Chronic Conditions Warehouse

CODEBOOK:

Medicare-Medicaid Linked Enrollee Analytic Data Source (MMLEADS)

August 2021 | VERSION 1.0

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Revision Log

Date	Changed by	Revisions	Version
August 2021	C. Alleman K. Schneider	Initial MMLEADS codebook	1.0

Tips on Navigating the Codebook

This document is a detailed codebook that describes each variable in the Medicare-Medicaid Linked Enrollee Data Source (MMLEADS) research files. We have included several ways for users to quickly find the information they need:

- A complete listing of all variables in the files, in alphabetical order based on their SAS variable names.
- Individual entries for each variable contain a short description of the variable, the possible values for the variable, and, in many cases, comments discussing the variable construction and use.

Hyperlinks are included throughout the codebook to make it easier for users to navigate between the table of contents and the detailed entries for the individual variables:

- Clicking on any variable name in the Table of Contents will take you to the detailed description for that variable.
- From the detailed description for any individual variable, clicking on the ^Back to TOC^ link after each variable description will take you back to the Table of Contents.

Table of Contents

This section of the codebook contains a list of all variables in alphabetical order based on the SAS variable name.

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Variable Details

This section of the codebook contains one entry for each variable in the MMLEADS files. Each entry contains variable details to facilitate understanding and use of the variables.

AGE

LABEL: Age (in Years)

DESCRIPTION: This is the beneficiary's age, expressed in years and calculated as of the end of the calendar year — or for beneficiaries that died during the year, age as of the date of death.

TYPE: NUM

LENGTH: 8

SOURCE: Medicare MBSF/T-MSIS Demographic and Eligibility (DE) file

VALUES: YYY (may be negative or zero for prenatal services)

COMMENT: For the population with Medicare coverage, this value is obtained directly from the MBSF; for the population with only Medicaid, this value is obtained directly from the T-MSIS DE file.

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ALIVE_MOS

LABEL: Months Alive

DESCRIPTION: Number of months alive in the reference year.

TYPE: NUM

LENGTH: 8

SOURCE: MBSF/T-MSIS DE file (derived)

VALUES: 1–12

COMMENT: CCW creates this variable using MBSF for the Medicare population; for the population with only Medicaid, CCW creates this variable from the T-MSIS DE file.

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BENE_ID

LABEL: CCW Beneficiary Identifier

DESCRIPTION: The unique CCW identifier for a beneficiary.

The CCW assigns a unique beneficiary identification number to each individual who receives Medicare and/or Medicaid and uses that number to identify an individual's records in all CCW data files (e.g., Medicare claims, MAX claims, T-MSIS claims, and MDS assessment data).

This number does not change during a beneficiary's lifetime, and CCW uses each number only once.

The BENE_ID is specific to the CCW and is not applicable to any other identification system or data source.

TYPE: NUM

LENGTH: 8

SOURCE: MBSF/T-MSIS DE file (derived)

VALUES: Null/Missing if not applicable

COMMENT: If there is not a BENE_ID for the record, use the MSIS_ID in combination with the STATE_CD to identify the person.

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BIRTH_DT

LABEL: Date of Birth

DESCRIPTION: This is the beneficiary's date of birth.

TYPE: NUM

LENGTH: 8

SOURCE: MBSF/T-MSIS DE file (derived)

VALUES: DDMMMYYYY (e.g., 09FEB1942)

COMMENT: For the population with Medicare coverage, this value is obtained directly from the MBSF; for the population with only Medicaid, this value is obtained directly from the T-MSIS DE file.

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DEATH_DT

LABEL: Date of Death

DESCRIPTION: This variable indicates the date of death of the beneficiary. A null value means that no death date was reported for the beneficiary.

TYPE: NUM

LENGTH: 8

SOURCE: MBSF/T-MSIS DE file (derived)

VALUES: DDMMMYYYY (e.g., 09FEB2016); or null/missing

COMMENT: For the population with Medicare coverage, this value is obtained directly from the MBSF; for the population with only Medicaid, this value is obtained directly from the T-MSIS DE file.

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FD_MOS

LABEL: Medicare — Full Dual Months

DESCRIPTION: This variable is the number of months during the year that the beneficiary was dually eligible for full Medicare-Medicaid benefits.

TYPE: NUM

LENGTH: 8

SOURCE: MBSF (derived)

VALUES: 0–12 or null/missing (if no Medicare enrollment)

COMMENT: CCW calculates this variable as the count of months where DUAL_STUS_CD_*MM* in ('02' '04' '08') from the MBSF.

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MDCD_ABD_01

MDCD_ABD_02

MDCD_ABD_03

MDCD_ABD_04

MDCD_ABD_05

MDCD_ABD_06

MDCD_ABD_07

MDCD_ABD_08

MDCD_ABD_09

MDCD_ABD_10

MDCD_ABD_11

MDCD_ABD_12

LABEL: Medicaid Enrollment — Aged, Blind, Disabled Indicator — January–December (01–12)

DESCRIPTION: This variable indicates whether the eligibility group code applicable to the beneficiary in the month is for aged, blind, or disabled (A/B/D). There are separate variables for each of the 12 months during the year.

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS DE file (derived)

VALUES: 1 = criteria met
0 = enrolled in Medicaid for month but criteria not met
Null/Missing = not enrolled in Medicaid for month

COMMENT: CCW creates this variable using the DE file; when the monthly ELIGBLTY_GRP_CD_*MM* in ('11' '12' '13' '14' '15' '16' '17' '18' '19' '20' '21' '22' '23' '24' '25' '26' '37' '38' '39' '40' '41' '42' '43' '44' '45' '46' '47' '48' '49' '50' '51' '52' '59' '60' '69') the beneficiary is considered to be eligible due to being aged, blind or disabled.

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MDCD_ABD_MOS

LABEL: Medicaid Enrollment — Aged, Blind, Disabled Months

DESCRIPTION: This variable is the number of months during the year that the beneficiary was enrolled in Medicaid benefits due to being aged, blind or disabled (A/B/D).

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS DE file (derived)

VALUES: 0–12 or null/missing (if no Medicaid enrollment)

COMMENT: CCW calculates this variable as the count of months where the monthly Medicaid enrollment — aged, blind, disabled indicator is equal to one (MDCD_ABD_*MM* = 1).

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MDCD_BEHAVIORAL_COV_MOS

LABEL: Medicaid Managed Care Mental Health or Substance Abuse Coverage Months

DESCRIPTION: This variable is the number of months during the year that the beneficiary was enrolled in a Medicaid managed care mental health or substance abuse managed care plan.

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS DE file (derived)

VALUES: 0–12 or null/missing (if no Medicaid enrollment)

COMMENT: CCW creates this variable using the DE Managed Care Supplemental file; we obtain the maximum value (number of months) from the following variables:

- Mental Health (MH) Prepaid Inpatient Health Plan (PIHP) Months
- MH Prepaid Ambulatory Health Plan (PAHP) Months
- Substance Use Disorders (SUD) PIHP Months
- SUD PAHP Months

(Variables called MH_PIHP_MOS, MH_PAHP_MOS, SUD_PIHP_MOS, SUD_PAHP_MOS, MH_SUD_PIHP_MOS and MH_SUD_PAHP_MOS, respectively).

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MDCD_CARE_LEVEL_MOS

LABEL: Medicaid — Total LTSS Months (All Levels of Care)

DESCRIPTION: This variable is the number of months during the year where the beneficiary's monthly level of care status code indicated that some level of care was required to meet a beneficiary's needs. Medicaid uses this information to determine Long-Term Services and Supports (LTSS) program eligibility.

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS DE file (derived)

VALUES: 0–12, or null/missing (if no Medicaid enrollment or no care level status)

COMMENT: CCW calculates this variable using the DE Disability and Need Supplemental file; we count each month where the care level status code is not missing (CARE_LVL_STUS_CD_*MM* ne ' '). The five levels of care include: hospital, inpatient psychiatric facility, nursing facility, intermediate care facility, or other type of facility.

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MDCD_CHIP_NON_ABD_MOS

LABEL: MDCD or CHIP Enrollment — Non-ABD Months

DESCRIPTION: This variable is the number of months during the year that the beneficiary was enrolled in Medicaid or CHIP but was not eligible for Medicaid benefits due to aged, blind or disabled (A/B/D) categories.

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS DE file (derived)

VALUES: 0–12 or null/missing (if not Medicaid or CHIP enrolled during the year)

COMMENT: CCW calculates this variable as the count of months where the CHIP_CD is populated (indicating enrollment) and the monthly eligibility group code indicates the beneficiary is not eligible due to aged, blind or disabled status(A/B/D); that is: where ELIGBLTY_GRP_CD_*MM* NOTIN ('11' '12' '13' '14' '15' '16' '17' '18' '19' '20' '21' '22' '23' '24' '25' '26' '37' '38' '39' '40' '41' '42' '43' '44' '45' '46' '47' '48' '49' '50' '51' '52' '59' '60' '69').

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MDCD_CMC_COV_MOS

LABEL: Medicaid — Comprehensive Managed Care Months

DESCRIPTION: This variable is the number of months during the year the beneficiary was enrolled in a Medicaid Comprehensive Managed Care Organization (MCO) Managed Care Plan.

TYPE: NUM

LENGTH: 3

SOURCE: T-MSIS Demographic and Eligibility (DE) File

VALUES: 0–12, or null/missing (if no Medicaid enrollment)

COMMENT: CCW obtains this directly from the DE Managed Care Supplemental file CMPRHNSV_MCO_MOS variable.

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MDCD_CUSTODIAL_CARE_MOS

LABEL: Medicaid — Custodial Level of Care for LTSS Months

DESCRIPTION: This variable is the number of months during the year where the beneficiary's Medicaid monthly Long-Term Services and Supports (LTSS) Level of Care Code indicated that custodial care was required to meet a beneficiary's needs.

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS DE file (derived)

VALUES: 0–12, or null/missing (if no Medicaid enrollment or no LTSS)

COMMENT: CCW calculates this variable using the DE Disability and Need Supplemental file; we count each month where the LTSS_LVL_CD_1_*MM* = '3' (custodial care). Note that the LTSS level source variable from DE identifies three levels of care: skilled, intermediate, and custodial care. Each of these levels is included in MMLEADS. In addition, the MDCD_LTSS_LEVEL_MOS variable is the total count of months during the year when any of these LTSS levels was indicated.

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MDCD_DENTAL_COV_MOS

LABEL: Medicaid — Managed Care Dental Coverage Months

DESCRIPTION: This variable is the number of months during the year that the beneficiary was enrolled in a Medicaid Dental Prepaid Ambulatory Health Plan (PAHP) Managed Care Plan.

TYPE: NUM

LENGTH: 3

SOURCE: T-MSIS DE file

VALUES: 0–12, or null/missing (if no Medicaid enrollment)

COMMENT: CCW obtains this directly from the DE Managed Care Supplemental file DNTL_PAHP_MOS variable.

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MDCD_DISEASE_MGMT_COV_MOS

LABEL: Medicaid — Managed Care Disease Management Plan Coverage Months

DESCRIPTION: This variable is the number of months during the year the beneficiary was enrolled in a Medicaid Disease Management Prepaid Ambulatory Health Plan (PAHP).

TYPE: NUM

LENGTH: 3

SOURCE: T-MSIS DE file

VALUES: 0–12, or null/missing (if no Medicaid enrollment)

COMMENT: CCW obtains this directly from the DE Managed Care Supplemental file DISEASE_MGMT_PAHP_MOS variable.

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MDCD_ELGBLTY_GRP_CD_01

MDCD_ELGBLTY_GRP_CD_02

MDCD_ELGBLTY_GRP_CD_03

MDCD_ELGBLTY_GRP_CD_04

MDCD_ELGBLTY_GRP_CD_05

MDCD_ELGBLTY_GRP_CD_06

MDCD_ELGBLTY_GRP_CD_07

MDCD_ELGBLTY_GRP_CD_08

MDCD_ELGBLTY_GRP_CD_09

MDCD_ELGBLTY_GRP_CD_10

MDCD_ELGBLTY_GRP_CD_11

MDCD_ELGBLTY_GRP_CD_12

LABEL: Medicaid — Eligibility Group Code — January–December (01–12)

DESCRIPTION: The eligibility group applicable to the Medicaid beneficiary based on the eligibility determination process, in the month. There are separate variables for each of the 12 months during the year.

TYPE: CHAR

LENGTH: 2

SOURCE: T-MSIS DE file

VALUES:
01 = Parents and Other Caretaker Relatives
02 = Transitional Medical Assistance
03 = Extended Medicaid due to Earnings
04 = Extended Medicaid due to Spousal Support Collections
05 = Pregnant Women
06 = Deemed Newborns
07 = Infants and Children > Age 19
08 = Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care
09 = Former Foster Care Children
11 = Individuals Receiving SSI
12 = Aged, Blind, and Disabled Individuals in 209(b) States
13 = Individuals Receiving Mandatory State Supplements
14 = Individuals Who Are Essential Spouses
15 = Institutionalized Individuals Continuously Eligible Since 1973
16 = Blind or Disabled Individuals Eligible in 1973
17 = Individuals Who Lost Eligibility for SSI/SSP Due to an Increase in OASDI Benefits in 1972

18 = Individuals Who Would be Eligible for SSI/SSP but for OASDI COLA increases since April 1977
19 = Disabled Widows and Widowers Ineligible for SSI due to Increase in OASDI
20 = Disabled Widows and Widowers Ineligible for SSI due to Early Receipt of Social Security
21 = Working Disabled under 1619(b)
22 = Disabled Adult Children
23 = Qualified Medicare Beneficiaries (QMB)
24 = Qualified Disabled and Working Individuals (QDWI)
25 = Specified Low Income Medicare Beneficiaries (SLMB)
26 = Qualifying Individuals
27 = Optional Coverage of Parents and Other Caretaker Relatives
28 = Reasonable Classifications of Individuals under Age 21
29 = Children with Non-IV-E Adoption Assistance
30 = Independent Foster Care Adolescents
31 = Optional Targeted Low-Income Children
32 = Individuals Electing COBRA Continuation Coverage
33 = Individuals above 133% FPL > Age 65
34 = Certain Individuals Needing Treatment for Breast or Cervical Cancer
35 = Individuals Eligible for Family Planning Services
36 = Individuals with Tuberculosis
37 = Aged, Blind or Disabled Individuals Eligible for but Not Receiving Cash Assistance
38 = Individuals Eligible for Cash Assistance except for Institutionalization
39 = Individuals Receiving Home and Community Based Services under Institutional Rules
40 = Optional State Supplement Recipients — 1634 States, and SSI Criteria States with 1616 Agreements
41 = Optional State Supplement Recipients — 209(b) States, and SSI Criteria States without 1616 Agreements
42 = Institutionalized Individuals Eligible under a Special Income Level
43 = Individuals participating in a PACE Program under Institutional Rules
44 = Individuals Receiving Hospice Care
45 = Qualified Disabled Children > Age 19
46 = Poverty Level Aged or Disabled
47 = Work Incentives Eligibility Group
48 = Ticket to Work Basic Group
49 = Ticket to Work Medical Improvements Group
50 = Family Opportunity Act Children with Disabilities
51 = Individuals Eligible for Home and Community-Based Services
52 = Individuals Eligible for Home and Community-Based Services — Special Income Level
53 = Medically Needy Pregnant Women
54 = Medically Needy Children > Age 18
55 = Medically Needy Children Age 18–20
56 = Medically Needy Parents and Other Caretakers
59 = Medically Needy Aged, Blind or Disabled
60 = Medically Needy Blind or Disabled Individuals Eligible in 1973
61 = Targeted Low-Income Children
62 = Deemed Newborn
63 = Children Ineligible for Medicaid Due to Loss of Income Disregards
64 = Coverage from Conception to Birth
65 = Children with Access to Public Employee Coverage

66 = Children Eligible for Dental Only Supplemental Coverage
67 = Targeted Low-Income
69 = Individuals with Mental Health Conditions (expansion group)
70 = Family Planning Participants (expansion group)
71 = Other expansion group
72 = Adult Group — Individuals at or below 133% FPL, 19–64, newly eligible for all states
73 = Adult Group — Individuals at or below 133% FPL, 19–64, not newly eligible for non-1905z(3) states
74 = Adult Group — Individuals at or below 133% FPL, 19–64, not newly eligible parent/caretaker-relative(s) in 1905z(3) states
75 = Adult Group — Individuals at or below 133% FPL, 19–64, not newly eligible non-parent/caretaker-relative(s) in 1905z(3) states
Null/missing = source value is missing, unknown, or not Medicaid enrolled

COMMENT: CCW obtains this directly from the DE ELGBLTY_GRP_CD_*MM* variables.

