

APPENDIX B

DEFINITIONS OF TERMS AND VARIABLES FOR THE MEDICARE CURRENT BENEFICIARY SURVEY

Activities of daily living (ADLs): Activities of daily living are activities related to personal care. They include bathing or showering, dressing, getting in and out of bed or a chair, walking (added for 2009 tables), using the toilet, and eating. If a sample person had any difficulty performing an activity by himself/herself and without special equipment, or did not perform the activity at all because of health problems, the person was deemed to have a limitation in that activity. The limitation may have been temporary or chronic at the time of the survey. Sample persons who were administered a community interview answered health status and functioning questions themselves, unless they were unable to do so. A proxy, such as a nurse, always answered questions about the sample person's health status and functioning for long-term care facility interviews.

Arthritis: The category arthritis includes rheumatoid arthritis, osteoarthritis, and other forms of arthritis.

Balance billing: In the Medicare program, the practice of billing a Medicare beneficiary in excess of Medicare's allowed charge is known as balance billing. The balance billing amount is the difference between Medicare's allowed charge and the provider's actual charge to the patient.

Capitation payment: A capitation payment is a predetermined, per-member, per-month payment from the Medicare program to risk health maintenance organizations (HMOs) (see health maintenance organization). Risk HMOs use the capitation payment to finance all necessary Medicare-covered services provided to Medicare beneficiaries enrolled in the HMO. The amount paid for each Medicare enrollee does not depend on the actual cost of services provided to the individual.

Chronic conditions: Chronic conditions consists of heart disease, cancer (other than skin cancer), Alzheimer's disease/other dementias, mental illness/disorder (depression/anxiety disorders), hypertension (high blood pressure), diabetes, arthritis, osteoporosis, broken hip, pulmonary disease, stroke, Parkinson's disease, and urinary

incontinence that occurs once a week or more often. In 2003, cancer (other than skin cancer), Alzheimer's disease/other dementias, and mental illness/disorder (depression/anxiety disorders) were added to the list of chronic conditions.

Claim-only event: A claim-only event is a medical service or event known only through the presence of a Medicare claim. The event did not originate from, and was not matched to, an event or service reported by a sample person during an interview.

Cognitive impairment: Cognitive impairment is defined based on four community interview questions and seven facility interview questions. The community interview questions include memory loss interfering with daily activity, problems making decisions, trouble concentrating, and losing interest the last 12 months. The facility interview questions include problems with short term or long term memory, recalling current season, recalling location of room, recalling names and faces, recalling he/she is in a nursing home, or making decisions. If a sample person had problems with any measures of cognitive functioning, the person was counted as cognitive impaired. Starting in October 2010, CMS transitioned its data collection for facility beneficiaries from MDS 2.0 to MDS 3.0. This resulted in changes in the facility questionnaire and subsequent changes in variables measuring cognitive impairment among facility beneficiaries. In order to maintain continuity with previous years' estimates in this table series, MDS 2.0 variables were used in 2013 when possible. Due to the transition to MDS 3.0, the seven facility interview questions above are only asked of individuals who did not receive a Brief Interview for Medical Status (BIMS). This may result in undercounting of facility beneficiaries with cognitive impairments, due to the fact that individuals who are severely impaired tend to receive a BIMS interview. Sample persons responded to health status and functioning questions themselves in community interviews, unless they were unable to do so. A proxy, such as a nurse, answered questions about the sample person's health status and functioning in facility interviews.

Coinsurance: A coinsurance is the percentage of covered hospital or medical expense, after subtraction of any deductible, for which an insured person is responsible. For example, after the annual deductible has been met, Medicare will generally pay 80 percent of approved charges for services and supplies covered under Medicare Part B. The remaining 20 percent of the approved charge is the coinsurance amount, for which the beneficiary is liable.

Copayment: A copayment is a form of cost-sharing whereby the insured pays a specific amount at the point of service or use (e.g., \$10 per doctor visit).

Cost-sharing liability: Cost-sharing is the portion of payment to a provider of health care services that is the liability of the patient. Cost-sharing liabilities include deductibles, copayments, coinsurance, and balance billing amounts.

Deductible: A deductible is an initial expense of a specific amount of approved charges for covered services within a given time period (e.g., \$100 per year) payable by an insured person before the insurer assumes liability for any additional costs of covered services. For example, from the first day through the 60th day of an inpatient hospital stay in 2013, Medicare Part A paid for all covered services except for the first \$1,184. The \$1,184 constituted the inpatient hospital deductible.

