits and their charges are summed with other services (described above) and as separate categories (**H_PMTVST** and **H_PMTCHO**). We summed office visits and office visit charges separately for two reasons. An office visit is a universally understood measure of service use and access to medical care. It also is an accurate measure of levels of service use across separate groups, unlike charge or payment figures which vary depending on the services that have been performed. Office visits are identified by HCPCS codes in the series 90000-90090 and 99201-99215 in the Part B line item trailer group(s).

Survey Identification Record (RIC 1)

“Initial interview” variables

Some questions are asked only in the initial interview for an individual and are not asked again during subsequent sessions because the responses are not likely to change. Such questions include “Have you ever served in the armed forces?” and “What is the highest grade of school you ever completed?” Similarly, once the sample person has told us that he or she has a chronic condition (such as diabetes), the interviewer will not ask, “Have you ever been told you have diabetes?” in a subsequent interview. For this reason, the answers to these questions are missing from Round 22 for people from the 1995, 1996, and 1997 panels. To maximize the usefulness of this public use release as a cross-sectional file, we have back filled this information from the initial interviews, for persons joining the survey in the 1995, 1996, and 1997 panels. Variables that have been reproduced this way are annotated “Initial interview” in this section.

When the complete date of birth was entered (**D_DOB**), the CAPI program automatically calculated the person’s age, which was then verified with the respondent. In spite of this validation,

Section 3: Notes on Using the Data

the date of birth given by the respondent (**D_DOB**) does not always agree with the Medicare record date of birth (**H_DOB**). In these cases, the sample person was asked again, in the next interview, to provide a date of birth. Some recording errors have been identified this way, but in most cases beneficiaries provided the same date of birth both times they were asked. In some cases, proxies indicated that no one was 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 was used to select and stratify the sample. (Initial interview variable)

The VA disability rating (**D_VARATE**) is a percentage and is expressed in multiples of ten; it refers to disabilities that are officially recognized by the government as service-related. (Initial interview variable)

Race categories (**D_RACE**) are recorded as interpreted by the respondent. Categories were not suggested by the interviewer, nor did the interviewer try to explain or define any of the groups. Ethnic groups such as Irish or Cuban were not recorded. (Initial interview variable)

Hispanic (**D_ETHNIC**) includes persons of Mexican, Puerto Rican, Cuban Central or South American or other Spanish culture or origin, regardless of race. Again, these answers are recorded as interpreted by the respondent. (Initial interview variable)

SPCHNLNM: Respondents were asked to report all living children, whether stepchildren, natural or adopted children. (Initial interview variable)

SPHIGRAD: Education does not include education or training received in vocational, trade or business schools outside of the regular school system. This variable only includes years the sample person actually finished. If the sample person had earned a GED, the response was coded “high school--4th year”. If the sample person said he or she earned a college degree in fewer than 4 years, the response was coded “college and graduate school--4 years”. If the sample person attended school in a foreign country, in an ungraded school, under a tutor or under special circumstances, the nearest equivalent or the number of years of attendance was coded. (Initial interview variable)

INCOME: Income represents the best source or estimate of income during 1997. Round 21 represents the most detailed information for 1997 and is used when available. For individuals not completing Round 21 (that is, continuing panel people unavailable for that round and the Round 22 rotating panel), the most recent information available was used. It should be noted that INCOME includes all sources, such as pension, Social Security and retirement benefits, for the sample person and spouse. In some cases the respondent would not, or could not, provide specific information but did say the income was below \$25,000 (or, conversely, \$25,000 or more).

In Round 22 some Ainitial interview≡ questions (which were previously viewed as not likely to change) were carried over to subsequent sessions, because the responses were likely to change.

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The respondent was allowed to define marital status categories (**SPMARSTA**); there was no requirement for a legal arrangement (for example, separated). The answers to these questions are present in Round 22 for people from the 1995, 1996, 1997, and 1998 panels.

Section 3: Notes on Using the Data

Survey Health Status and Functioning Record (RIC 2 and RIC 2F)

Part of the process of converting the facility instrument from a “paper and pencil” format to a Computer Assisted Personal Interviewing (CAPI) format was to adapt applicable questions from the facility instrument to the Resident Assessment Instrument (RAI) format. The RAI requires a Medicare and Medicaid certified long term care facility to conduct a comprehensive standardized assessment of the resident’s functional capacity and health status within 10 days of admission. In addition, a RAI must be completed once a year or whenever a resident’s health status changes. By adapting the applicable MCBS questions, interviewers can extract data regarding a resident’s health status and functioning directly from the RAI.

Note: Due to the number of variables that were altered in the facility instrument, resulting from the CAPI conversion, a separate RIC (2F) was created. As a result, RIC 2 includes only the community population. The RIC 2F was created for the sample population responding to the health status and functioning section of the facility instrument.

The answers in the health status and functioning section of the questionnaire are a reflection of the respondent’s opinion, not a professional medical opinion.

Limitations on activities and social life (**HELMTACT**) reflect the sample person’s experience over the preceding month, even if that experience was atypical.

In the height measurement **HEIGHTIN**, 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. (Initial interview variable)

In the weight measurement (**WEIGHT**), 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. (Initial interview variable)

The sample person was asked to recall or estimate, not to measure or weigh himself or herself.

HYSTEREC: “Hysterectomy” includes partial hysterectomies. (Initial interview variable)

If the sample person had not received a flu shot last winter, the SP was asked why. The list of variables in **HS14A** are “CODE ALL THAT APPLY”. Similarly, if the sample person had no history of receiving a shot for pneumonia, the SP was asked why. The list of variables in **HS15A** are “CODE ALL THAT APPLY”.

Section 3: Notes on Using the Data

Use of other forms of tobacco, such as chewing tobacco, are not relevant to the “smoking” questions (**EVERSMOK** and **SMOKNOW**). Trying a cigarette once or twice was not considered “smoking,” but any period of regular smoking, no matter how brief or long ago, was considered smoking. “Now” meant within the current month or so and not necessarily whether the sample person had a cigarette, cigar, or pipe tobacco on the day of the interview. Even the use of a very small amount at the present time qualified as a “yes.” Stopping temporarily (as for a cold) qualified as a “yes.” (**EVERSMOK** is an initial interview variable)

The answers about difficulty with various tasks (**DIFSTOOP**, **DIFLIFT**, **DIFREACH**, **DIFWRITE**, **DIFWALK**) reflect whether or not the sample person usually had and anticipates continued trouble with these tasks, even if a short-term injury made them temporarily difficult.

The questions about various conditions (**OCARTERY**, **OCHBP**, **OCMYOCAR**, **OCCHD**, **OCOTHART**, **OCSTROKE**, **OCCSKIN**, **OCCANCER**, **OCCLUNG**, **OCCOLON**, **OCCBREST**, **OCCUTER**, **OCCOROST**, **OCCCERVX**, **OCCBLAD**, **OCCOVARY**, **OCCSTOM**, **OCCKIDNY**, **OCCBRAIN**, **OCCTHROA**, **OCCBACK**, **OCCHEAD**, **OCCFONEC**, **OCCOTHER**, **OCDIABTS**, **OCARTHHR**, **OCARTH**, **OCAARM**, **OCAFEET**, **OCABACK**, **OCANECK**, **OCAALOVR**, **OCAOTHER**, **OCMENTAL**, **OCALZHMR**, **OCPSYCH**, **OCOSTEOP**, **OCBRKHIP**, **OCPARKIN**, **OCEMPHYS**, **OCPPARAL** and **OCAMPUTE**) were coded if the sample person had at some time been diagnosed with the conditions, even if the condition had been corrected by time or treatment. The condition must have been diagnosed by a physician, and not by the sample person. Misdiagnosed conditions were not included. If the respondent was not sure about the definition of a condition, the interviewer offered no advice or information, but recorded the respondent’s answer, verbatim. (Initial interview variables)

IADLs and ADLs

“Difficulty” in these questions has a qualified meaning. Only difficulties associated with a health or physical problem were considered. If a sample person only performed an activity with help from another person (including just needing to have the other person present while performing the activity), or did not perform the activity at all, then that person was 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 were 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,” were coded “yes.”

Section 3: Notes on Using the Data

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

The distinction between light housework (**PRBLHWK**) and heavy housework (**PRBHHWK**) was made clear by examples. Washing dishes, straightening up and light cleaning represent light housework; scrubbing floors and washing windows represent heavy housework. The interviewer was 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 sample person would qualify as help from another person.

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.

HPPDBATH: Those 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 hand rails or a seat in the shower stall;
- # the person never bathes at all (a highly unlikely possibility); or,
- # the person receives no help, uses no special equipment or aids, but acknowledges having difficulty.

Section 3: Notes on Using the Data

HPPDDRES: Dressing is the overall complex behavior of getting clothes from closets and drawers and then putting the clothes on. Tying shoelaces is not considered part of dressing, but putting on socks or hose is. 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.

HPPDCHAR: Getting in and out of chairs includes getting into and out of wheelchairs. If the sample person holds onto walls or furniture for support, he or she is considered to receive "help from special equipment or aids," since the general population does not use such objects in getting in and out of chairs. Special equipment includes mechanical lift chairs and railings.

HPPDWALK: Walking means using one's legs for locomotion without the help of another person or special equipment or aids such as a cane, walker or crutches. Leaning on another person, having someone stand nearby in case help is needed, and using walls or furniture for support all count as receiving help. Orthopedic shoes and braces are special equipment.

HPPDTOIL: Using the toilet is the overall complex behavior of going to the bathroom for bowel and bladder function, transferring on and off the toilet, cleaning after elimination, and arranging clothes. Elimination itself, and consequently incontinence, are not included in this activity, but were asked as a separate question, discussed next.

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

Survey Access to Care Record (RIC 3)

Definitions applied to medical providers

Doctor - Medical doctors (M.D.) and doctors of osteopathy (D.O.). Chiropractors, nurses, technicians, optometrists, podiatrists, physician's assistants, physical therapists, psychologists, mental health counselors and social workers are not included. Generic specialties shown in parenthesis following one of the specialties were coded as the specialty. For example, if the respondent mentioned a "heart" doctor, cardiology was coded. Generic answers not listed were not converted to specialties.

Section 3: Notes on Using the Data

Doctor's office or group practice - an office maintained by a doctor or a group of doctors practicing together; generally, the patient makes an appointment to see a particular physician.

Doctor's clinic - A group of doctors who have organized their practice in a clinic setting and work cooperatively; generally, patients either come in without an appointment or make an appointment and see whatever doctor is available.

HMO - An organization that provides a full range of health care coverage in exchange for a fixed fee.

Neighborhood/family health center - A non-hospital facility which provides diagnostic and treatment services, frequently maintained by government agencies or private organizations.

Free-standing surgical center - A facility performing minor surgical procedures on an outpatient basis, and not physically connected to a hospital.

Rural health clinic - provides outpatient services, routine diagnostic services for individuals residing in an area that is not urbanized and is designated as a health staff shortage area or an area with a shortage of personal health services. These services are provided for a nominal copayment and deductible.

Company clinic - A company doctor's office or clinic which is operated principally for the employees (and sometimes their dependents).

Other clinic - a non-hospital facility such as a drug abuse clinic, a "free" clinic, a family planning clinic or military base clinic.

Walk-in urgent center - a facility not affiliated with a nearby hospital, offering services for acute conditions. Typically, people are seen without appointments.

Home (doctor comes to sample person's home) - home is anywhere the sample person is staying; it may be his or her home, the home of a friend, a hotel room, etc.

Hospital emergency room - means the emergency room of a hospital. "Urgent care" centers are not included. (NOTE: All hospital emergency room visits were included, even if the sample person went there for a "non-emergency" condition such as a cold, flu or intestinal disorder.)

Section 3: Notes on Using the Data

Hospital outpatient department - unit of a hospital, or a facility connected with a hospital, providing health and medical services to individuals who receive services from the hospital but do not require hospitalization.

Differences in the questionnaire sequence for the continuing and supplemental panel

It should be noted in using data in this section that the questionnaire sequence on access to care for supplemental panel persons differs from that for continuing panel persons and may lead to apparent differences in expected number of responses to questions in the access to care codebook section. For example, continuing panel persons indicating use of emergency room (and later, outpatient hospital) care in the utilization section of the core questionnaire are asked, after the conclusion of questions on utilization in that section, appropriate access to care questions about the visit (AC3-AC6). The CAPI program then reverts back to the next utilization section in the core questionnaire. Questions AC1 and AC2 are not later asked of these people.

The supplemental panel people, on the other hand, are not asked the core questions during their initial interview and go through the entire sequence of access to care questions. Thus, the number of persons responding to AC3 on whether or not they had an appointment (ERAPPT) is greater than those who responded to question AC1 on whether they had gone to a hospital emergency room for medical care during the reference period (ERVISIT).

Open-ended questions

Respondents were asked a number of open-ended questions (reasons for dissatisfaction with care, kinds of problems experienced in getting health care, etc.). The respondents answered these questions in their own words, and interviewers recorded the responses verbatim. The interviewer was prohibited from paraphrasing or summarizing the respondents' answer.

This file contains no verbatim responses. We have supplied, instead, codes that summarize the answer. Often there will be more than one code because the answer included several specific topics.

Other variables

The questions about satisfaction with care represent the respondent's general opinion of all medical care received in the year preceding the interview.

MCDRNSEE: If a respondent mentioned any health problem that was not cared for, it was recorded without discrimination; the respondent might have referred to a small ache or pain, or to a serious illness or symptom.

Section 3: Notes on Using the Data

USMCCHK: The distinction in question US12 is between the doctor or doctor's office and the sample person or family. For example, if the check usually goes to the daughter, the answer would be coded "to the sample person."

USFINDMC: "Ever tried to find a doctor ..." refers to some type of active search. It does not refer to simply thinking or talking about it.

USHOWLNG: If the sample person had an actual visit with the doctor listed in **USUALDOC** by the time of the interview, "less than one year" was coded.

Survey Health Insurance Record (RIC 4)

To help the respondent answer the questions about Medicaid, the interviewers used the name of the Medicaid program in the state where the sample person was living.

A health insurance plan is one that covers any part of hospital bills, doctor bills, or surgeon bills. It does not include any of the following:

- # Public plans, including Medicare and Medicaid, mentioned elsewhere in the questionnaire.
- # Disability insurance which pays only on the basis of the number of days missed from work.
- # Veterans' benefits.
- # "Income maintenance" insurance which pays a fixed amount of money to persons both in and out of the hospital or "Extra Cash" policies. These plans pay a specified amount of cash for each day or week that a person is hospitalized, and the cash payment is not related in any way to the person's hospital or medical bills.
- # Workers' Compensation.
- # Any insurance plans which are specifically for contact lenses or glasses only. Any insurance plans or maintenance plans for hearing aids only.
- # Army Health Plan and plans with similar names (e.g., CHAMPUS, CHAMPVA, Air Force Health Plan).

Section 3: Notes on Using the Data

- # Dread disease plans which are limited to certain illnesses or diseases such as cancer, stroke or heart attacks.
- # Policies which cover students only during the hours they are in school, such as accident plans offered in elementary of secondary schools.
- # Care received through research programs such as the National Institutes of Health.

D_PHREL1 - D_PHREL5: The “Policy Holder or “Main insured person” is the member of the group or union or the employee of the company that provides the insurance plans. It would also be the name on the policy, if the respondent had it available.

D_ANAMT1 - D_ANAMT5: A premium amount was recorded even if the sample person did not directly pay the premium (if, for example, a son or daughter paid the premium). Premium amounts have been annualized, even though the sample person may not have held the policy for the full 12 months.

Survey Enumeration Record (RIC 5)

A household is defined as the group of individuals either related or unrelated who live together and share one kitchen facility. This may be one person living alone, a head of household and relatives only, or may include head of household, relatives, boarders and any other non-related individual living in the same dwelling unit.

Household membership includes all persons who currently live at the household or who normally live there but are away temporarily. Unmarried students away at school, family members away receiving medical care, etc., 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 was any question about the composition of the household, the respondent’s perception was accepted.

Because the date of birth or exact relationship of a household member was sometimes unknown (perhaps because a proxy provided the information), the sum of the variables “number related”/”number not related” (**D_HHREL/D_HHUNREL**) or “number under 50”/”number 50 or older” (**D_HHLT50/D_HHGE50**) may not equal the total number of people in the household (**D_HHTOT**).

Survey Facility Residence History (RIC 6)

In converting the MCBS Facility questionnaire to CAPI in Round 19 (fall/1997), full advantage was taken of the work done by the Agency for Health Care Policy and Research in its development of the CAPI protocol for the National Nursing Home Expenditure Survey (NNHES) and that of the Federally mandated Minimum Data Set (MDS). To increase interview efficiency and decrease small business burden, the facility instrument was adapted to match the MDS content. Much of the design of the MCBS facility instrument was modeled after the NNHES. Adaptation was done carefully to insure both the continuity of the MCBS data and their comparability with NNHES.

As a result of converting the facility instrument to CAPI, the variable **ORIGADMN** was added to represent the first admission date into a facility/home of beneficiary while participating in the MCBS. Previously, all that was reported was the date first admitted to the most recent facility/home, **ADMIN**. The variable **ADMIN** still represents the most recent admission date.

Survey Facility Identification Record (RIC 7)

As mentioned above in the RIC 6 (Survey Facility Residence History) notes, advantage was taken of the work done by the AHCPR CAPI development for the NNHES. Although the adaptation was done to insure continuity with the MCBS instrument, changes to this record occurred in Round 19. The following is a breakdown of those changes.

Additional responses were added to the following two variables:

- X **FACOWNED** (other specify)
- X **FACDIOS** (Adult foster care / group home mentally ill) and (Senior center P. A. C. E.)

Variables that are no longer collected:

- X Levels of care provided by facility (**PROVLEVL**, **LEVISKIL**, **LEVLINTR**, **LEVLOTH1**, **LEVLOTS1**, **LEVLOTH2**, **LEVLOTS2**, **LEVLOTH3**, and **LEVLOTS3**)
- X Primary groups served by the facility (**PRIMDEAF**, **PRIMBLND**, **PRIMUWED**, **PRIMABUS**, **PRIMORPH**, **PRIMMDEF**, **PRIMMENT**, **PRIMMIMR**, **PRIMGERI**, **PRIMNEUR**, **PRIMOTHR**, **PRIMOS**, and **PRIMGRP**)
- X Facility provided services (**ROOMCARE**, **SUPRVMED**, **FHLPBATH**, **FHLPDRES**, **FHLPSHOP**, **FHLPWALK**, **FHLPEAT**, **FHLPNURS**)
- X Number of ICF beds only **MCDICFN**
- X Reason for no rates **NORATE**

Variables that were added to the record:

Section 3: Notes on Using the Data

X Number of beds in a facility of a particular certification (**MCAREBED**, **MCAIDBED**, **MANDMBED**, **MNORMBED**, **ICFMRBED**, **OTLTCBED**, and **NLTCBEDS**)

The value of variables representing “number of beds” (**FACLTBED** and **FACTOBED**) will be missing when either there were no beds of that type in the facility, or the question was skipped.

Survey Interview Description Record (RIC 8)

This record was added in the 1992 MCBS Access to Care public use release. Most of the material in it was included in the Survey Identification record in the 1991 MCBS Access to Care public use release.

Multiple Interviews

Some sample people had more than one interview in this round. To avoid duplication of data, the information in this file represents the last interview conducted with the sample person in Round 22. The variable **INTERVU** indicates which type of interview was conducted. Please see the description of the KEY Record (RIC K) earlier in this section for a more detailed description of multiple interviews and of this variable.

Proxy rules

Wherever possible, the community interviews were conducted directly with the sample person. In most cases, the sample person was able to respond to the interview unassisted. In a few cases, the sample person was assisted with the interview by a friend or relative, and in some cases the sample person was too ill or otherwise incapacitated to be interviewed. The variables **PROXY**, **D_PROXR**, **RREHELP** and **D_IHLPR** provide information about who was interviewed, and how those respondents are related to the sample person.

People who were too ill, or who could not complete the community interview for other reasons were asked to designate a proxy, someone very knowledgeable about the sample person’s health and living habits. In many cases, the proxy was a close relative such as the spouse, a son or daughter. In other cases, the proxy was a non-relative like a close friend or care giver. The variable **PROXY** indicates whether or not a community interview was conducted with a proxy respondent, and the variable **D_PROXR** indicates the relationship of the proxy to the sample person. (Since all facility interviews are conducted with proxy respondents, this variable is “missing” for facility cases.)

If the sample person appeared confused or disoriented at the time of the interview, and no proxy could be identified, the interviewer was instructed to complete the questionnaire as well as

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possible. If the interviewer felt that the respondent was not able to supply reasonably accurate data, this perception was recorded in the interviewer remarks questionnaire and appears in this record as the variable **RINFOSAT**.

“Proxy needed -- language problem” was given as a reason for the use of a proxy in 133 cases. More often, language problems were addressed without the use of a proxy. Interpreters were used in some cases, and Spanish-language versions of the questionnaires were used by bilingual interviewers when the respondent preferred to be interviewed in Spanish. There are both English and Spanish versions of the CAPI survey instrument; the variable **LANG** indicates which version was used.

Proxy respondents were always used in nursing homes, homes for the mentally retarded, and psychiatric hospitals. Sample persons were interviewed directly in prisons when that was permitted. The need for a proxy when interviewing respondents in other institutions was evaluated on a case-by-case basis.

In long-term care facilities, the proxy respondents were members of the staff at the facility identified by the administrator. Usually, more than one respondent was used; for example, a nurse may have answered the questions about health status and functioning, while someone in the business office handled questions about financial arrangements.

Other variables

Several questionnaires are administered in the facility interview: a personal baseline for individuals in the supplemental sample found to reside in a nursing facility and for new admissions to a facility from the continuing sample; the core and supplement questionnaires for the continuing sample. The facility screener was administered in every case. Please see Section 4 for copies of all of the instruments and for a more detailed description of when each is administered.

Two variables are supplied to further characterize the interview: **LENGTH** contains the length of the interview, in minutes, and **RESTART** indicates whether or not the interview was interrupted. Community interviews are sometimes interrupted to accommodate the respondent's schedule or for other reasons. We did not calculate the duration of the community interview if the interview was interrupted. Facility interviews are conducted with several instruments and often involve a number of respondents. Since nearly all of the facility interviews are interrupted and total duration is difficult to capture (and interpret), **LENGTH** and **RESTART** are always missing for facility interviews.

Survey HMO Supplement Record (RIC H)

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This record was added to the 1996 MCBS Access to Care public use release as a result of growing interest on the coverage and service provided by Medicare HMOs to Medicare beneficiaries. The questions in this record were asked only if the sample person was currently enrolled in a Medicare HMO.

D_ANHMO: Applicable for sample people with premiums. The premiums have been annualized regardless of the length of time the sample person actively held the policy.

Survey CMS Beneficiary Knowledge Supplement (RIC BK)

Note: This supplement was conducted during the January through April 1999 interview period, as opposed to the September through December interview period (with the rest of the Access to Care file). As a result of collecting this information during the following interview period, a reduction in sample size occurs. This reduction is due to: the absence of the annual HMO over sample (which are included in the survey only during the September through December interview period); the retiring of the 1995 rotating panel (after completing the September through December interview); and natural attrition.