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MDCD_ELGBLTY_GRP_CD_LTST

LABEL: Medicaid — Eligibility Group Code — Latest in Year

DESCRIPTION: The eligibility group applicable to the Medicaid beneficiary based on the eligibility determination process for the calendar year; most recent in the calendar year.

TYPE: CHAR

LENGTH: 2

SOURCE: T-MSIS DE file

VALUES:
01 = Parents and Other Caretaker Relatives
02 = Transitional Medical Assistance
03 = Extended Medicaid due to Earnings
04 = Extended Medicaid due to Spousal Support Collections
05 = Pregnant Women
06 = Deemed Newborns
07 = Infants and Children > Age 19
08 = Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care
09 = Former Foster Care Children
11 = Individuals Receiving SSI
12 = Aged, Blind, and Disabled Individuals in 209(b) States
13 = Individuals Receiving Mandatory State Supplements
14 = Individuals Who Are Essential Spouses
15 = Institutionalized Individuals Continuously Eligible Since 1973
16 = Blind or Disabled Individuals Eligible in 1973
17 = Individuals Who Lost Eligibility for SSI/SSP Due to an Increase in OASDI Benefits in 1972
18 = Individuals Who Would be Eligible for SSI/SSP but for OASDI COLA increases since April 1977
19 = Disabled Widows and Widowers Ineligible for SSI due to Increase in OASDI
20 = Disabled Widows and Widowers Ineligible for SSI due to Early Receipt of Social Security
21 = Working Disabled under 1619(b)
22 = Disabled Adult Children
23 = Qualified Medicare Beneficiaries (QMB)
24 = Qualified Disabled and Working Individuals (QDWI)
25 = Specified Low Income Medicare Beneficiaries (SLMB)
26 = Qualifying Individuals
27 = Optional Coverage of Parents and Other Caretaker Relatives
28 = Reasonable Classifications of Individuals under Age 21
29 = Children with Non-IV-E Adoption Assistance
30 = Independent Foster Care Adolescents
31 = Optional Targeted Low-Income Children
32 = Individuals Electing COBRA Continuation Coverage
33 = Individuals above 133% FPL > Age 65
34 = Certain Individuals Needing Treatment for Breast or Cervical Cancer
35 = Individuals Eligible for Family Planning Services
36 = Individuals with Tuberculosis
37 = Aged, Blind, or Disabled Individuals Eligible for but Not Receiving Cash Assistance

38 = Individuals Eligible for Cash Assistance except for Institutionalization
39 = Individuals Receiving Home and Community Based Services under Institutional Rules
40 = Optional State Supplement Recipients — 1634 States, and SSI Criteria States with 1616 Agreements
41 = Optional State Supplement Recipients — 209(b) States, and SSI Criteria States without 1616 Agreements
42 = Institutionalized Individuals Eligible under a Special Income Level
43 = Individuals participating in a PACE Program under Institutional Rules
44 = Individuals Receiving Hospice Care
45 = Qualified Disabled Children > Age 19
46 = Poverty Level Aged or Disabled
47 = Work Incentives Eligibility Group
48 = Ticket to Work Basic Group
49 = Ticket to Work Medical Improvements Group
50 = Family Opportunity Act Children with Disabilities
51 = Individuals Eligible for Home and Community-Based Services
52 = Individuals Eligible for Home and Community-Based Services — Special Income Level
53 = Medically Needy Pregnant Women
54 = Medically Needy Children > Age 18
55 = Medically Needy Children Age 18–20
56 = Medically Needy Parents and Other Caretakers
59 = Medically Needy Aged, Blind or Disabled
60 = Medically Needy Blind or Disabled Individuals Eligible in 1973
61 = Targeted Low-Income Children
62 = Deemed Newborn
63 = Children Ineligible for Medicaid Due to Loss of Income Disregards
64 = Coverage from Conception to Birth
65 = Children with Access to Public Employee Coverage
66 = Children Eligible for Dental Only Supplemental Coverage
67 = Targeted Low-Income
69 = Individuals with Mental Health Conditions (expansion group)
70 = Family Planning Participants (expansion group)
71 = Other expansion group
72 = Adult Group — Individuals at or below 133% FPL, 19–64, newly eligible for all states
73 = Adult Group — Individuals at or below 133% FPL, 19–64, not newly eligible for non-1905z(3) states
74 = Adult Group — Individuals at or below 133% FPL, 19–64, not newly eligible parent/caretaker-relative(s) in 1905z(3) states
75 = Adult Group — Individuals at or below 133% FPL, 19–64, not newly eligible non-parent/caretaker-relative(s) in 1905z(3) states
Null/missing = source value is missing, unknown, or not Medicaid enrolled

COMMENT: CCW obtains this directly from the DE ELGBLTY_GRP_CD_LTST variable.

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MDCD_FFS_MEDICAL_01

MDCD_FFS_MEDICAL_02

MDCD_FFS_MEDICAL_03

MDCD_FFS_MEDICAL_04

MDCD_FFS_MEDICAL_05

MDCD_FFS_MEDICAL_06

MDCD_FFS_MEDICAL_07

MDCD_FFS_MEDICAL_08

MDCD_FFS_MEDICAL_09

MDCD_FFS_MEDICAL_10

MDCD_FFS_MEDICAL_11

MDCD_FFS_MEDICAL_12

LABEL: Medicaid — Fee-for-Service Medical Coverage Indicator — January–December (01–12)

DESCRIPTION: This variable is a monthly variable that indicates whether the beneficiary was enrolled in traditional Medicaid fee-for-service (FFS), or whether the beneficiary was enrolled in a comprehensive medical managed care plan.

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS DE file (derived)

VALUES: 0 = not Medicaid FFS during month
1 = Medicaid FFS during the month
Null/missing = (if no Medicaid enrollment for the month — or if the plan type code was missing)

COMMENT: CCW creates this variable using the DE file. We consider the beneficiary to have FFS Medical coverage If the beneficiary had Medicaid or CHIP enrollment for the month, and the monthly managed care plan type code was not for a comprehensive managed care plan or a health insuring organization (i.e., where MC_PLAN_TYPE_CD_*MM* not in ('01' '04').

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MDCD_FFS_MEDICAL_MOS

LABEL: Medicaid — Fee-for-Service Medical Coverage Months

DESCRIPTION: This variable is the number of months during the year when the beneficiary had Medicaid FFS Medical Coverage.

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS DE file (derived)

VALUES: 0–12, or null/missing (if no Medicaid enrollment or if the plan type code was missing)

COMMENT: CCW calculates this variable as the count of months where the monthly Medicaid FFS Medical Coverage Indicator is equal to one (MDCD_FFS_MEDICAL_*MM* = 1).

If the beneficiary has comprehensive managed care or is enrolled in a health insuring organization, they are considered to have comprehensive managed care medical coverage (MDCD_MC_MEDICAL_MOS). If the beneficiary does not have comprehensive managed care medical coverage during the month, then we set the monthly fee-for-service indicator to 1 (MDCD_FFS_MEDICAL_01–12). We count the number of months with FFS coverage (MDCD_FFS_MEDICAL_MOS). These variables are set to null/missing for beneficiaries who are not enrolled in Medicaid during the year.

The sum of these two variables (MDCD_MC_MEDICAL_MOS + MDCD_FFS_MEDICAL_MOS) is equal to the total months of Medicaid coverage during the year. Note that this sum does not always equal the number of months enrolled in Medicaid due to missing data in the source fields (e.g., eligibility group code associated with the beneficiary state).

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MDCD_HIO_COV_MOS

LABEL: Medicaid — Health Insuring Organization (HIO) Months

DESCRIPTION: This variable is the number of months during the year that the beneficiary was enrolled in a Medicaid Health Insuring Organization (HIO) Managed Care Plan.

TYPE: NUM

LENGTH: 3

SOURCE: T-MSIS DE file

VALUES: 0–12, or null/missing (if no Medicaid enrollment)

COMMENT: CCW obtains this directly from the DE Managed Care Supplemental file HIO_MOS variable.

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MDCD_HLTH_MDCL_HOME_COV_MOS

LABEL: Medicaid — Health or Medical Home Months

DESCRIPTION: This variable is the number of months during the year that the beneficiary was enrolled in a Medicaid Health or Medical Home.

TYPE: NUM

LENGTH: 3

SOURCE: T-MSIS DE file

VALUES: 0–12, or null/missing (if no Medicaid enrollment)

COMMENT: CCW obtains this directly from the DE Managed Care Supplemental file HLTH_MDCL_HOME_MOS variable.

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MDCD_HOSPITAL_LTSS_MOS

LABEL: Medicaid — Hospital LTSS Months

DESCRIPTION: This variable is the number of months during the year where the beneficiary's monthly level of care status code indicated that hospital care was required to meet a beneficiary's needs. Medicaid uses this information to determine Long-Term Services and Supports (LTSS) program eligibility.

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS DE file (derived)

VALUES: 0–12, or null/missing (if no Medicaid enrollment or no care level status)

COMMENT: CCW calculates this variable using the DE Disability and Need Supplemental file; we count each month where the CARE_LVL_STUS_CD_*MM* = '001' (hospital). Note that the care level status source variable from DE identifies five levels of care: hospital, inpatient psychiatric facility, nursing facility, intermediate care facility, or other type of facility. Each of these levels is included in MMLEADS. In addition, the MDCD_CARE_LEVEL_MOS variable is the total count of months during the year when any of these levels of care was indicated.

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MDCD_ICF_IID_LTSS_MOS

LABEL: Medicaid — Intermediate Care Facility for individuals with intellectual disabilities — LTSS Months

DESCRIPTION: This variable is the number of months during the year where the beneficiary's monthly level of care status code indicated that intermediate care facility for individuals with intellectual disabilities (ICF/IID) was required to meet a beneficiary's needs. Medicaid uses this information to determine Long-Term Services and Supports (LTSS) program eligibility.

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS DE file (derived)

VALUES: 0–12, or null/missing (if no Medicaid enrollment or no care level status)

COMMENT: CCW calculates this variable using the DE Disability and Need Supplemental file; we count each month where the CARE_LVL_STUS_CD_*MM* = '004' (Intermediate care facility for individuals with intellectual disabilities (ICF/IID)). Note that the care level status source variable from DE identifies five levels of care: hospital, inpatient psychiatric facility, nursing facility, intermediate care facility, or other type of facility. Each of these levels is included in MMLEADS. In addition, the MDCD_CARE_LEVEL_MOS variable is the total count of months during the year when any of these levels of care was indicated.

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MDCD_INTEGRATED_DUAL_COV_MOS

LABEL: Medicaid — Integrated care for Dual Eligible Months

DESCRIPTION: This variable is the number of months during the year the beneficiary was enrolled in a Medicaid Integrated Care for Dual Eligibles Managed Care Plan.

TYPE: NUM

LENGTH: 3

SOURCE: T-MSIS DE file

VALUES: 0–12, or null/missing (if no Medicaid enrollment)

COMMENT: CCW obtains this directly from the DE Managed Care Supplemental file INTGRTD_CARE_DUAL_ELGBL_MOS variable.

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MDCD_INTERMEDIATE_CARE_MOS

LABEL: Medicaid — Intermediate level of Care for LTSS Months

DESCRIPTION: This variable is the number of months during the year where the beneficiary's Medicaid monthly Long-Term Services and Supports (LTSS) Level of Care Code indicated that intermediate care was required to meet a beneficiary's needs.

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS DE file (derived)

VALUES: 0–12, or null/missing (if no Medicaid enrollment or no LTSS)

COMMENT: CCW calculates this variable using the DE Disability and Need Supplemental file; we count each month where the LTSS_LVL_CD_1_*MM* = '2' (Intermediate Care). Note that the LTSS level source variable from DE identifies three levels of care: skilled, intermediate, and custodial care. Each of these levels is included in MMLEADS. In addition, the MDCD_LTSS_LEVEL_MOS variable is the total count of months during the year when any of these LTSS levels was indicated.

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MDCD_IP_TOTAL_SPEND

LABEL: Medicaid Payment Amount — Inpatient

DESCRIPTION: This variable is the total Medicaid payment amount from all Inpatient (IP) claims for the beneficiary during the year. Note that this dollar amount may be an undercount if the beneficiary had managed care claims.

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Inpatient Claims File (derived)

VALUES: $

COMMENT: CCW calculates this variable as the sum of all MDCD_PD_AMT from the Inpatient (header) claims. The Center for Medicaid and CHIP Services (CMCS) at CMS has required redaction of this payment field for managed care claims due to the proprietary and confidential nature of this information. Therefore, when summing Medicaid expenditures using the claim files it is important to keep in mind that totals will include only fee-for-service expenditures and not reflect the redacted managed care expenditures

MMLEADS counts all claims in the MDCD_IP_TOTAL_USE variable. Use caution when calculating average spend per claim. There may be claims (i.e., use) for which there is no corresponding payment information.

^ Back to TOC ^

MDCD_IP_TOTAL_USE

LABEL: Medicaid Use (Claim Count) — Inpatient

DESCRIPTION: This variable is the total count of Medicaid Inpatient (IP) (header) claims for the beneficiary during the year.

