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**BPHC Program Cost Analyses Data Support**

**Medicaid Data Documentation**

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**Section 1: Introduction**

Raw Data Files:

We obtained the following data files from CMS:

1. MAX 2009 Personal Summary (PS) file
2. MAX 2009 Inpatient (IP) file
3. MAX 2009 Other Services (OT) file
4. MAX 2009 Drug (RX) file

Data were obtained for the year 2009 for the following states: Alabama (AL), California (CA), Colorado (CO), Connecticut (CT), Florida (FL), Iowa (IA), Illinois (IL), Mississippi (MS), Montana (MT), North Carolina (NC), Texas (TX), Vermont (VT), and West Virginia (WV).

Data were also obtained for Maine (ME) but they were not included in the final files because MAX 2009 IP and OT claims data were not available.

Final Analysis Files:

The final analysis files include two sets of two files each: A1 and A2, and B1 and B2.

Each set of files, A and B, include a file of beneficiaries (benes) who had at least one claim during the year – i.e. those with non zero utilization and a file of benes who had no claims for the year – i.e. those with zero utilization. Together, the two files include all benes in the sample as described in Section 2 below. Both files include bene ID and demographic information about each bene. The utilizers file includes utilization and costs data as well.

The difference between the A and B sets of files is in the treatment of behavioral health care. As described in Section 4, in some states a large percent of benes were enrolled in behavioral health managed care, but received all other care through fee for service. Due to difficulties in clearly identifying behavioral health claims for these individuals, it was impossible to create comparable aggregate cost and utilization variables that would include these benes and the mental health services they received. Therefore, we present one set of files, set A, which includes all benes, but excludes behavioral health, and hence has comparable costs and utilization for all benes. Set B includes mental health costs for those benes who receive those services under fee for services. Those benes who had behavioral health managed care have only a capitation cost for mental health. The user is cautioned that for benes enrolled in behavioral health managed care, costs might therefore be underestimated in this file.

Furthermore, the utilization data for mental health is based on encounter data and may be underreported.

The files are:

**A1.** anlys\_fl2\_rcvd\_care\_nobhv\_rvsd2.sas7bdat: a bene-level analysis file for all benes that had at least one non-behavioral health care episode during the year. All behavioral health care claims have been excluded from this file. See Section 4 for a definition of behavioral health care.

**A2.** analysis\_file2\_no\_care\_ noBhv.sas7bdat: a bene-level analysis file for all benes that received no non-behavioral health care during the year.

**B1.** anlys\_fl2\_rcvd\_care\_rvsd2.sas7bdat: A beneficiary (bene) level analysis file for all benes that had at least one episode of care during the year. This file includes eligibility information, costs, utilization, CDPS (severity) weights and risk variables, PQI, PDI and marker condition indicators, and PCSA/FIPS characteristics. Note: Behavioral health claims were used in the construction of this file.

**B2.** analysis\_file1\_no\_care.sas7bdat: A bene-level analysis file for all benes that received no care during the year, including behavioral health care. This file includes only eligibility information, PCSA/FIPS characteristics, and CDPS weights.

**Section 2: Benes and Claims Dropped from Analysis**

Beneficiaries Dropped from Raw Data Files:

|  |  |
| --- | --- |
| Drop Description | Methodology |
| Benes with missing eligibility data or SCHIP only eligibility | Drop all benes that have MSNG\_ELG\_DATA='1' or ‘2’ in PS file. |
| ESRD benes | Drop all benes that have any of the following:  In OT file: PLC\_OF\_SRVC\_CD=65 (renal dialysis facility) or DIAG\_CD\_1 or DIAG\_CD\_2= ICD-9 codes- '5856' or '28521'. Or,  In IP file: any DIAG\_CD (i.e. DIAG\_CD\_1-DIAG\_CD\_9) = ICD-9 codes- '5856' or '28521'. Or,  In PS file: MDCR\_ORIG\_REAS\_CD = 2 or 3. |
| Transplant benes | Drop all benes that have at least one transplant IP diagnosis code (DIAG\_CD\_1-DIAG\_CD\_9) from the transplant ICD-9 code list that UCI created- see ’ excel file-‘transplant\_dx\_cds.xlsx’. |
| Benes enrolled in demonstrations | Drop all benes served by a provider participating in a demo for at least one month of the year. In PS file: (EL\_MAX\_ELGBLTY\_CD\_LTST=51 or 52 or 54 or 55) or (MAX\_ELG\_CD\_MO\_*X*=51 or 52 or 54 or 55, where *X*=1-12, denoting January-December). |
| Benes with no MAX/CHIP eligible non-MCP member months | Drop all benes in which the only MAX and/or CHIP eligible months are MCP member months (based on Option 4 in Section 3.1 below). |
| Drop benes with PHP\_TYPE=77 claims | Drop all benes that have at least one IP, OT, or RX claim with PHP\_TYPE=77 (i.e. THIS RECORD IS AN ENCOUNTER/CAPITATION RECORD, BUT THERE WAS NO MATCH BETWEEN THE MANAGED CARE PLAN IDENTIFICATION NUMBER' AND THE PLAN IDENTIFIERS IN THE ELIGIBILITY RECORD FOR THIS PERSON IN THIS MONTH) in a MAX/CHIP eligible non-MCP month. See Section 3.2 below for more details. |
| Benes that have at least one claim where PHP\_TYPE=88 and TYPE\_CLM\_CD=2 or 3 | Drop all benes that have at least one IP, OT or RX claim with PHP\_TYPE=88 (i.e. Managed Care Type of Plan= Not Applicable) and TYPE\_CLM\_CD=2 or 3 (i.e. Capitated payment or Encounter respectively). (NOTE: we did not drop PHP\_TYPE=88 and TYPE\_CLM\_CD=Capitated payment in VT). See Section 3.3 for details. |

**Claims Dropped from the OT, IP and RX files, where applicable:**

|  |  |
| --- | --- |
| Drop Description | Methodology |
| Managed care member-month claims | Drop all claims where SRVC\_BGN\_DT is in a Managed Care Plan (MCP) member-month, based on Option 4 in Section 3.1. |
| Dental claims | Drop all claims where PHP\_TYPE=2 (i.e. dental MCP) or MAX\_TOS=9 (i.e. Dental). |
| Claims in months of no eligibility | Drop all claims where SRVC\_BGN\_DT is in a month of no MAX and/or CHIP eligibility. Month *X* is a month of no MAX and/or CHIP eligibility if, in the PS file, MAX\_ELG\_CD\_MO\_*X*=00 or 99 and EL\_CHIP\_FLAG\_*X*=0 or 9, where X=1-12, i.e. January-December. |
| Drop claims with service year not in 2009 | Drop all claims where the year of SRVC\_BGN\_DT is not 2009. |
| Drop all Transportation claims | Drop all OT claims where MAX\_TOS=26 or POS=41 or 42. See MAX OT Data Dictionary. |

**Section 3: Methods for Dealing with Managed Care, Capitated Payments and Encounters**

Section 3.1: Methods for Dropping Managed Care Member Months

We used the 2009 Medicaid PS file (bene-level file) in calculating % managed care benes and member-months to drop.

The Managed Care Plan type codes in the MAX files are:

1. Comprehensive
2. Dental
3. Behavioral\*
4. Prenatal/Delivery
5. Long-term care
6. PACE
7. Primary Care Case Management (PCCM)
8. Other\*\*

88. Not enrolled in MCP

99. Unknown (these make up approximately 1.7% of benes and when looking at the outpatient claims for benes with unknown MCP, 43% were encounter claims while the other 57% were capitated payment claims).

\* In states like CO, FL, and IA there are a lot of benes enrolled in a behavioral MCP that do not have behavioral managed care claims. Hence, we did not exclude benes who were enrolled in behavioral MCPs but created a flag for them.

\* \*MCP=Other in MS is a non-emergency transportation service that nearly all MS Medicaid benes are enrolled in. In NC, MCP=Other is a MCP that offers services like radiation therapy, cardiac imaging and ultrasounds that around 54% of NC Medicaid benes are enrolled in November and December only. Hence, benes in MS and NC that are enrolled in MCP=Other were excluded.

The yellow highlighted MCP claims report only encounter and capitated payments and the data are not considered reliable and complete. Therefore, we excluded either benes enrolled in these categories or member-months that beneficiaries were enrolled in these categories.

We considered the following options for exclusions:

1. Drop all beneficiaries that are enrolled in an excluded MCP for at least one month during the year. Exclusion rate - **35% of beneficiaries.**
2. Drop all excluded MCP member-months. Exclusion rate - **29% of eligible member months** (An eligible member month is a month in which the bene is eligible for Medicaid and/or S-CHIP).This option will result in keeping non-MCP member –months for beneficiaries that go in and out of managed care. To minimize this issue we have proposed options 3 and 4.
3. Keep all member months up until they switch to an excluded MCP. Exclusion rate - **31% of eligible member months.**
4. Keep all consecutive non-excluded MCP member months from the beginning and end of the year- 30**% of eligible member months.**

For example, a beneficiary has January-February in non-MCP, March in MCP, April in non-MCP, May in MCP and June-December in non-MCP. Option 1 will drop all member-months for this beneficiary, Option 2 will drop only March and May, Option 3 will drop March-December, and Option 4 will drop March-May.

Option 4 is a tradeoff between maximizing the number of member months we retain in the analysis and avoiding cases of those who go in and out of managed care, which may be either errors or a chaotic pattern. We lose less than 1 percentage point of eligible member months compared to the possible maximum – which is Option 2 with 29% dropped.

The decision has been made to adopt Option 4. See Table 1 for state-level figures for each option.

**Table 1: Options for the % Benes/member-months to be dropped based on Managed Care Enrollment**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | % Benes to drop | % eligible member-months to drop | | |
|  | OPTION 1: At least one month in Managed Care (Type: highlighted yellow) | OPTION 2: Drop all highlighted MCP member-months | OPTION 3: Drop all member-months once a bene switches to a highlighted MCP | OPTION 4: Keep all consecutive non-MCP member-months from beginning & end of year |
| Overall | 35% | 29% | 31% | 30% |
| AL | 72% | 67% | 68% | 67% |
| CA | 40% | 36% | 37% | 36% |
| CO | 9% | 7% | 8% | 7% |
| CT | 71% | 63% | 64% | 64% |
| FL | 43% | 32% | 36% | 33% |
| IA | 1% | 0% | 1% | 0% |
| IL | 9% | 7% | 8% | 7% |
| MS | 0% | 0% | 0% | 0% |
| MT | 0% | 0% | 0% | 0% |
| NC | 0% | 0% | 0% | 0% |
| TX | 49% | 39% | 43% | 41% |
| VT | 0% | 0% | 0% | 0% |
| WV | 52% | 45% | 47% | 46% |

Section 3.2: Methods for Dropping Medicaid Beneficiaries with Missing Managed Care Plan ID

We have excluded all member-months for benes enrolled in a MCP based on the methods explained in Section 3.1, using Option 4. However, even after excluding these member months we still found MCP claims in the utilization files.

We took a 5% sample of benes (1 million benes) and examined all of their Inpatient (IP) and Other Services (OT) claims after dropping all bene MCP member month claims (based on option 4 in Section 3.1). Of the OT claims, approximately 10% had MCP Type Code=77 (SAS variable name: PHP\_VAL), i.e. this record is an encounter/capitation record, but there was no match between the MCP identification number and the plan identifiers in the eligibility record for this person in this month. Of the IP claims, approximately 0.3% have MCP Type Code=77.

For the benes with these claims, the MCP enrollment information in the Personal Summary (PS) file gives no indication that these benes are enrolled in MCPs and hence they were not picked up in our initial MCP enrollment analysis. We also cannot get a lot of information about these claims since Type of Service (TOS) and Place of Service (POS) are not available and in most cases procedure codes and diagnosis codes are also not available.