Dental service: The basic unit measuring use of dental services is a single visit to the dentist, at which time a variety of services, including cleaning, x-rays, and an exam, might be rendered.

End-stage renal disease (ESRD): End-stage renal disease is that state of kidney impairment that is irreversible, cannot be controlled by conservative management alone, and requires dialysis or kidney transplantation to maintain life.

Fee-for-service payment: Fee-for-service is a method of paying for medical services in which each service delivered by a provider bears

a charge. This charge is paid by the patient receiving the service or by an insurer on behalf of the patient.

Functional limitations: Sample persons who reported no limitations in any of the activities of daily living (ADLs) or instrumental activities of daily living (IADLs) due to health problems were included in the category “none.” Sample persons with limitations in at least one IADL, but no ADL, were included in the category “IADL only.” Sample persons with ADL limitations were categorized by the number of limitations (1 to 2, 3 or more) regardless of the presence or number of IADL limitations. Sample persons who were administered a community interview answered questions about their functional limitations themselves, unless they were unable to do so. A proxy, such as a nurse, always answered questions about the sample person’s functional limitations for long-term care facility interviews.

Health status: A sample person was asked to rate his or her general health compared to other people of the same age. Sample persons who were administered a community interview answered health status questions themselves, unless they were unable to do so. A proxy, such as a nurse, always answered questions about the sample person’s health status for long-term care facility interviews.

Heart disease: For community-dwelling beneficiaries, the category heart disease includes myocardial infarction (heart attack), angina pectoris or coronary heart disease, congestive heart failure, problems with valves in the heart, or problems with rhythm of the heartbeat. Starting in October 2010, CMS transitioned its data collection for facility beneficiaries from MDS 2.0 to MDS 3.0. This resulted in changes in the facility questionnaire and subsequent changes in variables measuring heart disease among facility beneficiaries. Beginning with the 2013 Cost and Use file, MDS 2.0 variables measuring angina pectoris or coronary heart disease, arteriosclerotic heart disease, and cardiovascular disease were dropped from the MCBS dataset. As a result, the 2013 construction of the heart disease indicator for facility beneficiaries uses two variables that remained in the dataset (myocardial infarction (heart attack) and congestive heart

failure) and two variables that are newly added (coronary artery disease and atrial fibrillation/other dysrhythmias).

Income: Income is for calendar year 2013. It is for the sample person, or the sample person and spouse if the sample person was married in 2013. All sources of income from jobs, pensions, Social Security benefits, Railroad Retirement and other retirement income, Supplemental Security Income (SSI), interest, dividends, and other income sources are included. This chartbook categorizes the continuous income variable into five income classes.

Inpatient hospital stay: The basic unit measuring use of inpatient hospital services is a single admission. Inpatient hospital expenses include charges for an emergency room visit that resulted in an inpatient admission. Inpatient hospital events are included in the 2013 Cost and Use files if the discharge date for the stay was in 2013.

Instrumental activities of daily living (IADLs): Instrumental activities of daily living are activities related to independent living. They include preparing meals, managing money, shopping for groceries or personal items, performing light or heavy housework, and using a telephone. If a sample person had any difficulty performing an activity by himself/herself, or did not perform the activity at all, because of health problems, the person was deemed to have a limitation in that activity. The limitation may have been temporary or chronic at the time of the survey. Sample persons who were administered a community interview answered health status and functioning questions themselves, unless they were unable to do so. A proxy, such as a nurse, always answered questions about the sample person's health status and functioning for long-term care facility interviews. Facility interviewers did not ask about the sample person's ability to prepare meals or perform light or heavy housework, since they are not applicable to the sample person's situation; however, interviewers did question proxies about the sample person's ability to manage money, shop for groceries or personal items, or use a telephone.

Insurance coverage: Insurance categories were derived from annual insurance coverage variables in the 2013 Cost and Use files. The annual variables indicate whether a sample person held that type of insurance at some point during 2013. Insurance categories in this chartbook were constructed to be mutually exclusive by prioritizing insurance holdings. Medicaid coverage had the highest priority; i.e., if a sample person was eligible for Medicaid benefits at some point during 2013, the person was included in the Medicaid category, regardless of other insurance holdings during the year. Enrollment in a Medicare Advantage plan had the second-highest priority, after Medicaid eligibility. Other public health insurance plans, including Veterans Administration eligibility or a State-sponsored drug plan, are distributed across the insurance categories according to the sample person's highest-priority insurance coverage. For example, a person eligible for Medicaid coverage who was also eligible for a State-sponsored drug plan is categorized under "Medicaid."