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Inpatient Claims File (derived)

VALUES: XX

COMMENT: The corresponding Medicaid payment information for IP is in the MDCD_IP_TOTAL_SPEND variable; however, due to CMS payment redaction requirements the dollar totals will not reflect the (redacted) managed care expenditures. MMLEADS counts all claims in the MDCD_IP_TOTAL_USE variable. Use caution when calculating average spend per claim. There may be claims (i.e., use) for which there is no corresponding payment information.

^ Back to TOC ^

MDCD_IPF_LTSS_MOS

LABEL: Medicaid — IP Psych Facility for Individuals under age 21 — LTSS Months

DESCRIPTION: This variable is the number of months during the year where the beneficiary's Medicaid level of care status code indicated that Inpatient psychiatric facility for individuals under age 21 care was required to meet a beneficiary's needs. Medicaid uses this information to determine Long-Term Services and Supports (LTSS) program eligibility.

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS DE file (derived)

VALUES: 1–12, or null/missing (if no Medicaid enrollment or no care level status)

COMMENT: CCW calculates this variable using the DE Disability and Need Supplemental file; we count each month where the CARE_LVL_STUS_CD_*MM* = '002' (Inpatient psychiatric facility for individuals under age 21). Note that the care level status source variable from DE identifies five levels of care: hospital, inpatient psychiatric facility for individuals under age 21, nursing facility, intermediate care facility, or other type of facility. Each of these levels is included in MMLEADS. In addition, the MDCD_CARE_LEVEL_MOS variable is the total count of months during the year when any of these levels of care was indicated.

^ Back to TOC ^

MDCD_LT_TOTAL_SPEND

LABEL: Medicaid Payment Amount — Long-Term Care

DESCRIPTION: This variable is the total Medicaid payment amount from all long-term care (LT) claims for the beneficiary during the year. Note that this dollar amount may be an undercount if the beneficiary had managed care claims.

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Long-Term Care Claims File (derived)

VALUES: $

COMMENT: CCW calculates this variable as the sum of all MDCD_PD_AMT from the Long-Term care (header) claims. The Center for Medicaid and CHIP Services (CMCS) at CMS has required redaction of this payment field for managed care claims due to the proprietary and confidential nature of this information. Therefore, when summing Medicaid expenditures using the claim files it is important to keep in mind that totals will not reflect the redacted managed care expenditures.

MMLEADS counts all claims in the MDCD_LT_TOTAL_USE variable. Use caution when calculating average spend per claim. There may be claims (i.e., use) for which there is no corresponding payment information.

^ Back to TOC ^

MDCD_LT_TOTAL_USE

LABEL: Medicaid Use (Claim Count) — Long-Term Care

DESCRIPTION: This variable is the total count of Medicaid long-term care (LT) (header) claims for the beneficiary during the year.

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Long-Term Care Claims File (derived)

VALUES: XX

COMMENT: The corresponding Medicaid payment information for LT is in the MDCD_LT_TOTAL_SPEND variable; however, due to CMS payment redaction requirements the dollar totals will not reflect the (redacted) managed care expenditures. MMLEADS counts all claims in the MDCD_LT_TOTAL_USE variable. Use caution when calculating average spend per claim. There may be claims (i.e., use) for which there is no corresponding payment information.

^ Back to TOC ^

MDCD_LTC_COV_MOS

LABEL: Medicaid — Long-Term Care Prepaid Inpatient Health Plan (PIHP) Months

DESCRIPTION: This variable is the number of months during the year the beneficiary was enrolled in a Long-Term Care (LTC) Prepaid Inpatient Health Plan (PIHP) Managed Care Plan.

TYPE: NUM

LENGTH: 3

SOURCE: T-MSIS DE file

VALUES: 0–12, or null/missing (if no Medicaid enrollment)

COMMENT: CCW obtains this directly from the DE Managed Care Supplemental file LTC_PIHP_MOS variable.

^ Back to TOC ^

MDCD_LTSS_LEVEL_MOS

LABEL: Medicaid — LTSS Provider 1 Level of Care Code Months

DESCRIPTION: This variable is the number of months during the year where the beneficiary's Medicaid monthly Long-Term Services and Supports (LTSS) Level of Care Code indicated that some level of support was required to meet a beneficiary's needs.

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS DE file (derived)

VALUES: 0–12, or null/missing (if no Medicaid enrollment or no LTSS)

COMMENT: CCW calculates this variable using the DE Disability and Need Supplemental file; we count each month where the LTSS_LVL_CD_1_*MM* ne ' ' (i.e., count any month that has a populated value). Note that the LTSS level source variable from DE identifies three levels of care: skilled, intermediate, and custodial care. Each of these levels is included in MMLEADS. In addition, the MDCD_LTSS_LEVEL_MOS variable is the total count of months during the year when any of these LTSS levels was indicated.

^ Back to TOC ^

MDCD_MC_CAPTD_SPEND_01

MDCD_MC_CAPTD_SPEND_02

MDCD_MC_CAPTD_SPEND_03

MDCD_MC_CAPTD_SPEND_04

MDCD_MC_CAPTD_SPEND_05

MDCD_MC_CAPTD_SPEND_06

MDCD_MC_CAPITD_SPEND_07

MDCD_MC_CAPTD_SPEND_08

MDCD_MC_CAPTD_SPEND_09

MDCD_MC_CAPTD_SPEND_10

MDCD_MC_CAPTD_SPEND_11

MDCD_MC_CAPTD_SPEND_12

LABEL: Medicaid Managed Care Capitated Payment Amount — January–December (01–12)

DESCRIPTION: This variable is a monthly variable that calculates managed care capitated spending for the beneficiary.

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS OT Claims File (derived)

VALUES: $

COMMENT: CCW creates this variable by identifying OT header claims that are for managed care capitated payments. These are header claims where the claim type code (T-MSIS variable called CLM_TYPE_CD) is equal to '2' (Medicaid or expansion claim) 'B' (S-CHIP claim) or 'V' (Other Services claim).

^ Back to TOC ^

MDCD_MC_MEDICAL_MOS

LABEL: Medicaid — Managed Care Medicaid Coverage Months

DESCRIPTION: This variable is the number of months during the year when the beneficiary had Medicaid managed care medical coverage.

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS DE file (derived)

VALUES: 0–12, or null/missing (if no Medicaid enrollment)

COMMENT: CCW calculates this variable using the DE file. We consider the beneficiary to have Managed Care Medical coverage during the month If the beneficiary had Medicaid or CHIP enrollment for the month, and the monthly managed care plan type code was for a comprehensive managed care plan or a health insuring organization (i.e., where MC_PLAN_TYPE_CD_*MM* is ('01' '04').

We set this variable to null/missing for beneficiaries who are not enrolled in Medicaid during the year.

The sum of MDCD_MC_MEDICAL_MOS + MDCD_FFS_MEDICAL_MOS is equal to the total months of Medicaid coverage during the year. Note that this does not always equal the number of months enrolled in Medicaid due to missing data in the source fields (e.g., eligibility group code associated with the beneficiary state).

^ Back to TOC ^

MDCD_NF_LTSS_MOS

LABEL: Medicaid — Nursing Facility LTSS Months

DESCRIPTION: This variable is the number of months during the year where the beneficiary's monthly level of care status code indicated that nursing facility care was required to meet the beneficiary's needs. Medicaid uses this information to determine Long-Term Services and Supports (LTSS) program eligibility.

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS DE file (derived)

VALUES: 0–12, or null/missing (if no Medicaid enrollment or no care level status)

COMMENT: CCW calculates this variable using the DE Disability and Need Supplemental file; we count each month where the CARE_LVL_STUS_CD_*MM* = '003' (nursing facility). Note that the care level status source variable from DE identifies five levels of care: hospital, inpatient psychiatric facility, nursing facility, intermediate care facility, or other type of facility. Each of these levels is included in MMLEADS. In addition, the MDCD_CARE_LEVEL_MOS variable is the total count of months during the year when any of these levels of care was indicated.

^ Back to TOC ^

MDCD_NON_CAPTD_SPEND_01

MDCD_NON_CAPTD_SPEND_02

MDCD_NON_CAPTD_SPEND_03

MDCD_NON_CAPTD_SPEND_04

MDCD_NON_CAPTD_SPEND_05

MDCD_NON_CAPTD_SPEND_06

MDCD_NON_CAPTD_SPEND_07

MDCD_NON_CAPTD_SPEND_08

MDCD_NON_CAPTD_SPEND_09

MDCD_NON_CAPTD_SPEND_10

MDCD_NON_CAPTD_SPEND_11

MDCD_NON_CAPTD_SPEND_12

LABEL: Medicaid Non-Capitated Payment Amount — January–December (01–12)

DESCRIPTION: This variable is the sum of the Medicaid payment amounts from the inpatient (IP), long-term care (LT), pharmacy (RX) and other services (OT) (header) claims for the beneficiary for the month – after removing the Medicaid managed care capitated payments. Note that this dollar amount may be an undercount if the beneficiary had managed care claims.

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Claims File (derived)

VALUES: $

COMMENT: CCW creates this variable as the sum of all MDCD_PD_AMT from all claims for the month, however we identify and remove the OT header claims that are for managed care capitated payments. These are header claims where the claim type code (T-MSIS variable called CLM_TYPE_CD) is equal to '2' (Medicaid or expansion claim) 'B' (S-CHIP claim) or 'V' (Other Services claim). These capitated payment claims are captured in MMLEADS in the monthly MDCD_MC_CAPTD_SPEND_01–12 variables.

Note that the Center for Medicaid and CHIP Services (CMCS) at CMS has required redaction of the MDCD_PD_AMT field for managed care claims due to the proprietary and confidential nature of this information. Therefore, this total does not reflect the redacted managed care expenditures. MMLEADS counts all claims in the monthly MDCD_TOTAL_USE_01–12 variables. Use caution when calculating average spend per claim. There may be claims (i.e., use) for which there is no corresponding payment information.

^ Back to TOC ^

MDCD_ONLY_MOS

LABEL: Medicaid Aged, Blind, Disabled Only Months

DESCRIPTION: This variable is the number of months during the year that the beneficiary was enrolled in Medicaid benefits due to being aged, blind, or disabled (A/B/D).

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS DE file (derived)

VALUES: 0–12 or null/missing (if no Medicaid enrollment)

COMMENT: CCW calculates this variable as the count of months where MME_TYPE_CD_*MM* = 1 (Medicaid only A/B/D). This is when the T-MSIS DE File ELIGBLTY_GRP_CD_*MM* IN ('11' '12' '13' '14' '15' '16' '17' '18' '19' '20' '21' '22' '23' '24' '25' '26' '37' '38' '39' '40' '41' '42' '43' '44' '45' '46' '47' '48' '49' '50' '51' '52' '59' '60' '69').

^ Back to TOC ^

MDCD_OT_MC_CAPTD_SPEND

LABEL: Medicaid Managed Care Capitated Payment Amount— Other Services

DESCRIPTION: This variable is the total Medicaid payment amount from all Other Services (OT) claims for capitated payments for the beneficiary during the year.

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Other Services Claims file (derived)

VALUES: $

COMMENT: CCW calculates this variable as the sum of all MDCD_PD_AMT from the OT header claims that are for managed care capitated payments. These are header claims where the claim type code (T-MSIS variable called CLM_TYPE_CD) is equal to '2' (Medicaid or expansion claim) 'B' (S-CHIP claim) or 'V' (Other Services claim). MMLEADS may count claims (in the MDCD_OT_MC_CAPTD_USE variable) for which there is no corresponding payment information.

^ Back to TOC ^

MDCD_OT_MC_CAPTD_USE

LABEL: Medicaid Managed Care Capitated Claim Count — Other Services

DESCRIPTION: This variable is the total count of the Other Services (OT) claims for capitated payments for the beneficiary during the year.

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Other Services Claims file (derived)

VALUES: XX

COMMENT: These are header claims where the claim type code (T-MSIS variable called CLM_TYPE_CD) is equal to '2' (Medicaid or expansion claim) 'B' (S-CHIP claim) or 'V' (Other Services claim). The corresponding payment information for these claims is in the MDCD_OT_MC_CAPTD_SPEND field.

^ Back to TOC ^

MDCD_OT_TOTAL_SPEND

LABEL: Medicaid Payment Amount — Other Services

DESCRIPTION: This variable is the sum of Medicaid payment amount from the other services (OT) (header) claims for the beneficiary during the year, after removing the managed care capitated payments. Note that this dollar amount may be an undercount if the beneficiary had managed care claims.

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Other Services Claims file (derived)

VALUES: $

COMMENT: CCW filtered the OT claims header records to distinguish between capitated payments and payments for services. Capitated payments are header claims where the claim type code (T-MSIS variable called CLM_TYPE_CD) is equal to '2' (Medicaid or expansion claim) 'B' (S-CHIP claim) or 'V' (Other Services claim). These capitated payment claims are not included in this variable; they are captured in MMLEADS in the MDCD_OT_MC_CAPTD_SPEND variable.

CCW calculates this variable as the sum of all MDCD_PD_AMT from the non-capitated payment Other Services (header) claims. The Center for Medicaid and CHIP Services (CMCS) at CMS has required redaction of this payment field for managed care claims due to the proprietary and confidential nature of this information. Therefore, when summing Medicaid expenditures using the claim files it is important to keep in mind that totals will not reflect the redacted managed care expenditures.

MMLEADS counts all claims in the MDCD_OT_TOTAL_USE variable. Use caution when calculating average spend per claim. There may be claims (i.e., use) for which there is no corresponding payment information.

^ Back to TOC ^

MDCD_OT_TOTAL_USE

LABEL: Medicaid Use (Claim Count) — Other Services

DESCRIPTION: This variable is the total count of Medicaid other services (OT) (header) claims for the beneficiary after removing the managed care capitated payments.

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Other Services Claims file (derived)

VALUES: XX

COMMENT: CCW filtered the OT claims header records to distinguish between capitated payments and payments for services. Capitated payments are header claims where the claim type code (T-MSIS variable called CLM_TYPE_CD) is equal to '2' (Medicaid or expansion claim) 'B' (S-CHIP claim) or 'V' (Other Services claim). These capitated payment claims are captured in MMLEADS in the MDCD_OT_MC_PREMIUM_USE variable.

The Medicaid payment information corresponding to this variable is in the MDCD_OT_TOTAL_SPEND variable; however, due to CMS payment redaction requirements the dollar totals will not reflect the (redacted) managed care expenditures. MMLEADS counts all claims in the MDCD_OT_TOTAL_USE variable. Use caution when calculating average spend per claim. There may be claims (i.e., use) for which there is no corresponding payment information.

^ Back to TOC ^

MDCD_OTHER_LTSS_MOS

LABEL: Medicaid — Other Type of Facility LTSS Months

DESCRIPTION: This variable is the number of months during the year where the beneficiary's monthly level of care status code indicated that some other type of facility was required to meet a beneficiary's needs. Medicaid uses this information to determine Long-Term Services and Supports (LTSS) program eligibility.