In terms of eligible member-months left after the original MCP drop, approximately 27% are member months for benes that have at least one IP or OT claim with MCP Type Code=77 (see state-level figures in Table 2). When we examined all claims for these benes, we found that some benes had only MCP Type=77 claims while most had a mix of both FFS claims and MCP Type=77 claims.

Given the fact that there is very little information about these claims and we have no data on the enrollment patterns in and out of these unknown MCP types we dropped all benes that have at least one IP or OT claim where MCP type=77.

We also dropped all benes that had at least one RX claim with MCP type=77. Of the RX claims, approximately 0.1% have MCP Type Code=77 and an additional 0.1% of eligible member-months are dropped when we drop all benes that have at least one RX claim with MCP Type Code=77.

**Table 2: Medicaid 2009 5% sample of benes - Analysis of member months for benes with OT or IP claims where Managed Care Plan (MCP) type code=77**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| State | % of MAX/CHIP eligible member-months dropped in original MCP analysis (Section 3.1) | Of the eligible months left, % dropped if we drop all eligible member months for benes that have at least one OT or IP claim with MCP code=77 |  | Total % of MAX/CHIP eligible member-months left after both MCP drops |
| Overall | 30% | 27% |  | 51% |
| AL | 67% | 2% |  | 32% |
| CA | 36% | 3% |  | 62% |
| CO | 7% | 13% |  | 81% |
| CT | 64% | 0% |  | 36% |
| FL | 33% | 19% |  | 54% |
| IA | 0% | 40% |  | 60% |
| IL | 7% | 69% |  | 29% |
| MS | 0% | 0% |  | 100% |
| MT | 0% | 59% |  | 41% |
| NC | 0% | 73% |  | 27% |
| TX | 41% | 3% |  | 57% |
| VT | 0% | 4% |  | 96% |
| WV | 46% | 0% |  | 54% |

Section 3.3: Non-Managed Care Plan Claims that are Capitated Payments or Encounters:

In a 5% sample of the OT file (after all exclusions above have been made), approximately 0.5% of claims have PHP\_TYPE=88 (i.e. Not Applicable) and TYPE\_OF\_CLM=2 or 3 (i.e. Capitated Payments or Encounters respectively). There are minimal occurrences of this in most states. However, in VT, approximately 90% of benes have capitated payments for non-MCP OT claims. Using the MSIS state anomalies report, we found that VT pays a capitation fee per member per month ($5) to bene’s primary care provider for case management and administration. We have not excluded these benes in VT but we have excluded all benes in other states that have at least one of these OT claims. This drop affected TX the most, by dropping approximately 5% of TX benes. Note: this is 5% of TX benes left after all other exclusions described above have been made.

In a 5% sample of the IP file, approximately 0.2% of claims have PHP\_TYPE=88 (i.e. Not Applicable) and TYPE\_OF\_CLM=3 (i.e. Encounters). 90% of these claims occur in AL and all of which have a Medicaid payment amount= $0 and a Prepaid Plan Service Value (i.e. encounter cost) = $0. We have dropped all benes with these IP claims from the analysis.

There are no claims of this sort in the RX file.

**Section 4: Definition of Behavioral Health Claims**

We have defined a claim to be a behavioral health claim if it satisfies any of the following criteria:

In the OT file:

1. Place of Service (POS) code=51-56. Or,
2. MAX Type of Service (TOS) code=2, 4, 5, or 53. Or,
3. Managed Care Type of Plan code (PHP\_TYPE) =3. Or,
4. Primary Diagnosis Code=29X, 30X, or 31X.

In the IP file:

1. MAX Type of Service (TOS) code=2, 4, 5, or 53. Or,
2. Managed Care Type of Plan code (PHP\_TYPE) =3. Or,
3. Primary Diagnosis Code=29X, 30X, or 31X.

In the RX file:

1. Managed Care Type of Plan code (PHP\_TYPE) =3. Or,

**Section 5: Methods for Identifying FQHCs and FQHC claims**

Section 5.1: Identification of FQHC Sites and Grantees

We used 8 different methods for finding NPIs for Health Centers (HC) grantees and sites in the 14 Medicare (MC) & Medicaid (MA) states only – AL, CA, CO, CT, FL, IA, IL, ME, MS, MT, NC, TX, VT, and WV. We then merged the 8 datasets and dropped all duplicates. This document explains each of the 8 methods separately and then explains the way the 8 methods were merged together.

Methods of Identifying FQHCs

1. **FQHC/RHC Cost Report 2009 – NPPES**

Note: The Costs Reports (CR) consist of 2 datasets- 1) The cost reports of all independent rural health clinics (RHCs) and freestanding FQHCs, these we will denote as “CR grantees” (we omitted the RHCs from the data) and 2) a consolidated cost report dataset which includes the cost reports of the sites of those grantees which furnish Medicare (MC) services to a CR grantee. We will denote these sites as CR sites. The consolidated cost reports contain both the MC provider number of the site and of the corresponding CR grantee.

The cost report data of CR grantees were merged with the NPPES (the NPI master file) data by MC provider number. The NPPES file contains up to 50 provider ids for each observation. There is also a provider id type code for each of these 50 provider ids (such as MA, MC UPIN, MC Oscar, MC NSC, Other), however these code types do not appear to be very reliable, so we tried to match cost report MC provider number to NPPES provider numbers regardless of code type. First, we merged the MC provider number from the cost reports to provider id 1 from NPPES and verified that each of the matches were legitimate matches, based on visual inspection of the names and addresses. The remaining cost report observations that did not ‘legitimately’ merge to NPPES by provider id 1 were then matched to provider id 2. This process was repeated up to provider id 14. Provider ids 15-50 contain only 2 digits, hence they did not match with the MC provider ids in the cost reports. The remaining observations whose CR MC provider numbers could not be ‘legitimately’ matched to the 14 NPPES provider numbers were retained and we tried to match these observations by CR name to NPPES legal business name. Observations that still did not match were lastly merged by CR name to NPPES other business name.

Of the 456 CR grantees, 424 (93%) were successfully matched to NPPES (giving us 584 ‘sites’ since some MC provider numbers matched to more than one NPI). These were retained and matched to the 438 UDS grantees in the 14 MC & MA states by visual inspection of names and address in CRs and UDS. 339 UDS grantees were matched to the CR grantees (509 sites-hence we have found at least one NPI for 339 of the UDS grantees based on the match with CR grantees). All non-matches were dropped. Those were Tribal and Look Alike HCs for the most part. Note: there were no CRs for MT so FQHCs in MT had to be identified by other methods later on (methods 3-8).

1. **Consolidated Cost Report 2009 – NPPES**

A similar method was used to match CR site MC provider number to NPPES. First, CR site MC provider number was matched to NPPES provider id 1 and then to provider id 2 up to 14. All matches were retained and then matched to UDS grantees by the MC provider number of the CR grantee. All non-matches to UDs were dropped. From this match we identified 932 sites corresponding to 193 UDS grantees. There were some duplicate NPIs because it can sometimes be the case that several sites have the same NPI, so duplicates were not dropped. Note: there were no consolidated CRs for IA, IL, FL and MT so they had to be identified by other methods later on (methods 3-8).

1. **Google Search**

There were 36 UDS grantees that could not be identified based on methods 1, 2, 4 and 5 of identifying HCs (methods 4 and 5 are described below). We did a Google search to find NPIs for these 36 HCs by UDS grantee or site name and address (UDS site info was obtained from snapshot 5B 2009). 106 NPIs were found that matched to the 36 HCs. These 106 NPIs were merged with the NPPES data by NPI.

1. **HRSA’s NPI List**

We used HRSA’s NPPES match from July 2011 (NPI-FINAL-7 PM-7-15-11 UPDATED CONSOLIDATED N.xlsx tab-Consolidated list of NPIs). This match was based on the following conditions:

1) UDS Grantee Name = NPPES Legal Business Name, UDS Physical/ Mailing City = NPPES Business Practice Location City, UDS Physical/Mailing State = NPPES Business Practice Location State, UDS Physical/Mailing City = NPPES Provider Business Mailing City, UDS Physical/Mailing State = NPPES Provider Business Mailing State or

2) UDS Grantee Site Name = NPPES Legal Business Name, UDS Site Physical/Mailing City = NPPES Business Practice Location City, UDS Site Physical/Mailing State = NPPES Business Practice Location State, UDS Site Physical/Mailing City = NPPES Provider Business Mailing City, UDS Site Physical/Mailing State = NPPES Provider Business Mailing State.

Only observations with UDS state in one of the 14 states of interest were retained and all duplicate NPIs were deleted. Hence, 1,893 sites/grantees were identified and matched to NPPES.

1. **UDS Name**

There were 16 UDS grantees that had no matches after methods 1-4. These 16 grantees were matched to NPPES based on name and state, UDS name=NPPES legal business name and UDS state= NPPES physical state. 75 sites were identified for these 16 UDS grantees.

1. **MAXPC**

The 438 UDS grantees were matched with MAXPC based on name, UDS name=MAXPC Business Name and MAXPC Business State = State of one of the UDS sites corresponding to the UDS grantee (some UDS grantees have sites in more than one state), the legitimacy of matches was also checked visually. All duplicate NPIs were dropped and the NPIs found in the match were merged with NPPES. 1,821 sites for 378 UDS grantees were found based on this match.

Method for Merging the 6 Datasets

The CR site dataset was appended onto the CR grantee dataset and all duplicates were dropped, next the Google search dataset was appended onto the new dataset and again all duplicates were dropped. This process was repeated for HRSA’s NPI list, then the UDS name dataset, and then the MAXPC dataset. After combining the 6 datasets we had a total of 3,567 sites.

More Methods of Identifying HCs

1. **NPPES Name**

Using the total 3,567 observations linked to NPPES, we created a dataset with just the UDS info and NPPES Name, physical state and mailing state for each observation. We merged this dataset with the raw NPPES file by NPPES Name and physical or mailing state. 5,183 matches were found and merged back with the 3,567 matches already found. 1,759 new sites were added, giving a total of 5,326 sites.

1. **Taxonomy Code = ‘261QF0400X’ (i.e. FQHCs)**

The raw NPPES file contains up to 15 taxonomy codes, since an agency can specify more than one taxonomy code when they apply for an NPI. Taxonomy codes 3-15 seem to be only 2-digit codes, which do not correspond to the general taxonomy code format, so we ignored them and just focused on taxonomy codes 1 and 2.

We found all NPPES observations where either taxonomy code 1 =’ 261QF0400X’ or taxonomy code 2=’ 261QF0400X’, i.e. all sites where FQHC was listed as one of the two main classifications of the site. A total of 2,428 observations were found, 358 of which were additional to the 5,326 already found. Of the 358 observations, many were Rural, Tribal, and Look Alike HCs. Only 231 were FQHCs and they were appended to the full site list. This gives us a total of 5,557 sites in total after all dataset are combined.

For each observation in the final dataset we have UDS grantee info (UDS number, grantee name and address), NPPES info (NPI, provider ids, taxonomy codes, legal business name, other name, physical and mailing address etc.), a variable indicating the method used to identify the site/grantee (i.e. method 1-8 above).

In the excel file-‘NPIs identification Overview 8 9 12.xlsx’, column G gives the total number of NPIs identified by each of the 8 methods. Column H gives the number of unduplicated NPIs identified by each of the 8 methods (method 2 was the only one in which duplicate NPIs appeared, this occurred because several sites had the same NPI-for example, there could be a UDS grantee with say 3 sites, we identify a unique NPI for each of the 3 sites and also one NPI that corresponds to all three sites). Column I gives the additional NPIs identified after appending the dataset to the previous dataset. Column J gives the cumulative # NPIs found after each merge.