This supplement is annually fielded during the January through April interview period. Due to an initiative by several CMS components to create a baseline for assessing achievements in CMS's Strategic Plan, the RIC PR (now known as RIC BK) was included for the first time in the 1997 Access to Care file. Use of the MCBS provides the opportunity to quantify and establish baseline measures for many of the Strategic Plan objectives, specifically, involve the beneficiaries in defining their health care needs by aggregating and using data for continuous policy and process improvement, assess outreach and information to the beneficiaries on programs, services and health care choices. Also, the MCBS can provide information on health promotion and preventive techniques from the core instrument. The supplement can be broken into four separate focus areas. These four areas are as follows:

- X Information Medicare beneficiaries seem to want (such as what medical services Medicare covers and does not cover; finding or choosing a doctor or other health care provider; availability and benefits of health maintenance organizations; supplemental insurance; and how much they need to pay for a particular medical service covered by Medicare);
- X Sources from which beneficiaries want to receive information on the broad topics identified in the first focus area;
- X Modes of media through which beneficiaries want to receive information on the broad topics identified in the first focus area; and
- X General satisfaction on the understandability of Medicare.

Survey CMS Beneficiary Information Needs Supplement (RIC BN)

Note: This supplement was conducted during the May through August 1999 interview period, as opposed to the September through December interview period (with the rest of the Access to Care file). As a result of collecting this information during this latter interview period, a reduction in sample size occurs. This reduction is due to: the absence of the annual HMO over sample (which are included in the survey only during the September through December interview period); the retiring of the 1995 rotating panel (after completing the September through December interview); and natural attrition.

This supplement was included for the first time in the 1998 Access to Care file, with plans for fielding annually (during the May through August interview period). Although associated with the BK supplement, the BN supplement was developed to identify how beneficiaries receive information, about their Medicare benefits and changes in the Medicare program. This supplement enables the assessment of current outreach and information campaigns directed toward Medicare beneficiaries.

The supplement can be broken into three separate focus areas, they are as follows:

- How much do beneficiaries already know about their Medicare benefits.
- Who / where do beneficiaries go for information about the Medicare program.
- What dissemination medium is preferred for receiving information about the Medicare program.

Survey Cross-sectional Weights Record (RIC X)

Cross-sectional and three sets of longitudinal weights are provided. Cross-sectional weights apply to the entire file of 20,889 people (1995, 1996, 1997, 1998 panels and annual HMO Aone-round= supplement). These cross-sectional weights can be used for making estimates of the population enrolled for Medicare for the whole of 1998.

As noted in the Introduction, the inclusion of a special-purpose one-time supplemental sample with the regular MCBS sample for the September through December interview period increases the precision of national estimates of Medicare managed care enrollees and comparisons to fee-for-service enrollees. For analyses involving Medicare managed care and comparisons of managed care and fee-for-service, we recommend the use of the entire file, including the continuing sample (1995, 1996, 1997 rotating panels), the regular Round 22 supplemental panel (1998 rotating panel), and the annual HMO “one-round” supplement. Each person’s experience should be multiplied by the corresponding cross-section weight, **R22CWGT**, for estimating population

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parameters based on the full sample, and replicate weights, **R22CS001** through **R22CS100**, when making estimates of sampling error.

For cross-sectional analyses based on the classical view of the MCBS stratified at the national level by seven broad age intervals, we suggest adjusting the cross-sectional and replicate weights by the variable, **FACTOR**. Fee-for-service respondents outside of the high penetration market areas have a **FACTOR** value of 1.0. Thus, they contribute the same weight under either the combined or the classical MCBS view. The respondents in the one-time supplement have **FACTOR** values = 0. Multiplying the weights by the corresponding **FACTOR**s results in a zero weight, which effectively excludes them from the analysis. Thus, they make no contribution under the classical view. Their weights, therefore, must be spread among the corresponding groups in the ongoing sample, that is, to the high penetration market area managed care group, to the high penetration market area fee-for-service group, and to the remaining managed care group. Sample persons in these groups will have **FACTOR**s greater than 1.0. Table 3.1 demonstrates the effect the spreading of the experience of the oversample to the remaining ongoing sample under the classic view.

To enable SUDAAN (Professional Software for SURvey DATA ANALysis for Multi-stage Sample Designs) users to compute population estimates and the associated variance estimates, two variables have been included in this record, SUDSTRAT AND SUDUNIT. Please see Section 6 for a further discussion about weights and estimation using these files.

Table 3.1 Comparison of unweighted sample size and weighted population by area and type of coverage (weighted numbers to follow)

	<u>Classical</u>		<u>Oversampled</u>	
	Ongoing Unweighted	Ongoing Weighted	Combined Unweighted	Combined Weighted
High penetration area				
Risk	217	507,623	1,949	450,619
FFS	350	854,999	1,764	760,063
National, other than high				
Risk	2,070	4,729,763	3,134	4,622,958
FFS	14,037	30,446,325	14,042	30,394,024
National, all areas				
Risk	2,287	5,237,386	5,083	5,073,577
FFS	14,387	31,301,324	15,806	31,154,087
Total	16,674	36,538,710	20,889	36,227,664

Survey Longitudinal Weights Records (RIC X4, X3, X2)

The first set of non-zero longitudinal weights (RIC X4) applies to 5,063 individuals from the Round 13 rotating panel who appeared in the CY 1995 (Round 13), CY 1996 (Round 16), CY 1997 (Round 19), and CY 1998 (Round 22) Access to Care releases (the weights for the remaining 11,611 individuals are zero). This set of weights can be used to subset the population in the study from the fifth year of the survey and their experience for making comparisons of that subpopulation between 1995 and 1998. This can be accomplished by match-merging the RIC K and the RIC X4 by BASEID and keeping all records with a non-zero weight in the RIC X4.

The second set of non-zero longitudinal weights (RIC X3) applies to 9,411 individuals (Round 13, and Round 16 rotating panel persons) who appeared in the CY 1996 (Round 16), CY 1997 (Round 19), and CY 1998 (Round 22) Access to Care releases (the weights for the remaining 7,263 individuals are zero). This set of weights can be used to subset the continuing sample and their experience for making comparisons of that subpopulation between 1996 and 1998. This can be accomplished by match-merging the RIC K and the RIC Y by BASEID and keeping all records with a non-zero weight in the RIC X3.

The third set of non-zero longitudinal weights (RIC X2) applies to 13,361 individuals (Round 13, Round 16, and Round 19 rotating panel persons) who appeared in the CY 1997 (Round 19), and CY 1998 (Round 22) Access to care releases (the weights for the remaining 3,313 individuals are zero). This set of weights can be used to subset the continuing sample and their experience for making comparisons of that subpopulation between the 1997 and 1998 populations. This can be accomplished by match-merging the RIC K and the RIC Y by BASEID and keeping all records with a non-zero weight in the RIC X2.

To enable SUDAAN (Professional Software for SURvey DATA ANALysis for Multi-stage Sample Designs) users to compute population estimates and the associated variance estimates, two variables have been included in these records, SUDSTRAT and SUDUNIT. Please see Section 6 for a further discussion about weights and estimation using these files.

It should be noted that this file and these longitudinal weights are not appropriate for doing mortality studies, an area of considerable interest. This file does not include those who may have died during calendar year 1998 prior to the fall interview. Analysts interested in this topic are encouraged to use the annual Cost and Use files which target the ever-enrolled population.

Claims Records (DME, HHA, HSP, INP, OTP, PHY, SNF)

The following rules were used to select bill and claims records for this file.

- # Inpatient bills were included if the **discharge or “through” date** fell on or after January 1, 1998 and on or before December 31, 1998.
- # Skilled nursing facility bills were included if the **admission or “from” date** fell on or after January 1, 1998 and on or before December 31, 1998.
- # Home health agency and outpatient facility bills were included if the **“through” date** fell on or after January 1, 1998 and on or before December 31, 1998.
- # Hospice bills were included if the **admission or “from” date** fell on or after January 1, 1998 and on or before December 31, 1998.
- # Physician or supplier claims were included if the **latest “service thru” date** fell on or after January 1, 1998 and on or before December 31, 1998.
- # Durable medical equipment (DME) claims were included if the **latest “service thru” date** fell on or after January 1, 1998 and on or before December 31, 1998.

A total of 6,911 (about 33.1 percent) of the sample people did not use Medicare reimbursed services in a fee-for-service setting in 1998; consequently, there are no bill records for them in this file. These individuals may have used no services at all, services only in a managed care plan, or services provided by a payer other than Medicare. For the other 13,978 individuals in the sample, we have captured bills meeting the date criteria, processed and made available by CMS through July 1999.

Medicare Current Beneficiary Survey CY 1998 Access to Care

Questionnaires

This section contains copies of the community and facility questionnaires that were administered during Round 22 of the Medicare Current Beneficiary Survey. Round 22 is the seventh annual update of information on Medicare beneficiaries' access to care. The questionnaires are similar in content and sequence of events; however, they differ in how they are administered. Of special note, beginning in 1997 data collected in RIC BK (formerly known as RIC PR): Beneficiary Knowledge Supplement was added to the Access to Care file. The BK data was collected in the January-April round. In addition to the RIC BK supplement, the RIC BN: Beneficiary Information Needs supplement was added to the Access file. This data was collected during the May-August round, it too is straightforward and easy to add to the Access file.

Because the questionnaires are conducted using CAPI, the questionnaires actually exist only as a computer program, and it is impossible to replicate it exactly in hard copy. The version represented here lists the questions, verbatim, and shows the skip patterns. It also displays instructions to the programmers (enclosed in boxes), to the program, and to the interviewer. Although these instructions would be hidden from the respondent, they have been retained in this copy because they are important for understanding the flow of the questionnaire and for establishing logical links between questions.

Questions in all of the questionnaires are preceded by a number, which is cross-referred to variables in the codebook (Section 2). Since more than one variable may be collected in response to one question, each question has also been annotated with all of the variable names associated with it. Variable names are also indexed in the codebook.

Community Component

The community component is conducted in the home of the respondent.

Components of the Community Questionnaire

The community instrument consists of the following components:

- Initial interview questionnaire
- Core questionnaire
- Supplement to the core questionnaire
- Interviewer remarks questionnaire

Initial interview questionnaire

This baseline questionnaire is used for the first interview when a sample person is added to the survey, that is, Round 13 for the 1995 panel, Round 16 for the 1996 panel, Round 19 for the 1997 panel, Round 22 for the 1998 panel, etc. In the initial interview, we collect information about the national origin, age, education and income of the sample person. The interviewer also verifies the sample person's address and telephone number and obtains the names and addresses of people who might be willing to serve as proxy respondents. The interviewer also uses this opportunity to acquaint the respondent with the intent of the survey and to familiarize him or her with the MCBS calendar, and to emphasize the importance of keeping accurate records of medical care and expenses.

In subsequent interviews, some of the information collected in the initial interview will need to be updated. For example, the sample person's designation of his or her race is not likely to change, and will not be asked about again. On the other hand, the sample person's address or telephone number may change, so this information is verified in every interview, and updated when necessary.

Core questionnaire (community)

NOTE: This release does not include any cost or utilization information from the core questionnaire.

The core questionnaire is the major component of the community instrument. The questions focus on the use of medical services and the resulting costs, and are asked in essentially the same way each and every time the sample person is interviewed (after the first time). In each interview, the sample person is asked about new encounters, and to complete any partial information that was collected in the last interview. For example, the sample person may mention a doctor visit during the "utilization" part of the interview. In the "cost" section, the interviewer will ask if the sample person has any receipts or statements from the visit. If the answer is "yes", the interviewer will record information about costs from the statements, but if the answer is "no," the question will be stored until the next interview.

In Round 22, only persons in the longitudinal sample (that is, 1995, 1996, and 1997 panels) were interviewed with this questionnaire.

Supplement to the core questionnaire (community)

Supplemental questions are added to the core questionnaire to gather information about specific topics. The Round 22 supplement focuses on health status and access to care. It includes questions about the sample persons' general health (including standard measures such as IADLs and ADLs), their sources of medical care, and their satisfaction with that care.

Interviewer remarks questionnaire

This questionnaire is completed by the interviewer after every interview with the sample person. The interviewer is asked to evaluate the sample person's ability to respond to the questionnaire and to provide some information about the interview (for example, if proxy answered the questionnaire, the interviewer provides reasons why the proxy was necessary). The interviewer is also encouraged to provide comments that will assist the interviewer in remembering unique facts about the sample person, such as hearing or vision impairments, or that the sample person cannot read.

Facility Questionnaire

Prior to the CAPI conversion, the facility questionnaire was conducted conventionally (using pen and paper). Interviews are conducted in the facility where the respondent is residing at the time of the interview. Information is obtained from facility records; therefore, the beneficiary is never interviewed directly. It was decided early in the design of the MCBS not to attempt interviews with sample persons in facilities, or with their family members. For that reason, the facility questionnaires do not ask about attitudes or other subjective items.

If an institutionalized person returns to the community, a community interview is conducted. If the sample person spent part of the reference period in the community and part in an institution, then a separate interview is conducted for each period of time. In this way, a beneficiary is followed in and out of facilities and a continuous record is maintained regardless of the location of the respondent.

The CY 1998 Access to Care release is intended to serve as a "snapshot" of the sample person at one point in time during Round 22. For this reason, we have selected the latest interview in the round to represent the entire round whenever the sample person was encountered in more than one setting in Round 22.

Components of the Facility Questionnaire

The facility instrument consists of the following components:

- Facility eligibility screener
- Initial (baseline) questionnaire
- Core questionnaire
- Supplement to the core questionnaire

Facility eligibility screener

This questionnaire gathers information about the facility to determine the facility type. The initial interview is conducted with the facility administrator. All other interviews are conducted with the staff designated by the director. A facility screener is administered upon the sample person's admission to a new facility, and once a year thereafter (in Rounds 13, 16, 19, and 22) to capture any changes in the facility's size or composition. The screener is not administered if the sample person simply re-enters the same facility.

Initial (baseline) questionnaire (facility)

This questionnaire gathers information on the health status, insurance coverage, residence history and demographics of the sample person. This questionnaire is administered the first time the sample person is admitted to a facility.

Core questionnaire (facility)

This questionnaire parallels the core questionnaire for the community, collecting information about use of medical services and their associated costs, including the facility cost. Like its community counterpart, this questionnaire is administered in each and every interview after the first one, as long as the sample person continues to reside in the facility.

Supplement to the core questionnaire (facility)

This questionnaire is asked once a year (in Rounds 13, 16, 19, and 22) to update our information about the sample person's health status. It includes questions about the sample person's general health (including standard measures such as IADLs and ADLs), but excludes the questions about access and the subjective questions about satisfaction with care.

Table 5.1 - Components of the Community Questionnaire

NOTE: This release contains information from only those sections marked with an arrow (→).

→	UPD	Name/Address Update
→	IN	Introduction
→	ENS*	Enumeration
→	EN	Enumeration
→	HIS*	Health Insurance Summary
→	HI	Health Insurance
	UTS*	Utilization Summary
	DU	Dental Utilization and Events
	ER	Emergency Room Utilization and Events
	IP	Inpatient Hospital Utilization and Events
	OP	Outpatient Hospital Utilization and Events
	IU	Institutional Utilization
	HHS*	Home Health Utilization Summary
	HH	Home Health Utilization and Events
	MP	Medical Provider Utilization and Events
	OM	Other Medical Expenses Utilization
	PMS*	Prescribed Medicine Summary
	PM	Prescribed Medicine Utilization
	ST	Charge Questions (Statement Series)
	NS	Charge Questions (No Statement Series)
	CPS*	Charge/Payment Summary
→	AC	Provider Probes/Access to Care
→	HS	Health Status and Functioning
→	SC	Satisfaction with Care
→	US	Usual Source of Care
→	DI	Demographics/Income (For Supplemental Sample People Only)
→	CL	Closing Materials
→	IR	Interviewer Remarks
→	MC	Managed Care
→	BK	Beneficiary Knowledge Supplement
→	BN	Beneficiary Information Needs Supplement

* Summary sections - Updates and corrections are collected through the summaries. The respondent is handed a hard copy summary of information gathered in previous interviews, and is asked to verify the material. Changes are recorded if the respondent notices information that is not accurate.

Table 5.2 - Components of the Facility Questionnaire

NOTE: This release contains information from only those sections marked with an arrow (→).

Facility Eligibility Screener

→ FQ Facility questions

Initial interview (facility)

→ A Demographic/Income
→ B Residence History
→ C Health Status and Functioning
→ D Health Insurance
L Tracing and Closing

Core questionnaire (facility)

→ A Residence History
B Provider Probes
C Medicine Summary
D Inpatient Hospital Stays
E Medical Charges
F Tracing and Closing

Supplement to the core (facility)

→ C Health Status and Functioning
→ D Health Insurance

Medicare Current Beneficiary Survey

CY 1998 Access to Care

Sample Design and Guidelines for Preparing Statistics

This section opens with a description of the population covered by the 1998 Access to Care release and a comparison of this “view” with others that are frequently used for analyzing the Medicare program. Next the targeted population is discussed in terms of the sampling strata. This is followed by a general discussion of the selection of the original and supplemental samples. Next appears a description of primary sampling units (PSU) and clusters of zip codes within PSU. Following is a general review of person level response rates, completed interviews by age strata, and selected item nonresponse rates. Guidelines for preparing population estimates using full sample weights and variance estimates using replicate weights are then reviewed.

Medicare population covered by the 1998 public use data

The calendar year 1998 MCBS public use data are focused on Medicare beneficiaries residing in the United States or Puerto Rico who were enrolled in one or both parts of the program throughout calendar 1998. This “always enrolled” population includes individuals enrolled on January 1, 1998 who remained enrolled through the end of December. Excluded are the following categories of Medicare enrollees:

- 1) residents of foreign countries and U.S. possessions and territories other than Puerto Rico;
- 2) persons who became enrolled after January 1, 1998; and
- 3) persons who disenrolled or died prior to the end of December 1998.

NOTE: A small number of sample people 167 included in this file died during 1998 subsequent to their Round 22 interview and are a subset of group 3) above. A discussion of how to subset this file to get the “always enrolled” population is included in Section 3, “Notes on Using the Data,” under ‘Specific Variables - Key Record (RIC K).’

The “always enrolled” population concept was used for the CY 1991 through CY 1997 MCBS Access to Care releases for operational considerations, and is carried forth into this release for the same reasons. While it differs from other views of the Medicare population commonly generated from CMS files or encountered in CMS publications such as “ever enrolled” or “mid-point enrollment,” the concept of “always enrolled” is consistent with the familiar concept of being exposed or “at risk” for using services for the entire 12-month period.

Section 5: Sample Design and Estimation

Table 5.1 shows data from CMS's 5-percent HISKEW file (health insurance skeleton write-off), which contains selected demographic and coverage information on a 5-percent sample of Medicare enrollees. Data for the targeted population are arrayed by age, gender, race using these three views: persons "ever-enrolled," persons enrolled as of the "mid-point of the year" (July 1), and persons "always enrolled." We have included these relationships to allow users to compare the population represented by this release to the more frequently used views of the Medicare population.

(It should be noted that the other series of files produced from the MCBS, known as Cost and Use, contains data composed to represent the ever-enrolled population to better capture total Medicare and other expenditures for a given year. A discussion of how the ever-enrolled population was composed for a given period to capture total utilization (covered and noncovered) and expenditures (Medicare and other) for that period is presented in the documentation for the 1997 file for that series.)

Section 5: Sample Design and Estimation

Table 5.1 1998 Medicare population, by gender, race and age

Gender	Race	Age	Always Enrolled	July 1 Midpoint	Ever Enrolled
Total			36,496,220	38,498,740	40,358,780
Males	Black	0-44	177,380	190,620	201,740
		45-64	284,140	305,180	324,300
		65-69	280,020	313,940	343,960
		70-74	273,940	282,200	290,100
		75-79	192,420	199,660	207,620
		80-84	103,320	109,840	115,820
		85+	83,600	91,100	97,300
	Non-black	0-44	708,220	758,720	800,620
		45-64	1,468,160	1,574,360	1,675,000
		65-69	3,203,840	3,584,020	3,897,140
		70-74	3,493,520	3,563,900	3,633,420
		75-79	2,663,560	2,741,460	2,821,940
		80-84	1,591,380	1,666,580	1,745,740
		85+	1,065,080	1,154,860	1,250,260
Females	Black	0-44	115,800	125,160	134,380
		45-64	255,660	276,020	295,280
		65-69	365,760	409,640	444,360
		70-74	404,880	412,060	419,840
		75-79	323,520	331,200	339,360
		80-84	217,140	224,620	232,700
		85+	236,800	251,080	265,760
	Non-black	0-44	477,240	512,100	543,880
		45-64	1,100,760	1,185,040	1,263,560
		65-69	3,687,820	4,120,600	4,473,640
		70-74	4,417,080	4,472,860	4,529,440
		75-79	3,828,140	3,897,520	3,973,420
		80-84	2,765,360	2,848,680	2,939,560
		85+	2,711,680	2,895,720	3,098,640
Female total			20,907,640	21,962,300	22,953,820
Male total			15,588,580	16,536,440	17,404,960
Black total			3,314,380	3,522,320	3,712,520
Non-black total			33,181,840	34,976,420	36,646,260

Based on March 1999 HISKEW files, inflated to 100 percent. "Always Enrolled" data are estimated.

Targeted population and sampling strata

Section 5: Sample Design and Estimation

The targeted population for Round 1 of the MCBS consisted of persons enrolled in one or both parts of the Medicare program, that is, Part A (Hospital Insurance) or Part B (Supplementary Medical Insurance) as of January 1, 1991, and whose address on the Medicare files was in one of the 50 states, the District of Columbia, or Puerto Rico. Correspondingly, for Rounds 4, 7, 10, 13, 16, 19, and 22 the targeted populations included those individuals enrolled as of January 1, 1992,¹ 1993,² 1994,³ 1995, 1996, 1997, and 1998, respectively.

The targeted universe is divided into seven sampling strata based on age as of December 31, 1998. The age categories are: 0 to 44, 45 to 64, 65 to 69, 70 to 74, 75 to 79, 80 to 84, and 85 or older. The goal of the sample design is to obtain complete annual data on health care use of both Medicare covered as well as noncovered services and the associated costs by source of payment on 12,000 beneficiaries per year, with 2,000 for each of the elderly strata and 1,000 for each of the disabled strata. See Table 5.2.

Table 5.2 Targeted number of MCBS sample persons with complete annual utilization and expenditure data by sampling stratum

Age group	Target
Total	12,000
0 - 44	1,000
45 - 64	1,000
65 - 69	2,000
70 - 74	2,000
75 - 79	2,000
80 - 84	2,000
85 +	2,000

(Note: Due to the switch to a rotating panel design described earlier in the Introduction, it was necessary to interview roughly 16,000 sample persons in the fall rounds 1994 - 1998 (Rounds 10, 13, 16, 19, and 22) in order to meet the targets for complete annual utilization and expenditure data for 1994 through 1998. This overlapping of panels will continue indefinitely under the rotating panel design for each fall interview session. See Table 5.3 for actual number of Round 22 completes by age stratum.)