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS DE file (derived)

VALUES: 0–12, or null/missing (if no Medicaid enrollment or no care level status)

COMMENT: CCW calculates this variable using the DE Disability and Need Supplemental file; we count each month where the CARE_LVL_STUS_CD_*MM* = '005' (Other Type of Facility). Note that the care level status source variable from DE identifies five levels of care: hospital, inpatient psychiatric facility, nursing facility, intermediate care facility, or other type of facility. Each of these levels is included in MMLEADS. In addition, the MDCD_CARE_LEVEL_MOS variable is the total count of months during the year when any of these levels of care was indicated.

^ Back to TOC ^

MDCD_OTHR_MC_MOS

LABEL: Medicaid — Other (non-Comprehensive) Managed Care Medicaid Coverage Months

DESCRIPTION: This variable is the number of months during the year when the beneficiary had some type of Medicaid managed care coverage, however it was not comprehensive medical managed care coverage.

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS DE file (derived)

VALUES: 0–12, or null/missing (if no Medicaid enrollment)

COMMENT: CCW calculates this variable using the DE file. We consider the beneficiary to have some other type of Managed Care coverage during the month If the beneficiary had Medicaid or CHIP enrollment for the month, and the monthly managed care plan type code was populated and not for a comprehensive managed care plan or a health insuring organization (i.e., we counted only the months where MC_PLAN_TYPE_CD_*MM* not in ('01' '04')). Note that the number of comprehensive medical managed care months is captured in MMLEADS in MDCD_MC_MEDICAL_MOS.

^ Back to TOC ^

MDCD_PACE_COV_MOS

LABEL: Medicaid — Program of All-Inclusive Care for the Elderly (PACE) Months

DESCRIPTION: This variable is the number of months during the year that the beneficiary was enrolled in a Program of All-Inclusive Care for the Elderly (PACE) Managed Care Plan.

TYPE: NUM

LENGTH: 3

SOURCE: T-MSIS DE file

VALUES: 0–12, or null/missing (if no Medicaid enrollment)

COMMENT: CCW obtains this directly from the DE Managed Care Supplemental file PACE_MOS variable.

^ Back to TOC ^

MDCD_PCCM_COV_MOS

LABEL: Medicaid — Primary Care Case Management (PCCM) Months

DESCRIPTION: This variable is the number of months during the year that the beneficiary was enrolled in a Medicaid Primary Care Case Management (PCCM) Managed Care Plan.

TYPE: NUM

LENGTH: 3

SOURCE: T-MSIS DE file (derived)

VALUES: 0–12, or null/missing (if no Medicaid enrollment)

COMMENT: CCW creates this variable using the DE Managed Care Supplemental file; we obtain the maximum value (number of months) from: TRDTNL_PCCM_MOS or ENHCD_PCCM_MOS.

^ Back to TOC ^

MDCD_PHARMACY_COV_MOS

LABEL: Medicaid — Managed Care Pharmacy Months

DESCRIPTION: This variable is the number of months during the year that the beneficiary was enrolled in a Medicaid Pharmacy Prepaid Ambulatory Health Plan (PAHP) Managed Care Plan.

TYPE: NUM

LENGTH: 3

SOURCE: T-MSIS DE file

VALUES: 0–12, or null/missing (if no Medicaid enrollment)

COMMENT: CCW obtains this directly from the DE Managed Care Supplemental file PHRMCY_PAHP_MOS variable.

^ Back to TOC ^

MDCD_PHP_COV_MOS

LABEL: Medicaid — Prepaid Inpatient or Ambulatory Health Plan (PIHP/PAHP) Months

DESCRIPTION: This variable is the number of months during the year that the beneficiary was enrolled in a Medicaid Medical-only Prepaid Inpatient or Ambulatory Health Plan (PIHP/PAHP) Managed Care Plan.

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS DE file (derived)

VALUES: 0–12, or null/missing (if no Medicaid enrollment)

COMMENT: CCW creates this variable using the DE Managed Care Supplemental file; we obtain the maximum value (number of months) from: PIHP_MOS or PAHP_MOS.

^ Back to TOC ^

MDCD_RACE_ETHNCTY_CD

LABEL: Medicaid — Race and Ethnicity Constructed Code — Latest in Year

DESCRIPTION: This variable indicates the Medicaid beneficiary's race and ethnicity code.

TYPE: CHAR

LENGTH: 1

SOURCE: T-MSIS DE file

VALUES:
1 = White, non-Hispanic
2 = Black, non-Hispanic
3 = Asian, non-Hispanic
4 = American Indian and Alaska Native (AIAN), non-Hispanic
5 = Hawaiian/Pacific Islander
6 = Multiracial, non-Hispanic
7 = Hispanic, all races
Null/missing = source value is missing, unknown, or not Medicaid enrolled

COMMENT: CCW obtains this directly from the DE RACE_ETHNCTY_CD variable.

^ Back to TOC ^

MDCD_RSTRCTD_BNFTS_CD_LTST

LABEL: Medicaid — Scope of Medicaid or CHIP Benefits — Latest in Year

DESCRIPTION: This variable indicates the scope of Medicaid or Children's Health Insurance Program (CHIP) benefits to which a beneficiary is entitled; most recent in the calendar year.

TYPE: CHAR

LENGTH: 1

SOURCE: T-MSIS DE file

VALUES:
0 = Not eligible for Medicaid or (CHIP) during the month
1 = Eligible for Medicaid or CHIP (full scope of benefits)
2 = Eligible for Medicaid or Medicaid-Expansion CHIP (restricted benefits based on alien status)
3 = Eligible for Medicaid (restricted benefits based on Medicare dual-eligibility status; e.g., QMB, SLMB, QDWI, QI)
4 = Eligible for Medicaid or CHIP (restricted benefits — pregnancy)
5 = Eligible for Medicaid or Medicaid-Expansion CHIP (restricted benefits — not 2, 3, or 4); e.g., substance abuse, medically needy or other
6 = Eligible for Medicaid or Medicaid-Expansion CHIP (restricted benefits — family planning)
7 = Eligible for Medicaid (alternative package of benchmark-equivalent coverage, as enacted by the Deficit Reduction Act of 2005)
A = Eligible for Medicaid and entitled to benefits under the Psychiatric Residential Treatment Facilities Demonstration Grant Program (PRTF); community alternatives to psychiatric resident treatment facilities for children
D = Eligible for Medicaid — Money Follows the Person (MFP) demo
Null/missing = source value is missing, unknown, or not Medicaid enrolled

COMMENT: CCW obtains this directly from the DE RSTRCTD_BNFTS_CD_LTST variable.

^ Back to TOC ^

MDCD_RX_TOTAL_SPEND

LABEL: Medicaid Payment Amount — Rx

DESCRIPTION: This variable is the total Medicaid payment amount from all pharmacy (RX) claims for the beneficiary during the year. Note that this dollar amount may be an undercount if the beneficiary had managed care claims.

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Pharmacy Claims file (derived)

VALUES: $

COMMENT: CCW calculates this variable as the sum of all MDCD_PD_AMT from the Pharmacy (header) claims. The Center for Medicaid and CHIP Services (CMCS) at CMS has required redaction of this payment field for managed care claims due to the proprietary and confidential nature of this information. Therefore, when summing Medicaid expenditures using the claim files it is important to keep in mind that totals will not reflect the redacted managed care expenditures.

MMLEADS counts all claims in the MDCD_RX_TOTAL_USE variable. Use caution when calculating average spend per claim. There may be claims (i.e., use) for which there is no corresponding payment information.

^ Back to TOC ^

MDCD_RX_TOTAL_USE

LABEL: Medicaid Use (Claim Count) — Rx

DESCRIPTION: This variable is the total count of Medicaid Pharmacy (RX) (header) claims for the beneficiary during the year.

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Pharmacy Claims file (derived)

VALUES: XX

COMMENT: The corresponding Medicaid payment information for RX is in the MDCD_RX_TOTAL_SPEND variable; however, due to CMS payment redaction requirements the dollar totals will not reflect the (redacted) managed care expenditures. MMLEADS counts all claims in the MDCD_RX_TOTAL_USE variable. Use caution when calculating average spend per claim. There may be claims (i.e., use) for which there is no corresponding payment information.

^ Back to TOC ^

MDCD_SKILLED_CARE_MOS

LABEL: Medicaid — Skilled Level of Care for LTSS Months

DESCRIPTION: This variable is the number of months during the year where the beneficiary's Medicaid monthly Long-Term Services and Supports (LTSS) Level of Care Code indicated that skilled care was required to meet a beneficiary's needs.

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS DE file (derived)

VALUES: 0–12, or null/missing (if no Medicaid enrollment or no LTSS)

COMMENT: CCW calculates this variable using the DE Disability and Need Supplemental file; we count each month where the LTSS_LVL_CD_1_*MM* = '1' (skilled care). Note that the LTSS level source variable from DE identifies three levels of care: skilled, intermediate, and custodial care. Each of these levels is included in MMLEADS. In addition, the MDCD_LTSS_LEVEL_MOS variable is the total count of months during the year when any of these LTSS levels was indicated.

^ Back to TOC ^

MDCD_STATE_CD_01

MDCD_STATE_CD_02

MDCD_STATE_CD_03

MDCD_STATE_CD_04

MDCD_STATE_CD_05

MDCD_STATE_CD_06

MDCD_STATE_CD_07

MDCD_STATE_CD_08

MDCD_STATE_CD_09

MDCD_STATE_CD_10

MDCD_STATE_CD_11

MDCD_STATE_CD_12

LABEL: Medicaid — State Alpha Abbreviation — January–December (01–12)

DESCRIPTION: This variable is the Medicaid beneficiary's state for the month.

TYPE: CHAR

LENGTH: 2

SOURCE: T-MSIS DE file (derived)

VALUES: 2-character postal state code

AK = Alaska
AL = Alabama
AR = Arkansas
AZ = Arizona
CA = California
CO = Colorado
CT = Connecticut
DC = District of Columbia
DE = Delaware
FL = Florida
GA = Georgia
HI = Hawaii
IA = Iowa
ID = Idaho
IL = Illinois
IN = Indiana
KS = Kansas
KY = Kentucky
LA = Louisiana
MA = Massachusetts
MD = Maryland
ME = Maine
MI = Michigan
MN = Minnesota
MO = Missouri
MS = Mississippi
MT = Montana
NC =North Carolina
ND = North Dakota
NE = Nebraska

NH = New Hampshire
NJ = New Jersey
NM = New Mexico
NV = Nevada
NY = New York
OH = Ohio
OK = Oklahoma
OR = Oregon
PA = Pennsylvania
PR = Puerto Rico
RI = Rhode Island
SC = South Carolina
SD = South Dakota
TN = Tennessee
TX = Texas
UT = Utah
VA = Virginia
VT = Vermont
WA = Washington
WI = Wisconsin
WV = West Virginia
WY = Wyoming
XX = Other territories or Unknown
Null/missing = not enrolled in the month

COMMENT: This variable only populated for Medicaid enrollees. If beneficiary is enrolled only in Medicaid, then we populate the variable with T-MSIS DE variable STATE_CD. A beneficiary (or an MSIS_ID) may be enrolled in Medicaid in more than one state within a month, in which case we select the state with the highest total Medicaid spend for the month.

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MDCD_TOTAL_NON_CAPTD_SPEND

LABEL: Medicaid Payment Amount — Non-Capitated Total

DESCRIPTION: This variable is the sum of Medicaid payment amount from other services (OT) (header) claims for the beneficiary during the year, after removing the Medicaid managed care capitated payments. Note that this dollar amount may be an undercount if the beneficiary had managed care claims.

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Claims files (derived)

VALUES: $

COMMENT: CCW calculates this variable as the sum of all MDCD_PD_AMT from the OT header claims; the exception is that CCW removed the OT claims header records for capitated payments. Capitated payments are header claims where the claim type code (T-MSIS variable called CLM_TYPE_CD) is equal to '2' (Medicaid or expansion claim) 'B' (S-CHIP claim) or 'V' (Other Services claim). These capitated payment claims are captured in MMLEADS in the MDCD_OT_MC_CAPTD_SPEND variable.

Note that the Center for Medicaid and CHIP Services (CMCS) at CMS has required redaction of the MDCD_PD_AMT field for managed care claims due to the proprietary and confidential nature of this information. Therefore, this total does not reflect the redacted managed care expenditures. MMLEADS counts all claims in the MDCD_TOTAL_USE variable. Use caution when calculating average spend per claim. There may be claims (i.e., use) for which there is no corresponding payment information.

^ Back to TOC ^

MDCD_TOTAL_SPEND

LABEL: Medicaid Payment Amount — Total

DESCRIPTION: This variable is the sum of Medicaid payment amount from the inpatient (IP), long-term care (LT), pharmacy (RX) and other services (OT) (header) claims for the beneficiary during the year. Note that this dollar amount may be an undercount if the beneficiary had managed care claims.

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Claims files (derived)

VALUES: $

COMMENT: CCW calculates this variable as the sum of all MDCD_PD_AMT from all IP, LT, OT, and RX header claims. Unlike the MMLEADS variable called MDCD_TOTAL_NON_ CAPTD_SPEND, this variable does not remove records for capitated payments. All claims are included in this amount.

Note that the Center for Medicaid and CHIP Services (CMCS) at CMS has required redaction of the MDCD_PD_AMT field for managed care claims due to the proprietary and confidential nature of this information. Therefore, this total does not reflect the redacted managed care expenditures. MMLEADS may count claims (in the MDCD_TOTAL_USE variable) for which there is no corresponding payment information.

^ Back to TOC ^

MDCD_TOTAL_SPEND_01

MDCD_TOTAL_SPEND_02

MDCD_TOTAL_SPEND_03

MDCD_TOTAL_SPEND_04

MDCD_TOTAL_SPEND_05

MDCD_TOTAL_SPEND_06

MDCD_TOTAL_SPEND_07

MDCD_TOTAL_SPEND_08

MDCD_TOTAL_SPEND_09

MDCD_TOTAL_SPEND_10

MDCD_TOTAL_SPEND_11

MDCD_TOTAL_SPEND_12

LABEL: Medicaid Payment Amount — January–December (01–12)

DESCRIPTION: This variable is the sum of Medicaid payment amount from the inpatient (IP), long-term care (LT), pharmacy (RX), and other services (OT) (header) claims for the beneficiary for each month. Note that this dollar amount may be an undercount if the beneficiary had managed care claims.

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Claims files (derived)

VALUES: $

COMMENT: Monthly claims total spending is calculated independent of Medicaid eligibility status; the CCW sums the MDCD_PD_AMT for all claim header records. This means there may be payment amounts for months when the beneficiary did not meet the MMLEADS population criteria. Therefore, for a small number of beneficiaries, you may observe payments for months that do not correspond with monthly Medicaid or Medicare enrollment in the MMLEADS Beneficiary file.