Note: In the raw NPPES file there are variables that indicate which of the two taxonomy codes is the primary taxonomy code for the site. Columns L, M, N give information about the number of observations from each of the 8 methods that have primary taxonomy code= 261QF0400X (i.e. FQHC). The cell highlighted yellow is the total number of sites with primary taxonomy code=FQHC (2,492, 45% of all sites identified). Columns P, Q, R give information about the number of observations from each of the 8 methods where either taxonomy code 1 or taxonomy code 2= 261QF0400X/FQHC. The cell highlighted blue is the total number of sites with taxonomy code 1 or 2=FQHC (2,561, 46% of all sites identified). Columns T, U, V give information on the number of UDS grantees for which sites/grantees have been identified. For example, in line 3, 509 sites are identified for 339 UDS grantees. 307 of these sites have primary taxonomy code=FQHC. This indicates that for at least 32 of the 339, only sites with taxonomy code not equal to FQHC were found.

Note:

* It was not possible to calculate the proportion of sites from snapshot 5B 2009 that were identified because there is no way to link the two files. However, there are 3,519 sites in the 14 states of interest in snapshot 5B and we have found 5,557 sites from our matching (before excluding sites based on taxonomy code).
* We have not excluded any observations based on enumeration date variable.
* For each of the 5,557 observations found we have up to 14 provider ids, each with a provider id type code to indicate if the provider id is a: Medicare UPIN, Medicaid, Medicare Oscar/Certification, Medicare NSC, Medicare PIN, Medicare ID-Type Unspecified or Other. These type codes may not be the most reliable so we cannot assume based on these type codes what kind of provider ids we have available. However, we definitely have MC provider number for the 1,432 CR matches since they provided MC provider number.

Section 5.2: Identifying FQHC sites and Grantees – using Medicare Outpatient files

1. **Updating the NPI master list**

We tried to crosswalk the 5,557 sites and grantees in our final NPI match dataset with the Outpatient (OP) MC claims data.

The OP claims data contains the MC provider number of the organization, the last four digits of which indicate what type of facility the organization is. MC providers whose last four digits are between 1000-1199 or 1800-1989 are FQHCs (however, this includes- FQHCs, rural HCs, look-alikes and tribal HCs). We pulled all claims with FQHC MC Provider numbers (1.15m claims out of the total 16.44m claims) and merged these by provider NPI to our final NPI match dataset.

Out of the 1.15m claims- 1.11m claims (96%) matched to the final NPI match dataset. However, in terms of NPIs, only 1,345 NPIs matched and 1,090 NPIs did not. The 1,090 NPIs that did not match accounted for only 46,150 claims (4%).

Of the 1,090 non matching NPIs only 102 have their physical address in the 14 states of our study. Of those only 2 are NPIs of FQHCs, while the other 100 NPIs are for look-alike and tribal HCs which we excluded. The 2 FQHC sites have been added to our final list.

The other 988 of the 1090 non matching NPIs have physical address outside of the 14 states of interest (these correspond with 25% of the 46,150 claims that did not match to the final NPI match dataset). 36 of these are not FQHC sites (look-alikes and tribal HCs). The other 952 are FQHC sites and have been added to our final list of NPIs. We determined that these 952 were FQHC sites by matching the provider name and physical state to FQHC name and state or site name and site physical state in UDS snapshot 5b 2009 list of FQHC sites; those that did not match using SAS were matched visually.

1. **Verifying taxonomy codes**

We checked the rates, in the Medicare OP claims data, at which 1) providers are claiming they are FQHCs based on taxonomy codes but are not (taxonomy code false positive rate) and 2) providers are claiming to not be FQHCs based on taxonomy codes but are (taxonomy code false negative rate).We are assuming that Medicare provider numbers in the FQHC range are indeed FQHCs, and use it as a gold standard against which to measure the taxonomy codes. We note, however, that the MC provider number can include tribal, rural and look-alikes.

The results are presented in Table 3 and summarized below:

False positive rate: In the OP claims data there are 24,593 unique NPIs, of these, 1,611 NPIs are for providers with primary taxonomy code=FQHC. Of these, 8 NPIs (0.5% of NPIs with primary taxonomy=FQHC) are for providers that are not in fact FQHCs based on MC provider number. Hence, the false positive rate is 0.5%.

False negative rate: Out of the 24,593 unique NPIs in the OP claims data, 2,403 NPIs are for providers with MC provider number in FQHC range. Of these, 800 NPIs are for providers that do not have FQHC taxonomy code. Hence, the false negative rate is 33%.

1. **Final list of FQHC NPIs**

Our final FQHC NPI dataset included the following:

1. 1345 NPIs: these have MC provider number in the FQHC range and they appear in our final NPI match list of 5,557 NPI sites.
2. 2 NPIs: these have MC provider number in FQHC range and correspond to sites in UDS 2009 snapshot 5b of all FQHC sites and grantees.
3. 952 NPIs: these have MC provider number in FQHC range and correspond to sites in UDS 2009 snapshot 5b of all FQHC sites and grantees and have physical address outside of our 14 Medicaid states of interest. However, the claims we have for them are for patients residing in our states, at least for the Medicare analysis. We will not have data for them for the Medicaid analysis. Therefore, they will not be included in the MAX analysis.
4. 7 NPIs: these have MC provider number in FQHC range and correspond to sites in UDS 2009 snapshot 5b of all FQHC sites. These sites were not captured in the 1,345 because these NPIs have been deactivated and are no longer on the NPPES database. (Note that the NPPES is a current file and we obtained it in mid 2012, while trying to match it to FQHCs in 2009).
5. 1545 NPIs: these are in our final NPI match list of 5,557 NPI sites and they have primary taxonomy=FQHC. We should include them because we have shown a very low false positive rate.

* Total NPIs: 3,851 (these include sites from the 14 states (2,899) + FQHC sites from other states that appeared in the MC OP claims data (952)).

(Note: 2009 UDS snapshot 5b of all sites and grantees contains 3,519 sites in the 14 states)

**Table 3: NPI-level Analysis of false positives and false negatives identified by FQHCs taxonomy codes: Medicare Outpatient providers with Medicare provider number in FQHC range as gold standard**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PART I** |  |  | Providers with Primary Taxonomy code not equal FQHC | # NPIs: 22982 |  |  | |  |  |
|  | All OP data |  |  |  |  |  | |  |  |
|  | # NPIs: 24593 |  |  | Providers with Primary Taxonomy code=FQHC and MC provider number in FQHC range | # NPIs: 1603 | |  |  |
|  |  |  | Providers with Primary Taxonomy code=FQHC | # NPIs: 1611 |  |  | |  |  |
|  |  |  |  |  | Providers with Primary Taxonomy code=FQHC and MC provider number not in FQHC range | # NPIs: 8 | | False Positive Rate | 0.50% |
|  |  |  |  |  |  |  | |  |  |
|  |  |  |  |  |  |  | |  |  |
| **PART II** |  |  | OP claims with MC provider number not in FQHC range | # NPIs: 22190 |  |  |  | |  |
|  |  |  |  |  |  |  | |  |  |
|  | All OP data | # NPIs: 24593 |  |  | Providers with MC provider number in FQHC range and Primary Taxonomy=FQHC | # NPIs: 1603 | |  |  |
|  |  |  | OP claims with MC provider number in FQHC range | # NPIs: 2403 |  |  | |  |  |
|  |  |  |  |  | Providers with MC provider number in FQHC range and Primary Taxonomy not equal to FQHC | # NPIs: 800 | | False Negative Rate | 33% |

Section 5.3: Identifying FQHC Claims in the MAX 2009 OT file

In Section 5.2, we came up with a final edited list of 3,851 FQHC NPIs by taking NPIs from both our original list of 5,557 NPIs and NPIs from the MC OP data (where MC provider number was in the FQHC range). These NPIs are all organizational NPIs, so we need each MA OT claim to have an organizational NPI in order to use this method of identifying FQHC claims in the MA OT data.

In the MA OT data, unlike the MC OP data, we do not have an organizational NPI for each claim; we have billing provider number, servicing provider number, and servicing provider NPI. The billing and servicing provider numbers were often the same. We have therefore focused on servicing provider NPIs and billing provider numbers.

Approximately 48% of claims have an organizational servicing provider NPI, approximately 32% have an individual servicing NPI, and approximately 20% have no servicing provider NPI (either missing or a state assigned legacy number).

The billing number for a claim can be either an NPI or a state assigned number. We cross walked the billing numbers with MAXPC to find out if those with a state assigned billing number also had an associated NPI. For those that did, we assumed these NPIs to be the billing provider’s NPIs and verified that they were legitimate NPIs by cross walking them with NPPES (the NPI master file). Approximately 52% of claims have organizational billing provider NPIs, approximately 6% have an individual billing NPI, and approximately 42% have no billing provider NPI (either missing or a state assigned legacy number).

We split the claims into 4 mutually exclusive groups (see excel file-‘Classification of MA OT Claims as FQHC Claims 10.22.12.xlsx’, Part I row 8):

* Group 1: Claims where both the servicing provider NPI and the billing provider NPI are organizational NPIs (37%). (The billing and servicing NPIs may not necessarily be the same.)
* Group 2: Claims where only the servicing provider NPI is an organizational NPI (11%).
* Group 3: Claims where only the billing provider NPI is an organizational NPI (15%).
* Group 4: Claims where neither provider NPI is an organizational NPI (37%).

For Groups 1-3 (63% of OT claims) we can use our FQHC list to identify FQHC claims. We can also calculate false positive and false negative rates of FQHC classification based on a variable - Type of Program (TOP) which indicates if the service was provided under a special type of program. Codes for the TOP variable are as follows:

* 0 = NO SPECIAL PROGRAM
* 1 = EARLY PERIODIC SCREENING DIAGNOSIS AND TREATMENT (EPSDT)
* 2 = FAMILY PLANNING
* 3 = RURAL HEALTH CLINIC
* 4 = FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs)
* 5 = INDIAN HEALTH SERVICES
* 6 = HOME AND COMMUNITY BASED CARE FOR DISABLED ELDERLY AND INDIVIDUALS AGE 65 AND OLDER
* 7 = HOME AND COMMUNITY
* 9 = UNKNOWN

**Group 1**

For Group 1, we matched both billing and servicing organization NPIs to a list of 6,518 possible FQHC NPIs (based on the original list of 5,557 possible FQHC NPIs + 961 additional FQHC NPIs found in the Medicare OP claims data). We split this NPI list in two, the 3,851 ‘keeper’ FQHC NPIs (we are confident that these are FQHC NPIs) and 2,667 FQHC ‘non-keeper’ NPIs (these we are not very confident in but they are associated in some way to an FQHC, see excel file-NPIs identification Overview 8 9 12.xlsx). We have assumed that all claims with a servicing and/or billing NPI in the FQHC keeper list should be classified as FQHC claims. For these claims, 85% have TOP=4=FQHC, hence the false negative rate of TOP classification is 15% (note: 9% out of the 15% have TOP=Family Planning).

For claims with a servicing and/or billing NPI from the non-keeper list, we need further validation that these claims are in fact FQHC claims. We used the TOP variable for this purpose. We assumed that all claims with a servicing and/or billing NPI from the non-keeper list and TOP=4=FQHC should be classified as FQHC claims. For these claims, only 18% have TOP=4=FQHC, thus suggesting that a lot of these NPIs are not FQHC NPIs.

Claims that have neither a servicing nor billing NPI in the list of 6,518 NPIs, were not classified as FQHC claims even if TOP=FQHC, as this may result in classifying a lot of Tribal and look-alike health center claims as FQHC claims (on visual inspection of a sample of the NPIs for these claims, over half were look-alikes).

**Group 2**

For Group 2, we used a similar method as that for Group 1, but we used only servicing NPI. We classified the following claims as FQHC claims:

1. all claims where the servicing NPI is in the keeper list. These claims have a false negative TOP=FQHC classification of 12%.
2. all claims where the servicing NPI is in the non-keeper list and TOP=4=FQHC.