The categories defined below apply to community residents. Facility residents have only four insurance categories: Medicare fee-for-service-only, Medicaid, private insurance, and Medicare Advantage. No distinction was made during the collection of the facility data as to the source of a private health insurance plan. The four insurance categories are analogous to those defined below for community residents. For beneficiaries who resided in a long-term care facility for part of the year and in the community for part of the year, community insurance status is shown.

- **Medicare fee-for-service-only** encompasses sample persons eligible for Part A and/or Part B Medicare benefits, and who did not have Medicaid coverage, private insurance, and who were not enrolled in a private HMO or Medicare Advantage plan at any time during 2013. However, sample persons may have had other public insurance coverage, such as a State-sponsored prescription drug plan, or may have been eligible for Veterans Administration health care benefits.

- **Medicaid** encompasses sample persons eligible for Part A and/or Part B Medicare benefits, and who were eligible for State Medicaid benefits at some point during 2013, regardless of the person's other insurance holdings.
- **Individually-purchased private insurance** encompasses sample persons eligible for Part A and/or Part B Medicare benefits, and who had self-purchased private insurance plans ("Medigap" insurance), but did not have Medicaid, private HMO or Medicare Advantage plan, or employer-sponsored private insurance coverage at any point during 2013.
- **Employer-sponsored private insurance** encompasses sample persons eligible for Part A and/or Part B Medicare benefits, and who had employer-purchased private insurance plans, but did not have Medicaid, Medicare Advantage plan, or self-purchased private insurance coverage at any point during 2013. Sample persons enrolled in private HMOs, who did not have Medicaid or Medicare Advantage coverage at any point during 2013, are also included in this category.
- **Both types of private insurance** encompasses sample persons eligible for Part A and/or Part B Medicare benefits, and who had both employer-sponsored private insurance and self-purchased private insurance, but who did not have Medicaid or Medicare Advantage coverage at any point during 2013.
- **Medicare Advantage (MA)** encompasses sample persons enrolled in any type of MA, who were not eligible for Medicaid benefits at any point during 2013.

Living arrangement: For community residents, sample persons were separated into mutually exclusive categories: 1) beneficiary lives alone, 2) beneficiary lives with a spouse only, or lives with a spouse and other relatives or nonrelatives, 3) beneficiary lives with his or her children, or lives with his or her children and other relatives or nonrelatives, but does not live with a spouse, or 4) beneficiary lives with other relatives or nonrelatives, but not with his or her children or a spouse. For beneficiaries who resided in a long-term care facility for

part of the year and in the community for part of the year, community residence status is shown.

Long-term care facility: The basic unit measuring use of facility services is a "stay" in a long-term care facility. Stays are measured in terms of days of residence in that facility. If the beneficiary was still in the facility at the end of the year, the stay is not complete, but all data for 2013 are present. To qualify for the survey, a long-term care facility must have three or more long-term care beds, and provide either personal care services to residents, continuous supervision of residents, or long-term care services throughout the facility or in a separately identifiable unit. Types of long-term care facilities include licensed nursing homes, intermediate care facilities, retirement homes, domiciliary or personal care facilities, distinct long-term care units in a hospital complex, mental health facilities and centers, assisted and foster care homes, and institutions for the intellectually and developmentally disabled.

Medicare Advantage (MA): An MA provides, or arranges for the provision of, a comprehensive package of health care services to enrolled persons for a fixed capitation payment (see capitation payment). The term "Medicare Advantage" includes all types of MAs that contract with Medicare, encompassing risk MAs, cost MAs, and health care prepayment plans (HCPPs).

Medicare home health services: Home health care services are narrowly defined in the MCBS public use files. Home health care is limited to skilled nursing services and other therapeutic services provided by a Medicare participating home health agency. In the MCBS, home health use represents events where medical care, as opposed to personal care and support, was furnished to the sample person. Medicare pays 100 percent of the approved cost of covered home health visits, and 80 percent of the approved cost of durable medical equipment.