Note that the Center for Medicaid and CHIP Services (CMCS) at CMS has required redaction of the MDCD_PD_AMT field for managed care claims due to the proprietary and confidential nature of this information. Therefore, these monthly totals do not reflect the redacted managed care expenditures. MMLEADS counts all claims in the monthly MDCD_TOTAL_USE_01–12 variables. Use caution when calculating average spend per claim. There may be claims (i.e., use) for which there is no corresponding payment information.

^ Back to TOC ^

MDCD_TOTAL_USE

LABEL: Medicaid Use (Claim Count) — Total

DESCRIPTION: This variable is the total count of Medicaid inpatient (IP), long-term care (LT), pharmacy (RX), and other services (OT) (header) claims for the beneficiary for during the year, after removing the managed care capitated payment claims from the OT file.

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Claims files (derived)

VALUES: XX

COMMENT: CCW filtered the OT claims header records to distinguish between claims for capitated payments and claims for services. Capitated payment claims are header claims where the claim type code (T-MSIS variable called CLM_TYPE_CD) is equal to '2' (Medicaid or expansion claim) 'B' (S-CHIP claim) or 'V' (Other Services claim).

The Medicaid payment information corresponding to this variable is in the MDCD_TOTAL_NON_CAPTD_SPEND variable; however, due to CMS payment redaction requirements the dollar totals will not reflect the total managed care expenditures. MMLEADS may count claims (in this MDCD_TOTAL_USE variable) for which there is no corresponding payment information.

^ Back to TOC ^

MDCD_TOTAL_USE_01

MDCD_TOTAL_USE_02

MDCD_TOTAL_USE_03

MDCD_TOTAL_USE_04

MDCD_TOTAL_USE_05

MDCD_TOTAL_USE_06

MDCD_TOTAL_USE_07

MDCD_TOTAL_USE_08

MDCD_TOTAL_USE_09

MDCD_TOTAL_USE_10

MDCD_TOTAL_USE_11

MDCD_TOTAL_USE_12

LABEL: Medicaid Use (Claim Count) — January–December (01–12)

DESCRIPTION: This variable is the total count of Medicaid inpatient (IP), long-term care (LT), pharmacy (RX) and other services (OT) (header) claims for the beneficiary for each month, after removing the managed care capitated payment claims from the OT file.

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Claims files (derived)

VALUES: XX

COMMENT: CCW filtered the OT claims header records to distinguish between capitated payments and payments for services. Capitated payment claims are header claims where the claim type code (T-MSIS variable called CLM_TYPE_CD) is equal to '2' (Medicaid or expansion claim) 'B' (S-CHIP claim) or 'V' (Other Services claim).

The Medicaid payment information corresponding to this variable is in the monthly MDCD_TOTAL_SPEND_01–12 variables variable; however, due to CMS payment redaction requirements the dollar totals will not reflect the (redacted) managed care expenditures. MMLEADS counts all claims in these monthly MDCD_ TOTAL_USE_01–12 variables. Use caution when calculating average spend per claim. There may be claims (i.e., use) for which there is no corresponding payment information.

^ Back to TOC ^

MDCD_TRANSPORTATION_COV_MOS

LABEL: Medicaid — Managed Care Transportation Months

DESCRIPTION: This variable is the number of months during the year that the beneficiary was enrolled in a Medicaid Transportation Prepaid Ambulatory Health Plan (PAHP) Managed Care Plan.

TYPE: NUM

LENGTH: 3

SOURCE: T-MSIS DE file

VALUES: 0–12, or null/missing (if no Medicaid enrollment)

COMMENT: CCW obtains this directly from the DE Managed Care Supplemental file TRNSPRTN_PAHP_MOS variable.

^ Back to TOC ^

MDCD_WVR_1115_TYPE_CD

LABEL: Medicaid — 1115 Waiver Type Code — Latest in Year

DESCRIPTION: This variable is the code to indicate the type of 1115 waiver under which the beneficiary received Medicaid coverage; most recent in the calendar year.

TYPE: CHAR

LENGTH: 2

SOURCE: T-MSIS DE file

VALUES: 01 = 1115(a) Other demonstration
22 = 1115 Pharmacy plus waiver
24 =1115 Family planning demonstration
89 =Two or more 1115 waivers in the latest month
Null/missing = not one of the 1115 waivers, source value missing/unknown, or not Medicaid enrolled

COMMENT: CCW obtains this directly from the DE Waiver Supplemental file WVR_1115_TYPE_CD variable.

^ Back to TOC ^

MDCD_WVR_1915B_MOS

LABEL: Medicaid — 1915(b) Waiver Months

DESCRIPTION: This variable is the number of months the beneficiary was enrolled in a Medicaid Section 1915(b) waiver during the year.

TYPE: NUM

LENGTH: 3

SOURCE: T-MSIS DE file

VALUES: 0–12, or null/missing (if no Medicaid enrollment)

COMMENT: CCW obtains this directly from the DE Waiver Supplemental file WVR_1915B_MOS variable.

^ Back to TOC ^

MDCD_WVR_1915BC_MOS

LABEL: Medicaid — 1915(b)(c) Waiver Months

DESCRIPTION: This variable is the number of months the beneficiary was enrolled in a Medicaid concurrent (combined) Section 1915(b)(c) waiver during the year.

TYPE: NUM

LENGTH: 3

SOURCE: T-MSIS DE file

VALUES: 0–12, or null/missing (if no Medicaid enrollment)

COMMENT: CCW obtains this directly from the DE Waiver Supplemental file WVR_1915BC_MOS variable.

^ Back to TOC ^

MDCD_WVR_1915C_MOS

LABEL: Medicaid — 1915(c) Waiver Months

DESCRIPTION: This variable is the number of months the beneficiary was enrolled in a Medicaid Section 1915(c) (Home- and Community-Based Care) waiver during the year.

TYPE: NUM

LENGTH: 3

SOURCE: T-MSIS DE file

VALUES: 0–12, or null/missing (if no Medicaid enrollment)

COMMENT: CCW obtains this directly from the DE Waiver Supplemental file WVR_1915C_MOS variable.

^ Back to TOC ^

MDCD_WVR_1915C_TYPE_CD

LABEL: Medicaid — 1915(c) Waiver Type Code — Latest in Year

DESCRIPTION: This variable is the code to indicate the type of 1915(c) waiver under which the beneficiary received Medicaid coverage; most recent in the calendar year.

TYPE: CHAR

LENGTH: 2

SOURCE: T-MSIS DE file

VALUES:
06 = 1915(c) — Aged and Disabled
07 = 1915(c) — Aged
08 = 1915(c) — Physical Disabilities
09 = 1915(c) — Intellectual Disabilities
10 = 1915(c) — Intellectual and Developmental Disabilities
11 = 1915(c) — Brain Injury
12 = 1915(c) — HIV/AIDS
13 = 1915(c) — Technology Dependent or Medically Fragile
14 = 1915(c) — Disabled (other)
15 = 1915(c) — Enrolled in 1915(c) waiver for unspecified or unknown populations
16 = 1915(c) — Autism/Autism spectrum disorder
17 = 1915(c) — Developmental Disabilities
18 = 1915(c) — Mental Illness — Age 18 or Older
19 = 1915(c) — Mental Illness — Under Age 18
20 = 1915(c) waiver concurrent with an 1115 or 1915(b) managed care authority
33 = 1915(c) waiver (T-MSIS DD v2.1)
89 = Two or more 1915(c) waivers in the latest month
Null/missing = not one of the 1915 waivers, source value missing/unknown, or not Medicaid enrolled

COMMENT: CCW obtains this directly from the DE Waiver Supplemental file WVR_1915C_TYPE_CD variable.

^ Back to TOC ^

MDCR_BUYIN_01

MDCR_BUYIN_02

MDCR_BUYIN_03

MDCR_BUYIN_04

MDCR_BUYIN_05

MDCR_BUYIN_06

MDCR_BUYIN_07

MDCR_BUYIN_08

MDCR_BUYIN_09

MDCR_BUYIN_10

MDCR_BUYIN_11

MDCR_BUYIN_12

LABEL: Medicare — Entitlement/Buy-In Indicator — January–December (01–12)

DESCRIPTION: This variable is the monthly Medicare Part A and/or Part B entitlement indicator. There are separate variables for each of the 12 months during the year.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare MBSF

VALUES:
0 = Not entitled to Medicare
1 = Part A only
2 = Part B only
3 = Part A and Part B
A = Part A state buy-in
B = Part B state buy-in
C = Part A and Part B state buy-in
Null/missing = not Medicare enrolled for the month

COMMENT: CCW obtains this directly from the MBSF BENE_MDCR_ENTLMT_BUYIN_IND_01–12 variables.

This variable indicates whether the beneficiary was entitled to Medicare Part A, Part B, or both for a given month. It also indicates whether the beneficiary's state of residence paid his/her monthly premium for Part B coverage (and Part A if necessary). State Medicaid programs can pay those premiums for certain dual eligibles; this action is "buying in" and so this variable is the "buy-in code."

^ Back to TOC ^

MDCR_C_SNP_MOS

LABEL: Medicare-Medicaid Chronic Conditions Special Needs Plan (C-SNP) Months

DESCRIPTION: This variable is the number of months during the year that the beneficiary was enrolled in a Medicare Special Needs Plan (SNP) for a chronic condition.

TYPE: NUM

LENGTH: 8

SOURCE: MBSF (derived)

VALUES: 0–12, or null/missing (if no Medicare enrollment)

COMMENT: CCW creates this variable by linking the MBSF monthly Part D contract ID with the Plan Characteristics file, and then counting the months where the Plan Characteristics special needs plan variable indicated the plan was for a chronic condition (where SNP_TYPE = C). Additional details regarding C-SNP plans are available on the CMS website: https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/C-SNPs

^ Back to TOC ^

MDCR_COUNTY_CD

LABEL: Medicare — County FIPS Code — Latest in Year

DESCRIPTION: This field specifies the county Federal Information Processing Standard (FIPS) code for the Medicare beneficiary.

TYPE: CHAR

LENGTH: 12

SOURCE: Medicare MBSF

VALUES: 3-digit FIPS county code (e.g., 143) or null/missing (if no Medicare enrollment)

https://www.nber.org/research/data/ssa-federal-information-processing-series-fips-state-and-county-crosswalk

COMMENT: CCW derives this variable from the last 3 digits of the MBSF monthly state/county FIPS code (source variables called STATE_CNTY_FIPS_CD_01–12).

^ Back to TOC ^

MDCR_COVSTART

LABEL: Medicare — Coverage Start Date

DESCRIPTION: This variable is the date when the beneficiary first became eligible for Medicare coverage (Part A or Part B).

TYPE: NUM

LENGTH: 8

SOURCE: Medicare MBSF

VALUES: DDMMMYYYY (e.g., 01FEB2001)

COMMENT: CCW obtains this directly from the MBSF COVSTART variable.

^ Back to TOC ^

MDCR_CREC

LABEL: Medicare — Current Reason for Entitlement Code (CREC)

DESCRIPTION: This variable is the current reason for Medicare entitlement

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare MBSF

VALUES:
0 = Old age and survivor's insurance (OASI)
1 = Disability insurance benefits (DIB)
2 = End-stage renal disease (ESRD)
3 = Both DIB and ESRD
Null/missing = not Medicare enrolled

COMMENT: CCW obtains this directly from the MBSF BENE_ENTLMT_RSN_CURR variable.

The current reason for entitlement can differ from the original reason that a beneficiary qualified for Medicare (reference the MDCR_OREC variable in MMLEADS).

CMS obtains this information from the Social Security Administration (SSA) and Railroad Retirement Board (RRB) record systems.

^ Back to TOC ^

MDCR_D_SNP_MOS

LABEL: Medicare-Medicaid Dual Eligible Special Needs Plan (D-SNP) Months

DESCRIPTION: This variable is the number of months during the year that the beneficiary was enrolled in a Medicare Special Needs Plan (SNP) for dual eligible beneficiaries, which means the individuals were entitled to both Medicare and Medicaid benefits.

TYPE: NUM

LENGTH: 8

SOURCE: MBSF (derived)

VALUES: 0–12, or null/missing (if no Medicare enrollment)

COMMENT: CCW creates this variable by linking the MBSF monthly Part D contract ID with the Plan Characteristics file, and then counting the months where the Plan Characteristics special needs plan variable indicated the plan was for dual eligible (where SNP_TYPE = D). Additional details regarding D-SNP plans are available on the CMS website: https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/D-SNPs

^ Back to TOC ^

MDCR_DIB_AWD_CD

LABEL: Medicare — SSA Disability Insurance Benefit Award Code

DESCRIPTION: This variable is the disability insurance benefits (DIB) award code from the Social Security Administration (SSA).

TYPE: CHAR

LENGTH: 1

SOURCE: CMS SSA tables

VALUES:
A = Health Insurance/Supplemental Medical Insurance (HI/SMI) Entitlement Based Upon Disability on Another Claim Number
C = Retirement Insurance Benefit/Disability Insurance Benefit (RIB/DIB) Entitlement
F = Favorable Decision for DIB Re-entitlement
K = Invalid Code Entered
L = 1972 Blind Provision
N = BLIND, 1967 Definition
P = BLIND Prior to Age 31, 1967 Definition
R = Insured Under Special Insured Status Provision for Young Disabled
S = BLIND — Original Definition
T = BLIND, Prior to Age 31, Original Definition
U = Short-Term Disability
X = No Waiting Period
Null/missing = no record of SSA disability determination

COMMENT: CMS obtains information regarding SSA disability benefits and stores it as part of the Common Medicare Environment (CME) database.

^ Back to TOC ^

MDCR_DIB_JSTFCTN_CD

LABEL: Medicare — Disability Insurance Benefit Entitlement to Medicare Justification Code

DESCRIPTION: This variable is the disability justification code from the Social Security Administration (SSA).

TYPE: CHAR

LENGTH: 1

SOURCE: CMS SSA tables

VALUES: 1 = Beneficiary is entitled to Medicare coverage due to prior periods of SSA disability entitlement
A = Beneficiary is entitled to Medicare based upon SSA disability and the 24-month waiting period has been waived
H = Beneficiary is entitled to Medicare due to health hazard
Null/missing = no record of SSA disability determination

COMMENT: CMS obtains information regarding SSA disability benefits and stores it as part of the Common Medicare Environment (CME) database.

^ Back to TOC ^

MDCR_DIB_PRMRY_IMPRMNT_CD

LABEL: Medicare — SSA Disability Insurance Benefit Dx Primary Impairment Code

DESCRIPTION: This variable is the disability primary impairment diagnosis code from the Social Security Administration (SSA). The SSA groups diagnoses into categories.

TYPE: CHAR

LENGTH: 4

SOURCE: CMS SSA tables

VALUES: 0001–9999 (e.g., 2960,) or null/missing

COMMENT: Note that these are not ICD-10 (or ICD-9) diagnosis codes. Reference the SSA website: https://secure.ssa.gov/poms.nsf/lnx/0426510015

CMS obtains information regarding SSA disability benefits and stores it as part of the Common Medicare Environment (CME) database.