In response to a request from CMS \ Office of Strategic Planning (OSP), formerly Research and Demonstration (ORD), the Round 22 MCBS sample includes a special one-time supplement of

Section 5: Sample Design and Estimation

beneficiaries in risk HMO or Fee-For-Service (FFS) health plans. This special OSP/HMO supplement targets beneficiaries in Denver, Minneapolis, and South Florida who are enrolled in both types of plans, and beneficiaries outside these areas who are enrolled in risk HMO plans. Target sample sizes for the special supplement were 3,025 risk HMO and FFS completes in the three designated areas (also not including the MCBS sample) and 1,000 risk HMO completes outside of these areas. Within each of the three target areas, the additional sample was allocated in a way that was designed to yield roughly 600 completed interviews with risk HMO beneficiaries and 600 completed interviews with FFS members when combined with the corresponding samples in the continuing MCBS sample.

Beneficiaries for the original sample (Round 1), the first supplement (Round 4), and the second supplement (Round 7) were selected from the standard 5-percent sample of CMS's Enrollment Data Base (EDB). The decision to select the MCBS sample from within the standard 5-percent CMS sample was based mostly on considerations of convenience. The 5-percent sample has been used for many research projects involving the Medicare population, and data files have been constructed to allow access to the claims for this group.

The development of the National Claims History File makes the claims data generally available for the entire population, not just those individuals included in the standard sample. In addition, for some PSU areas, the number of beneficiaries within the standard 5-percent sample is relatively small and the list of potential sample people can become exhausted. As a result, beginning in Round 10, samples are being drawn from 5-percent samples other than the standard 5-percent sample.

The MCBS sample is designed to be nearly self-weighting within the age strata. A systematic sampling scheme with random starts is employed. The use of random starts provides justification for the variance calculations used in the WESVAR procedures described later in this section.

Sample selection

A sample of 15,411 beneficiaries was selected in 1991 for Round 1 of the MCBS. This initial sample was representative of beneficiaries who were entitled on January 1, 1991. Round 1 interviews started in September of 1991, and participating beneficiaries have been re-interviewed roughly every four months for up to a maximum of six years (i.e., until they were scheduled to exit the MCBS sample under the rotating panel design described in the Introduction).

A supplemental sample of 2,410 beneficiaries was added to the sample in 1992 for Round 4. The 1992 supplemental sample was primarily designed to include newly enrolled beneficiaries (i.e., beneficiaries who were enrolled during the period February 1991 through January 1992 (see

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Endnote1)), but also included previously enrolled beneficiaries to compensate for losses in the original sample due to the cumulative effects of deaths, emigration, and nonresponse. The 1992 Access to Care questions were administered in September through December 1992 as part of the Round 4 interview for the continuing sample, and as part of the initial interview for the supplemental sample.

In 1993 an additional supplemental sample of 2,449 beneficiaries was added to the sample for Round 7. Like the 1992 supplemental sample, the 1993 supplemental sample was intended primarily to include newly enrolled beneficiaries (i.e., beneficiaries who were enrolled during the period February 1992 through December 1992), as well as previously enrolled beneficiaries (i.e., beneficiaries who were enrolled on or before January 1, 1992) to maintain the desired sample size. The 1993 Access to Care questions were administered in September through December 1993 as part of the Round 7 interview for the continuing sample, and as part of the initial interview of the 1993 supplemental sample.

The MCBS rotating panel design became operational in 1994. Under the rotating panel design, a nationally representative sample is selected for each Fall interviewing round to replace beneficiaries who are scheduled to exit the study in the preceding Spring round. In 1994, a supplemental sample of 6,390 beneficiaries was added to the MCBS sample for Round 10. The 1994 supplemental sample included newly enrolled beneficiaries (i.e., beneficiaries who were enrolled during the period January 1993 through December 1993) as well as previously enrolled beneficiaries (i.e., beneficiaries who were enrolled on or before December 1992). The 1994 Access to Care questions were administered in September through December 1994 as part of the Round 10 interview for the continuing sample, and as part of the initial interview of the 1994 supplemental sample.

In 1995, a supplemental sample of 6,349 beneficiaries was added to the sample for Round 13. The 1995 supplemental sample included newly enrolled beneficiaries (i.e., beneficiaries who were enrolled during the period January 1994 through January 1995) as well as previously enrolled beneficiaries (i.e., beneficiaries who were enrolled on or before December 1993). The 1995 Access to Care questions were administered in September through December 1995 as part of the Round 13 interview for the continuing sample, and as part of the initial interview of the 1995 supplemental sample.

In 1996, a supplemental sample of 6,506 beneficiaries was added to the sample for Round 16. The 1996 supplemental sample included newly enrolled beneficiaries (i.e., beneficiaries who were enrolled during the period February 1995 through January 1996) as well as previously enrolled beneficiaries (i.e., beneficiaries who were enrolled on or before January 1995). In addition to the 6,506 beneficiaries selected for the “regular” supplement, an additional 2,799 beneficiaries were selected for a one-time ORD/HMO special supplement. These 2,799 beneficiaries included 1,490 in risk HMO or FFS plans in selected target areas of South California and South Florida and 1,309

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beneficiaries in risk HMO plans outside of the targeted areas. The 1996 Access to Care questions were administered in September through December 1996 as part of the Round 16 interview for the continuing sample, and as part of the initial interview for the 1996 supplemental samples. In addition to questions on access to care, satisfaction with care, and health status, the Round 16 supplement included questions specific to managed care issues.

In 1997, a supplemental sample of 6,599 beneficiaries was added to the sample for Round 19. The 1997 supplemental sample included newly enrolled beneficiaries (i.e., beneficiaries who were enrolled during the period February 1996 through January 1997) as well as previously enrolled beneficiaries (i.e., beneficiaries who were enrolled on or before January 1996). In addition to the 6,599 beneficiaries selected for the “regular” supplement, an additional 2,536 beneficiaries were selected for a one-time ORD/HMO special supplement. These 2,536 beneficiaries included 2,089 in risk HMO and FFS plans in selected targeted areas of Arizona and Philadelphia and 447 beneficiaries in risk HMO plans outside of the targeted areas. The 1997 Access to Care questions were administered in September through December 1997 as part of the Round 19 interview for the continuing sample, and as part of the initial interview for the 1997 supplemental samples. In addition to questions on access to care, satisfaction with care and health status, the Round 19 supplement included questions specific to managed care issues.

In 1998, a supplemental sample of 6,450 beneficiaries was added to the sample for Round 22. The 1998 supplemental MCBS sample included newly enrolled beneficiaries (i.e., beneficiaries who were enrolled during the period February 1997 through January 1998) as well as previously enrolled beneficiaries (i.e., beneficiaries who were enrolled on or before January 1997). In addition to the 6,450 beneficiaries selected for the “regular” supplement, an additional 5,162 beneficiaries were selected for a one-time ORD/HMO special supplement. These 5,162 beneficiaries included 3,909 beneficiaries in risk HMO and FFS plans in selected targeted areas of Denver, Minneapolis, and South Florida and 1,253 beneficiaries in risk HMO plans outside of the targeted areas. The 1998 Access to Care questions were administered in September through December 1998 as part of the Round 22 interview for the continuing sample, and as part of the initial interview for the 1998 supplemental samples. In addition to questions on access to care, satisfaction with care, and health status, the Round 22 supplement included questions specific to managed care issues.

Primary Sampling Units

The MCBS sample is spread across 107 primary sampling units (PSUs) which are metropolitan areas and clusters of non-metropolitan counties. Within the PSUs, the initial sample was concentrated in 1,163 clusters of ZIP code areas (5 digits). With the introduction of the 1992 and 1993 supplements, the number of sample ZIP code clusters expanded to 1,366 and 1,412, respectively. The area covered by the 1994 supplement included 1,443 clusters. A supplemental sample of 5 new ZIP clusters was selected in 1995, bringing the total number of sample ZIP clusters

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to 1,448. For 1996, twenty new zip clusters were selected for a total of 1,468 clusters; for 1997, nineteen new clusters were added, bring the total to 1,487 clusters; for 1998, twenty new clusters were added, bring the total to 1,507 clusters.

All eight samples were selected from CMS's master file of beneficiaries enrolled in Medicare, using the beneficiary's address recorded in that file as of March of the year the individual was selected to be in the sample.

Response Rates

As a result of the switch to a rotating panel design, all of the remaining 2,867 beneficiaries in the 1991, 1992, and 1993 supplements were released at Rounds 18 and 19. Previously, 3,678 sampled beneficiaries were released from the 1991 and 1992 panels at Rounds 12 and 13, and an additional 3,319 sampled beneficiaries were released from the 1991--1993 panels at Rounds 15 and 16. Also released at Round 16 were 168 sampled beneficiaries from the 1994 and 1995 panels who were selected in mis-sampled zip fragments (see page 14).

By Round 22, 69 percent of the 1995 panel were still in a formal responding status (that is, either the SP was alive and still participating or had died after Round 13 but left behind a cooperative proxy for the collection of data on the last months of life) or had participated in the survey until death, leaving enough data to estimate the last months of life. For the 1996 and 1997 panels, the corresponding figures were 72 and 75 percent, respectively. The 1998 panel (Round 22) had an initial response rate of 83 percent.

There were 3,313 interviews successfully completed at Round 22 with still-living members of the 1995 panel. For brevity, we refer to these 3,313 interviews as "live completes." For the 1996 and 1997 panels there were 3,950 and 4,348 live Round 22 completes, respectively.

Completed interviews by sampling strata

Table 5.3 lists the number of completed interviews for Round 22 for the continuing (Rounds 13, 16, and 19) and supplemental (Round 22) panels by age strata.

Table 5.3 MCBS Round 22 completed interviews for the continuing and supplemental panels

Age group	- Round 22 Completed Interviews -		Total
	Continuing	Supplemental	

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Total	11,611	9,278	20,889
0 - 44	837	621	1,458
45 - 64	964	652	1,616
65 - 69	1,658	2,077	3,735
70 - 74	2,339	1,572	3,911
75 - 79	2,030	1,548	3,578
80 - 84	1,923	1,578	3,501
85 +	1,860	1,230	3,090

Item Nonresponse

As in any other survey, some respondents could not, or would not, supply answers to some questions. Item non-response rates are low in the CY 1998 Access to Care release, but the analyst still needs to be aware of the missing data and be cautious about patterns of nonresponse.

Some of the missing data is attributable to the fact that some of the community interviews and all of the facility interviews are conducted by proxy. In other words, the respondent had no knowledge of the information sought on the sample person. In other situations the respondent simply refused to answer. While no effort was made to specifically impute missing data for the Access to Care variables, where possible, much of the data not collected in the current round has been filled in through editing to earlier files or through the use of files that have been imputed.

Each user can decide how to handle the missing data. One simple approach is to delete records with missing data. The cumulative effect of deleting each record with any missing data can significantly reduce the data available for analysis. Another approach is to create an “unknown” or “missing” category within each variable distribution. This approach retains more observations than the first approach.

There are other more complicated alternatives for handling cases with missing data. One is to impute the missing data. This can be done fairly easily in such a way as to improve univariate tabulations, but techniques that retain correlation structure for multivariate analyses are extremely complex. For more discussion of imputation, the user is referred to Kalton and Kasprzyk (1986). An alternative is model-based estimation where a joint mechanism is hypothesized that underlies both the substantive data and the missing data structure. For a discussion of this technique, see Little and Rubin (1987).

Preparing Statistics (Using the Full Sample Weights)

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Four sets of final “full sample” Round 22 weights have been provided for different types of statistics. (The term “full sample” is used to distinguish these weights from the replicate weights discussed in the next section). One set of weights is labeled **R22COWGT** (RIC X). **R22COWGT** is a cross-sectional weight and applies to both the continuing sample and to the supplemental sample, which was fielded for the first time in Round 22. This weight has been adjusted to include the ORD/HMO supplement and is intended for use in cross-sectional statistics involving Round 22 by itself. Each weight is greater than zero for all 20,889 beneficiaries on the file. **R22COWGT** should be used to make estimates of the levels of access to care for the Medicare population alive in the fall of 1998.

The second set of weights is labeled **R22NRWGT** (RIC X4). It is intended for use in longitudinal statistics involving continuing people from the 1995 panel who had Round 13, Round 16, Round 19, and Round 22 interviews. The longitudinal weight, **R22NRWGT**, does not apply to the Round 16, Round 19, and Round 22 panels. This weight should only be used when the CY 1995 (Round 13), CY 1996 (Round 16), CY 1997 (Round 19), and CY 1998 (Round 22) Access to Care releases have been merged together. Records must be merged at the beneficiary level, and only those beneficiaries who completed all four rounds (that is, have positive numeric **R22NRWGT**) should be included in the final file.

This weight can then be used to make estimates of changes in characteristics (say, health status) or attitudes (say, satisfaction with care) of a given subset of the population over the three-year period. **R22NRWGT** is greater than zero only for continuing persons in the 1995 panel; it is inapplicable (“.”) for the Round 16, Round 19, and the Round 22 panels. There are 3,313 beneficiaries who completed Round 13, Round 16, Round 19, and Round 22 interviews; these beneficiaries are identified as **D_SMPTYP=‘95’** (RIC K, Key Record).

The third set of weights is labeled **R222P** (RIC X3). These weights are intended for use in longitudinal statistics involving continuing sample people (from the 1995 and 1996 panels) who completed interviews in Round 16, Round 19, and Round 22. The longitudinal weight, **R222P**, does not apply to the Round 19 or Round 22 panel cases. This weight should only be used when the CY 1996 (Round 16), CY 1997 (Round 19), and CY 1998 (Round 22) Access to Care releases have been merged together. Records must be merged at the beneficiary level, and only those beneficiaries who completed all three interviews should be included in the final file.

This weight can then be used to make estimates of year-to-year changes from 1996 to 1998. **R222P** is greater than zero only for persons who completed Round 16, Round 19, and Round 22; it is inapplicable (“.”) for the Round 19 and Round 22 panels. There are 7,263 beneficiaries who completed Round 16, Round 19, and Round 22 interviews; these beneficiaries are identified as **D_SMPTYP=‘95’** or **D_SMPTYP=‘96’** (RIC K, Key record).

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The fourth set of weights is labeled **R223P** (RIC X2). These weights are intended for use in longitudinal statistics involving continuing sample people (from the 1995, 1996, and the 1997 panels) who completed interviews in both Round 19 and Round 22. The longitudinal weight, **R223P**, does not apply to the Round 22 panel cases. This weight should only be used when the CY 1997 (Round 19) and CY 1998 (Round 22) Access to Care releases have been merged together. Records must be merged at the beneficiary level, and only those beneficiaries who completed both interviews should be included in the final file.

This weight can then be used to make estimates of year-to-year changes, such as the number of persons who went from being very satisfied with their care to being dissatisfied with their care. **R223P** is greater than zero only for persons who completed Rounds 19 and 22; it is inapplicable (“.”) for the Round 22 panel. There are 11,611 beneficiaries who completed both Round 19 and Round 22 interviews; these beneficiaries are identified as **D_SMPTYP**=‘95’, **D_SMPTYP**=‘96’, or **D_SMPTYP**=‘97’ (RIC K, Key record).

Although it is possible to create some cross-sectional estimates using **R22NRWGT**, **R222P**, or **R223P** and create longitudinal estimates using **R22COWGT**, both of these actions are strongly discouraged. In general, estimates of the same population statistic produced using the two types of weights (that is, cross-sectional and longitudinal) will differ systematically. When **R22NRWGT**, **R222P**, or **R223P** are used for cross-sectional estimation, recently enrolled beneficiaries will not be represented. When **R22COWGT** is used for longitudinal estimation, positive weights will be given to cases without baseline data and the weights for long-term enrollees will be too small.

Variance Estimation (Using the Replicate Weights)

In many statistical packages, including SAS, the procedures for calculating variances assume that the data were collected in a simple random sample. Procedures of this type are not appropriate for calculating the variance for statistics based upon a stratified, unequal-probability, multi-stage sample such as the MCBS.

The replicate weights associated with the MCBS data can be used to create estimated standard errors for MCBS variables. Just as there are four full sample weights for Round 22, one for cross-sectional analyses and three for longitudinal analyses, there are four corresponding sets of replicate weights.

The replicate cross-sectional weights are labeled **R22CO1** through **R22CO100** and may be found in the Cross-sectional Weights record (RIC X). The first set of replicate longitudinal weights are labeled **R22NR1** through **R22NR100** and may be found on the first Longitudinal Weights Record (RIC X4). The second set of replicate longitudinal weights are labeled **R222P1** through **R222P100** and may be found on the second Longitudinal Weights Record (RIC X3). The third set

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of replicate longitudinal weights are labeled **R223P1** through **R223P100** and may be found on the third Longitudinal Weights Record (RIC X2).

These replicate weights should be used for variance estimation. The user has three options for using the replicate weights. The first option is to use a software package called WesVar PC7 that is available from Westat at no charge. The program can be downloaded from Westat's home page on the World Wide Web at: **WWW.WESTAT.COM**. Additional documentation is available from Westat and can be obtained by submitting a request to: **WESVAR@WESTAT.COM**. Technical questions may be directed to Adam Chu at Westat, telephone 301.251.4326.

Identification of weight variable and variables for analysis can be done using the WesVar PC7 menus. To run WesVar PC7 with MCBS data and weights, the method should be specified as Fay's method with a factor of 0.3.

The second option is for the user to write a small custom program using a very simple algorithm. Let X_0 be an estimate of a statistic of interest formed using one of the full sample weights. Let X_1 through X_{100} be estimates (calculated by the user) of the exact same statistic of interest formed using the corresponding 100 replicate weights. The estimated variance of X_0 is then simply:

$$Var(X_0) = \frac{2.04}{100} \sum_{i=1}^{100} (X_i - X_0)^2$$

The third option is for users who prefer to use alternate software such as SUDAAN7 (Professional Software for SURvey DATA ANalysis for Multi-stage Sample Designs) to compute population estimates and the associated variance estimates. Two variables, SUDSTRAT and SUDUNIT, have been included in the cross sectional and longitudinal weight records to allow use of SUDAAN.

An example of using SUDAAN statements to compute an estimate of the proportion of the Medicare population (excluding newly enrolled after January 1998) that had an inpatient stay in 1998 is shown below:

```
PROC CROSSTAB DATA=dsn FILETYPE=SAS DESIGN=WR;  
  NEST SUDSTRAT SUDUNIT / MISSUNIT;  
  WEIGHT R22COWGT;  
  SUBGROUP H_INPSW;  
  LEVELS 2;
```

PRINT NSUM ROWPER SEROW;

The data set dsn is the name of the file that contains the weights and statistics of interest. The variable H_INPSW is an inpatient switch indicator from the RIC A. Note that variables specified in the NEST, WEIGHT, and SUBGROUP statements have to be numeric and that SUBGROUP must run between 1 and the number of levels with no gaps.

Consistency with Medicare Program Statistics and with CY 1991, CY 1992, CY 1993, CY 1994, CY 1995, CY 1996, and CY 1997 Access to Care releases

In general, MCBS estimates are not consistent with Medicare program statistics such as tabulations of the HISKEW. There are several reasons for the inconsistencies. The most important reason is that the EDB, and hence the HISKEW, includes people who are no longer alive. This may occur where people have entitlement, say for Part A only, and receive no Social Security check. When field-staff try to locate these beneficiaries for interviews, they establish the fact of these deaths. This over-reporting on the HISKEW files is expected to diminish somewhat due to recent efforts to modify CMS edit procedures that rejected records from SSA which had valid dates of death but other erroneous information and due to a recent replenishing of the EDB with SSA records to get nine-digit zip codes. Unrecorded deaths are still present on the EDB.

For cross-sectional estimates of the CY 1992 and CY 1993 Access to Care, special weighting procedures were used to force some MCBS estimates to agree with HISKEW tabulations. This was not the case for the CY 1991 release nor is it the case for CY 1994, CY 1995, CY 1996, CY 1997, or CY 1998.

Although revised 1992 weights have not been published, internal analyses indicate that the estimated mean reimbursement per enrollee in 1992 was slightly too low in all but the youngest age category. The estimate of mean total Medicare reimbursement amount in 1992 increased 0.25 percent from \$5,022 per beneficiary before reweighting to \$5,035 per beneficiary after reweighting. This downward bias was due to the presence of a relatively small number of individuals on the enrollment database who are listed as alive when in fact they are dead (primarily individuals not receiving social security benefits but deemed “insured” for purposes of Medicare at the beginning of the program). Consequently, the number of enrollees was estimated to be too large. This effect was concentrated in the 85+ age category since that is where most of the unrecorded deaths were detected during survey field operations. Results of internal analysis indicate that the estimated proportion of beneficiaries in the 85 + age group decreased from 9.6 percent to 9.0 percent after reweighting.

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Also, research has shown that MCBS estimates by Census Division (the nation is divided into nine of these areas) are subject to extremely high variance. Users are urged to collapse down to the standard four Census Regions for geographic analyses.

There was an error in the 1992 weighting that skewed sample estimates toward non-metropolitan characteristics. Results from the reweighting indicate that mean total 1992 Medicare reimbursement increased from \$4,238 to \$4,269 for non-metropolitan beneficiaries, but decreased from \$5,334 to \$5,303 for beneficiaries in metropolitan areas.

Finally, an error in sampling was discovered early in 1996 that resulted in the selection of 320 beneficiaries from ZIP clusters that are not in sampled PSUs. Of these missampled cases, 64 were sampled with the 1992 supplementary panel, 38 were sampled with the 1993 supplementary panel, 115 were sampled with the 1994 supplementary panel, and 103 were sampled with the 1995 supplementary panel. Most of these cases are located in Central Florida (92 cases) and Puerto Rico (181 cases). Missampled cases in the 1991-1993 panels were released at Round 16. Seven missampled cases in the 1992 panel remained in the sample at Round 16 but will be released at Round 19 when this panel rotates out of the sample.

Weighting procedures for the 1996 Access to Care releases included a special adjustment to correct for the missampling. Weights for the previous Access to Care releases have not been revised to reflect this correction. Although preliminary analysis indicates that the effect on overall estimates is small, estimates for Hispanics appear to be more affected by the sampling errors, and analysts are advised to use caution when interpreting results for this subgroup that are obtained from earlier Access to Care releases.

References

- Kalton, G. and Kasprzyk, D. (1986), "The Treatment of Missing Survey Data," *Survey Methodology*, **12**, 1-16.
- Little, R.J.A. and Rubin, D.B. (1987), *Statistical Analysis with Missing Data*, New York: John Wiley and Sons.

Notes

1. Because people often are listed in the enrollment database before eligibility for Medicare benefits actually begins, the Round 4 supplement includes some beneficiaries who became eligible in February 1992 or later.

2. The primary goal of the survey is the dissemination of detailed calendar year utilization and expenditure data. Therefore, it was decided to delay sampling the January 1993 accretes to coincide with sampling for the balance of 1993 accretes. Since the target for the CY 1993 Access to Care file was all those enrolled for all of 1993, which includes the January 1993 accretes, a weighting adjustment was made so that the cross-sectional weights on that file do reflect the inclusion of this group.

3. The primary goal of the survey is the dissemination of detailed calendar year utilization and expenditure data. Therefore, it was decided to delay sampling the January 1994 accretes to coincide with sampling for the balance of 1994 accretes. Since the target for the CY 1994 Access to Care file was all those enrolled for all of 1994, which includes the January 1994 accretes, a weighting adjustment was made so that the cross-sectional weights on that file do reflect the inclusion of this group.