Medicare hospice services: Hospice services are narrowly defined in the MCBS public use files. Hospice care is limited to Medicare-covered services for terminally ill individuals who have elected to

receive hospice care rather than standard Medicare benefits. Hospice services include medical, nursing, counseling, and other supportive services rendered to terminally ill people and their families. Hospice care is intended to be palliative and to improve quality of life rather than to cure disease or extend life. Almost all services provided to the hospice beneficiary are fully covered by Medicare. Two exceptions are prescribed medicines and inpatient respite care. These two types of services require a small amount of copayment.

Mental illnesses/disorders: The category mental illnesses/disorders includes intellectual disabilities, depression, and other mental disorders. This definition was expanded to include intellectual disabilities, schizophrenia, and bipolar disorder for facility residents in 1997; and it was further expanded to include depression for community residents in 2000.

Missing values: When amounts (e.g., beneficiary counts or expenditures per beneficiary) are displayed in a table in this chartbook, sample persons with missing responses or who belong to a category of a variable not shown in the table (e.g., “other” for the variable “race/ethnicity”) are excluded from individual categories displayed, but are included in the total. When column or row percentages are displayed in a table, sample persons with missing responses are assumed to be distributed the same as reported data and are included in the percentages. That is, column or row percentages sum to 100 percent of the column or row total.

Mobility limitation: If the sample person had no difficulty at all walking a quarter of a mile, the response was coded as “no.” If the sample person had a little, some, or a lot of difficulty, or could not walk a quarter of a mile, the response was coded as “yes.” The response reflects whether the sample person usually had trouble walking, rather than temporary difficulty, such as from a short-term

injury. Sample persons who were administered a community interview answered health status and functioning questions themselves, unless they were unable to do so. A proxy, such as a nurse, always answered questions about the sample person’s health status and functioning for long-term care facility interviews.

Mortality rate: The number of deaths divided by the total number of Medicare beneficiaries.

Outpatient hospital services: For a survey-reported event, the basic unit measuring use of outpatient services is a separate visit to any part of an outpatient department or outpatient clinic at a hospital. For Medicare claim-only events, it may represent 1) a single visit; 2) multiple procedures or services within one visit; or 3) multiple visits billed together. Outpatient hospital events include emergency room visits that did not result in an inpatient hospital admission

Personal health care expenditures: Personal health care expenditures consist of health care goods and services purchased directly by individuals. They exclude public program administration costs, the net cost of private health insurance, research by nonprofit groups and government entities, and the value of new construction put in place for hospitals and nursing homes.

- **Total personal health care expenditures** in this chartbook equal the sum of expenditures by Medicare, Medicaid, private insurance, out-of-pocket, and other sources, as defined below.
- **Medicare expenditures** equal Medicare program payments for fee-for-service beneficiaries, annual capitation payments to Medicare Advantage plans on behalf of enrollees¹, and pass-through expense for inpatient hospital services (see definition below). They exclude reported or imputed charges for individual events reported by Medicare Advantage plan enrollees.

¹ In this chartbook, the following changes were made in calculating total MA expenditures: a) administrative cost (about 10 percent of the total annual MA capitated payments) was subtracted from the total annual MA capitated payments; and b) annual MA premiums were added to the total annual MA capitated payments.

Capitation payments were allocated across medical service types in the same proportions as Medicare fee-for-service payments for medical service types.

- Medicare expenditures for ***inpatient hospital services*** include pass-through expenses. Medicare's Prospective Payment System (PPS) for inpatient hospital services pays a fixed, predetermined amount per case. However, this payment excludes some hospital expenses, particularly for capital costs, that are reimbursed on a cost basis (i.e., capital costs are "passed through" for payment). In order to calculate total Medicare program payments (actual PPS case payment plus the prorated share of pass-through costs), estimated pass-through costs were added to charges for inpatient hospital events.
- Medicare expenditures for ***long-term care services*** consist of payments made by Medicare to long-term care facilities for skilled nursing or skilled rehabilitation services that are not included in any of the other event records.
- ***Medicaid expenditures*** consist of payments for services made by State Medicaid programs. Medicaid covers coinsurance amounts, copayments, deductibles, and charges for some non-Medicare covered services not paid for by other public or private insurance plans.
- ***Private insurance expenditures*** consist of payments made by individually-purchased private insurance plans and employer-sponsored private insurance plans, plus payments reported by or imputed for sample persons enrolled in private health maintenance organizations. The definition applies to community residents and part-year community/part-year facility residents. For facility residents, private insurance expenditures consist of payments made by private health insurance plans, whose sources (i.e., individual purchase or employer-sponsored) are unknown. No distinction was made during the collection of the facility data as to the source of private health insurance plans.