^ Back to TOC ^

MDCR_DIB_SCNDRY_IMPRMNT_CD

LABEL: Medicare — SSA Disability Insurance Benefit Dx Secondary Impairment Code

DESCRIPTION: This variable is the disability secondary impairment diagnosis code from the Social Security Administration (SSA). The SSA groups diagnoses into categories.

TYPE: CHAR

LENGTH: 4

SOURCE: CMS SSA tables

VALUES: 0001–9999 (e.g., 2960) or null/missing

COMMENT: Note that these are not ICD-10 (or ICD-9) diagnosis codes. Reference the SSA website: https://secure.ssa.gov/poms.nsf/lnx/0426510015

CMS obtains information regarding SSA disability benefits and stores it as part of the Common Medicare Environment (CME) database.

^ Back to TOC ^

MDCR_DUAL_STUS_CD_01

MDCR_DUAL_STUS_CD_02

MDCR_DUAL_STUS_CD_03

MDCR_DUAL_STUS_CD_04

MDCR_DUAL_STUS_CD_05

MDCR_DUAL_STUS_CD_06

MDCR_DUAL_STUS_CD_07

MDCR_DUAL_STUS_CD_08

MDCR_DUAL_STUS_CD_09

MDCR_DUAL_STUS_CD_10

MDCR_DUAL_STUS_CD_11

MDCR_DUAL_STUS_CD_12

LABEL: Medicare — Medicaid Dual Eligibility Code — January–December (01–12)

DESCRIPTION: This variable is the monthly Medicare and Medicaid dual enrollment status variable. There are separate variables for each of the 12 months during the year.

TYPE: CHAR

LENGTH: 2

SOURCE: Medicare MBSF

VALUES:
00 = Medicare beneficiary not enrolled in Medicare for the month
01 = Qualified Medicare Beneficiary (QMB)-only
02 = QMB and full Medicaid coverage, including prescription drugs
03 = Specified Low-Income Medicare Beneficiary (SLMB)-only
04 = SLMB and full Medicaid coverage, including prescription drugs
05 = Qualified Disabled Working Individual (QDWI)
06 = Qualifying individuals (QI)
08 = Other dual eligible (not QMB, SLMB, QWDI, or QI) with full Medicaid coverage, including prescription Drugs
09 = Other dual eligible, but without Medicaid coverage
99 = Unknown
NA = Medicare enrolled — non-Medicaid (i.e., no dual status)
Null/missing = not Medicare enrolled

COMMENT: CCW obtains this directly from the MBSF DUAL_STUS_CD_01–12 variables.

The original source for this variable is the State Medicare Modernization Act (MMA) files that states submit to CMS. Those files are considered the “gold standard” for identifying dual eligibles because the information in them is used to determine the level of Medicare Part D low-income subsidies.

^ Back to TOC ^

MDCR_FFS_MEDICAL_01

MDCR_FFS_MEDICAL_02

MDCR_FFS_MEDICAL_03

MDCR_FFS_MEDICAL_04

MDCR_FFS_MEDICAL_05

MDCR_FFS_MEDICAL_06

MDCR_FFS_MEDICAL_07

MDCR_FFS_MEDICAL_08

MDCR_FFS_MEDICAL_09

MDCR_FFS_MEDICAL_10

MDCR_FFS_MEDICAL_11

MDCR_FFS_MEDICAL_12

LABEL: Medicare — Fee-for-Service Medical Coverage Indicator — January–December (01–12)

DESCRIPTION: This variable is a monthly variable that indicates whether the beneficiary was enrolled in traditional Medicare fee-for-service (FFS), or whether the beneficiary was enrolled in a Medicare advantage (MA) managed care plan.

TYPE: NUM

LENGTH: 8

SOURCE: MBSF (derived)

VALUES: 0 = not Medicare FFS during month
1 = Medicare FFS during the month
Null/missing = not Medicare enrolled for the month

COMMENT: CCW creates this variable using the MBSF file. We consider the beneficiary to have FFS Medical coverage if the beneficiary had Medicare enrollment for the month, and the monthly beneficiary HMO (Medicare Advantage) indicator code was either '0' (Not a member of an HMO) or '4' (Fee-for-service participant in case or disease management demonstration project) (i.e., BENE_HMO_IND_*MM* IN ('0' '4').

^ Back to TOC ^

MDCR_FFS_MEDICAL_MOS

LABEL: Medicare — Fee-for-Service Medical Coverage Months

DESCRIPTION: This variable is the number of months during the year when the beneficiary had Medicare FFS medical coverage.

TYPE: NUM

LENGTH: 8

SOURCE: MBSF (derived)

VALUES: 0–12, or null/missing (if no Medicare enrollment)

COMMENT: CCW calculates this variable as the count of months where the monthly Medicare FFS Medical Coverage Indicator is equal to one (MDCR_FFS_MEDICAL_*MM* = '1').

^ Back to TOC ^

MDCR_HMO_MOS

LABEL: Medicare — HMO Coverage Months

DESCRIPTION: This variable is the number of months during the year when the beneficiary had Medicare Advantage/HMO medical coverage.

TYPE: NUM

LENGTH: 8

SOURCE: MBSF (derived)

VALUES: 0–12, or null/missing (if no Medicare enrollment)

COMMENT: CCW creates this variable using the MBSF. We consider the beneficiary to have Medicare Advantage (also referred to as health maintenance organization [HMO]) coverage if the beneficiary had Medicare enrollment for the month, and the monthly beneficiary HMO (Medicare Advantage) indicator code was a value other than '0' (Not a member of an HMO) or '4' (Fee-for-service participant in case or disease management demonstration project) (i.e., BENE_HMO_IND_*MM* NOT IN ('0' '4').

^ Back to TOC ^

MDCR_HOP_TOTAL_FFS_SPEND

LABEL: Medicare FFS Payment Amount — Hospital Outpatient

DESCRIPTION: This variable is the total Medicare payment amount from all Hospital Outpatient (HOP) claims for the beneficiary during the year. Note that only fee-for-service (FFS) claims are included.

TYPE: NUM

LENGTH: 8

SOURCE: Medicare Hospital Outpatient Claims file (derived)

VALUES: $

COMMENT: CCW calculates this variable as the sum of all CLM_PMT_AMT from the HOP claims.

^ Back to TOC ^

MDCR_HOP_TOTAL_FFS_USE

LABEL: Medicare Use (FFS Claim Count) — Hospital Outpatient

DESCRIPTION: This variable is the total count of Medicare Hospital Outpatient (HOP) claims for the beneficiary during the year.

TYPE: NUM

LENGTH: 8

SOURCE: Medicare Hospital Outpatient Claims file (derived)

VALUES: XX

COMMENT: The corresponding Medicare payment information for HOP is in the MDCR_HOP_TOTAL_FFS_SPEND variable.

^ Back to TOC ^

MDCR_I_SNP_MOS

LABEL: Medicare-Medicaid Institutional Special Needs Plan (I-SNP) Months

DESCRIPTION: This variable is the number of months during the year that the beneficiary was enrolled in a Medicare Special Needs Plan (SNP) for institutional care.

TYPE: NUM

LENGTH: 8

SOURCE: MBSF (derived)

VALUES: 0–12, or null/missing (if no Medicare enrollment)

COMMENT: CCW creates this variable by linking the MBSF monthly Part D contract ID with the Plan Characteristics file, and then counting the months where the Plan Characteristics special needs plan variable indicated the plan was for institutional care (where SNP_TYPE = I). Institutional Special Needs Plans (I-SNPs) are SNPs that restrict enrollment to MA eligible individuals who, for 90 days or longer, have had or are expected to need the level of services provided in a long-term care (LTC) skilled nursing facility (SNF), a LTC nursing facility (NF), a SNF/NF, an intermediate care facility for individuals with intellectual disabilities (ICF/IDD), or an inpatient psychiatric facility.

Additional details regarding I-SNP plans are available on the CMS website:
https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/I-SNPs

^ Back to TOC ^

MDCR_LTCH_MOS

LABEL: Medicare — Long-Term Care Hospital Months (from Claims)

DESCRIPTION: This variable is the total count of months during the year when CCW identified a Medicare claim for a Long-term Care Hospital (LTCH) stay.

TYPE: NUM

LENGTH: 8

SOURCE: Medicare Inpatient Claims (derived)

VALUES: 1–12, or null/missing (if no Medicare enrollment)

COMMENT: CCW uses a CMS algorithm to identify LTCH: Using the Inpatient Claims File, identify claims where the 3rd and 4th digits of the provider number (source variable called PRVDR_NUM) = 20, 21, 22.

CCW creates Medicare Timeline file to identify the type of facility or level of acuity of care received by the beneficiary each day. Using CMS rules, CCW employs a hierarchy of claims and MDS assessment data. If the beneficiary does not have Medicare claims for inpatient hospitalization, or skilled nursing facility (SNF), then CCW determines if there is an MDS assessment for the day. For MMLEADS, CCW calculates the number of months during the year when the beneficiary was in a long-term care hospital. Note that the number of months with a Medicare SNF claim or a Minimum Data Set (MDS) assessment are captured in the MDCR_SNF_MOS and MDCR_NF_MOS variables, respectively.

^ Back to TOC ^

MDCR_MC_MMP_MOS

LABEL: Medicare-Medicaid Plan (MMP) Coverage Months

DESCRIPTION: This variable is the number of months during the year when the beneficiary was enrolled in a Medicare-Medicaid managed care plan.

TYPE: NUM

LENGTH: 8

SOURCE: MBSF (derived)

VALUES: 0–12, or null/missing (if no Medicare enrollment)

COMMENT: CCW creates this variable using the MBSF. We consider the beneficiary to be enrolled in an MMP managed care plan if the beneficiary had Medicare fee-for-service enrollment for the month and had one or more months when the MBSF monthly Part C plan type code (variable called PTC_PLAN_TYPE_CD_*MM*) = 48 (Medicare-Medicaid plan) or 49 (Medicare-Medicaid plan HMO point-of-service [MMP HMOPOS]).

^ Back to TOC ^

MDCR_MC_OTHER_MOS

LABEL: Medicare — Other Managed Care Months

DESCRIPTION: This variable is the number of months during the year when the beneficiary had some sort of managed care coverage, but not Medicare Advantage (MA), Program of All-inclusive Care for the Elderly (PACE) or a Medicare-Medicaid Plan (MMP).

TYPE: NUM

LENGTH: 8

SOURCE: MBSF (derived)

VALUES: 0–12, or null/missing (if no Medicare enrollment)

COMMENT: We consider the beneficiary to have other managed care coverage (not through Medicare Advantage, PACE, or MMP plans) if the beneficiary had Medicare enrollment for the month, the monthly beneficiary HMO (Medicare Advantage) indicator code was a value other than '0' (Not a member of an HMO) or '4' (Fee-for-service participant in case or disease management demonstration project) (i.e., BENE_HMO_IND_*MM* NOT IN ('0' '4'), and the plan type code was for any type of plan other than PACE or MMP (i.e., where PTC_PLAN_TPE_CD_*MM* NOT IN ('20' '48' '49')).

^ Back to TOC ^

MDCR_MC_PACE_MOS

LABEL: Medicare — Program of All-Inclusive Care for the Elderly (PACE) Months

DESCRIPTION: This variable is the number of months during the year when the beneficiary was enrolled in a Program of All-inclusive Care for the Elderly (PACE) managed care plan.

TYPE: NUM

LENGTH: 8

SOURCE: MBSF (derived)

VALUES: 0–12, or null/missing (if no Medicare enrollment)

COMMENT: We consider the beneficiary to be covered by a PACE plan if the beneficiary had Medicare enrollment for the month, the monthly beneficiary HMO (Medicare Advantage) indicator code was a value other than '0' (Not a member of an HMO) or '4' (Fee-for-service participant in case or disease management demonstration project), and the Part C managed care plan type code was for PACE (i.e., where PTC_PLAN_TPE_CD_*MM* = '20').

^ Back to TOC ^

MDCR_MC_PTA_PTB_CAPTD_SPEND

LABEL: Medicare PTA/PTB Managed Care Capitated Payment Amount — Total

DESCRIPTION: This variable is total capitated premium payment amount for Medicare Part A and Part B for the beneficiary during the year. Note that only Part A and B capitated payments are included (not Part D).

TYPE: NUM

LENGTH: 8

SOURCE: CMS Medicare Advantage Prescription Drug System (MARx) data (derived)

VALUES: $

COMMENT: CMS and Medicare Advantage (MA) plans use the MARx System to exchange data files and reports between the Plans and CMS. The capitation payments provided to MA and Medicare Advantage Prescription Drug (MAPD) sponsors are calculated and paid monthly.

CCW calculates this variable as the sum of all the monthly Part A and Part B capitated premium payments. The dollar amounts reflect the final beneficiary payments and adjustments.

^ Back to TOC ^

MDCR_MC_PTA_PTB_CAPTD_SPEND_01

MDCR_MC_PTA_PTB_CAPTD_SPEND_02

MDCR_MC_PTA_PTB_CAPTD_SPEND_03

MDCR_MC_PTA_PTB_CAPTD_SPEND_04

MDCR_MC_PTA_PTB_CAPTD_SPEND_05

MDCR_MC_PTA_PTB_CAPTD_SPEND_06

MDCR_MC_PTA_PTB_CAPTD_SPEND_07

MDCR_MC_PTA_PTB_CAPTD_SPEND_08

MDCR_MC_PTA_PTB_CAPTD_SPEND_09

MDCR_MC_PTA_PTB_CAPTD_SPEND_10

MDCR_MC_PTA_PTB_CAPTD_SPEND_11

MDCR_MC_PTA_PTB_CAPTD_SPEND_12

LABEL: Medicare PTA/PTB Managed Care Capitated Payment Amount — January–December (01–12)

DESCRIPTION: This variable is the monthly capitated premium payment amount for Medicare Part A and Part B.

TYPE: NUM

LENGTH: 8

SOURCE: CMS Medicare Advantage Prescription Drug System (MARx) data (derived)

VALUES: $

COMMENT: CMS and Medicare Advantage (MA) plans use the MARx System to exchange data files and reports between the Plans and CMS. The capitation payments provided to MA and Medicare Advantage Prescription Drug (MAPD) sponsors are calculated and paid monthly.

CCW obtains both the monthly Part A and Part B capitated premium payment information. The dollar amounts reflect the final beneficiary payments and adjustments.

^ Back to TOC ^

MDCR_MC_UNKNOWN_MOS

LABEL: Medicare — Unknown Plan Type Manage Care Months

DESCRIPTION: This variable is the number of months during the year when the beneficiary had some sort of managed care coverage, but there is no information available regarding the type of plan (i.e., the plan type code is missing).