1998 ACCESS TO CARE ALPHABETIC LIST OF VARIABLES

Start	RIC	Variable	Description				
455	3	ACCOMPUS	DOES SOMEONE ACCOMPANY SP TO DOCTOR?	283	BK	AVLTVRAD	HMO AVAI INFO FROM TV OR RADIO
935	BK	ACCPUSRC	WHO GIVES MOST ACCURATE HEALTH PLAN INFO	285	BK	AVLZINE	HMO AVAI INFO FROM NEWSPAPER OR MAGAZINE
235	2F	ADDNHOSP	DID SP HAVE DO NOT HOSPITALIZE ORDER?	967	BK	BADAARP	CONTACT AARP TO REPORT COMPLAINTS
232	2F	ADDNRES	DID SP HAVE DO NOT RESUSCITATE ORDER?	977	BK	BADCOUN	CONTACT MCAR COUNSEL TO REPORT COMPLNTS
229	2F	ADLIVWIL	DID SP HAVE LIVING WILL?	979	BK	BADEMPLR	CONTACT EMPLOYER TO REPORT COMPLAINTS
40	6	ADMFROS	PLACE SP WAS ADMITTED FROM (OTHER)	969	BK	BADFAMLY	CONTACT FAMILY TO REPORT COMPLAINTS
18	6	ADMIN	MOST RECENT ADMISSION DATE	981	BK	BADHOTLN	CONTACT 800 HOTLINE TO REPORT COMPLAINTS
38	6	ADMTFROM	PLACE SP WAS ADMITTED FROM	961	BK	BADINSCO	CONTACT INSUR CO TO REPORT COMPLAINTS
238	2F	ADOTREST	FEEDING/MEDICATION/OTHER RESTRICTIONS?	983	BK	BADLAW	CONTACT LAW ENFORC TO REPORT COMPLAINTS
	2F	ALCOH	WAS SP ALCOHOL DEPENDENT?	985	BK	BADMCBS	CONTACT MCBS TO REPORT COMPLAINTS
	2F	ALLERGY	DID SP HAVE ALLERGIES?	959	BK	BADNONE	CONTACT NO ONE TO REPORT COMPLAINTS
	2F	ALZHMR	DID SP HAVE ALZHEIMERS DISEASE?	965	BK	BADOGVOT	CONTACT OTHER GOVOT TO REPORT COMPLAINTS
307	2F	ANEMIA	DID SP HAVE ANEMIA?	989	BK	BADOTHOS	CONTACT OTHER SPECIFY COMPLAINTS
310	2F	ANXIETY	DID SP HAVE ANXIETY DISORDER?	987	BK	BADOTHR	CONTACT OTHER PERS TO REPORT COMPLAINTS
313	2F	APHASIA	DID SP HAVE APHASIA?	975	BK	BADOTPRV	CONTACT OTHER PROV TO REPORT COMPLAINTS
132	3	AREAMHMO	ARE THERE MEDICARE HMOS IN YOUR AREA	973	BK	BADPROV	CONTACT BAD PROV TO REPORT COMPLAINTS
142	2F	ARTHARMS	WERE ARMS AFFECTED BY ARTHRITIS?	971	BK	BADSRCTR	CONTACT SR CENTER TO REPORT COMPLAINTS
148	2F	ARTHBACK	WAS BACK AFFECTED BY ARTHRITIS?	963	BK	BADSSOFF	CONTACT SOC SEC OFF TO REPORT COMPLAINTS
154	2F	ARTHJOIN	WERE JOINTS AFFECTED BY ARTHRITIS?	4	1	BASEID	UNIQUE IDENTIFICATION NUMBER
145	2F	ARTHLEGS	WERE LEGS AFFECTED BY ARTHRITIS?	4	2	BASEID	UNIQUE IDENTIFICATION NUMBER
151	2F	ARTHNECK	WAS NECK AFFECTED BY ARTHRITIS?	4	3	BASEID	UNIQUE IDENTIFICATION NUMBER
157	2F	ARTHOTHR	WERE OTHER PARTS AFFECTED BY ARTHRITIS?	4	4	BASEID	MCBS UNIQUE IDENTIFICATION NUMBER
139	2F	ARTHTRIT	DID SP HAVE ARTHRITIS?	4	5	BASEID	UNIQUE IDENTIFICATION NUMBER
76	2F	ASHD	SP HAVE ANTERIOSCLEROTIC HEART DISEASE?	4	6	BASEID	UNIQUE IDENTIFICATION NUMBER
316	2F	ASTHMA	DID SP HAVE ASTHMA?	4	7	BASEID	UNIQUE IDENTIFICATION NUMBER
269	BK	AVLAARP	HMO AVAI INFO FROM AARP/SR CITIZENS ORG	4	8	BASEID	UNIQUE IDENTIFICATION NUMBER
335	BK	AVLANSW	WERE HMO AVAI QUESTIONS ANSWERED BY INFO	4	2F	BASEID	UNIQUE IDENTIFICATION NUMBER
333	BK	AVLBEST	HMO AVAI INFO THAT WAS MOST HELPFUL	4	A	BASEID	UNIQUE IDENTIFICATION NUMBER
279	BK	AVLCOUN	HMO AVAI INFO FROM MEDICARE COUNSELING	4	A2	BASEID	UNIQUE IDENTIFICATION NUMBER
277	BK	AVLDOCTR	HMO AVAI INFO FROM DR OFFICE	5	BK	BASEID	UNIQUE IDENTIFICATION NUMBER
289	BK	AVLEMPLR	HMO AVAI INFO FROM CURR/FORMER EMPLOYER	5	BN	BASEID	UNIQUE IDENTIFICATION NUMBER
271	BK	AVLFAMLY	HMO AVAI INFO FROM FAMILY OR FRIEND	4	H	BASEID	MCBS UNIQUE IDENTIFICATION NUMBER
257	BK	AVLFIND	SP TRIED TO FIND MHMO AVAILABIULTY INFO	4	K	BASEID	UNIQUE IDENTIFICATION NUMBER
291	BK	AVLHMO	HMO AVAI INFO FROM HMO	5	W1	BASEID	MCSB UNIQUE IDENTIFICATION NUMBER
275	BK	AVLHOSP	HMO AVAI INFO FROM LOCAL HOSPITAL	5	W2	BASEID	MCSB UNIQUE IDENTIFICATION NUMBER
293	BK	AVLINET	HMO AVAI INFO FROM INTERNET	5	W3	BASEID	MCSB UNIQUE IDENTIFICATION NUMBER
261	BK	AVLINSCO	HMO AVAI INFO FROM INSURANCE CLAIMS	4	X	BASEID	MCSB UNIQUE IDENTIFICATION NUMBER
299	BK	AVLMCBS	HMO AVAI INFO FROM MCBS	917	BK	BKACTINF	RECD MCAR INFO REQS TAKING SOME ACTION
265	BK	AVLMCOFF	HMO AVAI INFO FROM MEDICARE/OFC HOTLINE	905	BK	BKHMOCCH	JOINING MHMOS LIMITS CHOICE OF DOCTOR
263	BK	AVLMEDGP	HMO AVAI INFO FROM MEDIGAP/SUP	909	BK	BKHMOCOV	MHMOS OFFER MORE COVERAGE THAN NON-SUPP
259	BK	AVLNOFND	HMO AVAI INFO NOT FOUND	911	BK	BKMCARTV	MCAR IN MEDIA LEADS TO MORE INVESTIGATN
287	BK	AVLOGOVT	HMO AVAI INFO FROM OTHER GOVT AGENCY	907	BK	BKMCCOVR	KEEP MCAR COVERAGE WHEN MHMO IS DROPPED
297	BK	AVLOSMNR	HMO AVAI INFO FROM OTHER SEMINAR	915	BK	BKMCEXP	MOST SP MCAR KNOWLEDGE FROM EXPERIENCE
301	BK	AVLOTHER	HMO AVAI INFO FROM OTHER PERSON/PLACE	901	BK	BKMCINFO	MEDICARE HAS BEGUN TO OFFER MORE INFO
303	BK	AVLOTHOS	HMO AVAI INFO FROM OTHER SPECIFIED	897	BK	BKPLNCHC	MANY HLTH PLAN CHOICES AVLBL W/ MEDICARE
281	BK	AVLPUBL	HMO AVAI INFO FROM MEDICARE PUBLICATIONS	903	BK	BKRPTHMO	CAN REPORT POOR MHMO/SUPP PLANS FOR MCAR
295	BK	AVLSEMNR	HMO AVAI INFO FROM HMO/INS CO SEMINAR	899	BK	BKSRVCHG	"IF HAPPY W/ CURRENT CARE, NO CHANGES REQ"
273	BK	AVLSRCTR	HMO AVAI INFO FROM LOCAL SR CENTER	895	BK	BKSUPPAY	MCARE W/O SUPPL DOES PAY ALL EXPENSE
267	BK	AVLSSOFF	HMO AVAI INFO FROM SOC SECURITY OFFICE	913	BK	BKTVTRUS	MCAR INFO FROM TV/NEWS CANNOT BE TRUSTED
181	BN	BNCOLCAN	MCAR COVERS COLORECTAL CANCER SCREENING	53	2	BLOODTST	SP HAD BLOOD TEST FOR PROSTATE CANCER?
				187	BN	BNFLUSHT	MEDICARE COVERS AN ANNULA FLU SHOT

37	BN	BNGOCOV	GO TO SOURCE FOR MCARE COVERAGE INFO
39	BN	BNGOCVOS	OTHER MCAR COVERAGE SOURCE SPECIFIED
71	BN	BNGOMCOS	OTHER MCAR MNGD CARE PLAN SOURCE SPCFD
69	BN	BNGOMMCP	GO TO SRC FOR MCAR MNGD CARE PLAN INFO
103	BN	BNGOSPOS	OTHER SUPL/MGAP INS SOURCE SPECIFIED
101	BN	BNGOSUPL	GO TO SOURCE FOR SUPL/MGAP INS INFO
191	BN	BNHAVCAB	SP HAS CABLE TV IN HOME
189	BN	BNHAVCOM	SP HAS PERSONAL COMPUTER IN HOME
193	BN	BNHAVVCR	SP HAS VCR IN HOME
21	BN	BNKNCHDR	KNOW ABOUT CHOOSING DR/HLTH CARE PROV
13	BN	BNKNCOVR	KNOW ABOUT WHAT SERVICES MEDICARE COVERS
23	BN	BNKNHLTH	KNOW ABOUT STAYING HEALTHY
25	BN	BNKNMDCD	KNOW ABOUT MEDICAID PLAN
19	BN	BNKNMMCP	KNOW ABOUT MEDICARE MANAGED CARE PLANS
15	BN	BNKNPAYM	KNOW ABOUT WHAT SP MUST PAY FOR SERVICES
17	BN	BNKNSUPL	KNOW ABOUT SUPPL/MEDIGAP INS COVERAGE
183	BN	BNMAMGRM	MCAR COVERS A MAMMOGRAM FOR WOMAN
185	BN	BNSUPMCP	MGAP/SUPL INS IS SAME AS MCAR MNGD CARE
31	BN	BNTOPIC1	TOPIC MOST IMPORTANT TO HAVE INFO ABOUT
33	BN	BNTOPIC2	TOPIC 2ND IMPORTANT TO HAVE INFO ABOUT
35	BN	BNTOPIC3	TOPIC 3RD IMPORTANT TO HAVE INFO ABOUT
621	BK	BOKWRVB1	VERB DESC OF WHAT WORRIED SP IN BOOK-L1
666	BK	BOKWRVB2	VERB DESC OF WHAT WORRIED SP IN BOOK-L2
711	BK	BOKWRVB3	VERB DESC OF WHAT WORRIED SP IN BOOK-L3
364	2F	BONEFRAC	DID SP HAVE PATHOLOGICAL BONE FRACTURE?
619	BK	BOOKHAVE	SP STILL HAS MEDICARE & YOU BOOK
607	BK	BOOKOPT	BOOK USED TO GET HEALTH PLAN INFO
603	BK	BOOKREAD	AMOUNT OF BOOK READ BY SP
569	BK	BOOKRECD	SP RECEIVED MEDICARE & YOU BOOK
571	BK	BOOKSRC	SOURCE THAT SENT MEDICARE & YOU BOOK
573	BK	BOOKSROS	OTHER SPECIFY SOURCE THAT SENT BOOK
605	BK	BOOKTELE	BOOK USED TO GET PHONE NUMBER
609	BK	BOOKUNDR	BOOK UNDERSTOOD BY SP
611	BK	BOOKWORY	BOOK CONTENT WORRIES SP
385	2F	BRAININJ	DID SP HAVE TRAUMATIC BRAIN INJURY?
460	2F	BRAINS	DID SP HAVE NONPSYCHOTIC BRAIN SYNDROME?
427	2F	BREAST	DID SP HAVE BREAST DISORDERS?
274	2F	BSDISRP	HOW OFTEN DID DISRUPTIVE BEHAVIOR OCCUR?
271	2F	BSPHYSAB	OCCURENCE OF PHYS ABUSIVE BEHAVIOR?
277	2F	BSRESIST	HOW OFTEN DID SP RESIST CARE?
268	2F	BSVERBAB	OCCURENCE OF VERBALLY ABUSIVE BEHAVIOR?
265	2F	BSWANDER	HOW OFTEN DID WANDERING OCCUR?
29	BN	BUYINBEN	AWARE OF MEDICARE BUY-IN BENEFITS
27	BN	BUYINPRG	HEARD OF MEDICARE BUY-IN PROGRAMS
103	2F	CANCER	DID SP HAVE CANCER?
319	2F	CARDDYSR	DID SP HAVE DYSRHYTHMIA?
88	2F	CARDIOV	DID SP HAVE CARDIOVASCULAR DISEASE?
322	2F	CATARCT	DID SP HAVE CATARACTS?
21	2F	CATAROP	SP EVER HAVE OPERATION FOR CATARACTS?
430	2F	CERDEG	DID SP HAVE CEREBRAL DEGENERATION?
325	2F	CERPALSY	DID SP HAVE CEREBRAL PALSY?
48	7	CERTBEDS	NUMBER OF UNCERTIFIED BEDS
201	BK	CVRPUBL	COVERAGE INFO FROM MEDICARE PUBLICATIONS

21	4	CHOICHMO	SP HAVE CHOICE JOINING MEDICAID HMO?
613	BK	CHTLOOK	SP SEEN MEDICARE & YOU COMPARISON CHART
615	BK	CHTUNDR	COMPARISON CHART UNDERSTOOD BY SP
617	BK	CHTWORY	COMPARISON CHART WORRIES SP
756	BK	CHTWVRB1	VERB DESC OF WHAT WORRIED SP IN CHART-L1
801	BK	CHTWVRB2	VERB DESC OF WHAT WORRIED SP IN CHART-L2
846	BK	CHTWVRB3	VERB DESC OF WHAT WORRIED SP IN CHART-L3
933	BK	CNFPLCHC	CONFIDENCE IN ABILITY TO CHOOSE NEW PLAN
121	2F	CNRBLADD	DID SP HAVE BLADDER CANCER?
109	2F	CNRBOWEL	DID SP HAVE COLON/RECTUM/BOWEL CANCER?
112	2F	CNRBREAS	DID SP HAVE BREAST CANCER?
127	2F	CNRCERVI	DID SP HAVE CERVIX CANCER?
106	2F	CNRLUNG	DID SP HAVE LUNG CANCER?
133	2F	CNROTHER	DID SP HAVE OTHER CANCER?
124	2F	CNROVARY	DID SP HAVE OVARIAN CANCER?
118	2F	CNRPROST	DID SP HAVE PROSTATE CANCER?
100	2F	CNRSKIN	DID SP HAVE SKIN CANCER?
130	2F	CNRSTOMA	DID SP HAVE STOMACH CANCER?
115	2F	CNRUTERU	DID SP HAVE UTERUS CANCER?
241	2F	COMATOSE	WAS SP COMATOSE?
14	2	COMPLHTH	HEALTH COMPARED TO ONE YEAR AGO
433	2F	CONST	DID SP HAVE CONSTIPATION?
91	2F	CRDVTYPE	SP HAVE ANGINA/CORONARY HEART DISEASE?
250	2F	CSCURSEA	WAS ABLE TO RECALL CURRENT SEASON?
262	2F	CSDECIS	HOW SKILLED WAS SP IN MAKING DECISIONS?
259	2F	CSINNH	COULD RECALL SP WAS IN NURSING HOME?
253	2F	CSLOCROM	WAS ABLE TO RECALL LOCATION OF ROOM?
247	2F	CSMEMLT	WAS LONG TERM MEMORY OK?
244	2F	CSMEMST	WAS SHORT TERM MEMORY OK?
256	2F	CSNAMFAC	WAS ABLE TO RECALL NAMES AND FACES?
226	2F	CTBADDC	LEVEL OF BLADDER CONTROL
280	2F	CTBOWEC	LEVEL OF BOWEL CONTROL?
189	BK	CVRAARP	COVERAGE INFO FROM AARP/SR CITIZENS ORG
255	BK	CVRANSW	WERE COVERAGE QUESTIONS ANSWERED BY INFO
253	BK	CVRBEST	COVERAGE INFO THAT WAS MOST HELPFUL
199	BK	CVRCOUN	COVERAGE INFO FROM MEDICARE COUNSELING
197	BK	CVRDOCTR	COVERAGE INFO FROM DR OFFICE
209	BK	CVREMPLR	COVERAGE INFO FROM CURR/FORMER EMPLOYER
191	BK	CVRFAMILY	COVERAGE INFO FROM FAMILY OR FRIEND
177	BK	CVRFIND	SP TRIED TO FIND MEDICARE COVERAGE INFO
211	BK	CVRHMO	COVERAGE INFO FROM HMO
195	BK	CVRHOSP	COVERAGE INFO FROM LOCAL HOSPITAL
213	BK	CVRINET	COVERAGE INFO FROM INTERNET
181	BK	CVRINSCO	COVERAGE INFO FROM INSURANCE CLAIMS
219	BK	CVRMCBS	COVERAGE INFO FROM MCBS
185	BK	CVRMCOFF	COVERAGE INFO FROM MEDICARE/OFC HOTLINE
183	BK	CVRMEDGP	COVERAGE INFO FROM MEDIGAP/SUP
179	BK	CVRNOFND	COVERAGE INFO NOT FOUND
207	BK	CVROGOVT	COVERAGE INFO FROM OTHER GOVT AGENCY
217	BK	CVROSMNR	COVERAGE INFO FROM OTHER SEMINAR
221	BK	CVROTHER	COVERAGE INFO FROM OTHER PERSON/PLACE
223	BK	CVROTHOS	COVERAGE INFO FROM OTHER SPECIFIED
215	BK	CVRSEMNR	COVERAGE INFO FROM HMO/INS CO SEMINAR