- ***Out-of-pocket expenditures*** consist of direct payments to providers made by the sample person, or by another person on behalf of the sample person. These payments are for coinsurance amounts, copayments, deductibles, balance billings, and charges for non-Medicare covered services not paid for by public or private insurance plans.
- ***Other source expenditures*** consist of payments made by other public health plans and private liability insurance plans. For sample persons who resided in the community, examples of other public sources of payment include State pharmaceutical assistance programs and payments for sample persons who received medical services from the Veterans Administration. For sample persons who resided in a long-term care facility, examples of other public sources of payment include payments from State, county, or community departments of mental health, State supplemental assistance and welfare programs, and Black Lung funds.

Physician/supplier services: Physician/supplier services include medical doctor, osteopathic doctor, and health practitioner visits; diagnostic laboratory and radiology services; medical and surgical services; durable medical equipment; and nondurable medical supplies. Health practitioners include audiologists, optometrists, chiropractors, podiatrists, mental health professionals, therapists, nurses, paramedics, and physician's assistants. For survey-reported events, the basic unit measuring use of physician/supplier services is a separate visit, procedure, service, or purchase of a medical supply or medical equipment. For Medicare claim-only events, it may represent 1) single or multiple visits; 2) single or multiple procedures; 3) single or multiple services; or 4) single or multiple supplies, depending on the number of items bundled together on a single bill.

Poverty: Poverty is defined by using the annual Federal poverty thresholds to measure levels of sample person's/family's total income, controlling for the size of the family and the age of the head of the household.

Prescription medicines: The basic unit measuring use of prescription medicines is a single purchase of a single drug in a single container. Prescription drug use is collected only for sample persons living in the community, and does not include prescription medicines administered during an inpatient hospital stay.

Pulmonary disease: The category pulmonary disease includes emphysema, asthma, and cardiopulmonary disease.

Race/ethnicity: Race and ethnic categories were recorded as interpreted by the respondent. Sample persons who reported they were white and not of Hispanic ancestry were coded as white non-Hispanic; those who reported they were black/African-American and not of Hispanic ancestry were coded as black non-Hispanic; persons who reported they were of Hispanic ancestry, regardless of their race, were coded as Hispanic; persons who reported they were American Indian, an Asian or Pacific Islander, or other race and not of Hispanic ancestry were coded as other race/ethnicity. Hispanic includes persons of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race. Beginning in calendar year 1998, sample persons with more than one racial background were captured in a separate category and collapsed into the “other” category in the chartbook.

Residence status: Full-year community residents are Medicare beneficiaries who lived solely in household units during 2013, referred to as “community settings” in this chartbook, and who received community interviews only. Full-year facility residents are Medicare beneficiaries who lived solely in a long-term care facility during 2013 (see long-term care facility), and who received facility interviews only. Part-year community/part-year facility residents are Medicare beneficiaries who lived part of the year in the community and part of the year in a long-term care facility, and who received both community and facility interviews. Skilled nursing facility users are Medicare beneficiaries who lived in either the community or a facility, and who used skilled nursing facility services during 2013.

Satisfaction with care: In section 5 of the detailed tables, “(Very) unsatisfied” includes a response of either “unsatisfied” or “very unsatisfied.” Sample persons with responses of “satisfied” and “no experience” are not shown in the tables but are included in the total population, which constitutes the denominator for calculating percentages of persons with a given response. The questions about satisfaction with care represent the respondent’s general opinion of all medical care received in the year preceding the interview.

- **General care** refers to the sample person’s rating of the over-all quality of medical care received. Of the 10,101 community-only resident sample persons represented in the tables, 4,594 responded they were “satisfied,” and 209 responded they had “no experience.”
- **Follow-up care** refers to the sample person’s rating of follow-up care received after an initial treatment or operation. Of the 10,101 community-only resident sample persons represented in the tables, 5,263 responded they were “satisfied,” and 1,414 responded they had “no experience.”
- **Availability** refers to the sample person’s rating of the availability of medical care at night and on weekends. Of the 10,101 community-only resident sample persons represented in the tables, 3,482 responded they were “satisfied,” and 4,298 responded they had “no experience.”
- **Ease of access to doctor** refers to the sample person’s rating of the ease and convenience of getting to a doctor from her or his residence. Of the 10,101 community-only resident sample persons represented in the tables, 5,769 responded they were “satisfied,” and 169 responded they had “no experience.”
- **Can obtain care in same location** refers to the sample person’s rating of his or her ability to get all medical care needs taken care of at the same location. Of the 10,101 community-only resident sample persons represented in the tables, 5,433 responded they were “satisfied,” and 1,199 responded they had “no experience.”