**Group 3**

For Group 3, we used a similar method as that for Group 1, but we used only billing NPI. We classified the following claims as FQHC claims:

1. all claims where the billing NPI is in the keeper list. These claims have a false negative TOP=FQHC classification of 45%. Note that this is much higher than that for Groups 1 and 2, thus suggesting that billing provider NPI may not be as reliable as servicing provider NPI.
2. all claims where the billing NPI is in the non-keeper list and TOP=4=FQHC.

**Group 4**

For Group 4, we cannot use the FQHC list to classify NPIs. We classified the following claims as FQHC claims:

1. all claims where TOP=4=FQHC (12% of Group 4 claims).

This criterion may result in us falsely classifying look-alike and Tribal health centers as FQHCs in Group 4. If we assume the false positive rate is similar to that for Groups 1-3 (approximately 11%) then overall, we will be facing a false positive rate of FQHC classification of approximately 1.3% (11% of 12%,) since Group 4 is the only group in which false positives are an issue because we will not be classifying the false positives in Groups 1-3 as FQHC claims.

For Group 4 we also have a problem with false negatives. If we assume the false negative rate is similar to that for Groups 1-3 (approximately 22%, even though Group 3 is increasing the rate significantly) then we will be facing an overall rate of false negative FQHC classification of approximately 8% (22% of 37%). This rate is an underestimate since there are probably some false negatives in Groups 1-3 also.

**Proposal to reclassify “non keepers” as “keeper” NPIs.**

We also propose to increase the final list of ‘keeper” FQHC NPIs to include in addition to the current 3,851 NPIs those ‘non-keeper’ NPIs which have claims with TOP=FQHC.

There are 783 unique non-keeper NPIs (either servicing or billing) in the MAX OT claims. The distribution of TOP=FQHC among these NPIs is as follows:

Number of NPIs percent of claims with TOP=FQHC

602 0%

16 0%-50%

35 50%-90%

130 greater than 90%

We therefore propose to add all ‘non-keeper’ NPIs with TOP=FQHC (181 NPIs) to the list of “keeper’ NPIs.

Note: this list will be used for the Medicare analysis as well.

**Section 6: Methods for Dealing with Claims that were not Successfully Adjusted**

Section 6.1: Claims that were not Successfully Adjusted

In the OT, IP and RX claims data there is a variable- adjustment code, which can have the following values:

1. The claim did not require adjustment.
2. The claim was successfully adjusted.
3. It was not possible to correctly complete the adjustment process.

For claims with an adjustment code of 2, indicating that they have not been successfully adjusted, there is no additional information to determine which part of the claim is erroneous. Therefore, all elements of the claim are suspect. The frequency of adjustment code=2 (adj2) claims varies significantly by state (see Table 4).

**OT Data**

CO, FL, MT, TX have the highest number of adj2 claims in the OT data. In CT, most of these claims have Type of Service (TOS) Code= targeted case management or rehabilitation services or durable medical equipment (DME) or residential care or X-ray/Lab. In FL most of the adj2 claims have TOS Code= outpatient hospital or X-ray/Lab or other services. In MT most of the adj2 claims have TOS Code= other services or psychiatric services. In TX most of the adj2 claims have TOS Code= physician or X-ray/Lab or PCCM capitated payments or DME.

When we compared the Medicaid costs for adj2 vs. non-adj2 claims by state and TOS, we found that the costs are generally significantly different in one direction or another. Mostly, adj2 claims have larger costs than non-adj2 claims by between 20-200%. In MT however, for TOS=psychiatric services, the mean cost for adj2 claims are approximately 30% lower than non-adj2 claims.

**IP Data**

There are a high number of IP adj2 claims in CT, FL, IA, IL, NC, and TX. For these states, when we compared the Medicaid IP cost by state for adj2 vs. non-adj2 claims, we found that for all states but IL and NC, the average Medicaid IP cost is between 50% -100% larger for adj2 claims and the median cost is between 50%-400% large for adj2 claims. For IL and NC, the mean cost for adj2 claims are approximately 75% and 150% smaller than non-adj2 claims respectively and the median cost for adj2 claims are approximately 3000% and 100% smaller respectively.

**RX Data**

There are very few adj2 claims in the RX data.

**Table 4: Frequencies of Claims with Adjustment code=2 by State**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
|  | State | OT | IP | RX |
|  | Overall | 2% | 6% | 0% |
|  | AL | 0% | 1% | 0% |
|  | CA | 0% | 0% | 0% |
|  | CO | 1% | 0% | 0% |
|  | CT | 5% | 19% | 0% |
|  | FL | 6% | 26% | 0% |
|  | IA | 2% | 8% | 2% |
|  | IL | 1% | 6% | 0% |
|  | MS | 0% | 0% | 0% |
|  | MT | 7% | 0% | 0% |
|  | NC | 0% | 16% | 0% |
|  | TX | 4% | 3% | 0% |
|  | VT | 0% | 0% | 0% |
|  | WV | 0% | 0% | 0% |

Section 6.2: Imputing Costs for Claims that were not Successfully Adjusted

We imputed the costs for adj2 claims in the OT and IP files. The Medicaid payment amount, third party payment amount and the prepaid plan service value were all imputed, where applicable. However, adj2 claims for duals have not been imputed since we are not confident in the accuracy of costs for duals (see Section 9 for more details). The non-adj2 claims for duals have not been used to impute the costs for adj2 non-dual claims because costs for duals are significantly different from costs for non-duals.

**OT**

In the OT file, we imputed costs for all adj2 claims for non-duals. This was done by calculating the average costs for all non-adj2, non-dual OT claims by state and MAX Type of Service (TOS) and replacing the adj2 claims for non-duals with the appropriate average cost.

**IP**

In the IP file, we imputed costs for all adj2 claims for non-duals. This was done by calculating the average costs for all non-adj2, non-dual IP claims by state, number of Medicaid covered IP days, age, sex, and disability status and replacing the adj2 claims for non-duals with the appropriate average cost. A bene is considered disabled if their latest MAX eligibility code (EL\_MAX\_ELGBLTY\_CD\_LTST) in the PS file =12, 22, 32, or 42.

**Section 7: Classification of Claims in OT file**

In order to calculate costs and utilization we split the OT file as follows:

1. Capitated Claims (Name of file: OT\_Cap):

All OT claims with Type of Claim Code (TYPE\_CLM\_CD) = 2. These are generally per-member-per-month payments to behavioral MCP and PCCM plans. Also, in VT, approximately 90% of benes have capitated claims even though they are not a part of a MCP. Based on the MSIS state anomalies report, we found that in VT, Medicaid pays a capitated fee per-member-per-month ($5) to the bene’s primary care provider for case management and administration.

1. OT claims with POS=IP Hospital (Name of file: OT\_POS\_IP):

All OT claims with POS=21=IP Hospital. Costs for these claims will be included in IP costs.

Notes: 7% of OT claims have POS=IP hospital. Of these, 47% have TOS=Physician and 46% have TOS=X-ray. Most of these claims have one day of service (i.e. SRVC\_END\_DT –SRVC\_BGN\_DT=0). 73% of benes with these OT claims also have at least one IP claims in the IP file. Of the benes that have an IP claim from the IP file, 82% have at least one OT claim with POS=IP Hospital.

OT Emergency Room (ER) claims:

An OT claim is defined as an ER claim if any one of the following is satisfied:

1. POS Code=23=Emergency Room Hospital. Or,
2. UB 92 Revenue Code=450, 451, 452, 456, 459, or 981. Or,
3. Procedure Code=99281-99285, or 99288.

The ER claims were separated into two files based on whether they were associated with an IP admission or not.

1. OT ER claims associated with an IP admission (Name of file: OT\_IP\_ER):

An OT ER claim is associated with an IP admission if the ER claim has the same service begin date (SRVC\_BGN\_DT) as either an IP admission date (ADMSN\_DT) or the day before an IP admission date. The costs for these claims are included in IP costs.

1. OT ER claims not associated with an IP admission (Name of file: OT\_ER):

All OT ER claims that do not have the same SRVC\_BGN\_DT as either an IP ADMSN\_DT or the day before an IP ADMSN\_DT.

1. All OT claims left after dropping the four datasets above (Name of file: OT\_LEFT):

All OT claims left after dropping capitated payment claims, ER claims and ‘POS Code=IP’ claims.

**Section 8: Medicaid Beneficiary Classification into Categories- Federally Qualified Health Centers (FQHC), Outpatient Clinics (OPC), Physician Offices (PO), and Other**

Because FQHCs provide primarily primary care and may send their patients to specialists outside the FQHC, bene categorization into the 4 groups is based only on primary care claims. The methodology was developed on a 5% random sample of the OT\_LEFT file.

**Step I:** **Classification of Claims**

5% of Other Services (OT\_LEFT) claims were classified in two ways: by provider type and by primary vs. specialty care.

Classification by provider type:

We have classified OT\_LEFT claims into one of the four mutually exclusive categories as follows:

1. FQHC claims- based on the classification methods described in Section 5.3.
2. OPC claims- if the claim is not an FQHC claim and has either Place of Service (POS) = Outpatient Hospital or TOS =Outpatient Hospital.
3. PO claims- if the claim is not an FQHC claim and has both POS=Office and TOS=Physician.
4. Other claims= all other claims.

By Care type:

We used the union of two methods for defining primary care: the first was developed by us and the second was adapted from Gurewich with permission.\*\*

**\*\*Note: Deborah Gurewich asked that if we use her CPT codes we acknowledge it in publications. Please remember to do so. Citation: Gurewich D., Tyo K.R., Zhu J., Shepard D.S. “Comparative Performance of Community Health Centers and Other Usual Sources of Primary Care” Journal of Ambulatory Care Management/October–December 2011 Vol. 34, No. 4, pp. 380–390.**

UCI Method:

1. Place of Service (POS) code not highlighted yellow (see Table 5 below), AND
2. MAX Type of Service (TOS) code not highlighted yellow (see Table 5 below) AND
3. Servicing Provider Taxonomy Code not highlighted red (see file ‘spec\_care\_taxonomy 2.11.13.xlsx’ included with Supplementary Documents).

Adapted “Gurewich qualifying FQHC-type claim” Method:

CPT and HCPCS codes for preventative and primary care services that are generally found in an FQHC developed by Gurewich and updated to include additional codes added by 2009 and which were not available in Gurewich but are closely linked to her codes. Typically these are codes expanding on previous codes.

We defined a claim to be a Primary Care (PC) claim if it satisfied either of the following conditions:

1. the claim is a primary care claim based on UCI methodology, OR
2. the claim is a 'Gurewich qualifying FQHC-type claim’.

To get a sense of the type of claims that fell into the PC Other category we looked at the POS and MAX TOS for these claims. The majority had some combination of POS=’Office’ or ‘State or Local Public Health Clinic’ or ‘Rural Health Clinic’ or ‘Unknown/Other’ and MAX TOS=’Physician’ or ‘Clinic’ or ‘Targeted Case Management’.

**Step II: Classification of PC Bene-Days**

A PC bene-day is defined as a bene-day that has at least one PC claim. We classified each PC bene-day into one of the four distinct categories (FQHC, OPC, PO, Other) based on the type of PC claims on that day. 96% of PC bene-days have only PC claims in one of the four categories and hence they are easily classified into that category. For the 4% of PC bene days that have a mix of PC claims we hierarchically classified the bene-day as follows:

1. If there is at least one PC FQHC claim then the day is an FQHC bene-day.
2. Else, if there is at least one PC PO claim then the day is a PO bene-day.
3. Else, if there is at least one PC OPC claim then the day is an OPC bene-day.
4. Else, the day is an Other bene-day.