TYPE: NUM

LENGTH: 8

SOURCE: MBSF (derived)

VALUES: 0–12, or null/missing (if no Medicare enrollment)

COMMENT: We consider the beneficiary to have an unknown type of managed care coverage if the beneficiary had Medicare enrollment for the month, the monthly beneficiary HMO (Medicare Advantage) indicator code was a value other than '0' (Not a member of an HMO) or '4' (Fee-for-service participant in case or disease management demonstration project) (i.e., BENE_HMO_IND_*MM* NOT IN ('0' '4'), and the plan type code was (source variable called PTC_PLAN_TPE_CD_*MM*) was missing.

^ Back to TOC ^

MDCR_MS_CD

LABEL: Medicare Status Code — Latest in Year

DESCRIPTION: This Medicare status code variable indicates how a beneficiary currently qualifies for Medicare.

TYPE: CHAR

LENGTH: 1

SOURCE: MBSF (derived)

VALUES:
10 = Aged without end-stage renal disease (ESRD)
11 = Aged with ESRD
20 = Disabled without ESRD
21 = Disabled with ESRD
31 = ESRD only
Null/missing = not Medicare enrolled

COMMENT: CCW obtains this directly from the MBSF, using the last populated monthly value of the MDCR_STATUS_CODE_*MM* variable.

^ Back to TOC ^

MDCR_NF_MOS

LABEL: Medicare — Nursing Facility months (from MDS)

DESCRIPTION: This variable is the total count of months during the year where the beneficiary was in a nursing facility (NF), according to the Minimum Data Set (MDS) assessment. A hierarchical algorithm is used, so that NF is only counted for the month if there is not a Medicare long-term care hospital or skilled nursing facility claim.

TYPE: NUM

LENGTH: 8

SOURCE: Minimum Data Set (MDS) (derived)

VALUES: 1–12, or null/missing (if no Medicare enrollment)

COMMENT: CCW creates a Medicare Timeline file to identify the type of facility or level of acuity of care received by the beneficiary each day. Using CMS rules, CCW employs a hierarchy of claims and MDS assessment data. If the beneficiary does not have Medicare claims for inpatient hospitalization, or skilled nursing facility (SNF), then CCW determines if there is an MDS assessment for the day. For MMLEADS, CCW calculates the number of months during the year when the beneficiary was in a NF. Note that the number of months with a Medicare long-term care hospital claim or a SNF claim are captured in the MDCR_LTCH_MOS and MDCR_SNF_MOS variables, respectively.

^ Back to TOC ^

MDCR_ONLY_MOS

LABEL: Medicare Only Months

DESCRIPTION: This variable is the number of months during the year that the beneficiary was enrolled in Medicare — and not dually eligible for full Medicare-Medicaid benefits.

TYPE: NUM

LENGTH: 8

SOURCE: MBSF (derived)

VALUES: 0–12, or null/missing (if no Medicaid enrollment)

COMMENT: CCW calculates this variable as the count of months where a beneficiary is enrolled in Medicare and the monthly dual status code from the MBSF did not indicate eligibility for full or partial dual Medicare-Medicaid benefits (i.e., where DUAL_STUS_CD_*MM* NOT IN ('01' '02' '03' '04' '05' '06' '08').

^ Back to TOC ^

MDCR_OREC

LABEL: Medicare — Original Reason for Entitlement Code (OREC)

DESCRIPTION: This variable is the original reason for Medicare entitlement

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare MBSF

VALUES:
0 = Old age and survivor's insurance (OASI)
1 = Disability insurance benefits (DIB)
2 = End-stage renal disease (ESRD)
3 = Both DIB and ESRD
Null/missing = not Medicare enrolled

COMMENT: CCW obtains this directly from the MBSF ENTLMT_RSN_ORIG variable.

The current reason for entitlement can differ from the original reason that a beneficiary qualified for Medicare (reference the MDCR_CREC variable in MMLEADS).

CMS obtains this information from the Social Security Administration (SSA) and Railroad Retirement Board (RRB) record systems.

^ Back to TOC ^

MDCR_PTA_MOS

LABEL: Medicare Part A Enrolled Months

DESCRIPTION: This variable is the number of months during the year that the beneficiary had Medicare Part A coverage.

TYPE: NUM

LENGTH: 8

SOURCE: MBSF (derived)

VALUES: 0–12, or null/missing (if no Medicare enrollment)

COMMENT: CCW creates this variable using the MBSF monthly Medicare entitlement buy-in variable. We count the months when any value indicates Part A coverage (i.e., where MDCR_ENTLMT_BUY_IND_*MM* in ('1' '3' 'A' 'C').

Within MMLEADS we include this monthly Medicare Entitlement/Buy-In Indicator variable as MDCR_BUYIN_01–12.

^ Back to TOC ^

MDCR_PTA_TOTAL_FFS_SPEND

LABEL: Medicare FFS Payment Amount — Part A

DESCRIPTION: This variable is the total Medicare payment amount from all Part A claims for the beneficiary during the year. Note that only fee-for-service (FFS) claims are included. The Part A claims include: Inpatient, skilled nursing facility (SNF), home health agency (HHA), and hospice.

TYPE: NUM

LENGTH: 8

SOURCE: Medicare Inpatient, Skilled Nursing Facility, Home Health and Hospice Claims Files (derived)

VALUES: $

COMMENT: CCW calculates this variable as the sum of all CLM_PMT_AMT from the IP, SNF, HHA, and hospice RIF claims.

^ Back to TOC ^

MDCR_PTA_TOTAL_FFS_USE

LABEL: Medicare Use (FFS Claim Count) — Part A

DESCRIPTION: This variable is the total number of Medicare Part A claims for the beneficiary during the year. Note that only fee-for-service (FFS) claims are included. The Part A claims include: Inpatient, skilled nursing facility (SNF), home health agency (HHA), and hospice.

TYPE: NUM

LENGTH: 8

SOURCE: Medicare Inpatient, Skilled Nursing Facility, Home Health, and Hospice Claims Files (derived)

VALUES: XX

COMMENT: CCW calculates this variable as the count of all claims from the IP, SNF, HHA, and hospice claims files.

The corresponding Medicare payment information for Part A claims is in the MDCR_PTA_TOTAL_FFS_SPEND variable.

^ Back to TOC ^

MDCR_PTAPTB_MOS

LABEL: Medicare Part A and Part B Enrolled Months

DESCRIPTION: This variable is the number of months during the year that the beneficiary had both Medicare Part A and Part B coverage.

TYPE: NUM

LENGTH: 8

SOURCE: MBSF (derived)

VALUES: 0–12, or null/missing (if no Medicare enrollment)

COMMENT: CCW creates this variable using the MBSF monthly Medicare entitlement buy-in variable. We count the months when any value indicates Part A coverage (i.e., where MDCR_ENTLMT_BUY_IND_*MM* in ('3' 'C').

Within MMLEADS we include this monthly Medicare Entitlement/Buy-In Indicator variable as MDCR_BUYIN_01–12.

^ Back to TOC ^

MDCR_PTB_MOS

LABEL: Medicare Part B Enrolled Months

DESCRIPTION: This variable is the number of months during the year that the beneficiary had Medicare Part B coverage.

TYPE: NUM

LENGTH: 8

SOURCE: MBSF (derived)

VALUES: 0–12, or null/missing (if no Medicare enrollment)

COMMENT: CCW creates this variable using the MBSF monthly Medicare entitlement buy-in variable. We count the months when any value indicates Part B coverage (i.e., where MDCR_ENTLMT_BUY_IND_*MM* in ('2' '3' 'B' 'C').

Within MMLEADS we include this monthly Medicare Entitlement/Buy-In Indicator variable as MDCR_BUYIN_01–12.

^ Back to TOC ^

MDCR_PTBNI_TOTAL_FFS_SPEND

LABEL: Medicare FFS Payment Amount — Part B Non-Institutional

DESCRIPTION: This variable is the total Medicare payment amount from all Part B non-institutional claims for the beneficiary during the year. The Part B non-institutional claims include: Carrier and durable medical equipment (DME). Note that only fee-for-service (FFS) claims are included.

TYPE: NUM

LENGTH: 8

SOURCE: Medicare Carrier and Durable Medical Equipment (DME) Claims files (derived)

VALUES: $

COMMENT: CCW calculates this variable as the sum of all CLM_PMT_AMT from the Carrier and DME claims.

^ Back to TOC ^

MDCR_PTBNI_TOTAL_FFS_USE

LABEL: Medicare Use (FFS Claim Count) — Part B Non-Institutional

DESCRIPTION: This variable is the total count of Medicare Part B non-institutional claims for the beneficiary during the year. The Part B non-institutional claims include: Carrier and Durable Medical Equipment (DME). Note that only fee-for-service (FFS) claims are included.

TYPE: NUM

LENGTH: 8

SOURCE: Medicare Carrier and Durable Medical Equipment (DME) Claims files (derived)

VALUES: XX

COMMENT: CCW calculates this variable as the count of all claims from the Carrier and DME claims files.

The corresponding Medicare payment information for Part B non-institutional claims is in the MDCR_PTBNI_TOTAL_FFS_SPEND variable.

^ Back to TOC ^

MDCR_PTD_MOS

LABEL: Medicare — Part D Months

DESCRIPTION: This variable is the number of months during the year that the beneficiary was enrolled in Medicare Part D.

TYPE: NUM

LENGTH: 8

SOURCE: MBSF (derived)

VALUES: 0–12, or null/missing (if no Medicare PTD enrollment)

COMMENT: CCW creates this variable using the MBSF monthly Part D Contract ID variable. We count all months where the PTD_CNTRCT_ID_*MM* variable began with ('S' 'H' 'X'), which indicates enrollment in a Medicare prescription drug plan.

^ Back to TOC ^

MDCR_PTD_TOTAL_SPEND

LABEL: Medicare Payment Amount — PDE

DESCRIPTION: This variable is the total prescription drug cost amount from all Medicare Part D Events (PDEs) for the beneficiary during the year.

TYPE: NUM

LENGTH: 8

SOURCE: Medicare PDE file(derived)

VALUES: $

COMMENT: CCW calculates this variable as the sum of all TOT_RX_CST_AMT from the PDE records. Note that all PDEs are included, whether the beneficiary was enrolled in a stand-alone prescription drug plan (PDP) or a Medicare Advantage (managed care) plan.

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MDCR_PTD_TOTAL_USE

LABEL: Medicare Use (Claim Count) — PDE

DESCRIPTION: This variable is the total count of the Medicare Part D Events (PDEs) for the beneficiary during the year.

TYPE: NUM

LENGTH: 8

SOURCE: MBSF (derived)

VALUES: XX

COMMENT: Note that all PDEs are included, whether the beneficiary was enrolled in a stand-alone prescription drug plan (PDP) or a Medicare Advantage (managed care) plan.

The corresponding payment information for PDEs is in the MDCR_PTD_TOTAL_SPEND variable.

^ Back to TOC ^

MDCR_RTI_RACE

LABEL: Medicare — Research Triangle Institute (RTI) Race Code

DESCRIPTION: This variable is the Medicare beneficiary race code, modified using an algorithm produced by the RTI.

TYPE: CHAR

LENGTH: 1

SOURCE: Medicare MBSF

VALUES:
0 = Unknown
1 = Non-Hispanic White
2 = Black (Or African American)
3 = Other
4 = Asian/Pacific Islander
5 = Hispanic
6 = American Indian/Alaska Native
Null/missing = not Medicare enrolled

COMMENT: CCW obtains this directly from the MBSF RTI_RACE_CD variable.

CCW creates this variable for the MBSF by taking the beneficiary race code that has historically been used by the Social Security Administration (and is in turn used in CMS's enrollment data base) and applying a CMS-approved algorithm that identifies more beneficiaries as Hispanic or Asian.

^ Back to TOC ^

MDCR_SNF_MOS

LABEL: Medicare — Skilled Nursing Facility Months (from Claims)

DESCRIPTION: This variable is the total count of months during the year where the beneficiary was in a skilled nursing facility (SNF), according to Medicare claims. A hierarchical algorithm is used, so that SNF is only counted for the month if there is not a Medicare long-term care hospital claim.

TYPE: NUM

LENGTH: 8

SOURCE: Medicare Skilled Nursing Facility claims (derived)

VALUES: 1–12, or null/missing (if no Medicare enrollment)

COMMENT: CCW uses Medicare SNF claims for this variable.

CCW creates Medicare Timeline file to identify the type of facility or level of acuity of care received by the beneficiary each day. Using CMS rules, CCW employs a hierarchy of claims and MDS assessment data. If the beneficiary does not have Medicare claims for inpatient hospitalization, then CCW determines if there are Medicare claims for skilled nursing facility (SNF). For MMLEADS, CCW calculates the number of months during the year when the beneficiary was in a SNF. Note that the number of months with a Medicare long-term care hospital (LTCH) claim or when there was not LTCH or SNF claims, but there was a Minimum Data Set (MDS) assessment are captured in the MDCR_LTCH_MOS and MDCR_NF_MOS variables, respectively.

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MDCR_STATE_CD

LABEL: Medicare — State Code — FIPS

DESCRIPTION: This field specifies the state Federal Information Processing Standard (FIPS) code for the Medicare beneficiary.

TYPE: CHAR

LENGTH: 2

SOURCE: MBSF (derived)

VALUES: 2-digit FIPS (e.g., 17) or null/missing (if no Medicare enrollment)

01 = Alabama
02 = Alaska
04 = Arizona
05 = Arkansas
06 = California
08 = Colorado
09 = Connecticut
10 = Delaware
11 = District of Columbia
12 = Florida
13 = Georgia
15 = Hawaii
16 = Idaho
17 = Illinois
18 = Indiana
19 = Iowa
20 = Kansas
21 = Kentucky
22 = Louisiana
23 = Maine
24 = Maryland
25 = Massachusetts
26 = Michigan
27 = Minnesota
28 = Mississippi
29 = Missouri
30 = Montana
31 = Nebraska
32 = Nevada
33 = New Hampshire
34 = New Jersey
35 = New Mexico
36 = New York
37 = North Carolina
38 = North Dakota
39 = Ohio
40 = Oklahoma
41 = Oregon
42 = Pennsylvania
44 = Rhode Island
45 = South Carolina
46 = South Dakota
47 = Tennessee
48 = Texas
49 = Utah
50 = Vermont
51 = Virginia
53 = Washington
54 = West Virginia
55 = Wisconsin
56 = Wyoming
60 = American Samoa
66 = Guam
68 = Florida
69 = Commonwealth of the Northern Mariana Islands
72 = Puerto Rico
78 = U.S. Virgin Islands
99 = Other/unknown
Null/missing = source value is missing or unknown

COMMENT: CCW derives this variable from the MBSF monthly state/county FIPS code (source variables called STATE_CNTY_FIPS_CD_01–12).

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MDCR_TOTAL_FFS_SPEND

LABEL: Medicare FFS Payment Amount — Total

DESCRIPTION: This variable is the total Medicare payment amount for all Medicare fee-for-service (FFS) claims and Part D events (PDEs) for the beneficiary during the year. Note that only fee-for-service (FFS) claims for services and PDEs are included.