- **Information from doctor** refers to the sample person's rating of the information given to the sample person about what was wrong with him or her. Of the 10,101 community-only resident sample persons represented in the tables, 6,090 responded they were "satisfied," and 229 responded they had "no experience."
- **Doctor's concern for overall health** refers to the sample person's rating of the doctor's concerns for her or his overall health rather than for an isolated symptom or disease. Of the 10,101 community-only resident sample persons represented in the tables, 5,828 responded they were "satisfied," and 274 responded they had "no experience."
- **Cost** refers to the sample person's rating of the out-of-pocket costs he or she paid for medical care. Of the 10,101 community-only resident sample persons represented in the tables, 5,504 responded they were "satisfied," and 327 responded they had "no experience."

Schooling: Schooling categories are based on the highest school grade completed. Before calendar year 1998, education does not specify education or training received in vocational, trade, or business schools outside of the regular school system. Since calendar year 1998, education or training received at these types of institutions are collapsed into "13–15 years" of schooling.

Skilled nursing facility (SNF): The basic unit measuring use of SNF services is a "stay" in a skilled nursing facility. SNF events are included in the 2013 Cost and Use files if the discharge date for the stay was in 2013. Expenditures for SNF were reported during a community interview or created through Medicare claims data.

Smoker: Smoker categories in this chartbook are mutually exclusive. Sample persons who had never smoked were categorized as "never smoked." Sample persons who smoked previously but were not current smokers were categorized as "former smoker." Sample persons who reported they currently smoked were categorized as "current smoker." Smoking includes a period of regular smoking of

cigarettes or pipes, but does not include use of other forms of tobacco, such as chewing tobacco.

Social activity limitation: If the sample person responded that health had not limited her or his social life in the past month, the response was coded as "no." If the sample person responded that health had limited her or his social life in the past month some, most, or all of the time, the response was coded as "yes." Limitations on social life include limitations on visiting with friends or close relatives, and reflect the sample person's experience over the preceding month, even if that experience was atypical. Sample persons who were administered a community interview answered health status and functioning questions themselves, unless they were unable to do so. A proxy, such as a nurse, always answered questions about the sample person's health status and functioning for long-term care facility interviews.

Source of payment: See personal health care expenditures.

Survey-reported event: A survey-reported event is a medical service or event reported by a sample person during an interview. The event may have been matched to a Medicare claim, or it may be a survey-only event, in which case it was not matched to a Medicare claim and is only known through the survey.

Upper extremity limitation: If the sample person had no difficulty at all reaching or extending his or her arms above shoulder level, and had no difficulty writing or handling and grasping small objects, the response was coded as "no." If the sample person had a little, some, or a lot of difficulty with these tasks, or could not do them at all, the response was coded as "yes." The response reflects whether the sample person usually had trouble reaching over her or his head or writing, rather than temporary difficulty, such as from a short-term injury. Sample persons who were administered a community interview answered health status and functioning questions themselves, unless they were unable to do so. A proxy, such as a nurse, always answered questions about the sample person's health status and functioning for long-term care facility interviews.

Urinary incontinence: If the sample person had lost urine beyond his or her control at least once during the past 12 months, the response was coded as “yes.” If the sample person was on dialysis or had a catheter, the response was coded as missing.

User rate: A user rate is defined as the percentage of beneficiaries with the given characteristics who used at least one of the relevant services during calendar year 2013. For example, the dental services user rate for persons age 85 or older who had Medicaid coverage is equal to the number of beneficiaries age 85 or older with Medicaid coverage who had at least one dental visit in 2013, divided by the total number of persons age 85 or older with Medicaid coverage.

Usual source of care: If the sample person responded that he or she did not have a particular medical person or clinic where he or she usually went for care or advice about health, the response was coded as “none.” If the sample person responded that he or she did have a usual source of care, the sample person was questioned about the type of place. “Other clinic/health center” includes a neighborhood or family health center, a freestanding surgical center, a rural health clinic, a company clinic, any other kind of clinic, a walk-in urgent center, a home visit from a doctor, and care in a Veterans Administration facility, a mental health center, or other place not included in the listed categories.