Note that of the 4% of PC bene days with a mixed of PC claims, 75% of them (i.e. 3% of all PC bene-days) had a mix of Other and PO PC claims only. Based on the hierarchy above, these bene-days were classified as PO days.

**Step III: Classification of Benes**

Finally, we classified benes based on the following criteria:

1. If the bene has no PC bene-days then we classified the bene as a ‘No Use’ bene (15% of benes).
2. If the bene has 1 or more PC bene-days (85% of benes) then we classified the bene based on the % of PC bene-days in each category.
   1. Benes with 75% or more of their PC bene-days in one category are classified as ‘75%+ in Category X’ benes (66% of benes), where Category X is one the following: FQHC/OPC/PO /Other.
      1. 75%+ in FQHC- 10% of benes.
      2. 75%+ in OPC- 6% of benes.
      3. 75%+ in PO- 31% of benes.
      4. 75%+ in Other- 20% of benes.
   2. Benes with 51%-75% of their PC bene-days in one category are classified as ‘51-75% in Category X’ benes (11% of benes), where Category X is one the following: FQHC/OPC/PO /Other.
      1. 51-75% in FQHC- 1% of benes.
      2. 51-75% in OPC- 1% of benes.
      3. 51-75% in PO- 5% of benes.
      4. 51-75% in Other- 4% of benes.
3. Benes with 50% or less of their PC bene-days in one category are classified as ‘<50%’ benes (8% of benes).

**Table 5:**

POS codes not highlighted used to define primary care:

03 = SCHOOL

04 = HOMELESS SHELTER

05 = INDIAN HEALTH SERVICE FREE-STANDING FACILITY

06 = INDIAN HEALTH SERVICE PROVIDER-BASED FACILITY

07 = TRIBAL 638 FREE-STANDING FACILITY

08 = TRIBAL 638 PROVIDER-BASED FACILITY

11 = OFFICE

12 = PATIENT'S HOME

15 = MOBILE UNIT

20 = URGENT CARE FACILITY

~~21 = INPATIENT HOSPITAL~~

22 = OUTPATIENT HOSPITAL

~~23 = EMERGENCY ROOM - HOSPITAL~~

24 = AMBULATORY SURGERY CENTER

25 = BIRTHING CENTER

26 = MILITARY TREATMENT FACILITY

32 = NURSING FACILITY

33 = CUSTODIAL CARE FACILITY

34 = HOSPICE

~~41 = AMBULANCE - LAND~~

~~42 = AMBULANCE - AIR OR WATER~~

50 = FEDERALLY QUALIFIED HEALTH CENTER

51 = INPATIENT PSYCHIATRIC FACILITY

52 = PSYCHIATRIC FACILITY PARTIAL HOSPITALIZATION

53 = COMMUNITY MENTAL HEALTH CENTER

54 = INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED

55 = RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY

56 = PSYCHIATRIC RESIDENTIAL TREATMENT CENTER

60 = MASS IMMUNIZATION CENTER

61 = COMPREHENSIVE INPATIENT REHABILITATION FACILITY

62 = COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY

~~65 = END STAGE RENAL DISEASE TREATMENT FACILITY~~

71 = STATE OR LOCAL PUBLIC HEALTH CLINIC

72 = RURAL HEALTH CLINIC

81 = INDEPENDENT LABORATORY

88 = NOT APPLICABLE (USED WITH TYPE OF SERVICE 20, 21 OR 22)

99 = OTHER (NOT LISTED ABOVE) OR UNKNOWN

**TOS codes not highlighted used to define primary care:**

~~01 = INPATIENT HOSPITAL~~

~~02 = MENTAL HOSPITAL SERVICES FOR THE AGED~~

~~04 = INPATIENT PSYCHIATRIC FACILITY FOR INDIVIDUALS UNDER THE AGE OF 21~~

~~05 = INTERMEDIATE CARE FACILITY (ICF) FOR THE MENTALLY RETARDED~~

~~07 = NURSING FACILITY SERVICES (NFS) - ALL OTHER~~

08 = PHYSICIANS

~~09 = DENTAL~~

10 = OTHER PRACTITIONERS

11 = OUTPATIENT HOSPITAL

12 = CLINIC

13 = HOME HEALTH

15 = LAB AND X-RAY

16 = DRUGS

19 = OTHER SERVICES

~~20 = CAPITATED PAYMENTS TO HMO, HIO, OR PACE PLANS~~

~~21 = CAPITATED PAYMENTS TO PREPAID HEALTH PLANS - PHPs~~

~~22 = CAPITATED PAYMENTS FOR PRIMARY CARE CASE MANAGEMENT - PCCM~~

24 = STERILIZATIONS

25 = ABORTIONS

~~26 = TRANSPORTATION SERVICES~~

30 = PERSONAL CARE SERVICES

31 = TARGETED CASE MANAGEMENT

33 = REHABILITATION SERVICES

34 = PT, OT, SPEECH, HEARING SERVICES

35 = HOSPICE BENEFITS

36 = NURSE MIDWIFE SERVICES

37 = NURSE PRACTITIONER SERVICES

38 = PRIVATE DUTY NURSING

39 = RELIGIOUS NON-MEDICAL HEALTH CARE INSTITUTIONS

51 = DURABLE MEDICAL EQUIPMENT AND SUPPLIES (INCLUDING EMERGENCY RESPONSE SYSTEMS AND HOME MODIFICATIONS)

52 = RESIDENTIAL CARE (DEFINITION CHANGED FOR 2003 AND LATER YEARS - ADDITIONAL INFORMATION IS AVAILABLE ON REQUEST)

53 = PSYCHIATRIC SERVICES (EXCLUDING ADULT DAY CARE)

54 = ADULT DAY CARE

99 = UNKNOWN

Note: Codes that have been struck-through were not present in the OT\_LEFT claims data.

**Section 9: Methods of Calculating Costs and Utilization**

Types of Claims

As described in Section 2, most managed care member months were excluded from the analysis. Benes with no managed care member months after these exclusions, have only fee-for-service claims. Fee-for-service claims were used to calculate both costs and utilization. However, 90% of VT benes who were fee-for-service also had a $5 per member per month capitation cost paid to the primary care physician for case management and administration. These capitation costs were added to the cost but not to the utilization.

PCCM had for the most part, fee-for-service claims as well as a monthly capitation claim. Their costs were based on their fee-for-service claim costs plus the capitation amount. The utilization was based on the fee-for-service claims plus encounter claims, if there were any.

Behavioral health managed care capitation costs were included in total costs and encounters were included in utilization only in file B1 which account for mental health services as well, but not in file A1 which excludes mental health services, as discussed in Section 1.

Types of Costs

In the utilization files (OT, IP, RX) there are several cost variables at the claims level:

1. Medicaid Payment Amount (MDCD\_PYMT\_AMT): the total amount paid by Medicaid for the service.
2. Third Party Payment Amount (TP\_PYMT\_AMT): the total amount paid by a third party (i.e. all sources other than Medicaid, Medicare and the eligible’s personal funds) for the service. The MAX 2009 Claim Anomaly Tables state that: Third-Party Liability (TPL) is not reported on individual claims in some states depending on its TPL collection process. Some states are 'pay and chase' states, sometimes TPL collection is included in managed care contracts, and sometimes it is not collected on an individual claim basis.

2.5% of non-duals have a third party payment while 6.6% of duals have a third party payment. In ‘pay and chase’ states, TPL often shows up in the Medicaid Payment Amount since the state pays first and then seeks to recover payment from the third party. For Duals, it is unclear what this variable represents and caution should be exercised when using this data element for duals.

1. Prepaid Plan Service Value/Encounter costs (PHP\_VAL): Dollar value placed on the service by the provider (available for encounter records only). The MAX 2009 data dictionaries state the following in the Prepaid Plan Service Value user note: Depending on the provider and type of prepaid plan, the dollar amounts in this data element may have different meanings. For example, in an independent practice plan the amount may be a provider’s charge to the plan. In a staff model plan the amount may be a measure of resources used. For this reason, extreme caution should be exercised when using this data element.
2. Medicare Coinsurance Payment Amount (MDCR\_COINSUR\_PYMT\_AMT): the amount paid by Medicaid, for the service for duals, towards the recipient’s Medicare coinsurance liability. NOTE: This variable is not available in the RX file.
3. Medicare Deductible Payment Amount (MDCR\_DED\_PYMT\_AMT): the amount paid by Medicaid, for the service for duals, towards the recipient’s Medicare deductible liability. NOTE: This variable is not available in the RX file.

For all benes, even duals, we have just focused on the first three cost variables since, for duals, variable 1 incorporates variables 4 and 5.

**OT**

From the OT\_LEFT claims file, we calculated bene-level OT costs (Medicaid, third party and encounter costs) and utilization. We split this file into Primary Care (PC) and Secondary Care (SC). PC and SC claims are defined based on the methods described in Section 8. A PC bene-day is defined as a bene-day that has at least one PC claim; otherwise, it is a SC bene-day. PC costs are costs on PC bene-days. Hence, we have assumed that the cost for a SC claim is in fact a PC cost if there is a PC claim on the same day. Note: two claims are on the same bene-day if they have the same SRVC\_BGN\_DT.

Using the OT\_LEFT claims file, we also created rolled-up MAX TOS, POS and TOP variables.

Using the OT\_ER claims file, we calculated bene-level ER costs (Medicaid, third party and encounter costs) and utilization (claims and days).

Using the OT\_Cap file, we calculated the Medicaid payment amount for capitated payments. Note: there were no encounter costs or third party payment amounts for capitated payment claims.

**IP**

We calculated IP utilization based on the IP file only. For each bene, we calculated the number of IP admissions, the total number of Medicaid covered IP days, and the total length of stay (LOS) (where one LOS= SRVC\_END\_DT-SRVC\_BGN\_DT and the total LOS is the sum of all LOS during the year). We also created several rolled-up patient status code variables.

We also looked at IP claims with a missing admission date. Most of these claims are in CA and IL, have no Medicaid covered IP days and have very low costs compared to IP claims with an admission date. The majority of these claims in IL have adjustment code=2, thus indicating that they are probably errors. Those in CA are virtually all for dual-benes and are not adjustment code=2 claims. These are likely to be Medicare observation days. We have created separate utilization and cost variables for IP claims with missing admission date and adjustment code=2 and IP claims with missing admission date and adjustment code not =2, to allow the analyst to decide how to deal with these.

Overall IP costs (denoted: All\_IP) were calculated by adding the IP file costs for IP claims with an admission date, OT\_IP\_ER costs, OT\_POS\_IP costs and IP file costs for claims with missing admission date and adjustment code not = 2.

**RX**

From the RX file, we calculated bene-level RX costs and utilization for all benes.

**Total Costs**

For each file (OT\_LEFT, OT\_ER, All\_IP, RX) there are three cost variables: Medicaid payment amount, third party payment amount and encounter costs. We calculate the total payment amount for each file (OT\_LEFT, OT\_ER, All\_IP, and RX) by summing the Medicaid payment amount and the third party payment amount. (Note OT\_Cap has only one cost variable Medicaid payment amount). Also, caution should be exercised when using the third party payment amount for duals because it is unclear if it is or is not included in the Medicaid payment.

We calculated total Medicaid costs by summing the following Medicaid payment amounts: OT\_LEFT, OT\_ER, OT\_Cap, IP\_All, and RX.

Total third party costs were calculated by summing the following third party payment amounts: OT\_LEFT, OT\_ER, IP\_All, and RX.

Total encounter costs were calculated by summing the following encounter costs: OT\_LEFT, OT\_ER, IP\_All, and RX.

Finally, Total costs were calculated by summing total Medicaid costs and total third party costs.