193	BK	CVRSRCTR	COVERAGE INFO FROM LOCAL SR CENTER	28	4	D_HMOCUR	IS SP CURRENTLY COVERED BY A MHMO?	
187	BK	CVRSSOFF	COVERAGE INFO FROM SOC SECURITY OFFICE	69	4	D_HMOPL1	IS PLAN 1 AN HMO	
203	BK	CVRTVRAD	COVERAGE INFO FROM TV OR RADIO	94	4	D_HMOPL2	IS PLAN 2 AN HMO	
205	BK	CVRZINE	COVERAGE INFO FROM NEWSPAPER OR MAGAZINE	119	4	D_HMOPL3	IS PLAN 3 AN HMO	
457	3	D_ACCREL	WHO TAKES SP TO USUAL SOURCE	144	4	D_HMOPL4	IS PLAN 4 AN HMO	
361	2	D_ADLHDB	DOB HELPER HELPS MOST-PRSNT/NOT PRSNT	169	4	D_HMOPL5	IS PLAN 5 AN HMO	
357	2	D_ADLHNM	NUMBER OF HELPERS	24	4	D_HMOTYP	TYPE OF MEDICARE HMO	
359	2	D_ADLHRL	PRIMARY HELPERS RELATIONSHIP	56	8	D_IHLPRL	HELPERS RELATIONSHIP TO SP	
20	1	D_AFEVER	SP EVER SERVE IN ARMED FORCES?	73	4	D_INDUS1	INDUSTRY OF EMPLOYER - PLAN 1	
24	1	D_AFKORE	SP SERVED IN AF DURING KOREAN CONFLICT?	98	4	D_INDUS2	INDUSTRY OF EMPLOYER - PLAN 2	
30	1	D_AFPEAC	SP SERVED IN AF DURING PEACE TIME?	123	4	D_INDUS3	INDUSTRY OF EMPLOYER - PLAN 3	
22	1	D_AFVIET	SP SERVED IN AF DURING VIETNAM ERA?	148	4	D_INDUS4	INDUSTRY OF EMPLOYER - PLAN 4	
28	1	D_AFWWI	SP SERVED IN AF DURING WORLD WAR I?	173	4	D_INDUS5	INDUSTRY OF EMPLOYER - PLAN 5	
26	1	D_AFWWII	SP SERVED IN AF DURING WORLD WAR II?	106	3	D_MDAPPT	DAYS SP WAITED FOR MD APPOINTMENT	
62	4	D_ANAMT1	PREMIUM MIP PAYS FOR PLAN 1-ANNUALIZED	110	3	D_MDVIS	MINUTES FOR MD VISIT ALTOGETHER	
87	4	D_ANAMT2	PREMIUM MIP PAYS FOR PLAN 2-ANNUALIZED	114	3	D_MDWAIT	MINUTES FOR MD VISIT SPENT WAITING	
112	4	D_ANAMT3	PREMIUM MIP PAYS FOR PLAN 3-ANNUALIZED	34	1	D_NGALL	ALL ACTIVE DUTY RELATED TO NATL GUARD?	
137	4	D_ANAMT4	PREMIUM PAYS FOR PLAN 4-ANNUALIZED	36	1	D_NGDSBL	SP HAVE ANY DISABILITY FROM AF SERVICE?	
162	4	D_ANAMT5	PREMIUM MIP PAYS FOR PLAN 5-ANNUALIZED	32	1	D_NGEVER	SP EVER ACTIVE NATL GUARD/RESERVE?	
42	4	D_ANHMO	ANNUAL AMOUNT PAID FOR MHMO COVERAGE	71	4	D_OBTNP1	HOW DID MIP GET PLAN 1	
52	H	D_ANHMO	ANNUAL AMOUNT PAID FOR COVERAGE	96	4	D_OBTNP2	HOW DID MIP GET PLAN 2	
12	H	D_COVANY	SP COVERED AT ANY TIME BY MEDICARE HMO	121	4	D_OBTNP3	HOW DID MIP GET PLAN 3	
14	H	D_COVCUR	IS THE HMO MOST CURRENT?	146	4	D_OBTNP4	HOW DID MIP GET PLAN 4	
58	4	D_COVNH1	PLAN 1 COVER STAY IN NURSING HOME	171	4	D_OBTNP5	HOW DID MIP GET PLAN 5	
83	4	D_COVNH2	PLAN 2 COVER STAY IN NURSING HOME	56	3	D_OPAPPT	DAYS SP WAITED FOR OPD APPT	
108	4	D_COVNH3	PLAN 3 COVER STAY IN NURSING HOME	60	3	D_OPVIS	MINUTES FOR OPD VISIT ALTOGETHER	
133	4	D_COVNH4	PLAN 4 COVER STAY IN NURSING HOME	64	3	D_OPWAIT	MINUTES FOR OPD VISIT SPENT WAITING	
158	4	D_COVNH5	PLAN 5 COVER STAY IN NURSING HOME	60	4	D_PAYSP1	MIP PAY ANY/ALL COST FOR PLAN 1	
54	4	D_COVNM1	# OF FAMILY MEMBERS COVERED BY PLAN 1	85	4	D_PAYSP2	MIP PAY ANY/ALL COST FOR PLAN 2	
79	4	D_COVNM2	# OF FAMILY MEMBERS COVERED BY PLAN 2	110	4	D_PAYSP3	MIP PAY ANY/ALL COST FOR PLAN 3	
104	4	D_COVNM3	# OF FAMILY MEMBERS COVERED BY PLAN 3	135	4	D_PAYSP4	MIP PAY ANY/ALL COST FOR PLAN 4	
129	4	D_COVNM4	# OF FAMILY MEMBERS COVERED BY PLAN 4	160	4	D_PAYSP5	MIP PAY ANY/ALL COST FOR PLAN 5	
154	4	D_COVNM5	# OF FAMILY MEMBERS COVERED BY PLAN 5	52	4	D_PHREL1	POLICY HOLDER RELATIONSHIP-PLAN 1	
56	4	D_COVRX1	PLAN 1 COVER PRESCRIBED MEDICINES	77	4	D_PHREL2	POLICY HOLDER RELATIONSHIP-PLAN 2	
81	4	D_COVRX2	PLAN 2 COVER PRESCRIBED MEDICINES	102	4	D_PHREL3	POLICY HOLDER RELATIONSHIP-PLAN 3	
106	4	D_COVRX3	PLAN 3 COVER PRESCRIBED MEDICINES	127	4	D_PHREL4	POLICY HOLDER RELATIONSHIP-PLAN 4	
131	4	D_COVRX4	PLAN 4 COVER PRESCRIBED MEDICINES	152	4	D_PHREL5	POLICY HOLDER RELATIONSHIP-PLAN 5	
156	4	D_COVRX5	PLAN 5 COVER PRESCRIBED MEDICINES	32	8	D_PROXRL	PROXYS RELATIONSHIP TO SP	
	K	D_DISPC	DISPOSITION CODE	41	1	D_RACE	RACE OF SP	
14	54	D_DIVCUR	CURRENT CENSUS DIVISION		K	D_SMPTYP	SAMPLE TYPE	
12	1	D_DOB	DATE OF BIRTH	12	35	A	D_STRAT	MCBS SAMPLE STRATUM
18	3	D_ERVIS	MINUTES FOR ER VISIT ALTOGETHER	35	A2	D_STRAT	MCBS SAMPLE STRATUM	
22	3	D_ERWAIT	MINUTES FOR ER VISIT SPENT WAITING	13	4	D_SUMINS	SUMMARY INSURANCE INDICATOR	
43	1	D_ETHNIC	SP OF HISPANIC ANCESTRY	50	4	D_TYPL1	TYPE OF PLAN - PLAN 1	
451	3	D_GETUS	MINUTES TO GET TO USUAL SOURCE OF CARE	75	4	D_TYPL2	TYPE OF PLAN - PLAN 2	
18	5	D_HHCOMP	HOUSEHOLD COMPOSITION CODE	100	4	D_TYPL3	TYPE OF PLAN - PLAN 3	
22	5	D_HHGE50	NO. IN HH 50 AND OVER (MAY INCLUDE SP)	125	4	D_TYPL4	TYPE OF PLAN - PLAN 4	
	5	D_HHLT50	NUMBER IN HH UNDER 50 (MAY INCLUDE SP)	150	4	D_TYPL5	TYPE OF PLAN - PLAN 5	
20	14	D_HHREL	NO. IN HH RELATED TO SP (INCLUDING SP)		3	D_USSPCW	MEDICAL PROVIDER SPECIALTY -USUAL CARE	
12	5	D_HHTOT	TOTAL NUMBER OF PEOPLE IN HH	44	58	1	D_VARATE	CURRENT VA DISABILITY RATING OF SP
16	5	D_HHUNRL	TOTAL NO. PEOPLE IN HH UNRELATED TO SP	35	2	DCTROUB	SP HAVE DIFFICULTY EATING SOLID FOODS?	
26	4	D_HMOCOV	WAS SP COVERED BY MHMO AN ANYTIME?	475	2F	DEHYD	DID SP EXPERIENCE DEHYDRATION?	
478	2F	DELUS	DID SP EXPERIENCE DELLUSIONS?	331	2F	DEMENT	DID SP HAVE DEMENTIA?	

334	2F	DEPRESS	DID SP HAVE DEPRESSION?
496	2F	DHBRIDGE	DID SP HAVE REMOVABLE BRIDGES?
502	2F	DHBROKEN	DID SP HAVE ANY BROKEN/LOOSE TEETH?
493	2F	DHDEBRIS	DID SP HAVE DEBRIS IN MOUTH?
505	2F	DHINFGUM	DID SP HAVE ANY GUM INFECTION?
499	2F	DHTEEL0S	DID SP HAVE ANY NATURAL TEETH LOST?
136	2F	DIABMEL	DID SP HAVE DIABETES MELLITUS?
337	2F	DIABRET	DID SP HAVE DIABETIC RETINOPATHY?
136	3	DIFFSRVC	PREFER AREA HMO WITH DIFF SERVICES
141	2	DIFLIFT	SP HAVE DIFFICULTY LIFTING 10 LBS?
64	2F	DIFLIFT	WAS LIFTING HEAVY ITEMS DIFFICULT?
143	2	DIFREACH	SP HAVE DIFFICULTY REACHING OVER HEAD?
67	2F	DIFREACH	WAS REACHING/EXTENDING ARMS DIFFICULT?
139	2	DIFSTOOP	SP HAVE DIFFICULTY STOOPING/KNEELING?
61	2F	DIFSTOOP	WAS STOOPING/KNEELING DIFFICULT?
147	2	DIFWALK	SP HAVE DIFFICULTY WALKING 2-3 BLOCKS?
73	2F	DIFWALK	WAS WALKING DIFFICULT?
145	2	DIFWRITE	SP HAVE DIFFICULTY WRITING?
70	2F	DIFWRITE	WAS WRITING/GRASPING DIFFICULT?
50	2	DIGTEXAM	SP HAD DIGITAL RECTAL PROSTATE EXAM?
34	6	DISCHTO	PLACE SP WAS DISCHARGED TO
36	6	DISCHTOS	PLACE SP WAS DISCHARGED TO (OTHER)
439	2F	DIVCOL	DID SP HAVE DIVERTICULA OF COLON?
285	2	DONTBATH	B/C HEALTH PROBLEM - SP DOESNT BATHE
259	2	DONTBILS	HEALTH REASON DONT MANAGE MONEY?
196	2F	DONTBILS	NOT USE MONEY DUE TO HLTH/PHYS PROBLEM
291	2	DONTCHAR	B/C HLTH PROB - SP DOESNT GET OUT OF BED
287	2	DONTDRES	B/C HEALTH PROBLEM - SP DOESNT DRESS
289	2	DONTEAT	B/C HEALTH PROBLEM - SP DOESNT EAT
253	2	DONTHHWK	HEALTH REASON DONT DO HEAVY HOUSEWORK?
251	2	DONTLHWK	HEALTH REASON DONT DO LIGHT HOUSEWORK?
255	2	DONTMEAL	HEALTH REASON DONT MAKE MEALS?
257	2	DONTSHOP	HEALTH REASON DONT DO SHOPPING?
193	2F	DONTSHOP	NOT SHOP DUE TO HLTH/PHYS PROBLEM
249	2	DONTTELE	HEALTH REASON DONT USE PHONE?
190	2F	DONTTELE	NOT USE PHONE DUE TO HLTH/PHYS PROBLEM
295	2	DONTTOIL	B/C HLTH PROBLEM - SP DOESNT USE TOILET?
293	2	DONTWALK	B/C HEALTH PROBLEM - SP DOESNT WALK
29	2	ECCATOP	SP EVER HAD OPERATION FOR CATARACTS?
19	2	ECHELP	SP WEAR EYEGLASSES/CONTACT LENSES?
21	2	ECTROUB	DESCRIPTION OF SP VISION
56	1	EDLEVELF	LEVEL OF EDUCATION
233	2	EMCAUSC1	1ST CAUSE OF MEDICARE ELIGIBILITY
235	2	EMCAUSC2	2ND CAUSE OF MEDICARE ELIGIBILITY
175	2F	EMPCOPD	DID SP HAVE EMPHYSEMA/COPD?
442	2F	EPILEP	DID SP HAVE EPILEPSY?
321	2	EQUIPBATH	USE EQUIPMENT TO HELP BATH/SHOWER?
327	2	EQUIPCHAR	USE EQUIPMENT TO HELP IN/OUT CHAIRS?
323	2	EQUIPDRES	USE EQUIPMENT TO HELP DRESS?
325	2	EQUIPEAT	USE EQUIPMENT TO HELP EAT?
331	2	EQUIPTOIL	USE EQUIPMENT TO HELP USE TOILET?
329	2	EQUIPWALK	USE EQUIPMENT TO HELP WALK?
2		FLUOTHER	OTHER REASON

26	3	ERADMT	WAS SP ADMITTED TO HOSPITAL FROM ER
14	3	ERAPPT	DID SP HAVE APPT FOR ER VISIT
16	3	ERDRTEL	DID MEDICAL PERSON TELL SP TO GO TO ER
12	3	ERVISIT	SINCE REF DATE DID SP GO TO ER
52	2F	EVERHYST	SP EVER HAD A HYSTERECTOMY?
135	2	EVERSMOK	SP EVER SMOKED CIGARETTES/CIGARS?
55	2F	EVRSMOKE	SP EVER SMOKED CIGARS/CIGARETTES/PIPE?
23	2	EYEEEXAM	SP HAD EYE EXAM WITHIN PAST YR?
24	7	FACDIOS	FACILITY DESCRIPTION--OTHER SPECIFIED
7		FACDISC	FACILITY DESCRIPTION
22	12	FACILID	MCBS FACILITY IDENTIFIER
12	7	FACILID	FACILITY ID
60	8	FACILID	FACILITY ID
26	7	FACLONGT	DOES FACILITY PROVIDE LONG TERM CARE?
28	7	FACLTBED	NUMBER OF LONG TERM BEDS ONLY
20	7	FACOWNED	DESCRIPTION OF OWNERSHIP OF FACILITY
32	7	FACTOBED	TOTAL NUMBER OF BEDS IN FACILITY
44	X	FACTOR	INVERSE OF R22 FINAL COMBINATION FACTORS
84	7	FHLPBATH	DOES FACIL PROVIDE HELP W/BATHING
94	7	FHLPCOMM	DOES FACIL PROVIDE HELP W/COMMUNICATION
86	7	FHLPDRES	DOES FACIL PROVIDE HELP W/DRESSING
92	7	FHLPEAT	DOES FACIL PROVIDE HELP W/EATING
96	7	FHLPNURS	DOES FACIL PROVIDE 24HR NURSING CARE
88	7	FHLPSHOP	DOES FACIL PROVIDE HELP W/SHOPPING
90	7	FHLPWALK	DOES FACIL PROVIDE HELP W/WALKING
2	1	FILEYR	FILE YEARS 91
2	2	FILEYR	YY REFERENCE YEAR OF RECORD
2	3	FILEYR	YY REFERENCE YEAR
2	4	FILEYR	YY REFERENCE YEAR
2	5	FILEYR	YY REFERENCE YEAR OF RECORD
2	6	FILEYR	YY REFERENCE YEAR OF RECORD
2	7	FILEYR	YY REFERENCE YEAR OF RECORD
2	8	FILEYR	YY REFERENCE YEAR
2	2F	FILEYR	YY REFERENCE YEAR OF RECORD
2	A	FILEYR	YY REFERENCE YEAR OF RECORD
2	A2	FILEYR	YY REFERENCE YEAR OF RECORD
3	BK	FILEYR	YY REFERENCE YEAR
3	BN	FILEYR	YY REFERENCE YEAR
2	H	FILEYR	YY REFERENCE YEAR
2	K	FILEYR	YY REFERENCE YEAR OF RECORD
3	W1	FILEYR	YY REFERENCE YEAR
3	W2	FILEYR	YY REFERENCE YEAR
3	W3	FILEYR	YY REFERENCE YEAR
2	X	FILEYR	YY REFERENCE YEAR
76	2	FLUAGNST	DOCTOR RECOMMEND AGAINST GETTING SHOT
91	2	FLUBEFOR	HAD SHOT BEFORE/DID NOT NEED AGAIN
61	2	FLUCAUSE	SHOT COULD CAUSE FLU
88	2	FLUCOST	COST OF SHOT NOT WORTH THE MONEY
73	2	FLUDOCNO	DOCTOR DID NOT RECOMMEND THE SHOT
82	2	FLULOCAT	UNABLE TO GET TO A LOCATION
85	2	FLUMISS	DID NOT THINK ABOUT IT/MISSED IT
58	2	FLUNEED	DID NOT KNOW IT WAS NEEDED
67	2	FLUPRVNT	DID NOT THINK IT WOULD PREVENT FLU

79	2	FLUREACT	DONT LIKE SHOTS OR NEEDLES	41	A2	H_ENT06	JUN MEDICARE ENTITLEMENT
70	2	FLURISK	NOT AT SERIOUS RISK OF CATCHING FLU	42	A	H_ENT07	JUL MEDICARE ENTITLEMENT
56	2	FLUSHOT	SP HAVE FLU SHOT FOR LAST WINTER?	42	A2	H_ENT07	JUL MEDICARE ENTITLEMENT
64	2	FLUSIDE	SHOT COULD HAVE SIDE EFFECTS	43	A	H_ENT08	AUG MEDICARE ENTITLEMENT
1027	BK	FUDAARP	CONTACT AARP TO REPORT FRAUD	43	A2	H_ENT08	AUG MEDICARE ENTITLEMENT
1037	BK	FUDCOUN	CONTACT MCAR COUNSEL TO REPORT FRAUD	44	A	H_ENT09	SEP MEDICARE ENTITLEMENT
1039	BK	FUEEMPLR	CONTACT EMPLOYER TO REPORT FRAUD	44	A2	H_ENT09	SEP MEDICARE ENTITLEMENT
1029	BK	FUDFAMLY	CONTACT FAMILY TO REPORT FRAUD	45	A	H_ENT10	OCT MEDICARE ENTITLEMENT
1041	BK	FUDHOTLN	CONTACT 800 HOTLINE TO REPORT FRAUD	45	A2	H_ENT10	OCT MEDICARE ENTITLEMENT
1021	BK	FUDINSCO	CONTACT INSUR CO TO REPORT FRAUD	46	A	H_ENT11	NOV MEDICARE ENTITLEMENT
1043	BK	FUDLAW	CONTACT LAW ENFORC TO REPORT FRAUD	46	A2	H_ENT11	NOV MEDICARE ENTITLEMENT
1045	BK	FUDMCBS	CONTACT MCBS TO REPORT FRAUD	47	A	H_ENT12	DEC MEDICARE ENTITLEMENT
1019	BK	FUDNONE	CONTACT NO ONE TO REPORT FRAUD	47	A2	H_ENT12	DEC MEDICARE ENTITLEMENT
1025	BK	FUDGOVTV	CONTACT OTHER GOVT TO REPORT FRAUD	145	A2	H_ESRBEG	BEGINNING DATE OF ESRD PERIOD
1049	BK	FUDOTHOS	CONTACT OTHER SPECIFY FOR FRAUD	153	A2	H_ESREND	ENDING DATE OF ESRD PERIOD
1047	BK	FUDOTHR	CONTACT OTHER PERS TO REPORT FRAUD	69	A	H_GHPSW	1= SOME GROUP HEALTH PARTICIPATION IN CY
1035	BK	FUDOTPRV	CONTACT OTHER PROV TO REPORT FRAUD	161	A2	H_GHPSW	1= SOME GROUP HEALTH PARTICIPATION IN CY
1033	BK	FUDPROV	CONTACT BAD PROV TO REPORT FRAUD		A	H_HHACCH	\$\$\$\$\$\$\$ TOTAL HHA COV CHGS CY
1031	BK	FUDSRCTR	CONTACT SR CENTER TO REPORT FRAUD	252	A2	H_HHACCH	\$\$\$\$\$\$\$ TOTAL HHA COV CHGS CY
1023	BK	FUDSSOFF	CONTACT SOC SEC OFF TO REPORT FRAUD	513	A	H_HHACHO	\$\$\$\$\$\$\$ TOT HHA OTHER COV CHGS CY
445	2F	GASTR	DID SP HAVE GASTRITIS?	519	A2	H_HHACHO	\$\$\$\$\$\$\$ TOT HHA OTHER COV CHGS CY
448	2F	GASTRO	DID SP HAVE GASTROENTERITIS?		A	H_HHARMB	\$\$\$\$\$\$\$ TOT HHA REIMB IN CY
12	2	GENHELTH	GENERAL HEALTH OF SP	264	A2	H_HHARMB	\$\$\$\$\$\$\$ TOT HHA REIMB IN CY
449	3	GETUSHOW	HOW DOES SP USUALLY GET TO DR	158	A	H_HHASW	1 = ONE OR MORE HHA VISITS IN CY
451	2F	GHEMOR	DID SP HAVE GASTROINTESTINAL HEMORRHAGE?	419	A2	H_HHASW	1 = ONE OR MORE HHA VISITS IN CY
340	2F	GLAUCOMA	DID SP HAVE GLAUCOMA?	248	A	H_HHAVST	TOTAL HHA VISITS IN CY
	A	H_AGE	AGE	509	A2	H_HHAVST	TOTAL HHA VISITS IN CY
32	32	A2	SSA LEGAL AGE	155	A	H_HOSSW	1 = ONE OR MORE HOSPICE BILLS IN CY
78	A2	H_CENSUS	CENSUS REGION OF RESIDENCE AS OF DEC 31	416	A2	H_HOSSW	1 = ONE OR MORE HOSPICE BILLS IN CY
184	A	H_DISDES	DISCHARGE DESTINATION FOR LAST STAY	81	A2	H_HSBEG1	BEGINNING DATE OF LATEST HOSPICE PERIOD
445	A2	H_DISDES	DISCHARGE DESTINATION FOR LAST STAY	97	A2	H_HSBEG2	BEGINNING DATE OF 2ND HOSPICE PERIOD
12	A	H_DOB	LEGAL DATE OF BIRTH	113	A2	H_HSBEG3	BEGINNING DATE OF 3RD HOSPICE PERIOD
12	A2	H_DOB	LEGAL DATE OF BIRTH	129	A2	H_HSBEG4	BEGINNING DATE OF 4TH HOSPICE PERIOD
20	A	H_DOD	DATE OF DEATH (LAST DAY OF DEATH MONTH)	270	A	H_HSDAYS	TOTAL COVRD HOSPICE DAYS CY
20	A2	H_DOD	DATE OF DEATH (LAST DAY OF DEATH MONTH)	531	A2	H_HSDAYS	TOTAL COVRD HOSPICE DAYS CY
28	A	H_DODSRC	SOURCE OF DEATH INFORMATION	89	A2	H_HSEND1	ENDING DATE OF LATEST HOSPICE PERIOD
28	A2	H_DODSRC	SOURCE OF DEATH INFORMATION	105	A2	H_HSEND2	ENDING DATE OF 2ND HOSPICE PERIOD
48	A	H_DOE	ENTITLEMENT START DATE	121	A2	H_HSEND3	ENDING DATE OF 3RD HOSPICE PERIOD
48	A2	H_DOE	ENTITLEMENT START DATE	137	A2	H_HSEND4	ENDING DATE OF 4TH HOSPICE PERIOD
56	A	H_DOT	ENTITLEMENT END DATE	279	A	H_HSREIM	\$\$\$\$\$\$\$ TOT HOSPICE REIMB CY
56	A2	H_DOT	ENTITLEMENT END DATE	540	A2	H_HSREIM	\$\$\$\$\$\$\$ TOT HOSPICE REIMB CY
36	A	H_ENT01	JAN MEDICARE ENTITLEMENT	273	A	H_HSTCHG	\$\$\$\$\$\$\$ TOT HOSPICE CHGS CY
36	A2	H_ENT01	JAN MEDICARE ENTITLEMENT	534	A2	H_HSTCHG	\$\$\$\$\$\$\$ TOT HOSPICE CHGS CY
37	A	H_ENT02	FEB MEDICARE ENTITLEMENT	211	A	H_INPCAM	\$\$\$\$\$\$\$ TOTAL INP COINS AMT CY
37	A2	H_ENT02	FEB MEDICARE ENTITLEMENT	472	A2	H_INPCAM	\$\$\$\$\$\$\$ TOTAL INP COINS AMT CY
38	A	H_ENT03	MAR MEDICARE ENTITLEMENT	197	A	H_INPCCH	\$\$\$\$\$\$\$ INPAT COVRD CHGS FOR CY
38	A2	H_ENT03	MAR MEDICARE ENTITLEMENT	458	A2	H_INPCCH	\$\$\$\$\$\$\$ INPAT COVRD CHGS FOR CY
39	A	H_ENT04	APR MEDICARE ENTITLEMENT	209	A	H_INPCDY	INPAT COINSURANCE DAYS USED IN CY
39	A2	H_ENT04	APR MEDICARE ENTITLEMENT	470	A2	H_INPCDY	INPAT COVRD DAYS USED IN CY
40	A	H_ENT05	MAY MEDICARE ENTITLEMENT	191	A	H_INPCHG	\$\$\$\$\$\$\$ INPAT CHARGES FOR CY
40	A2	H_ENT05	MAY MEDICARE ENTITLEMENT	452	A2	H_INPCHG	\$\$\$\$\$\$\$ INPAT CHARGES FOR CY
41	A	H_ENT06	JUN MEDICARE ENTITLEMENT	188	A	H_INPDAY	NO. OF INPAT COVRD DAYS FOR CY
449	A2	H_INPDAY	NO. OF INPAT COVRD DAYS FOR CY	203	A	H_INPRMB	\$\$\$\$\$\$\$ INPAT REIMB FOR CY