TYPE: NUM

LENGTH: 8

SOURCE: Medicare Claims Files (derived)

VALUES: $

COMMENT: CCW calculates this variable as the sum of all CLM_PMT_AMT from the IP, SNF, HHA, Hospice, HOP, Carrier, and DME claims as well as the TOT_RX_CST_AMT for all PDEs for the beneficiary for the year.

Within MMLEADS, there are four variables that also sum to this MDCR_TOTAL_FFS_SPEND: MDCR_PTA_TOTAL_FFS_SPEND, MDCR_HOP_TOTAL_FFS_SPEND, MDCR_PTBNI_TOTAL_FFS_SPEND, and MDCR_PTD_TOTAL_SPEND.

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MDCR_TOTAL_FFS_USE

LABEL: Medicare Use (FFS Claim Count) — Total

DESCRIPTION: This variable is the total count of claims for all Medicare fee-for-service (FFS) claims and Part D events (PDEs) for the beneficiary during the year. Note that only fee-for-service (FFS) claims for services and PDEs are included.

TYPE: NUM

LENGTH: 8

SOURCE: Medicare Claims files (derived)

VALUES: XX

COMMENT: CCW calculates this variable as the count of all claims from the IP, SNF, HHA, Hospice, HOP, Carrier, and DME claims as well as the count of PDEs for the beneficiary for the year.

Within MMLEADS, there are four variables that also sum to this MDCR_TOTAL_FFS_USE: MDCR_PTA_TOTAL_FFS_ USE, MDCR_HOP_TOTAL_FFS_ USE, MDCR_PTBNI_TOTAL_FFS_ USE, and MDCR_PTD_TOTAL_USE.

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MDCR_TOTAL_FFS_USE_01

MDCR_TOTAL_FFS_USE_02

MDCR_TOTAL_FFS_USE_03

MDCR_TOTAL_FFS_USE_04

MDCR_TOTAL_FFS_USE_05

MDCR_TOTAL_FFS_USE_06

MDCR_TOTAL_FFS_USE_07

MDCR_TOTAL_FFS_USE_08

MDCR_TOTAL_FFS_USE_09

MDCR_TOTAL_FFS_USE_10

MDCR_TOTAL_FFS_USE_11

MDCR_TOTAL_FFS_USE_12

LABEL: Medicare Use (FFS Claim Count) — January–December (01–12)

DESCRIPTION: This variable is the total count of claims for each month for all Medicare fee-for-service (FFS) claims and Part D events (PDEs) for the beneficiary. Note that only fee-for-service (FFS) claims for services and PDEs are included.

TYPE: NUM

LENGTH: 8

SOURCE: Medicare Claims files (derived)

VALUES: XX

COMMENT: CCW calculates this variable as the count of all claims from the monthly Inpatient, Skilled Nursing Facility, Home Health, Hospice, Hospital Outpatient, Carrier, and DME claims as well as the count of Part D Prescription Drug Events for the beneficiary.

Within MMLEADS, there are monthly variables that sum the total payments (the CLM_PMT_AMT field) for capitated payments (the MDCR_MC_PTA_PTB_CAPTD_SPEND_01–12). There are monthly totals that include the sum of the FFS claims (these claims) and capitated payments (MDCR_TOTAL_SPEND_01–12).

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MDCR_TOTAL_SPEND

LABEL: Medicare Payment Amount — Total

DESCRIPTION: This variable is the total Medicare payment amount for all Medicare fee-for-service (FFS) claims, Part D events (PDEs), and Medicare Advantage capitated payments for the beneficiary during the year.

TYPE: NUM

LENGTH: 8

SOURCE: Medicare Claims files and MARx file (derived)

VALUES: $

COMMENT: CCW calculates this variable as the sum of all CLM_PMT_AMT from the IP, SNF, HHA, Hospice, HOP, Carrier, and DME claims, plus the TOT_RX_CST_AMT for all PDEs, plus the MA capitated premium payments (MAPMT_AMT from the source MARx data) for the beneficiary for the year.

Within MMLEADS, there are five variables that also sum to this MDCR_TOTAL_ SPEND: MDCR_PTA_TOTAL_FFS_SPEND, MDCR_HOP_TOTAL_FFS_SPEND, MDCR_PTBNI_TOTAL_FFS_SPEND, MDCR_PTD_TOTAL_SPEND and MDCR_MC_PTA_PTB_CAPTD_SPEND.

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MDCR_TOTAL_SPEND_01

MDCR_TOTAL_SPEND_02

MDCR_TOTAL_SPEND_03

MDCR_TOTAL_SPEND_04

MDCR_TOTAL_SPEND_05

MDCR_TOTAL_SPEND_06

MDCR_TOTAL_SPEND_07

MDCR_TOTAL_SPEND_08

MDCR_TOTAL_SPEND_09

MDCR_TOTAL_SPEND_10

MDCR_TOTAL_SPEND_11

MDCR_TOTAL_SPEND_12

LABEL: Medicare Payment Amount — January–December (01–12)

DESCRIPTION: This variable is the total Medicare payment amount for each month for all Medicare fee-for-service (FFS) claims, Part D events (PDEs), and Medicare Advantage capitated payments for the beneficiary.

TYPE: NUM

LENGTH: 8

SOURCE: Medicare Claims files and MARx file (derived)

VALUES: $

COMMENT: CCW calculates this variable as the sum of all CLM_PMT_AMT from the IP, SNF, HHA, Hospice, HOP, Carrier, and DME claims, plus the TOT_RX_CST_AMT for all PDEs, plus the MA capitated payments (refer to MMLEADS variable MDCR_MC_PTA_PTB_CAPTD_SPEND_01-12) for the beneficiary for each month.

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MME_TYPE_CD

LABEL: Medicare — Medicaid Eligibility Type Code: Annual Dual Eligibility Status

DESCRIPTION: This variable is the annual indicator of the beneficiary's Medicare-Medicaid eligibility type code. CCW creates this variable using a hierarchy that is the maximum value of the monthly MME_TYPE_CD_*MM*.

TYPE: NUM

LENGTH: 8

SOURCE: MBSF/T-MSIS DE file (derived) (derived)

VALUES:
1 = Medicaid only — Aged/Blind/or Disabled (A/B/D)
2 = Medicare only
3 = Partial Dual
4 = Full Dual

COMMENT: MMLEADS also includes the monthly MME_TYPE_CD_01–12.

If the beneficiary has more than one MME_TYPE_CD_01–12 value during the year, then CCW uses the maximum value of the monthly MME_TYPE_CD_*MM*. The hierarchy (and definition of the MME_TYPE_CD) is:

Full dual (MME_TYPE_CD = 4) — the MBSF DUAL_STUS_CD_*MM* in ('02' '04' '08');

Partial dual (MME_TYPE_CD = 3) — the MBSF DUAL_STUS_CD_*MM* in ('01' '03' '05' '06');

Medicare only (MME_TYPE_CD = 2) — the MBSF DUAL_STUS_CD_*MM* = '00' '09' 'N/A' 'NA' '99' and MDCR_BUY_IN in ('1' '2' '3' 'A' 'B' 'C') then (Medicare Only); or else if

Medicaid only A/B/D (MME_TYPE_CD = 1) — the T-MSIS DE File ELIGBLTY_GRP_CD_*MM* IN ('11' '12' '13' '14' '15' '16' '17' '18' '19' '20' '21' '22' '23' '24' '25' '26' '37' '38' '39' '40' '41' '42' '43' '44' '45' '46' '47' '48' '49' '50' '51' '52' '59' '60' '69').

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MME_TYPE_CD_01

MME_TYPE_CD_02

MME_TYPE_CD_03

MME_TYPE_CD_04

MME_TYPE_CD_05

MME_TYPE_CD_06

MME_TYPE_CD_07

MME_TYPE_CD_08

MME_TYPE_CD_09

MME_TYPE_CD_10

MME_TYPE_CD_11

MME_TYPE_CD_12

LABEL: Medicare-Medicaid Eligibility Type Code: Dual Eligibility Status — January–December (01–12)

DESCRIPTION: This variable is the monthly indicator of the beneficiary's Medicare-Medicaid eligibility type code. CCW creates this variable using a hierarchy that gives priority to full benefit dual status over other types of enrollment.

TYPE: NUM

LENGTH: 8

SOURCE: MBSF/T-MSIS DE file (derived) (derived)

VALUES: 1 = Medicaid only— Aged/Blind/or Disabled (A/B/D) (non-dual)
2 = Medicare only (non-dual)
3 = Partial Dual)
4 = Full Dual
0 = Not MMLEADS population for the month
Null/missing = not enrolled in the month

COMMENT: CCW calculates this variable using the MBSF monthly dual status code (note that these source variables are also included in MMLEADS as MDCR_DUAL_STUS_CD_01–12). If the beneficiary has more than one value during the month (i.e., due to being enrolled in Medicaid in more than one state during the month), then CCW uses the maximum value of the monthly MME_TYPE_CD_*MM*:

If the DUAL_STUS_CD_*MM* in ('02' '04' '08') then MME_TYPE_CD = 4 (full dual); or else

If DUAL_STUS_CD_*MM* in ('01' '03' '05' '06') then MME_TYPE_CD = 3 (Partial duals); or else if

If DUAL_STUS_CD_*MM* = '00' '09' 'N/A' 'NA' '99' and MDCR_BUY_IN in ('1' '2' '3' 'A' 'B' 'C') then MME_TYPE_CD = 2 (Medicare Only); or else if

If the T-MSIS DE File ELIGBLTY_GRP_CD_*MM* IN ('11' '12' '13' '14' '15' '16' '17' '18' '19' '20' '21' '22' '23' '24' '25' '26' '37' '38' '39' '40' '41' '42' '43' '44' '45' '46' '47' '48' '49' '50' '51' '52' '59' '60' '69') then MME_TYPE_CD = 1

If Medicaid /CHIP enrolled but not Medicaid A/B/D, then MME_TYPE_CD = '0'

If not enrolled in Medicaid/Medicare for the month, then MME_TYPE_CD = '.' (i.e., if the DE CHIP_CD = '.' and ELIGBLTY_GRP_CD = '.' and the MBSF MDCR BUY_IN = '0' 'NA')

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MSIS_ID

LABEL: State Assigned Beneficiary Unique Identifier

DESCRIPTION: This variable is populated with the state-assigned unique identification number used to identify a Medicaid/CHIP enrolled beneficiary and any claims submitted to the system. Also referred to as the Medicaid Statistical Information System Identifier (MSIS_ID). This field is only populated in MMLEADIS if the CCW beneficiary identifier is not populates for the beneficiary.

TYPE: CHAR

LENGTH: 32

SOURCE: T-MSIS DE file

VALUES: Up to 32-character alphanumeric value; null/missing if there is a BENE_ID

COMMENT: Within MMLEADS the CCW beneficiary identifier (variable called BENE_ID), is assigned to all Medicare enrolled, and nearly all Medicaid enrolled beneficiaries. There are some TAF DE records that did not have sufficient identifiers to use for assigning the BENE_ID, therefore it is null/missing. For the records without a BENE_ID, we use the state-assigned MSIS_ID; the MSIS_ID along with the state code (STATE_CD) should be used as the person-level identifier.

^ Back to TOC ^

PD_MOS

LABEL: Partial Dual Months

DESCRIPTION: This variable is the number of months during the year that the beneficiary was dually eligible for partial Medicare-Medicaid benefits

TYPE: NUM

LENGTH: 8

SOURCE: MBSF (derived)

VALUES: 0–12 or null/missing (if no Medicare enrollment)

COMMENT: CCW calculates this variable as the count of months where DUAL_STUS_CD_*MM* in ('01' '03' '05' '06') from the MBSF.

^ Back to TOC ^

RFRNC_YR

LABEL: Reference Year

DESCRIPTION: This variable represents the year of the data file.

TYPE: CHAR

LENGTH: 4

SOURCE: CCW (derived)

VALUES: 2016

COMMENT: Only year possible is 2016.

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SAMPLE_GRP

LABEL: Sample Group Indicator — 1%

DESCRIPTION: This variable is designed to identify 1% random sample of beneficiaries. CCW creates a stratified random sample by state (variable called STATE_CD) and Medicare-Medicaid Enrollee Type (variable called MME_TYPE_CD). CCW designed the sample so that it is representative of each state's data in MMLEADS, and within the state it is representative of the underlying distribution of MME_TYPE_CD.

TYPE: NUM

LENGTH: 8

SOURCE: CCW (derived)

VALUES: 0 = not included in sample
1 = included in 1% sample

COMMENT: Since the MMLEADS files are very large, CCW developed this variable and includes it in MMLEADS as a simple way to test analytic code — or conduct exploratory analyses using a small subset of data.

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SEX_CD

LABEL: Sex (Biological) — Latest in Year

DESCRIPTION: This variable is the (biological) sex code for the beneficiary.

TYPE: CHAR

LENGTH: 1

SOURCE: MBSF/T-MSIS DE file (derived)

VALUES:
0 = Unknown
1 = Male
2 = Female

COMMENT: This variable is populated with the MBSF SEX_IDENT_CD variable. If beneficiary is enrolled only in Medicaid, then we populate the variable with T-MSIS DE variable SEX_CD.

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STATE_CD

LABEL: State Alpha Abbreviation

DESCRIPTION: This variable is the beneficiary state at the end of the year.

TYPE: CHAR

LENGTH: 2

SOURCE: MBSF/T-MSIS DE file (derived)

VALUES: 2-character postal state code

AK = Alaska
AL = Alabama
AR = Arkansas
AZ = Arizona
CA = California
CO = Colorado
CT = Connecticut
DC = District of Columbia
DE = Delaware
FL = Florida
GA = Georgia
HI = Hawaii
IA = Iowa
ID = Idaho
IL = Illinois
IN = Indiana
KS = Kansas
KY = Kentucky
LA = Louisiana
MA = Massachusetts
MD = Maryland
ME = Maine
MI = Michigan
MN = Minnesota
MO = Missouri
MS = Mississippi
MT = Montana
NC =North Carolina
ND = North Dakota
NE = Nebraska
NH = New Hampshire
NJ = New Jersey
NM = New Mexico
NV = Nevada
NY = New York
OH = Ohio
OK = Oklahoma
OR = Oregon
PA = Pennsylvania
PR = Puerto Rico
RI = Rhode Island
SC = South Carolina
SD = South Dakota
TN = Tennessee
TX = Texas
UT = Utah
VA = Virginia
VT = Vermont
WA = Washington
WI = Wisconsin
WV = West Virginia
WY = Wyoming
XX = Other territories or Unknown

COMMENT: This variable is populated with the MBSF STATE_CD variable. If beneficiary is enrolled only in Medicaid, then we populate the variable with the latest MMLEADS monthly state code for the year from the monthly Medicaid submitting state code variables (MDCD_STATE_CD_01–12).

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