**Section 10: Ambulatory Care Sensitive Conditions and Risk Variables**

We applied the Prevention Quality Indicators (PQI), Pediatric Quality Indicators (PDI), and marker condition algorithms to the IP data. Note: we created the marker conditions algorithm by adapting the PQI algorithm. See [www.qualityindicators.ahrq.gov](http://www.qualityindicators.ahrq.gov) for more information on PQI and PDI. Marker condition definitions are given in ‘Marker Condition Definitions.docx’.

We applied the CDPS+RX algorithms to the IP, OT and RX data. This resulted in 109 CDPS dichotomous variables and 15 MRX dichotomous variables. We also used weights provided by CDPS to calculate prospective and concurrent weight variables for each bene. See [www.cdps.ucsd.edu](http://www.cdps.ucsd.edu) for more information.

**Section 11: Data Dictionary**

|  |  |
| --- | --- |
| Data Dictionary Layout | |
| # | Variable Number |
| Source File | MAX file used to create variable |
| Var Type | Type of Variable: Elg (Eligibility), Costs, Util (Utilization), Risk, PCSA Chars (PCSA Characteristics), FIPS Chars (FIPS Characteristics) |
| SAS Name |  |
| Num/Char | Numeric or Character variable |
| Ln | Length of variable |
| Label |  |
| Description/Additional Information |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| # | Source File | Var Type | SAS Name | Num/Char | Ln | Label | Description/Additional Information |
| 1 | PS | Elg | uniq\_msis\_id | Char | 35 | Unique Beneficiary ID-MSIS ID & State Code | Combined MSIS\_ID variable and STATE\_CD variable to get unique MSIS Id across all states. |
| 2 | PS | Elg | BENE\_ID | Char | 15 | Encrypted 723 CCW Beneficiary ID | See PS Data Dictionary |
| 3 | PS | Elg | STATE\_CD | Char | 2 | State | See PS Data Dictionary |
| 4 | PS | Elg | EL\_SEX\_CD | Char | 1 | Sex | See PS Data Dictionary |
| 5 | PS | Elg | EL\_RACE\_ETHNCY\_CD | Char | 1 | Race/ethnicity (from MSIS) | See PS Data Dictionary |
| 6 | PS | Elg | EL\_RSDNC\_CNTY\_CD\_LTST | Char | 3 | County of residence | See PS Data Dictionary |
| 7 | PS | Elg | EL\_RSDNC\_ZIP\_CD\_LTST | Num | 8 | Zip code of residence | See PS Data Dictionary |
| 8 | PS | Elg | EL\_MAX\_ELGBLTY\_CD\_LTST | Char | 2 | MAX eligibility - most recent | See PS Data Dictionary |
| 9 | PS | Elg | EL\_ELGBLTY\_MO\_CNT | Num | 3 | Eligible months | See PS Data Dictionary |
| 10 | PS | Elg | EL\_PRVT\_INSRNC\_MO\_CNT | Num | 3 | Private insurance months | See PS Data Dictionary |
| 11 | PS | Elg | EL\_MDCR\_DUAL\_ANN | Char | 2 | Medicare dual code (Annual) | See PS Data Dictionary |
| 12 | PS | Elg | EL\_MDCR\_BEN\_MO\_CNT | Num | 3 | Medicare benefic mos (from Medicare EDB) | See PS Data Dictionary |
| 13 | PS | Elg | MAX\_ELG\_CD\_MO\_1 | Char | 2 | MAX eligibility group (Jan) | See PS Data Dictionary |
| 14 | PS | Elg | MAX\_ELG\_CD\_MO\_2 | Char | 2 | MAX eligibility group (Feb) | See PS Data Dictionary |
| 15 | PS | Elg | MAX\_ELG\_CD\_MO\_3 | Char | 2 | MAX eligibility group (Mar) | See PS Data Dictionary |
| 16 | PS | Elg | MAX\_ELG\_CD\_MO\_4 | Char | 2 | MAX eligibility group (Apr) | See PS Data Dictionary |
| 17 | PS | Elg | MAX\_ELG\_CD\_MO\_5 | Char | 2 | MAX eligibility group (May) | See PS Data Dictionary |
| 18 | PS | Elg | MAX\_ELG\_CD\_MO\_6 | Char | 2 | MAX eligibility group (Jun) | See PS Data Dictionary |
| 19 | PS | Elg | MAX\_ELG\_CD\_MO\_7 | Char | 2 | MAX eligibility group (Jul) | See PS Data Dictionary |
| 20 | PS | Elg | MAX\_ELG\_CD\_MO\_8 | Char | 2 | MAX eligibility group (Aug) | See PS Data Dictionary |
| 21 | PS | Elg | MAX\_ELG\_CD\_MO\_9 | Char | 2 | MAX eligibility group (Sep) | See PS Data Dictionary |
| 22 | PS | Elg | MAX\_ELG\_CD\_MO\_10 | Char | 2 | MAX eligibility group (Oct) | See PS Data Dictionary |
| 23 | PS | Elg | MAX\_ELG\_CD\_MO\_11 | Char | 2 | MAX eligibility group (Nov) | See PS Data Dictionary |
| 24 | PS | Elg | MAX\_ELG\_CD\_MO\_12 | Char | 2 | MAX eligibility group (Dec) | See PS Data Dictionary |
| 25 | PS | Elg | EL\_PPH\_PLN\_MO\_CNT\_CMCP | Num | 3 | Prepaid plan months (comprehensive plans) | See PS Data Dictionary |
| 26 | PS | Elg | EL\_PPH\_PLN\_MO\_CNT\_DMCP | Num | 3 | Prepaid plan months (DMCP) | See PS Data Dictionary |
| 27 | PS | Elg | EL\_PPH\_PLN\_MO\_CNT\_BMCP | Num | 3 | Prepaid plan months (BMCP) | See PS Data Dictionary |
| 28 | PS | Elg | EL\_PPH\_PLN\_MO\_CNT\_AICE | Num | 3 | Prepaid plan months (AICE) | See PS Data Dictionary |
| 29 | PS | Elg | EL\_PPH\_PLN\_MO\_CNT\_PCCM | Num | 3 | Prepaid plan months (PCCM) | See PS Data Dictionary |
| 30 | PS | Elg | RCPNT\_IND | Char | 1 | Recipient indicator | See PS Data Dictionary |
| 31 | PS | Elg | RCPNT\_DLVRY\_CD | Num | 3 | Delivery code | See PS Data Dictionary |
| 32 | PS | Elg | max\_elg\_full\_yr | Num | 8 | full year of MAX eligibility indicator | 0/1 variable indicating that bene had a full year (i.e. 12 months) of MAX eligibility, based on EL\_ELGBLTY\_MO\_CNT in PS file. |
| 33 | PS | Elg | one\_max\_elg\_prd | Num | 8 | indicator that MAX eligibility is 1 contiguous period | 0/1 variable indicating that the bene had one contiguous period of MAX eligibility. A month (X) is considered a MAX eligible month if MAX\_ELG\_CD\_MO\_X is not = 00 or 99 (X =1-12, i.e. January-December). |
| 34 | PS | Elg | tanf\_elg\_nomcp\_mo\_cnt | Num | 8 | TANF cash eligibility month count | The number of non-managed care months that the bene received TANF benefits. A month (X) is a TANF eligible month if EL\_TANF\_CASH\_FLG\_X=2 (where X=1-12 i.e. January-December) in the PS file. [[1]](#footnote-1) |
| 35 | PS | Elg | tanf\_elg\_nomcp\_ann | Num | 8 | TANF cash eligibility indicator (annual) | 0/1 variable indicating that the bene received TANF benefits for at least one non-managed care month in the year. 1 |
| 36 | PS | Elg | pvt\_elg\_nomcp\_mo\_cnt | Num | 8 | Private insurance month count | The number of non-managed care months the bene was enrolled in private insurance. A month (X) is a private insurance eligible month if EL\_PVT\_INS\_CD\_X=2, 3 or 4 (where X=1-12 i.e. January-December) in the PS file. 1 |
| 37 | PS | Elg | pvt\_elg\_nomcp\_ann | Num | 8 | Private insurance indicator (annual) | 0/1 variable indicating that the bene was enrolled in private insurance for at least one non-managed care month in the year. 1 |
| 38 | PS | Elg | rstrct\_elg\_nomcp\_mo\_cnt | Num | 8 | Restricted benefits month count | The number of non-managed care months the bene had restricted benefits. A month (X) is a restricted benefits month if EL\_RSTRCT\_BNFT\_FLG\_X= any of the following: 2-8, A, B, W-Z (where X=1-12 i.e. January-December) in the PS file. 1 |
| 39 | PS | Elg | rstrct\_elg\_nomcp\_ann | Num | 8 | Restricted benefits indicator (annual) | 0/1 variable indicating that the bene had restricted benefits for at least one non-managed care month in the year. 1 |
| 40 | PS | Elg | chip\_elg\_nomcp\_mo\_cnt | Num | 8 | SCHIP eligibility month count | The number of non-managed care months the bene was eligible for CHIP. A month (X) is a CHIP eligible month if EL\_CHIP\_FLAG\_X=2 or 3 (where X=1-12 i.e. January-December) in the PS file. 1 |
| 41 | PS | Elg | chip\_elg\_nomcp\_ann | Num | 8 | SCHIP eligibility indicator (annual) | 0/1 variable indicating that the bene was eligible for CHIP for at least one non-managed care month in the year. 1 |
| 42 | PS | Elg | waiver\_elg\_nomcp\_mo\_cnt | Num | 8 | MAX waiver month count | The number of non-managed care months the bene was enrolled in a waiver. A month (X) is a waiver month if MAX\_WAIVER\_TYPE\_1\_MO\_X or MAX\_WAIVER\_TYPE\_2\_MO\_X or MAX\_WAIVER\_TYPE\_3\_MO\_X equals any of the following: 1, 2, 4, 5, 6, 8, A, F-P (where X=1-12 i.e. January-December) in the PS file. 1 |
| 43 | PS | Elg | waiver\_elg\_nomcp\_ann | Num | 8 | MAX waiver indicator (annual) | 0/1 variable indicating that bene was enrolled in a waiver for at least one non-managed care month in the year. 1 |
| 44 | PS | Elg | dual\_ind | Num | 8 | Dual Bene indicator | 0/1 variable indicating that bene was a dual for at least one month of the year. A bene is considered a dual if any of the following are satisfied:  1) in PS file, EL\_MDCR\_DUAL\_IND=50-59, or  2) in IP file, MDCR\_COINSUR\_PYMT\_AMT > 0 or MDCR\_DED\_PYMT\_AMT > 0 or EL\_MDCR\_XOVR\_CLM\_BSD\_CD=1 or EL\_MDCR\_ANN\_XOVR\_99=50-59, or  3) in OT file, MDCR\_COINSUR\_PYMT\_AMT > 0 or MDCR\_DED\_PYMT\_AMT > 0 or EL\_MDCR\_XOVR\_CLM\_BSD\_CD=1 or EL\_MDCR\_ANN\_XOVR\_99=50-59. |
| 45 | PS | Elg | dod\_src | Char | 4 | Source of Date of Death | Code indicating which date of death variable was used for the final DOD variable.  Method: If there is an SSA\_DOD then the source is SSA, else, if there is an MDCR\_DOD then the source is MDCR, else, if there is an EL\_DOD then the source is MSIS. |
| 46 | PS | Elg | age | Num | 8 | Age | Age of beneficiary in 2009.  Method: 2009-(year of EL\_DOB). |
| 47 | PS | Elg | ltc\_ind | Num | 8 | Indicator-Beneficiary received long term care during year | 0/1 variable indicating that the bene received long term care during the year, i.e. in PS file, if TOT\_LTC\_CVR\_DAY\_CNT >0.  Note: This variable will be set to 1 even if bene only received long term care during a managed care month. 1 |