464	A2	H_INPRMB	\$\$\$\$\$\$ INPAT REIMB FOR CY
186	A	H_INPSTY	NO. OF INPAT STAYS FOR CY
447	A2	H_INPSTY	NO. OF INPAT STAYS FOR CY
156	A	H_INPSW	1 = ONE OR MORE INP DISCHARGES IN CY
417	A2	H_INPSW	1 = ONE OR MORE INP DISCHARGES IN CY
66	A	H_LAF	STATUS OF SSA BENEFIT CHECK (LAF) DEC 31
66	A2	H_LAF	STATUS OF SSA BENEFIT CHECK (LAF) DEC 31
173	A	H_LATDCH	DISCHARGE DATE OF LATEST INP STAY
434	A2	H_LATDCH	DISCHARGE DATE OF LATEST INP STAY
181	A	H_LATDRG	DRG CODE FOR LATEST INP STAY
442	A2	H_LATDRG	DRG CODE FOR LATEST INP STAY
380	A2	H_MACY01	BUY-IN AGENCY FOR JAN
383	A2	H_MACY02	BUY-IN AGENCY FOR FEB
386	A2	H_MACY03	BUY-IN AGENCY FOR MAR
389	A2	H_MACY04	BUY-IN AGENCY FOR APR
392	A2	H_MACY05	BUY-IN AGENCY FOR MAY
395	A2	H_MACY06	BUY-IN AGENCY FOR JUN
398	A2	H_MACY07	BUY-IN AGENCY FOR JUL
401	A2	H_MACY08	BUY-IN AGENCY FOR AUG
404	A2	H_MACY09	BUY-IN AGENCY FOR SEP
407	A2	H_MACY10	BUY-IN AGENCY FOR OCT
410	A2	H_MACY11	BUY-IN AGENCY FOR NOV
413	A2	H_MACY12	BUY-IN AGENCY FOR DEC
143	A	H_MCDE01	MEDICAID ELIGIBILITY FOR JAN
368	A2	H_MCDE01	MEDICAID ELIGIBILITY FOR JAN
144	A	H_MCDE02	MEDICAID ELIGIBILITY FOR FEB
369	A2	H_MCDE02	MEDICAID ELIGIBILITY FOR FEB
145	A	H_MCDE03	MEDICAID ELIGIBILITY FOR MAR
370	A2	H_MCDE03	MEDICAID ELIGIBILITY FOR MAR
146	A	H_MCDE04	MEDICAID ELIGIBILITY FOR APR
371	A2	H_MCDE04	MEDICAID ELIGIBILITY FOR APR
147	A	H_MCDE05	MEDICAID ELIGIBILITY FOR MAY
372	A2	H_MCDE05	MEDICAID ELIGIBILITY FOR MAY
148	A	H_MCDE06	MEDICAID ELIGIBILITY FOR JUN
373	A2	H_MCDE06	MEDICAID ELIGIBILITY FOR JUN
149	A	H_MCDE07	MEDICAID ELIGIBILITY FOR JUL
374	A2	H_MCDE07	MEDICAID ELIGIBILITY FOR JUL
150	A	H_MCDE08	MEDICAID ELIGIBILITY FOR AUG
375	A2	H_MCDE08	MEDICAID ELIGIBILITY FOR AUG
151	A	H_MCDE09	MEDICAID ELIGIBILITY FOR SEP
376	A2	H_MCDE09	MEDICAID ELIGIBILITY FOR SEP
152	A	H_MCDE10	MEDICAID ELIGIBILITY FOR OCT
377	A2	H_MCDE10	MEDICAID ELIGIBILITY FOR OCT
153	A	H_MCDE11	MEDICAID ELIGIBILITY FOR NOV
378	A2	H_MCDE11	MEDICAID ELIGIBILITY FOR NOV
154	A	H_MCDE12	MEDICAID ELIGIBILITY FOR DEC
379	A2	H_MCDE12	MEDICAID ELIGIBILITY FOR DEC
142	A	H_MCSW	Y=SOME MEDICAID ELIGIBILITY FOR CY
367	A2	H_MCSW	Y=SOME MEDICAID ELIGIBILITY FOR CY
64	A	H_MEDSTA	MEDICARE STATUS CODE AS OF DEC 31
64	A2	H_MEDSTA	MEDICARE STATUS CODE AS OF DEC 31
	A	H_METRO	METRO STATUS
68 82	A	H_PLTP03	GHP PLAN TYPE MAR

	A2	H_METRO	METRO STATUS
80285	A	H_OUTBIL	TOTAL OUTPT BILLS IN CY
546	A2	H_OUTBIL	TOTAL OUTPT BILLS IN CY
288	A	H_OUTCHG	\$\$\$\$\$\$ TOTAL OUTPT COV CHG CY
549	A2	H_OUTCHG	\$\$\$\$\$\$ TOTAL OUTPT COV CHG CY
294	A	H_OUTRMB	\$\$\$\$\$\$ TOTAL OUTPT REIMB CY
555	A2	H_OUTRMB	\$\$\$\$\$\$ TOTAL OUTPT REIMB CY
159	A	H_OUTSW	1 = ONE OR MORE OUTPT VISITS IN CY
420	A2	H_OUTSW	1 = ONE OR MORE OUTPT VISITS IN CY
162	A2	H_PARTLC	GROUP HEALTH PLAN PARTIAL COUNTY SWITCH
160	A	H_PBSW	1 = ONE OR MORE PART B CLAIMS IN CY
421	A	H_PBSW	1 = ONE OR MORE PART B CLAIMS IN CY
165	A2	H_PLAN01	GHP CONTRACT NUMBER JAN
182	A2	H_PLAN02	GHP CONTRACT NUMBER FEB
199	A2	H_PLAN03	GHP CONTRACT NUMBER MAR
216	A2	H_PLAN04	GHP CONTRACT NUMBER APR
233	A2	H_PLAN05	GHP CONTRACT NUMBER MAY
250	A2	H_PLAN06	GHP CONTRACT NUMBER JUN
267	A2	H_PLAN07	GHP CONTRACT NUMBER JUL
284	A2	H_PLAN08	GHP CONTRACT NUMBER AUG
301	A2	H_PLAN09	GHP CONTRACT NUMBER SEP
318	A2	H_PLAN10	GHP CONTRACT NUMBER OCT
335	A2	H_PLAN11	GHP CONTRACT NUMBER NOV
352	A2	H_PLAN12	GHP CONTRACT NUMBER DEC
72	A	H_PLPY01	MEDICARE PERCAP PAYMENT JAN
170	A2	H_PLPY01	MEDICARE PERCAP PAYMENT JAN
78	A	H_PLPY02	MEDICARE PERCAP PAYMENT FEB
187	A2	H_PLPY02	MEDICARE PERCAP PAYMENT FEB
84	A	H_PLPY03	MEDICARE PERCAP PAYMENT MAR
204	A2	H_PLPY03	MEDICARE PERCAP PAYMENT MAR
90	A	H_PLPY04	MEDICARE PERCAP PAYMENT APR
221	A2	H_PLPY04	MEDICARE PERCAP PAYMENT APR
96	A	H_PLPY05	MEDICARE PERCAP PAYMENT MAY
238	A2	H_PLPY05	MEDICARE PERCAP PAYMENT MAY
102	A	H_PLPY06	MEDICARE PERCAP PAYMENT JUN
255	A2	H_PLPY06	MEDICARE PERCAP PAYMENT JUN
108	A	H_PLPY07	MEDICARE PERCAP PAYMENT JUL
272	A2	H_PLPY07	MEDICARE PERCAP PAYMENT JUL
114	A	H_PLPY08	MEDICARE PERCAP PAYMENT AUG
289	A2	H_PLPY08	MEDICARE PERCAP PAYMENT AUG
120	A	H_PLPY09	MEDICARE PERCAP PAYMENT SEP
306	A2	H_PLPY09	MEDICARE PERCAP PAYMENT SEP
126	A	H_PLPY10	MEDICARE PERCAP PAYMENT OCT
323	A2	H_PLPY10	MEDICARE PERCAP PAYMENT OCT
132	A	H_PLPY11	MEDICARE PERCAP PAYMENT NOV
340	A2	H_PLPY11	MEDICARE PERCAP PAYMENT NOV
138	A	H_PLPY12	MEDICARE PERCAP PAYMENT DEC
357	A2	H_PLPY12	MEDICARE PERCAP PAYMENT DEC
70	A	H_PLTP01	GHP PLAN TYPE JAN
163	A2	H_PLTP01	GHP PLAN TYPE JAN
76	A	H_PLTP02	GHP PLAN TYPE FEB
180	A2	H_PLTP02	GHP PLAN TYPE FEB
197	A2	H_PLTP03	GHP PLAN TYPE MAR

88	A	H_PLTP04	GHP PLAN TYPE APR	177	A2	H_RPNM01	NUMBER RISK PLANS IN AREA FOR JAN
214	A2	H_PLTP04	GHP PLAN TYPE APR	194	A2	H_RPNM02	NUMBER RISK PLANS IN AREA FOR FEB
94	A	H_PLTP05	GHP PLAN TYPE MAY	211	A2	H_RPNM03	NUMBER RISK PLANS IN AREA FOR MAR
231	A2	H_PLTP05	GHP PLAN TYPE MAY	228	A2	H_RPNM04	NUMBER RISK PLANS IN AREA FOR APR
100	A	H_PLTP06	GHP PLAN TYPE JUN	245	A2	H_RPNM05	NUMBER RISK PLANS IN AREA FOR MAY
248	A2	H_PLTP06	GHP PLAN TYPE JUN	262	A2	H_RPNM06	NUMBER RISK PLANS IN AREA FOR JUN
106	A	H_PLTP07	GHP PLAN TYPE JUL	279	A2	H_RPNM07	NUMBER RISK PLANS IN AREA FOR JUL
265	A2	H_PLTP07	GHP PLAN TYPE JUL	296	A2	H_RPNM08	NUMBER RISK PLANS IN AREA FOR AUG
112	A	H_PLTP08	GHP PLAN TYPE AUG	313	A2	H_RPNM09	NUMBER RISK PLANS IN AREA FOR SEP
282	A2	H_PLTP08	GHP PLAN TYPE AUG	330	A2	H_RPNM10	NUMBER RISK PLANS IN AREA FOR OCT
118	A	H_PLTP09	GHP PLAN TYPE SEP	347	A2	H_RPNM11	NUMBER RISK PLANS IN AREA FOR NOV
299	A2	H_PLTP09	GHP PLAN TYPE SEP	364	A2	H_RPNM12	NUMBER RISK PLANS IN AREA FOR DEC
124	A	H_PLTP10	GHP PLAN TYPE OCT		A	H_SEX	SEX CODE
316	A2	H_PLTP10	GHP PLAN TYPE OCT	30	A2	H_SEX	SEX CODE
130	A	H_PLTP11	GHP PLAN TYPE NOV	302	A	H_SNFCAM	\$\$\$\$\$\$ TOTAL SNF COINS AMT CY
333	A2	H_PLTP11	GHP PLAN TYPE NOV	503	A2	H_SNFCAM	\$\$\$\$\$\$ TOTAL SNF COINS AMT CY
136	A	H_PLTP12	GHP PLAN TYPE DEC	227	A	H_SNFCCH	\$\$\$\$\$\$ TOTAL SNF COV CHRGS CY
350	A2	H_PLTP12	GHP PLAN TYPE DEC	488	A2	H_SNFCCH	\$\$\$\$\$\$ TOTAL SNF COV CHRGS CY
314	A	H_PMTACH	\$\$\$\$\$\$ TOT ALLOWED CHGS CY	239	A	H_SNFCDY	TOTAL SNF COINS DAYS IN CY
575	A2	H_PMTACH	\$\$\$\$\$\$ TOT ALLOWED CHGS CY	500	A2	H_SNFCDY	TOTAL SNF COINS DAYS IN CY
329	A	H_PMTCHO	TOTAL OFFICE VISIT CHARGES IN CY	221	A	H_SNFCHG	\$\$\$\$\$\$ TOTAL SNF CHRGS IN CY
590	A2	H_PMTCHO	TOTAL OFFICE VISIT CHARGES IN CY	482	A2	H_SNFCHG	\$\$\$\$\$\$ TOTAL SNF CHRGS IN CY
300	A	H_PMTCLM	TOTAL PHYSICIAN/SUPPLIER CLAIMS IN CY	218	A	H_SNFDAY	TOTAL SNF COVERED DAYS IN CY
561	A2	H_PMTCLM	TOTAL PHYSICIAN/SUPPLIER CLAIMS IN CY	479	A2	H_SNFDAY	TOTAL SNF COVERED DAYS IN CY
304	A	H_PMTLIN	TOTAL PHYSICIAN/SUPPLIER LINE ITEMS CY	233	A	H_SNFRMB	\$\$\$\$\$\$ TOTAL SNF REIMB IN CY
565	A2	H_PMTLIN	TOTAL PHYSICIAN/SUPPLIER LINE ITEMS CY	494	A2	H_SNFRMB	\$\$\$\$\$\$ TOTAL SNF REIMB IN CY
320	A	H_PMTRMB	\$\$\$\$\$\$ TOT PHYS REIMB CY	216	A	H_SNFSTY	TOTAL SNF STAYS IN CY
581	A2	H_PMTRMB	\$\$\$\$\$\$ TOT PHYS REIMB CY	477	A2	H_SNFSTY	TOTAL SNF STAYS IN CY
308	A	H_PMTSCH	\$\$\$\$\$\$ TOT SUBMITTED CHGS CY	157	A	H_SNFSW	1 = ONE OR MORE SNF ADMISSIONS IN CY
569	A2	H_PMTSCH	\$\$\$\$\$\$ TOT SUBMITTED CHGS CY	418	A2	H_SNFSW	1 = ONE OR MORE SNF ADMISSIONS IN CY
526	A	H_PMTVST	TOTAL OFFICE VISITS IN CY	73	A2	H_ZIP	POSTAL ZIPCODE OF RESIDENCE AS OF DEC 31
587	A2	H_PMTVST	TOTAL OFFICE VISITS IN CY	481	2F	HALLUC	DID SP EXPERIENCE HALLUCINATIONS?
174	A2	H_PNUM01	NUMBER GHPS IN BENE AREA FOR JAN	128	3	HCDELAY	HAS SP DELAYED CARE BECAUSE OF COST
191	A2	H_PNUM02	NUMBER GHPS IN BENE AREA FOR FEB	24	2F	HCHEAID	SP USE HEARING AID?
208	A2	H_PNUM03	NUMBER GHPS IN BENE AREA FOR MAR	27	2F	HCHECOND	DESCRIPTION OF HEARING
225	A2	H_PNUM04	NUMBER GHPS IN BENE AREA FOR APR	31	2	HCHELP	SP USE HEARING AID?
242	A2	H_PNUM05	NUMBER GHPS IN BENE AREA FOR MAY	122	3	HCTRC1	1ST CODE FOR HEALTH CARE TROUBLE
259	A2	H_PNUM06	NUMBER GHPS IN BENE AREA FOR JUN	124	3	HCTRC2	2ND CODE FOR HEALTH CARE TROUBLE
276	A2	H_PNUM07	NUMBER GHPS IN BENE AREA FOR JUL	126	3	HCTRC3	3RD CODE FOR HEALTH CARE TROUBLE
293	A2	H_PNUM08	NUMBER GHPS IN BENE AREA FOR AUG	33	2	HCTROUB	DESCRIPTION OF SP HEARING
310	A2	H_PNUM09	NUMBER GHPS IN BENE AREA FOR SEP	120	3	HCTROUBL	HAS SP HAD TROUBLE GETTING HEALTH CARE
327	A2	H_PNUM10	NUMBER GHPS IN BENE AREA FOR OCT	30	2F	HCUNCOND	ABILITY OF SP TO MAKE HIM/HER UNDERSTOOD
344	A2	H_PNUM11	NUMBER GHPS IN BENE AREA FOR NOV	33	2F	HCUNDOTH	ABILITY OF SP TO UNDERSTAND OTHERS
361	A2	H_PNUM12	NUMBER GHPS IN BENE AREA FOR DEC	130	3	HEARMHMO	EVER HEARD OF MEDICARE HMOS
161	A	H_PTARMB	\$\$\$\$\$\$ TOTAL PART A REIMB CY	36	2F	HEIGHT	HEIGHT OF SP
422	A2	H_PTARMB	\$\$\$\$\$\$ TOTAL PART A REIMB CY	37	2	HEIGHTFT	HEIGHT OF SP--FEET
167	A	H_PTBRMB	\$\$\$\$\$\$ TOTAL PART B REIMB CY	39	2	HEIGHTIN	HEIGHT OF SP--INCHES
428	A2	H_PTBRMB	\$\$\$\$\$\$ TOTAL PART B REIMB CY	17	2	HELMTACT	HEALTH LIMIT SOCIAL LIFE IN PAST MONTH?
	A	H_RACE	RACE CODE	297	2	HELPBATH	RECEIVE HELP BATHING/SHOWERING?
31	A2	H_RACE	RACE CODE	271	2	HELPBILS	RECEIVE HELP MANAGING MONEY?
31 70	A2	H_RESCTY	SSA COUNTY CODE OF RES. AS OF DEC 31	303	2	HELPCHAR	RECEIVE HELP GETTING IN/OUT OF CHAIRS?
68	A2	H_RESST	SSA STATE CODE OF RESIDENCE AS OF DEC 31	299	2	HELPDRES	RECEIVE HELP DRESSING?
301	2	HELPEAT	RECEIVE HELP EATING?	265	2	HELPHHWK	RECEIVE HELP WITH HEAVY HOUSEWORK?

263	2	HELPLHWK	RECEIVE HELP WITH LIGHT HOUSEWORK?	945	BK	JOINPPO	CAN MCARS JOIN PREFERRED PROVIDER ORGS
267	2	HELPMEAL	RECEIVE HELP MAKING MEALS?	951	BK	JOINPSO	CAN MCARS JOIN PROVIDER SPONSORED ORGS
269	2	HELPSHOP	RECEIVE HELP WITH SHOPPING?	937	BK	KNOWMSA	HAS SP HEARD OF MEDICAL SAVINGS ACCOUNT
261	2	HELPTLE	RECEIVE HELP WITH PHONE?	953	BK	KNOWPOS	HAS SP HEARD OF POINT OF SERVICE HMOS
307	2	HELPTOIL	RECEIVE HELP USING THE TOILET?	941	BK	KNOWPPO	HAS SP HEARD OF PREFERRED PROVIDER ORGS
305	2	HELPWALK	RECEIVE HELP WALKING?	947	BK	KNOWPSO	HAS SP HEARD OF PROVIDER SPONSORED ORGS
343	2F	HEMIPLPA	DID SP HAVE HEMIPLEGIA/HEMIPARESIS?	179	BN	KPUPBEST	BEST SOURCE FOR KEEPING UP WITH MEDICARE
436	2F	HERNIA	DID SP HAVE DIAPHRAGMATIC HERNIA?	139	BN	KPUPBROC	MCAR DEVLPS INFO FROM BROCHURE/PAMPHLET
140	3	HIADDINF	WHAT KIND OF INFORMATION LIKE TO HAVE	137	BN	KPUPFONE	MCAR DEVLPS INFO FROM TELEPHONE
138	3	HIINFO	HOW SATISFIED WITH INFO ABOUT CHOICES	145	BN	KPUPINET	MCAR DEVLPS INFO FROM THE INTERNET
169	2F	HIPFRACT	DID SP HAVE A HIP FRACTURE?	143	BN	KPUPNEWS	MCAR DEVLPS INFO FROM NEWSPAPER/MAGAZINE
273	2	HPPDBATH	ANY DIFFICULTY BATHING/SHOWERING?	133	BN	KPUPNONE	MCAR DEVLPS INFO NOT WANTED/NEEDED
279	2	HPPDCHAR	ANY DIFFICULTY GETTING IN/OUT OF CHAIRS?	149	BN	KPUPOS	OTHER MCAR DEVLPS SOURCE SPECIFIED
275	2	HPPDDRES	ANY DIFFICULTY DRESSING?	147	BN	KPUPOTH	MCAR DEVLPS INFO FROM OTHER SPECIFIED
277	2	HPPDEAT	ANY DIFFICULTY EATING?	135	BN	KPUPTALK	MCAR DEVLPS INFO FROM FACE2FACE TALK
283	2	HPPDTOIL	ANY DIFFICULTY USING THE TOILET?	141	BN	KPUPTVRD	MCAR DEVLPS INFO FROM TV OR RADIO
281	2	HPPDWALK	ANY DIFFICULTY WALKING?	28	8	LANG	LANGUAGE OF INTERVIEW
94	2F	HRTFAIL	DID SP HAVE CONGESTIVE HEART FAILURE?	26	2	LASTEXAM	HOW LONG SINCE LAST EYE EXAM?
454	2F	HYPER	DID SP HAVE HYPERPLASIA OF PROSTATE?	472	2F	LEGULC	"DID SP HAVE ULCER OF LEG, CHRONIC?"
79	2F	HYPETENS	DID SP HAVE HYPERTENSION?	23	8	LENGTH	DURATION OF INTERVIEW
82	2F	HYPETHYR	DID SP HAVE HYPERTHYROIDISM?	203	BN	LIBRACCS	LIBRARY IN NEIGHBORHOOD OF SP
457	2F	HYPOP	DID SP HAVE HYPOSTASSEMIA/HYPOKALEMIA?	207	BN	LIBRGOTO	SP CAN GET TO THE LIBRARY
346	2F	HYPOTENS	DID SP HAVE HYPOTENSION?	205	BN	LIBRUSED	SP USES PUBLIC LIBRARY
349	2F	HYPOTHYR	DID SP HAVE HYPOTHYROIDISM?	42	6	LIVWRELA	W/WHOM WAS SP LIVING PRIOR--ADMIT
48	2	HYSTEREC	SP EVER HAD HYSTERECTOMY?	333	2	LONGBATH	HOW LONG NEEDED HELP TO BATH/SHOWER?
49	2F	HYSTEREC	SP HAD A HYSTERECTOMY IN THE LAST YEAR?	339	2	LONGCHAR	HOW LONG NEEDED HELP IN/OUT CHAIRS?
68	7	ICFMRBED	NUMBER OF ICF-MR BEDS IN FACILITY	335	2	LONGDRES	HOW LONG NEEDED HELP TO DRESS?
160	3	IFMHMO	IF HMOS IN AREA WOULD SP CONSIDER JOIN	337	2	LONGEAT	HOW LONG NEEDED HELP TO EAT?
51	1	INCOME	INCOME OF SP	343	2	LONGTOIL	HOW LONG NEEDED HELP TO USE TOILET?
195	BN	INETACCS	SP HAS ACCESS TO THE INTERNET	341	2	LONGWALK	HOW LONG NEEDED HELP TO WALK?
199	BN	INETMNT	SP HAS USED INTERNET IN LAST MONTH	376	2	LOSTURIN	HOW OFTEN SP LOST URINE LAST 12 MONTHS
197	BN	INETUSED	SP HAS USED INTERNET OR OTH ON-LINE SERV	352	2F	MACDEGEN	DID SP HAVE MACULAR DEGENERATION?
201	BN	INETYEAR	SP HAS USED INTERNET IN LAST 12 MONTHS	43	2F	MAMMOGR	SP HAD A MAMMOGRAM IN THE LAST YEAR?
391	2F	INFCDIFF	DID SP HAVE CLOSTRIDIUM DIFFICILE?	44	2	MAMMOGRM	SP HAD MAMMOGRAM IN LAST YEAR?
394	2F	INFCONJ	DID SP HAVE CONJUNCTIVITIS?	60	7	MANDMBED	NUMBER OF MCAID AND MCARE CERTIFIED BEDS
397	2F	INFHIV	DID SP HAVE HIV?	355	2F	MANICDEP	DID SP HAVE MANIC DEPRESSION?
418	2F	INFHPPTS	DID SP HAVE VIRAL HEPATITIS?	891	BK	MATRLREC	HOW OFTEN SP RECD INFO FROM MEDICARE
388	2F	INFMRSA	SP HAVE ANTIBIOTIC RESISTANT INFECTION?	56	7	MCAIDBED	NUMBER OF MEDICAID ONLY CERTIFIED BEDS
15	BK	INFOSATI	SP SATISFACTION W/ MC INFO AVAILABILITY	18	4	MCAIDHMO	IS THIS A MEDICAID HMO?
400	2F	INFNPNEU	DID SP HAVE PNEUMONIA?	52	7	MCAREBED	NUMBER OF MEDICARE ONLY CERTIFIED BEDS
403	2F	INFRESP	DID SP HAVE RESPIRATORY INFECTION?	13	BK	MCARKNOW	WHAT SP THINKS THEY KNOW ABOUT MEDICARE
406	2F	INFSEPT	DID SP HAVE SEPTICEMIA?	172	3	MCAVAIL	SATIS WITH AVAILABILITY OF MEDICAL CARE
409	2F	INFSEXTR	SP HAVE SEXUALLY TRANSMITTED DISEASE?	212	3	MCAVOID	AVOID GOING TO THE DOCTOR
412	2F	INFTBRC	DID SP HAVE TUBERCULOSIS?	182	3	MCCONCRN	SATIS WITH DR CONCERN FOR OVERALL HEALTH
415	2F	INFURNRY	DID SP HAVE URINARY TRACT INFECTION?	176	3	MCCOSTS	SATIS WITH COSTS OF MEDICAL CARE
421	2F	INFWOUND	DID SP HAVE WOUND INFECTION?	429	BK	MCDAAP	MEDICAID INFO FROM AARP/SR CITIZENS ORG
13	8	INT_DATE	INTERVIEW DATE YYYYMMDD	495	BK	MCDANSW	WERE MEDICAID QUESTIONS ANSWERED BY INFO
12	4	INT_TYPE	TYPE OF INTERVIEW	493	BK	MICDBEST	MEDICAID INFO THAT WAS MOST HELPFUL
12	8	INTERVU	TYPE OF INTERVIEW	439	BK	MICDCOUN	MEDICAID INFO FROM MEDICARE COUNSELING
16	K	INTERVU	TYPE OF INTERVIEW	437	BK	MICDDOCTR	MEDICAID INFO FROM DR OFFICE
150	3	JOINMHMO	EVER CONSIDERED JOINING AN HMO	449	BK	MICDEMPLR	MEDICAID INFO FROM CURR/FORMER EMPLOYER
957	BK	JOINPOS	CAN MCARS JOIN POINT OF SERVICE HMOS	431	BK	MICDFAMLY	MEDICAID INFO FROM FAMILY OR FRIEND
417	BK	MICDFIND	SP TRIED TO FIND MEDICAID INFO	451	BK	MICDHMO	MEDICAID INFO FROM HMO

435	BK	MCDHOSP	MEDICAID INFO FROM LOCAL HOSPITAL	210	3	MCWORRY	WORRY ABOUT HEALTH MORE THAN OTHERS
44	7	MCDICFMR	NUMBER OF ICF-MR BEDS ONLY	102	3	MDAPPT	WAS MD VISIT APPOINTMENT OR WALK-IN
453	BK	MCDINET	MEDICAID INFO FROM INTERNET	86	3	MDCHKUP	REASON FOR MD VISIT-CHECK-UP
421	BK	MCDINSCO	MEDICAID INFO FROM INSURANCE CLAIMS	104	3	MDDRTEL	SOMEONE TELL SP TO COME BACK FOR MD VST
190	3	MCDISSFY	WHAT THINGS ARE YOU DISSATISFIED WITH	84	3	MDFOLUP	REASON FOR MD VISIT-FOLLOW-UP
459	BK	MCDMCBS	MEDICAID INFO FROM MCBS	80	3	MDMCOND	REASON FOR MD VISIT-MED COND NAMED
425	BK	MCDMCOFF	MEDICAID INFO FROM MEDICARE/OFC HOTLINE		3	MDOTHER	REASON FOR MD VISIT-OTHER
423	BK	MCDMEDGP	MEDICAID INFO FROM MEDIGAP/SUP	98	96	MDPMED	REASON FOR MD VISIT-MEDICATION
419	BK	MCDNOFND	MEDICAID INFO NOT FOUND	92	3	MDPSHOT	REASON FOR MD VISIT-PREVENTATIVE SHOT
447	BK	MCDGOVOT	MEDICAID INFO FROM OTHER GOVT AGENCY	88	3	MDRFR	REASON FOR MD VISIT-REFERRAL
457	BK	MCDOSMNR	MEDICAID INFO FROM OTHER SEMINAR	100	3	MDSCOND	WAS MD VISIT FOR A SPECIFIC CONDITION
461	BK	MCDOTHER	MEDICAID INFO FROM OTHER PERSON/PLACE	78	3	MDSPCLTY	WHAT WAS DRS SPECIALTY
463	BK	MCDOTHOS	MEDICAID INFO FROM OTHER SPECIFIED	90	3	MDSURGY	REASON FOR MD VISIT-SURGERY
441	BK	MCDPUBL	MEDICAID INFO FROM MEDICARE PUBLICATIONS	82	3	MDTESTS	REASON FOR MD VISIT-TESTS
220	3	MCDRATMP	DID SP ATTEMPT TO SEE DR FOR COND	94	3	MDTSHOT	REASON FOR MD VISIT-TREATMENT SHOT
218	3	MCDRNSEE	EVER HAVE PROBLEM & DIDNT SEE DR	118	3	MDVCHOIC	WAS DR FIRST CHOICE
216	3	MCDRsoon	VISIT DOCTOR AS SOON AS FEEL BAD	76	3	MDVISIT	SINCE REF DATE DID SP SEE MD
455	BK	MCDSEMNR	MEDICAID INFO FROM HMO/INS CO SEMINAR	17	4	MEDICAID	MEDICAID ELIGIBILITY
40	7	MCDSNFN	NUMBER OF SNF BEDS--MEDICAID	367	2	MEMLOSS	MEMORY LOSS INTERFERE WITH ACTIVITY?
433	BK	MCDSRCTR	MEDICAID INFO FROM LOCAL SR CENTER	160	2F	MENTAL	DID SP HAVE ANY MENTAL ILLNESSES?
427	BK	MCDSSOFF	MEDICAID INFO FROM SOC SECURITY OFFICE	349	BK	MGPAARP	MGAP/SUP INFO FROM AARP/SR CITIZENS ORG
443	BK	MCDTVRAD	MEDICAID INFO FROM TV OR RADIO	415	BK	MGPANWS	WERE MGAP/SUP QUESTIONS ANSWERED BY INFO
445	BK	MCDZINE	MEDICAID INFO FROM NEWSPAPER OR MAGAZINE	413	BK	MGPBEST	MGAP/SUP INFO THAT WAS MOST HELPFUL
174	3	MCEASE	SATIS WITH EASE OF GETTING TO DOCTOR	359	BK	MGPCOUN	MGAP/SUP INFO FROM MEDICARE COUNSELING
180	3	MCFOLUP	SATIS WITH FOLLOW-UP CARE	357	BK	MGPDOCTR	MGAP/SUP INFO FROM DR OFFICE
921	BK	MCHIHELP	WHO MAKES SP HEALTH INSURANCE DECISIONS	369	BK	MGPEMPLR	MGAP/SUP INFO FROM CURR/FORMER EMPLOYER
923	BK	MCHIROST	ROSTNUM OF WHO HELPS MAKE HI DECISIONS	351	BK	MGPFAMILY	MGAP/SUP INFO FROM FAMILY OR FRIEND
200	3	MCIMPROV	WHAT THINGS NEED TO BE IMPROVED	337	BK	MGPFIND	SP TRIED TO FIND MEDIGAP/SUP INSUR INFO
178	3	MCINFO	SATIS WITH INFO GIVEN SP WHAT WAS WRONG	371	BK	MGPHMO	MGAP/SUP INFO FROM HMO
919	BK	MCPHINFO	SP HAS CALLED 1-800-MEDICARE FOR INFO	355	BK	MGPHOSP	MGAP/SUP INFO FROM LOCAL HOSPITAL
170	3	MCQUALTY	SATIS WITH QUALITY OF MEDICAL CARE	373	BK	MGPINET	MGAP/SUP INFO FROM INTERNET
242	3	MCRACCP	REASON NO SEE DR-DR NOT ACCEPT MCAID	341	BK	MGPINSCO	MGAP/SUP INFO FROM INSURANCE CLAIMS
228	3	MCRAPPT	REASON NOT SEE DR-COULDNT GET APPT	379	BK	MGPNCBS	MGAP/SUP INFO FROM MCBS
230	3	MCRAVAIL	REASON NOT SEE DR-DR NOT AVAILABLE	345	BK	MGPNCOFF	MGAP/SUP INFO FROM MEDICARE/OFC HOTLINE
224	3	MCRcost	REASON NOT SEE DR-COST TOO MUCH	343	BK	MGPMDGP	MGAP/SUP INFO FROM MEDIGAP/SUP
244	3	MCRDOCTR	REASON NO SEE DR-NO TRUST DR / AFRAID	339	BK	MGPNOFND	MGAP/SUP INFO NOT FOUND
236	3	MCRDRCDM	REASON NOT SEE DR-DR COULDNT DO MUCH	367	BK	MGPOGOVT	MGAP/SUP INFO FROM OTHER GOVT AGENCY
240	3	MCRDRCHG	REASON NOT SEE DR-CHARGE MORE THAN MC	377	BK	MGPOMNR	MGAP/SUP INFO FROM OTHER SEMINAR
234	3	MCRFAMILY	REASON NOT SEE DR-COULDNT LEAVE FAMILY	381	BK	MGPOTHER	MGAP/SUP INFO FROM OTHER PERSON/PLACE
238	3	MCRFEAR	REASON NOT SEE DR-FAIR OF WHATS WRONG	383	BK	MGPOTHOS	MGAP/SUP INFO FROM OTHER SPECIFIED
246	3	MCRHOSP	REASON NO SEE DR-AFRAID PUT IN HOSP	361	BK	MGPUBL	MGAP/SUP INFO FROM MEDICARE PUBLICATIONS
254	3	MCRMAIN	MAIN REASON FOR NOT SEEING DOCTOR	375	BK	MGPSEMNR	MGAP/SUP INFO FROM HMO/INS CO SEMINAR
248	3	MCRNOCAR	REASON NO SEE DR-NO FEEL LIKE / NO CAR	353	BK	MGPSRCTR	MGAP/SUP INFO FROM LOCAL SR CENTER
222	3	MCRNSERS	REASON NOT SEE DR-NOT SERIOUS	347	BK	MGPSOFF	MGAP/SUP INFO FROM SOC SECURITY OFFICE
252	3	MCRTHR	REASON NOT SEE DR-OTHER	363	BK	MGPTRAD	MGAP/SUP INFO FROM TV OR RADIO
226	3	MCRTIME	REASON NOT SEE DR-DIDNT HAVE TIME	365	BK	MGPZINE	MGAP/SUP INFO FROM NEWSPAPER OR MAGAZINE
250	3	MCRUNABL	REASON NO SEE DR-NEEDED HOUSE CALL	32	H	MHBADHRS	PROVIDER'S OFFICE HRS NOT CONVENIENT
232	3	MCRWAY	REASON NOT SEE DR-NO WAY TO GET TO DR	32	4	MHMODENT	DOES MHMO PLAN COVER DENTAL?
184	3	MCSAMLOC	SATIS WITH GETTING CARE AT SAME LOCATION	40	H	MHMODENT	SP HAVE DENTAL COVERAGE THRU HMO
214	3	MCSICK	WHEN SICK - KEEP TO SELF	34	4	MHMOEYE	DOES MHMO PLAN COVER EYE EXAMS?
186	3	MCSPECAR	SATIS WITH SPECIALISTS CARE	42	H	MHMOEYE	SP HAVE OPTICAL COVERAGE THRU HMO
188	3	MCTELANS	SATIS WITH GETTING ANSWERS ON TELEPHONE	60	H	MHMOGET	HOW GET MEDICARE HMO
62	H	MHMOMEMB	MOST IMPORTANT REASON JOIN HMO	38	4	MHMONH	DOES MHMO PLAN COVER NURSING HOME?

46	H	MHMONH	SP HMO COVERAGE INCL NURSING HOME	18	7	NHSTAT	NURSING HOME STAT FL
40	4	MHMOPAY	DOES SP PAY ADDITIONAL FOR HMO COVERAGE?	76	7	NLTCBEDS	NUMBER OF BEDS OF UNKNOWN CERTIFICATION
50	H	MHMOPAY	SP PAYS ADDITIONAL FOR HMO COVERAGE	58	2F	NOWSMOKE	DOES SP SMOKE NOW?
36	4	MHMOPCAR	DOES MHMO PLAN COVER PREVENTITIVE CARE?	521	3	NUSAVAIL	NO SOURCE OF CARE-US DR NOT AVAILABLE
44	H	MHMOPCAR	SP HAVE PREVENTIVE CARE THRU HMO	525	3	NUSDIFFP	NO SOURCE OF CARE-LIKE DIFFERENT PLACE
48	H	MHMOPOS	IS MHMO POINT-OF-SERVICE PLAN	519	3	NUSMOVIN	NO SOURCE OF CARE-RECENTLY MOVED
30	4	MHMORX	DOES MHMO PLAN COVER DRUGS?	517	3	NUSNOTSK	NO SOURCE OF CARE-SELDOM OR NEVER SICK
38	H	MHMORX	SP HAVE PRES MED COVERAGE THRU MHMO	529	3	NUSTOOEX	NO SOURCE OF CARE-TOO EXPENSIVE
22	H	MHNOAUTH	HMO WOULDN'T AUTHORIZE SERVICE	527	3	NUSTOOFR	NO SOURCE OF CARE-TOO FAR AWAY
26	H	MHNOCONV	PROVIDER'S LOCATION NOT CONVENIENT	109	BK	NWBAARP	NEW BEN INFO FROM AARP/SR CITIZENS ORG
30	H	MHNOLIKE	SP DIDN'T LIKE HMO REFERRED DOCTORS	175	BK	NWBANSW	WERE NEW BEN QUESTIONS ANSWERED BY INFO
28	H	MHNOREFR	HMO WOULDN'T GIVE REFERRAL TO SP	173	BK	NWBBEST	NEW BEN INFO THAT WAS MOST HELPFUL
34	H	MHOTHER	KIND OF DIFFICULTY - OTHER	119	BK	NWBCOUN	NEW BEN INFO FROM MEDICARE COUNSELING
18	H	MHREFDIF	HAD DIFFICULTY OBTAINING REFERRALS	117	BK	NWBDOCTR	NEW BEN INFO FROM DR OFFICE
36	H	MHREFPAY	PLAN EVER REFUSED TO PAY FOR EMERGENCY	129	BK	NWBEMPLR	NEW BEN INFO FROM CURR/FORMER EMPLOYER
20	H	MHSPCLTY	WHAT KIND OF SPECIALIST/MEDICAL PROVIDER	111	BK	NWBFAMLY	NEW BEN INFO FROM FAMILY OR FRIEND
24	H	MHWAITLG	WAIT FOR APPOINTMENT WAS TOO LONG	97	BK	NWBFINO	SP TRIED TO FIND NEW BEN/CHANGES INFO
178	2F	MISSLIMB	WAS SP MISSING LIMB?	131	BK	NWBHMO	NEW BEN INFO FROM HMO
217	2F	MLCANE	DID SP USE CANE/WALKER?	115	BK	NWBHOSP	NEW BEN INFO FROM LOCAL HOSPITAL
223	2F	MLWHLOTH	DID SOMEONE WHEEL SP?	133	BK	NWBINET	NEW BEN INFO FROM INTERNET
220	2F	MLWHLSLF	DID SP WHEEL HER/HIMSELF?	101	BK	NWBINSO	NEW BEN INFO FROM INSURANCE CLAIMS
64	7	MNORMBED	NUMBER OF MCAID NOR MCARE CERTIFIED BEDS	139	BK	NWBMCBS	NEW BEN INFO FROM MCBS
29	BK	MPYAARP	MED PAYM INFO FROM AARP/SR CITIZENS ORG	105	BK	NWBMCOFF	NEW BEN INFO FROM MEDICARE/OFC HOTLINE
95	BK	MPYANSW	WERE MED PAYM QUESTIONS ANSWERED BY INFO	103	BK	NWBMEDGP	NEW BEN INFO FROM MEDIGAP/SUP
93	BK	MPYBEST	MED PAYM INFO THAT WAS MOST HELPFUL	99	BK	NWBNOFND	NEW BEN INFO NOT FOUND
39	BK	MPYCOUN	MED PAYM INFO FROM MEDICARE COUNSELING	127	BK	NWBOGOVT	NEW BEN INFO FROM OTHER GOVT AGENCY
37	BK	MPYDOCTR	MED PAYM INFO FROM DR OFFICE	137	BK	NWBOSMNR	NEW BEN INFO FROM OTHER SEMINAR
49	BK	MPYEMPLR	MED PAYM INFO FROM CURR/FORMER EMPLOYER	141	BK	NWBOTHER	NEW BEN INFO FROM OTHER PERSON/PLACE
31	BK	MPYFAMLY	MED PAYM INFO FROM FAMILY OR FRIEND	143	BK	NWBOTHOS	NEW BEN INFO FROM OTHER SPECIFIED
17	BK	MPYFIND	SP TRIED TO FIND MEDICAL PAYMENT INFO	121	BK	NWBPUBL	NEW BEN INFO FROM MEDICARE PUBLICATIONS
51	BK	MPYHMO	MED PAYM INFO FROM HMO	135	BK	NWBSEMNR	NEW BEN INFO FROM HMO/INS CO SEMINAR
35	BK	MPYHOSP	MED PAYM INFO FROM LOCAL HOSPITAL	113	BK	NWBSRCTR	NEW BEN INFO FROM LOCAL SR CENTER
53	BK	MPYINET	MED PAYM INFO FROM INTERNET	107	BK	NWBSSOFF	NEW BEN INFO FROM SOC SECURITY OFFICE
21	BK	MPYINSO	MED PAYM INFO FROM INSURANCE CLAIMS	123	BK	NWBTVRAD	NEW BEN INFO FROM TV OR RADIO
59	BK	MPYMCBS	MED PAYM INFO FROM MCBS	125	BK	NWBZINE	NEW BEN INFO FROM NEWSPAPER OR MAGAZINE
25	BK	MPYMCOFF	MED PAYM INFO FROM MEDICARE/OFC HOTLINE	NLY A	8	O	INTERVIEWS
23	BK	MPYMEDGP	MED PAYM INFO FROM MEDIGAP/SUP	211	2	OCAALOVR	PART BODY HAD ARTHRITIS-ALL OVER/JOINT?
19	BK	MPYNOFND	MED PAYM INFO NOT FOUND	203	2	OCAARM	PART OF BODY HAD ARTHRITIS-ARMS/HANDS?
47	BK	MPYOGOVT	MED PAYM INFO FROM OTHER GOVT AGENCY	207	2	OCABACK	PART OF BODY HAD ARTHRITIS-BACK?
57	BK	MPYOSMNR	MED PAYM INFO FROM OTHER SEMINAR	205	2	OCAFEET	PART OF BODY HAD ARTHRITIS-KNEES/FEET?
61	BK	MPYOTHER	MED PAYM INFO FROM OTHER PERSON/PLACE	217	2	OICALZMR	SP EVER TOLD HAD ALZHEIMERS DISEASE?
63	BK	MPYOTHOS	MED PAYM INFO FROM OTHER SPECIFIED	231	2	OCAMPUTE	SP EVER TOLD HAD LOSS ARM OR LEG?
41	BK	MPYPUBL	MED PAYM INFO FROM MEDICARE PUBLICATIONS	209	2	OCANECK	PART OF BODY HAD ARTHRITIS-NECK?
55	BK	MPYSEMNR	MED PAYM INFO FROM HMO/INS CO SEMINAR	213	2	OCAOTHER	PART OF BODY HAD ARTHRITIS-OTHER?
33	BK	MPYSRCTR	MED PAYM INFO FROM LOCAL SR CENTER	149	2	OCARTERY	SP EVER TOLD HAD HARDENING OF ARTERIES?
27	BK	MPYSOFF	MED PAYM INFO FROM SOC SECURITY OFFICE	201	2	OCARTH	SP EVER TOLD HAD ARTHRITIS?
43	BK	MPYTVRAD	MED PAYM INFO FROM TV OR RADIO	199	2	OCARTHHR	SP EVER TOLD HAD RHEUMATOID ARTHRITIS?
45	BK	MPYZINE	MED PAYM INFO FROM NEWSPAPER OR MAGAZINE	223	2	OCBRKHIP	SP EVER TOLD HAD BROKEN HIP?
85	2F	MYOCARD	DID SP HAVE MYOCARDIAL INFARCTION?	163	2	OCCANCER	SP EVER TOLD HAD OTHER CANCER/TUMOR?
74	3	NHLRESMM	MONTH OF LAST RESIDENCE IN NURSING HOME	189	2	OCCBACK	PART OF BODY HAD CANCER--BACK
70	3	NHLRESYY	YEAR OF LAST RESIDENCE IN NURSING HOME	175	2	OCCBLAD	PART OF BODY HAD CANCER--BLADDER
68	3	NHRESEVR	SP EVER BEEN A RESIDENT IN NUSING HOME	185	2	OCCBRAIN	PART OF BODY HAD CANCER--BRAIN
169	2	OCCBREST	PART OF BODY HAD CANCER--BREAST	181	2	OCCERVX	PART OF BODY HAD CANCER--CERVIX