| 48 | PS | Elg | dod | Num | 8 | Date of Death | Source of DOD variable is given in DOD\_SRC variable. |
| 49 | PS | Elg | age\_at\_death | Num | 8 | Age on date of death | Method: (DOD-EL\_DOB)/365. |
| 50 | PS | Elg | max\_elg\_non\_mcp\_full\_yr | Num | 8 | full year of non-managed care MAX eligibility indicator | 0/1 variable indicating that the bene had a full year (i.e. 12 months) of non-managed care MAX eligibility. 1 |
| 51 | PS | Elg | prcnt\_max\_elg\_cont\_nomcp\_mnths | Num | 8 | Percent MAX only Eligible non-MCP months (Option 4) | Percent of all MAX eligible months that are non-managed care. 1 |
| 52 | PS | Elg | tot\_max\_elg\_cont\_nomcp\_mnths | Num | 8 | Total # MAX only Eligible non-MCP months (Option 4) | Number of non-managed care MAX eligible months. 1 |
| 53 | OT\_LEFT[[2]](#footnote-2) | Util | prcnt\_pc\_fqhc\_days | Num | 8 | Percent Primary Care days in FQHC | Methods of calculation described in Section 8. |
| 54 | OT\_LEFT2 | Util | prcnt\_pc\_opc\_days | Num | 8 | Percent Primary Care days in Outpatient Clinic | Methods of calculation described in Section 8. |
| 55 | OT\_LEFT2 | Util | prcnt\_pc\_po\_days | Num | 8 | Percent Primary Care days in Physicians Office | Methods of calculation described in Section 8. |
| 56 | OT\_LEFT2 | Util | prcnt\_pc\_other\_days | Num | 8 | Percent Primary Care days in Other | Methods of calculation described in Section 8. |
| 57 | OT\_LEFT2 | Util | bene\_class\_gur | Char | 2 | Bene Classification based on Gurewich’s methods | Codes:  a = Bene had no primary care (PC) claims;  bX = bene had >= 75% of PC days in class X, where X: 1=FQHC, 2=OPC, 3=PO, 4=Other ;  cX = bene had > 50% of PC days in class X, where X: 1=FQHC, 2=OPC, 3=PO, 4=Other ;  d = bene had <= 50% of PC days in any class. |
| 58 | OT\_LEFT2 | Costs | mdcd\_pymt\_amt\_ot | Num | 8 | OT-Medicaid payment amount |  |
| 59 | OT\_LEFT2 | Costs | tp\_pymt\_amt\_ot | Num | 8 | OT-Third party payment amount |  |
| 60 | OT\_LEFT2 | Costs | php\_val\_ot | Num | 8 | OT-Encounter Costs |  |
| 61 | OT\_LEFT2 | Costs | tot\_pymt\_amt\_ot | Num | 8 | OT-Total payment amount | Method: sum of Medicaid payment amount for OT\_LEFT claims and Third party payment amount for OT\_LEFT claims. |
| 62 | OT\_LEFT2 | Costs | mdcd\_pymt\_amt\_ot\_pc | Num | 8 | OT-Primary care Medicaid payment amount | Note: Primary Care claims are all claims on a day that has at least one Primary Care claim. |
| 63 | OT\_LEFT2 | Costs | tp\_pymt\_amt\_ot\_pc | Num | 8 | OT-Primary care Third party payment amount | Note: Primary Care claims are all claims on a day that has at least one Primary Care claim. |
| 64 | OT\_LEFT2 | Costs | php\_val\_ot\_pc | Num | 8 | OT-Primary care Encounter Costs | Note: Primary Care claims are all claims on a day that has at least one Primary Care claim. |
| 65 | OT\_LEFT2 | Costs | tot\_pymt\_amt\_ot\_pc | Num | 8 | OT-Primary care Total payment amount | Note: Primary Care claims are all claims on a day that has at least one Primary Care claim.  Method: sum of Medicaid payment amount for PC OT\_LEFT claims and Third party payment amount for PC OT\_LEFT claims. |
| 66 | OT\_LEFT2 | Costs | mdcd\_pymt\_amt\_ot\_sc | Num | 8 | OT-Specialty care Medicaid payment amount | Note: Specialty Care claims are all claims on a day that has no Primary Care. |
| 67 | OT\_LEFT2 | Costs | tp\_pymt\_amt\_ot\_sc | Num | 8 | OT-Specialty care Third party payment amount | Note: Specialty Care claims are all claims on a day that has no Primary Care. |
| 68 | OT\_LEFT2 | Costs | php\_val\_ot\_sc | Num | 8 | OT-Specialty care Encounter Costs | Note: Specialty Care claims are all claims on a day that has no Primary Care. |
| 69 | OT\_LEFT2 | Costs | tot\_pymt\_amt\_ot\_sc | Num | 8 | OT-Specialty care Total payment amount | Note: Specialty Care (SC) claims are all claims on a day that has no Primary Care.  Method: sum of Medicaid payment amount for SC OT\_LEFT claims and Third party payment amount for SC OT\_LEFT claims. |
| 70 | OT\_LEFT2 | Util | nmbr\_tos\_8\_clms | Num | 8 | OT-Number of TOS=8 claims | Number of OT\_LEFT claims with MAX Type of Service=8. See OT Data Dictionary. |
| 71 | OT\_LEFT2 | Util | nmbr\_tos\_10\_clms | Num | 8 | OT-Number of TOS=10 claims | Number of OT\_LEFT claims with MAX Type of Service=10. See OT Data Dictionary. |
| 72 | OT\_LEFT2 | Util | nmbr\_tos\_11\_clms | Num | 8 | OT-Number of TOS=11 claims | Number of OT\_LEFT claims with MAX Type of Service=11. See OT Data Dictionary. |
| 73 | OT\_LEFT2 | Util | nmbr\_tos\_12\_clms | Num | 8 | OT-Number of TOS=12 claims | Number of OT\_LEFT claims with MAX Type of Service=12. See OT Data Dictionary. |
| 74 | OT\_LEFT2 | Util | nmbr\_tos\_13\_clms | Num | 8 | OT-Number of TOS=13 claims | Number of OT\_LEFT claims with MAX Type of Service=13. See OT Data Dictionary. |
| 75 | OT\_LEFT2 | Util | nmbr\_tos\_15\_clms | Num | 8 | OT-Number of TOS=15 claims | Number of OT\_LEFT claims with MAX Type of Service=15. See OT Data Dictionary. |
| 76 | OT\_LEFT2 | Util | nmbr\_tos\_16\_clms | Num | 8 | OT-Number of TOS=16 claims | Number of OT\_LEFT claims with MAX Type of Service=16. See OT Data Dictionary. |
| 77 | OT\_LEFT2 | Util | nmbr\_tos\_19\_clms | Num | 8 | OT-Number of TOS=19 claims | Number of OT\_LEFT claims with MAX Type of Service=19. See OT Data Dictionary. |
| 78 | OT\_LEFT2 | Util | nmbr\_tos\_37\_clms | Num | 8 | OT-Number of TOS=37 claims | Number of OT\_LEFT claims with MAX Type of Service=37. See OT Data Dictionary. |
| 79 | OT\_LEFT2 | Util | nmbr\_tos\_53\_clms | Num | 8 | OT-Number of TOS=53 claims | Number of OT\_LEFT claims with MAX Type of Service=53. See OT Data Dictionary. |
| 80 | OT\_LEFT2 | Util | nmbr\_top\_0\_clms | Num | 8 | OT-Number of TOP=0 claims | Number of OT\_LEFT claims with Type of Program=0. See OT Data Dictionary. |
| 81 | OT\_LEFT2 | Util | nmbr\_top\_1\_clms | Num | 8 | OT-Number of TOP=1 claims | Number of OT\_LEFT claims with Type of Program=1. See OT Data Dictionary. |
| 82 | OT\_LEFT2 | Util | nmbr\_top\_2\_clms | Num | 8 | OT-Number of TOP=2 claims | Number of OT\_LEFT claims with Type of Program=2. See OT Data Dictionary. |
| 83 | OT\_LEFT2 | Util | nmbr\_top\_3\_clms | Num | 8 | OT-Number of TOP=3 claims | Number of OT\_LEFT claims with Type of Program=3. See OT Data Dictionary. |
| 84 | OT\_LEFT2 | Util | nmbr\_top\_4\_clms | Num | 8 | OT-Number of TOP=4 claims | Number of OT\_LEFT claims with Type of Program=4. See OT Data Dictionary. |
| 85 | OT\_LEFT2 | Util | nmbr\_top\_5\_clms | Num | 8 | OT-Number of TOP=5 claims | Number of OT\_LEFT claims with Type of Program=5. See OT Data Dictionary. |
| 86 | OT\_LEFT2 | Util | nmbr\_top\_6\_clms | Num | 8 | OT-Number of TOP=6 claims | Number of OT\_LEFT claims with Type of Program=6. See OT Data Dictionary. |
| 87 | OT\_LEFT2 | Util | nmbr\_top\_7\_clms | Num | 8 | OT-Number of TOP=7 claims | Number of OT\_LEFT claims with Type of Program=7. See OT Data Dictionary. |
| 88 | OT\_LEFT2 | Util | nmbr\_top\_9\_clms | Num | 8 | OT-Number of TOP=9 claims | Number of OT\_LEFT claims with Type of Program=9. See OT Data Dictionary. |
| 89 | OT\_LEFT2 | Util | nmbr\_pos\_11\_clms | Num | 8 | OT-Number of POS=11 claims | Number of OT\_LEFT claims with Place of Service=11. See OT Data Dictionary. |
| 90 | OT\_LEFT2 | Util | nmbr\_pos\_12\_clms | Num | 8 | OT-Number of POS=12 claims | Number of OT\_LEFT claims with Place of Service=12. See OT Data Dictionary. See OT Data Dictionary. |
| 91 | OT\_LEFT2 | Util | nmbr\_pos\_22\_clms | Num | 8 | OT-Number of POS=22 claims | Number of OT\_LEFT claims with Place of Service=22. See OT Data Dictionary. |
| 92 | OT\_LEFT2 | Util | nmbr\_pos\_50\_clms | Num | 8 | OT-Number of POS=50 claims | Number of OT\_LEFT claims with Place of Service=50. See OT Data Dictionary. |
| 93 | OT\_LEFT2 | Util | num\_ot\_clms | Num | 8 | OT-Number of claims | Number of OT\_LEFT claims. |
| 94 | OT\_LEFT2 | Util | num\_ot\_pc\_clms | Num | 8 | OT-Number of Primary Care claims | Note: Primary Care claims are all claims on a day that has at least one Primary Care claim. |
| 95 | OT\_LEFT2 | Util | num\_ot\_sc\_clms | Num | 8 | OT-Number of Specialty Care claims | Note: Specialty Care claims are all claims on a day that has no Primary Care. |
| 96 | OT\_LEFT2 | Util | num\_ot\_days | Num | 8 | OT-Number of Days | A bene-day is based on SRVC\_BGN\_DT. |
| 97 | OT\_LEFT2 | Util | num\_ot\_pc\_days | Num | 8 | OT-Number of Primary Care Days | Note: Primary Care days are all days with at least one Primary Care claim. |
| 98 | OT\_LEFT2 | Util | num\_ot\_sc\_days | Num | 8 | OT-Number of Specialty Care Days | Note: Specialty Care days are days with no Primary Care. |
| 99 | OT\_ER2 | Util | nmbr\_clms\_er | Num | 8 | ER-Number of Claims | See Section 7 for a definition of ER claims.  Note: These are ER claims that do not have an associated IP admission. |
| 100 | OT\_ER2 | Costs | mdcd\_pymt\_amt\_er | Num | 8 | ER-Medicaid payment amount | See Section 7 for a definition of ER claims.  Note: These are ER claims that do not have an associated IP admission. |
| 101 | OT\_ER2 | Costs | tp\_pymt\_amt\_er | Num | 8 | ER-Third party payment amount | See Section 7 for a definition of ER claims.  Note: These are ER claims that do not have an associated IP admission. |