167	2	OCCCOLON	PART OF BODY HAD CANCER--COLON/BOWEL	311	2	PCHKDRES	PERSON NEARBY WHILE DRESSING?
193	2	OCCFONEC	PART OF BODY HAD CANCER-FEMALE ORGANS	313	2	PCHKEAT	PERSON NEARBY WHILE EATING?
155	2	OCCHD	SP EVER TOLD HAD ANGINA PECTORIS/CHD?	319	2	PCHKTOIL	PERSON NEARBY WHILE USING TOILET?
191	2	OCCHEAD	PART OF BODY HAD CANCER--HEAD	317	2	PCHKWALK	PERSON NEARBY WHILE WALKING?
183	2	OCCKIDNY	PART OF BODY HAD CANCER--KIDNEY	463	2F	PEPULC	DID SP HAVE PEPTIC ULCER?
165	2	OCCLUNG	PART OF BODY HAD CANCER--LUNG	214	2F	PFBATHNG	LEVEL OF SELF PERFORM: BATHING
195	2	OCCOTHER	PART OF BODY HAD CANCER--OTHER	205	2F	PFDRSSNG	LEVEL OF SELF PERFORM: DRESSING
177	2	OCCOVARY	PART OF BODY HAD CANCER--OVARY	208	2F	PFEATING	LEVEL OF SELF PERFORM: EATING
173	2	OCCPROST	PART OF BODY HAD CANCER--PROSTATE	202	2F	PFLOCOMO	LEVEL OF SELF PERFORM: LOCOMOT. ON UNIT
161	2	OCCSKIN	SP EVER TOLD HAD SKIN CANCER?	211	2F	PFTOILET	LEVEL OF SELF PERFORM: TOILET USE
179	2	OCCSTOM	PART OF BODY HAD CANCER--STOMACH	199	2F	PFTRNSFR	LEVEL OF SELF PERFORM: TRANSER
187	2	OCCTHROA	PART OF BODY HAD CANCER--THROAT	441	3	PLACEKND	KIND OF PLACE USUALLY GO FOR MED CARE
171	2	OCCUTER	PART OF BODY HAD CANCER--UTERUS	439	3	PLACEPAR	PARTICULAR PLACE USUALLY GO FOR MED CARE
197	2	OCDIABTS	SP EVER TOLD HAD DIABETES?	385	3	PMCOST	REAS DID NOT GET MED-COST TOO MUCH
227	2	OCEMPHYS	"SP EVER TOLD HAD EMPHYSEMA,ASTHMA,COPD?"	437	3	PMMAIN	MAIN REASON MED NOT OBTAINED
151	2	OCHBP	SP EVER TOLD HAD HYPERTENSION?	258	3	PMNAME1	NAME OF MEDICINE DID NOT GET - 1
215	2	OCMENTAL	SP EVER TOLD HAD MENTAL RETARDATION?	283	3	PMNAME2	NAME OF MEDICINE DID NOT GET - 2
153	2	OCMYOCAR	SP EVER TOLD HAD MYOCARDIAL INFARCTION?	308	3	PMNAME3	NAME OF MEDICINE DID NOT GET - 3
221	2	OCOSTEOP	SP EVER TOLD HAD OSTEOPOROSIS?	333	3	PMNAME4	NAME OF MEDICINE DID NOT GET - 4
157	2	OCOTHART	SP EVER TOLD HAD OTHER HEART CONDITIONS?	358	3	PMNAME5	NAME OF MEDICINE DID NOT GET - 5
225	2	OCPARKIN	SP EVER TOLD HAD PARKINSONS DISEASE?	383	3	PMNOCOND	REAS DID NOT GET MED-NOT FOR THE COND
229	2	OCPPARAL	SP EVER TOLD HAD PARTIAL PARALYSIS?	387	3	PMNOCOV	REAS DID NOT GET MED-NOT COV BY INSUR
219	2	OCPSYCH	SP EVER TOLD HAD MENTAL DISORDER?	397	3	PMNOHELP	REAS DID NOT GET MED-WOULD NOT HELP COND
159	2	OCSTROKE	SP EVER TOLD HAD STROKE/BRAIN HEMORRHAGE	403	3	PMNOLIKE	REAS DID NOT GET MED-NO LIKE TO TAKE MED
134	3	OFFRAREA	SP PREFER TO HAVE HMO OFFERED IN AREA	401	3	PMNONEED	REAS DID NOT GET MED-FELT BETTER-DDNT ND
484	2F	ONCHEW	DID SP EXPERIENCE CHEWING PROBLEMS?	391	3	PMNOSOON	REAS DID NOT GET MED-NOT GET SOON ENOUGH
490	2F	ONMOUTH	DID SP EXPERIENCE ANY MOUTH PAIN?	256	3	PMNOTGET	MEDS PRESCRIBED THAT SP DID NOT GET
487	2F	ONSWALL	DID SP EXPERIENCE SWALLOWING PROBLEMS?	389	3	PMNOTIME	REAS DID NOT GET MED-DIDNT HAVE TIME
52	3	OPDAPPT	WAS OPD VISIT APPOINTMENT OR WALK-IN	395	3	PMNOWAY	REAS DID NOT GET MED-NO WAY TO GET MED
36	3	OPDCHKUP	REASON FOR OPD VISIT-CHECKUP	405	3	PMOTHER	REAS DID NOT GET MED-OTHER
54	3	OPDDRTEL	SOMEONE TELL SP TO COME BACK FOR OPD VIS	407	3	PMOTHOS	REAS DID NOT GET MED-OTHER SPECIFY
34	3	OPDFOLUP	REASON FOR OPD VISIT-FOLLOWUP	393	3	PMPHARM	REAS DID NOT GET MED-NO PHARMACY CONV
30	3	OPDMCOND	REASON FOR OPD VISIT-MED COND NAMED	399	3	PMREACT	REAS DID NOT GET MED-AFRAID OF REACTIONS
48	3	OPDOOTHER	REASON FOR OPD VISIT-OTHER	97	2	PNEUSHOT	SP EVER HAVE SHOT FOR PNEUMONIA?
46	3	OPDPMED	REASON FOR OPD VISIT-MEDICATION	34	8	PNSPDED	PROXY NEEDED - SP DECEASED
42	3	OPDPSHOT	REASON FOR OPD VISIT-PREVENTATIVE SHOT	36	8	PNSPINH	PROXY NEEDED - SP IN HOSPITAL
38	3	OPDRFRL	REASON FOR OPD VISIT-REFERRAL	38	8	PNSPINS	PROXY NEEDED - SP INSTITUTIONALIZED
50	3	OPDSCOND	WAS OPD VISIT FOR A SPECIFIC CONDITION	40	8	PNSPLAN	PROXY NEEDED - LANGUAGE PROBLEM
40	3	OPDSURGY	REASON FOR OPD VISIT-SURGERY	42	8	PNSPNAM	PROXY NEEDED - SP NOT CAPABLE MENTALLY
32	3	OPDTESTS	REASON FOR OPD VISIT-TESTS	44	8	PNSPNAP	PROXY NEEDED - SP NOT CAPABLE PHYSICALLY
44	3	OPDTSHOT	REASON FOR OPD VISIT-TREATMENT SHOT	46	8	PNSPNOK	PROXY NEEDED - SP NOT KEEP MED RECORDS
28	3	OPDVISIT	SINCE REF DATA DID SP GO TO AN OPD	48	8	PNSPOTH	PROXY NEEDED - OTHER
26	6	ORIGADMN	FIRST MCBS ADMISSION DATE	50	8	PNSPPAP	PROXY NEEDED - SP PREFER PROXY ANSWER
166	2F	OSTEOP	DID SP HAVE OSTEOPOROSIS?	52	8	PNSPUNA	PROXY NEEDED - SP TEMP NOT AVAILABLE
72	7	OTLTCBED	NUMBER OF OTHER LTC BEDS IN FACILITY	117	2	PNUAGNST	DOCTOR RECOMMEND AGAINST GETTING SHOT
461	3	PAIDMORE	SP EVER PAY MORE THAN MEDICARE APPROVES	102	2	PNUCAUSE	SHOT COULD CAUSE PNEUMONIA
46	2	PAPSMEAR	SP HAD PAPSMEAR IN LAST YEAR?	129	2	PNUCOST	COST OF SHOT NOT WORTH THE MONEY
46	2F	PAPSMEAR	SP HAD A PAPSMEAR IN THE LAST YEAR?	114	2	PNUDOCNO	DOCTOR DID NOT RECOMMEND THE SHOT
361	2F	PARAPLEG	DID SP HAVE PARAPLEGIA?	123	2	PNULOCAT	UNABLE TO GET TO A LOCATION
172	2F	PARKNSON	DID SP HAVE PARKINSON DISEASE?	126	2	PNUMISS	DID NOT THINK ABOUT IT/MISSED IT
309	2	PCHKBATH	PERSON NEARBY WHILE BATHING/SHOWERING?	99	2	PNUNEEED	DID NOT KNOW IT WAS NEEDED
315	2	PCHKCHAR	PERSON NEARBY WHILE GETS IN/OUT CHAIRS?	132	2	PNUOTHER	OTHER REASON
108	2	PNUPRVNT	DID NOT THINK IT WOULD PREVENT PNEUMONIA	120	2	PNUREACT	DONT LIKE SHOTS OR NEEDLES

111	2	PNURISK	NOT AT SERIOUS RISK OF CATCHING IT
105	2	PNUSIDE	SHOT COULD HAVE SIDE EFFECTS
247	2	PRBBILS	ANY DIFFICULTY MANAGING MONEY?
187	2F	PRBBILS	WAS MANAGING MONEY DIFFICULT?
241	2	PRBHHWK	ANY DIFFICULTY DOING HEAVY HOUSEWORK?
239	2	PRBLHWK	ANY DIFFICULTY DOING LIGHT HOUSEWORK?
243	2	PRBMEAL	ANY DIFFICULTY MAKING MEALS?
245	2	PRBSHOP	ANY DIFFICULTY SHOPPING?
184	2F	PRBSHOP	WAS SHOPPING DIFFICULT?
237	2	PRBTELE	ANY DIFFICULTY USING PHONE?
181	2F	PRBTELE	WAS USING THE PHONE DIFFICULT?
469	3	PREVMEDC	USUALLY BEEN GOING TO SOME OTHER DR
473	3	PREVNOGO	WHY DOESNT SP GO TO OTHER DOCTOR
481	3	PREVREAS	MOST IMPORT REASON SP GOES TO USUAL DR
475	3	PREVSAC1	1ST CODE FOR PREV DR DISSATISFACTION
477	3	PREVSAC2	2ND CODE FOR PREV DR DISSATISFACTION
479	3	PREVSAC3	3RD CODE FOR PREV DR DISSATISFACTION
471	3	PREVSTIL	SP STILL GOING TO OTHER DOCTOR
370	2	PROBDECS	HAVING PROBLEM MAKING DECISIONS?
893	BK	PROMOREC	HOW OFTEN SP RECD ADS FROM HMO/INSUR CO
30	8	PROXY	SELF-RESPONDENT OR PROXY
295	2F	PWFACLIF	INVOLVED WITH LIFE AT FACILITY?
292	2F	PWGOALS	AT EASE ESTABLISHING GOALS?
298	2F	PWGRPACT	ACCEPTS INVITATIONS TO GROUP ACTIVITIES?
283	2F	PWINTOTH	AT EASE INTERACTING WITH OTHERS?
301	2F	PWNOFC	ABSENCE OF CONTACT WITH FAMILY/FRIENDS?
289	2F	PWSLFACT	AT EASE DOING SELF-INITIATED ACTIVITIES?
286	2F	PWSTRACT	AT EASE DOING PLANNED ACTIVITIES?
370	2F	QUADPLEG	DID SP HAVE QUADRIPLÉGIA?
845	W2	R222B100	ROUND 22 TWO YEAR BL REPL WEIGHT 100
45	W2	R222BWGT	ROUND 22 TWO YEAR BL FULL SAMPLE WEIGHT
53	W1	R223B001	ROUND 22 ONE YEAR BL REPL WEIGHT 1
845	W1	R223B100	ROUND 22 ONE YEAR BL REPL WEIGHT 100
45	W1	R223BWGT	ROUND 22 ONE YEAR BL FULL SAMPLE WEIGHT
	X	R22CS001	R22 CROSS-SECTIONAL REPLICATE WEIGHT 1
60	X	R22CS100	R22 CROSS-SECTIONAL REPLICATE WEIGHT 100
852	X	R22CWGT	R22 CROSS-SECTIONAL FULL SAMPLE WEIGHT
53	W3	R22NR001	ROUND 22 NR ADJ REPLICATE WEIGHT 1
845	W3	R22NR100	ROUND 22 NR ADJ REPLICATE WEIGHT 100
45	W3	R22NRWGT	ROUND 22 NR ADJ FULL SAMPLE WEIGHT
60	1	RACEAA	BLACK/ OR AFRICAN AMERICAN
66	1	RACEAI	"AMER INDIAN, ALASKA NATIVE"
	1	RACEAS	ASIAN
58	62	1	RACENH "NATIVE HAWAIIAN, PAC. ISLANDER"
	1	RACEOTH	OTHER
68	1	RACEWH	WHITE
64	64	H	RECMHMO RECOMMEND MHMO TO FAMILY/FRIENDS
485	3	RECOMDOC	DID FAMILY/FRIENDS RECOMMEND USUAL DR
483	3	REFERDOC	WAS SP REFERRED TO USUAL DR BY OTHER MD
373	2F	RENTFAIL	DID SP HAVE RENAL FAILURE?
466	2F	RENTUR	DID SP HAVE RENAL URETERAL DISORDER?
21	8	RESTART	NUMBER OF TIMES INTRV INTERRUPTED
523	BK	SRCGOVT	USED OTHER GOVT AGENCY TO GET INFO

931	BK	REVINFMO	WILL REVIEW NEW PLAN INFO IN NEXT 3 MOS	
929	BK	REVINFYR	INTEND TO REVIEW NEW PLAN INFO IN NVT YR	
927	BK	REVPLCHC	HAS REVIEWED NEW PLAN INFO FOR HOW LONG	
1	1	RIC	RECORD IDENTIFICATION CODE 1	
1	2	RIC	SURVEY HEALTH STATUS & FUNC RECORD	
1	3	RIC	ACCESS TO CARE RECORD	
1	4	RIC	SURVEY HEALTH INSURANCE RECORD	
1	5	RIC	RECORD IDENTIFICATION CODE 5	
1	6	RIC	SURVEY RESIDENCE HISTORY RECORD	
1	7	RIC	RIC CODE FOR SURVEY FACILITY ID RECORD	
1	8	RIC	SURVEY INTERVIEW RECORD	
1	2F	RIC	SURVEY HEALTH STATUS & FUNC RECORD	
1	A	RIC	RIC CODE FOR ADMIN IDENTIFICATION RECORD	
1	A2	RIC	RIC CODE FOR ADMIN IDENTIFICATION RECORD	
	BK	RIC	BENEFICIARY KNOWLEDGE	
	BN	RIC	BENEFICIARY NEEDS	
1	1	H	RIC	RECORD IDENTIFICATION CODE
1	1	K	RIC	RIC CODE FOR KEY RECORD
	1	W1	RIC	ROUND 22 ONE YEAR BL WEIGHTS
	1	W2	RIC	ROUND 22 TWO YEAR BL WEIGHTS
	1	W3	RIC	ROUND 22 NR ADJ WEIGHTS
		X	RIC	CROSS-SECTIONAL WEIGHTS
1	58	8	RINFOSAT	INFO PROVIDED BY RESPON IS SATISFACTORY
	80	7	ROOMCARE	DOES FACIL PROVIDE NURSE/MEDICAL CARE
	18	1	ROSTSEX	SEX OF HOUSEHOLD MEMBER
	54	8	RRECHLP	DID RESPONDENT RECEIVE HELP ANSWERING
	925	BK	RVDPLCHC	REVIEWED INFO ABT NEW HELTH PLAN CHOICES
	1079	BK	SATEXPR	SATISFACTION W/ WAYS OF MAKING SUGGEST
53	376	2F	SCHROPH001	ROUND 22 ONE YEAR BL REPL WEIGHT 1
	358	2F	SCLEROS	DID SP HAVE MULTIPLE SCLEROSIS?
	469	2F	SCOLIO	DID SP HAVE SCOLIOSIS?
	379	2F	SEIZURE	DID SP HAVE SEIZURE DISORDER?
	137	2	SMOKNOW	SP SMOKE NOW?
	36	7	SNFBEDN	NUMBER OF SNF BEDS--MEDICARE
	45	1	SPCHNLNM	# OF CHILDREN LIVING
	12	2F	SPHEALTH	GENERAL HEALTH OF SP
	47	1	SPHIGRAD	HIGHEST SCHOOL GRADE COMPLETED
	98	7	SPIDCNT	NUMBER OF SPS IN FACILITY
	49	1	SPMARSTA	MARITAL STATUS OF SP
	505	BK	SRCAARP	USED AARP/SR CITIZENS ORG TO GET INFO
	515	BK	SRCCOUN	USED MEDICARE COUNSELING TO GET INFO
	513	BK	SRCDOCTR	USED DR OFFICE TO GET INFO
	525	BK	SRCEMLR	USED CURR/FORMER EMPLOYER TOL GET INFO
	507	BK	SRCFAMLY	USED FAMILY OR FRIEND TO GET INFO
	527	BK	SRCHMO	USED HMO TO GET INFO
	511	BK	SRCHOSP	USED LOCAL HOSPITAL TO GET INFO
	529	BK	SRCINET	USED INTERNET TO GET INFO
	497	BK	SRCINSCO	USED INSURANCE CLAIMS TO GET INFO
	535	BK	SRCMCBS	USED MCBS TO GET INFO
	501	BK	SRCMCOFF	USED MEDICARE/OFC HOTLINE TO GET INFO
	499	BK	SRCMEDGP	USED MEDIGAP/SUP TO GET INFO
	533	BK	SRCOSMNR	USED OTHER SEMINAR TO GET INFO

537	BK	SRCOTHER	USED OTHER PERSON/PLACE TO GET INFO	497	3	USUNHIST	DR HAD GOOD UNDERSTANDING OF MEDICAL HIS
539	BK	SRCOTHOS	OTHER SPECIFIED SOURCE USED TO GET INFO	499	3	USUNWRNG	DR UNDERSTANDS THINGS THAT ARE WRONG
517	BK	SRCPUBL	USED MEDICARE PUBLICATIONS TO GET INFO	523	3	USWHYNAV	WHY IS USUAL DR NO LONGER AVAILABLE
531	BK	SRCSEMN	USED HMO/INS CO SEMINAR TO GET INFO		W1	VARSTRAT	VARIANCE STRATUM
509	BK	SRCRCTR	USED LOCAL SR CENTER TO GET INFO	13	W2	VARSTRAT	VARIANCE STRATUM
503	BK	SRCSSOFF	USED SOC SECURITY OFFICE TO GET INFO	13	W3	VARSTRAT	VARIANCE STRATUM
209	BN	SRCTRACS	SENIOR CENTER IN NEIGHBORHOOD OF SP	13	X	VARSTRAT	VARIANCE STRATUM
213	BN	SRCTRGET	SP CAN GET TO THE SENIOR CENTER	12	W1	VARUNIT	VARIANCE PSU
211	BN	SRCTRUSE	SP USES AS SENIOR CENTER	21	W2	VARUNIT	VARIANCE PSU
519	BK	SRCTVRAD	USED TV OR RADIO TO GET INFO	21	W3	VARUNIT	VARIANCE PSU
521	BK	SRCZINE	USED NEWSPAPER OR MAGAZINE TO GET INFO	21	X	VARUNIT	VARIANCE PSU
345	2	STILBATH	NEED HELP 3 MOS FROM NOW TO BATH?	208	2F	VASCULAR	DID SP HAVE PERIPHERAL VASCULAR DISEASE?
351	2	STILCHAR	NEED HELP 3 MOS FROM NOW IN/OUT CHAIRS?	142	3	VCHIADD1	CODE FOR HIADD
347	2	STILDRES	NEED HELP 3 MOS FROM NOW TO DRESS?	144	3	VCHIADD2	CODE FOR HIADD
349	2	STILEAT	NEED HELP 3 MOS FROM NOW TO EAT?	146	3	VCHIADD3	CODE FOR HIADD
355	2	STILTOIL	NEED HELP 3 MOS FROM NOW TO USE TOILET?	148	3	VCHIADD4	CODE FOR HIADD
353	2	STILWALK	NEED HELP 3 MOS FROM NOW TO WALK?	162	3	VCIFMH1	CODE FOR IFMHMO
97	2F	STROKE	DID SP HAVE A STROKE?	164	3	VCIFMH2	CODE FOR IFMHMO
	W1	SUDSTRAT	SUDAAN STRATUM	166	3	VCIFMH3	CODE FOR IFMHMO
29	W2	SUDSTRAT	SUDAAN STRATUM	168	3	VCIFMH4	CODE FOR IFMHMO
29	W3	SUDSTRAT	SUDAAN STRATUM	152	3	VCJOIN1	CODE FOR JOINHMO
29	X	SUDSTRAT	SUDAAN STRATUM	154	3	VCJOIN2	CODE FOR JOINHMO
28	W1	SUDUNIT	SUDAAN UNIT	156	3	VCJOIN3	CODE FOR JOINHMO
37	W2	SUDUNIT	SUDAAN UNIT	158	3	VCJOIN4	CODE FOR JOINHMO
37	W3	SUDUNIT	SUDAAN UNIT	192	3	VCMCDIS1	1ST VERBATIM CODE FOR MCDISSFY
37	X	SUDUNIT	SUDAAN UNIT	194	3	VCMCDIS2	2ND VERBATIM CODE FOR MCDISSFY
36	82	SUPRVMED	DOES FACIL SUPERVISE SELF-ADMIN MEDS	196	3	VCMCDIS3	3RD VERBATIM CODE FOR MCDISSFY
	K	SURVIVE	SURVIVOR INDICATOR	198	3	VCMCDIS4	4TH VERBATIM CODE FOR MCDISSFY
178	2F	TIA	DID SP HAVE TIA?	202	3	VCMCIMP1	1ST VERBATIM CODE FOR MCIMPROV
373	2	TROBCONC	HAVING TROUBLE CONCENTRATING?	204	3	VCMCIMP2	2ND VERBATIM CODE FOR MCIMPROV
939	BK	UNDRMSA	DOES SP UNSTAND MEDICAL SAVINGS ACCOUNT	206	3	VCMCIMP3	3RD VERBATIM CODE FOR MCIMPROV
955	BK	UNDRPOS	DOES SP UNSTAND POINT OF SERVICE HMOS	208	3	VCMCIMP4	4TH VERBATIM CODE FOR MCIMPROV
943	BK	UNDRPPO	DOES SP UNSTAND PREFERRED PROVIDER ORGS	328	2F	VEINTHR	DID SP HAVE DEEP VEIN THROMBOSIS?
949	BK	UNDRPSO	DOES SP UNSTAND PROVIDER SPONSORED ORGS	15	2F	VISAPPL	DOES SP USE A VISUAL APPLIANCE?
511	3	USANSQUX	DR ANSWERS ALL SP QUESTIONS	18	2F	VISION	ABILITY OF SP TO SEE?
487	3	USCHGMOR	SP KNOW DR CHARGE MORE THAN MCARE APPR	41	2	WEIGHT	WEIGHT OF SP--POUNDS
493	3	USCKEVR	DR CHECKS EVERYTHING WHEN EXAMINED	39	2F	WEIGHT	WEIGHT OF SP
495	3	USCOMPET	DR IS COMPETENT AND WELL-TRAINED	16	H	YEARSHMO	HOW MANY YEARS SP ENROLLED IN AN HMO
513	3	USCONFID	SP HAS GREAT CONFIDENCE IN DOCTOR				
515	3	USDEPEND	SP DEPENDS ON DOCTOR TO FEEL BETTER				
505	3	USDISCUS	HEALTH PROBLEMS NOT DISCUSSED				
503	3	USEXPPRB	DR DOES NOT EXPLAIN MEDICAL PROBLEMS				
507	3	USFAVOR	DR ACTS AS IF DOING SP A FAVOR				
463	3	USFINDMC	TRY TO FIND DR WHO ACCEPTS MCARE APP AMT				
491	3	USHICHEK	DOES INSURANCE SEND CHECK TO SP OR DR				
447	3	USHOUSCL	DOES DOCTOR MAKE HOUSE CALLS				
465	3	USHOWLNG	HOW LONG HAS SP SEEN USUAL DOCTOR				
501	3	USHURRY	DR SEEMS TO BE IN A HURRY				
459	3	USMCCKEK	DOES MEDICARE SEND CHECK TO SP OR DR				
467	3	USONEYYY	LESS THAN A YEAR OR A YEAR OR MORE				
489	3	USPAPWRK	DOES DR TAKE CARE OF INS PAPER WORK				
509	3	USTELALL	DR TELLS SP ALL SP WANTS TO KNOW				
443	3	USUALDOC	PARTICULAR DR USUALLY SEEN				