| 102 | OT\_ER2 | Costs | tot\_pymt\_amt\_er | Num | 8 | ER-Total payment amount | See Section 7 for a definition of ER claims.  Note: These are ER claims that do not have an associated IP admission.  Method: sum of Medicaid payment amount for OT\_ER claims and Third party payment amount for OT\_ER claims. |
| 103 | OT\_ER2 | Costs | php\_val\_er | Num | 8 | ER-Encounter Costs | See Section 7 for a definition of ER claims.  Note: These are ER claims that do not have an associated IP admission. |
| 104 | OT\_ER2 | Util | nmbr\_days\_er | Num | 8 | ER-Number of Days | See Section 7 for a definition of ER claims.  Note: These are ER claims that do not have an associated IP admission. |
| 105 | IP | Util | nmbr\_ip\_admsns | Num | 8 | IP-Number of admissions | Note: If an IP claim has no admission date then it is not counted in the number of IP admissions. |
| 106 | IP | Util | nmbr\_msng\_admsn\_dt\_noincl | Num | 8 | IP-Number of claims with missing admission date & Adjust\_Cd=2 | See Section 9 for more details. |
| 107 | IP | Util | nmbr\_msng\_admsn\_dt\_incl | Num | 8 | IP-Number of claims with missing admission date & Adjust\_Cd not =2 | See Section 9 for more details. |
| 108 | IP | Util | nmbr\_pat\_stus\_rout | Num | 8 | IP-Number of routine discharges | Number of IP claims with PATIENT\_STATUS\_CD=1. See IP Data Dictionary. |
| 109 | IP | Util | nmbr\_pat\_stus\_trnsf | Num | 8 | IP-Number of transfers to other facilities | Number of IP claims with PATIENT\_STATUS\_CD=2-6, or 8. See IP Data Dictionary. |
| 110 | IP | Util | nmbr\_pat\_stus\_exprd | Num | 8 | IP-Number of expired patient status code claims | Number of IP claims with PATIENT\_STATUS\_CD=20, 40, 41, or 42. See IP Data Dictionary. |
| 111 | IP | Util | nmbr\_pat\_stus\_oth | Num | 8 | IP-Number of other patient status code claims | Number of IP claims with PATIENT\_STATUS\_CD not =1-6, 8, 20, or 40-42. See IP Data Dictionary. |
| 112 | IP | Util | total\_ip\_los | Num | 8 | IP- Total length of stay in IP hospital in year | Sum of all IP hospital stays during the non-managed care months of the year. 1 A length of stay is calculated by: SRVC\_END\_DT-SRVC\_BGN\_DT. |
| 113 | IP | Util | total\_mdcd\_cvrd\_ip\_days | Num | 8 | Total Medicaid covered inpatient days | Sum of all Medicaid covered IP days during the non-managed care months of the year. 1 |
| 114 | IP | Costs | msng\_admsn\_mdcd\_amt\_ip\_noincl | Num | 8 | IP-Medicaid payment amount for claims with no admission date & Adjust\_Cd=2 | See Section 9 for more details. |
| 115 | IP | Costs | msng\_admsn\_tp\_amt\_ip\_noincl | Num | 8 | IP-Third party payment amount for claims with no admission date & Adjust\_Cd=2 | See Section 9 for more details. |
| 116 | IP | Costs | msng\_admsn\_tot\_amt\_ip\_noincl | Num | 8 | IP-Total payment amount for claims with no admission date & Adjust\_Cd=2 | See Section 9 for more details. |
| 117 | IP | Costs | msng\_admsn\_mdcd\_amt\_ip\_incl | Num | 8 | IP-Medicaid payment amount for claims with no admission date & Adjust\_Cd not =2 | See Section 9 for more details. |
| 118 | IP | Costs | msng\_admsn\_tp\_amt\_ip\_incl | Num | 8 | IP-Third party payment amount for claims with no admission date & Adjust\_Cd not =2 | See Section 9 for more details. |
| 119 | IP | Costs | msng\_admsn\_tot\_amt\_ip\_incl | Num | 8 | IP-Total payment amount for claims with no admission date & Adjust\_Cd not =2 | See Section 9 for more details. |
| 120 | IP, OT\_IP\_ER, OT\_POS\_IP2 | Costs | ip\_cost\_src | Char | 8 | IP Cost Source | This variable indicates which files contributed to the overall IP cost.  Codes:  IP – IP file costs  ER – OT\_IP\_ER costs  OT – OT\_POS\_IP costs.2 |
| 121 | IP, OT\_IP\_ER, OT\_POS\_IP2 | Costs | mdcd\_pymt\_amt\_all\_ip | Num | 8 | Total IP-Medicaid payment amount | Method of calculation: Sum of Medicaid payment amounts from :  1) IP file (for IP claims with an admission and for IP claims without an admission but with ADJUST\_CD not = 2),  2) OT claims with POS=21-Inpatient Hospital,  3) OT ER claims associated with an IP admission. See Section 7 for a definition of ER claims. |
| 122 | IP, OT\_IP\_ER, OT\_POS\_IP2 | Costs | tp\_pymt\_amt\_all\_ip | Num | 8 | Total IP-Third party payment amount | Method of calculation: Sum of Third Party payment amounts from:  1) IP file (for IP claims with an admission and for IP claims without an admission but with ADJUST\_CD not = 2),  2) OT claims with POS=inpatient hospital,  3) OT ER claims associated with an IP admission. See Section 7 for a definition of ER claims. |
| 123 | IP, OT\_IP\_ER, OT\_POS\_IP2 | Costs | tot\_pymt\_amt\_all\_ip | Num | 8 | Total IP-Total payment amount | Method of calculation: Total IP Medicaid payment amount + Total IP Third Party payment amount. |
| 124 | IP, OT\_IP\_ER, OT\_POS\_IP2 | Costs | php\_val\_all\_ip | Num | 8 | Total IP-Encounter Costs | Method of calculation: Encounter Costs from:  1) IP file (for IP claims with an admission and for IP claims without an admission but with ADJUST\_CD not = 2),  2) OT claims with POS=inpatient hospital,  3) OT ER claims associated with an IP admission. See Section 7 for a definition of ER claims. |
| 125 | RX | Util | nmbr\_prcrptns\_rx | Num | 8 | RX-Number of Prescriptions |  |
| 126 | RX | Costs | mdcd\_pymt\_amt\_rx | Num | 8 | RX-Medicaid payment amount |  |
| 127 | RX | Costs | tp\_pymt\_amt\_rx | Num | 8 | RX-Third party payment amount |  |
| 128 | RX | Costs | tot\_pymt\_amt\_rx | Num | 8 | RX-Total payment amount | Method of calculation: RX Medicaid payment amount + RX Third Party payment amount. |
| 129 | RX | Costs | php\_val\_rx | Num | 8 | RX-Encounter Costs |  |
| 130 | OT\_Cap2 | Costs | mdcd\_pymt\_amt\_cap | Num | 8 | Medicaid payment amount for Capitated Payments | Medicaid payment amount for OT claims with PHP\_TYPE=2. |
| 131 | OT\_Cap2 | Costs | cap\_php\_type | Char | 3 | Type of Managed Care Plans bene has Capitated Payments for | Type of Managed Care Plans that the bene has Capitated Payments for, based on TYPE\_CLM\_CD in OT file. |
| 132 | IP | Costs | ip\_adj2\_ind | Num | 8 | IP-Indicator that bene has Adjust\_Cd=2 claim | 0/1 variable indicating that the bene has at least one IP claim with ADJUST\_CD=2. See Section 6.1 for more information on Adjustment Code=2 claims. |
| 133 | OT | Costs | ot\_adj2\_ind | Num | 8 | OT-Indicator that bene has Adjust\_Cd=2 claim | 0/1 Variable indicating that the bene has at least one OT claim with ADJUST\_CD=2. See Section 6.1 for more information on Adjustment Code 2 claims. |
| 134 | RX | Costs | rx\_adj2\_ind | Num | 8 | RX-Indicator that bene has Adjust\_Cd=2 claim | 0/1 Variable indicating that the bene has at least one RX claim with ADJUST\_CD=2. See Section 6.1 for more information on Adjustment Code 2 claims. |
| 135 | IP | Risk | TAPQ01 | Num | 8 | DIABETES SHORT TRM COMPLICATN | Prevention Quality Indicators |
| 136 | IP | Risk | TAPQ02 | Num | 8 | PERFORATED APPENDIX | Prevention Quality Indicators |
| 137 | IP | Risk | TAPQ03 | Num | 8 | DIABETES LONG TERM COMPLICATN | Prevention Quality Indicators |
| 138 | IP | Risk | TAPQ05 | Num | 8 | COPD OR ASTHMA IN OLDER ADULTS | Prevention Quality Indicators |
| 139 | IP | Risk | TAPQ07 | Num | 8 | HYPERTENSION | Prevention Quality Indicators |
| 140 | IP | Risk | TAPQ08 | Num | 8 | CONGESTIVE HEART FAILURE | Prevention Quality Indicators |
| 141 | IP | Risk | TAPQ10 | Num | 8 | DEHYDRATION | Prevention Quality Indicators |
| 142 | IP | Risk | TAPQ11 | Num | 8 | BACTERIAL PNEUMONIA | Prevention Quality Indicators |
| 143 | IP | Risk | TAPQ12 | Num | 8 | URINARY INFECTION | Prevention Quality Indicators |
| 144 | IP | Risk | TAPQ13 | Num | 8 | ANGINA | Prevention Quality Indicators |
| 145 | IP | Risk | TAPQ14 | Num | 8 | DIABETES UNCONTROLLED | Prevention Quality Indicators |
| 146 | IP | Risk | TAPQ16 | Num | 8 | LOWER EXTREMITY AMPUTATION | Prevention Quality Indicators |
| 147 | IP | Risk | TAPD14 | Num | 8 | ASTHMA | Pediatric Quality Indicators |
| 148 | IP | Risk | TAPD15 | Num | 8 | DIABETES SHORT TRM COMPLICATN | Pediatric Quality Indicators |
| 149 | IP | Risk | TAPD16 | Num | 8 | GASTROENTERITIS | Pediatric Quality Indicators |
| 150 | IP | Risk | TAPD17 | Num | 8 | PERFORATED APPENDIX | Pediatric Quality Indicators |
| 151 | IP | Risk | TAPD18 | Num | 8 | URINARY INFECTION | Pediatric Quality Indicators |
| 152 | IP | Risk | TAMC01 | Num | 8 | AMI RATE with LOS>5 or died in hospital (Numerator) | Marker Conditions |
| 153 | IP | Risk | TAMC02 | Num | 8 | Appendicitis with appendectomy (Numerator) | Marker Conditions |
| 154 | IP | Risk | TAMC03 | Num | 8 | Fracture of hip/femur (age>=45) (Numerator) | Marker Conditions |
| 155 | IP | Risk | TAMC04 | Num | 8 | Gastrointestinal obstruction (Numerator) | Marker Conditions |
| 156 | IP, OT, PS | Risk | GIL | Num | 3 | Gastro, low | CDPS |
| 157 | IP, OT, PS | Risk | GINWD | Num | 3 | Gastro, not well def | CDPS |
| 158 | IP, OT, PS | Risk | PULL | Num | 3 | Pulmonary, low | CDPS |
| 159 | IP, OT, PS | Risk | INFSL | Num | 3 | Infectious, super low | CDPS |
| 160 | IP, OT, PS | Risk | INFM | Num | 3 | Infectious, medium | CDPS |
| 161 | IP, OT, PS | Risk | AIDSH | Num | 3 | AIDS, high | CDPS |
| 162 | IP, OT, PS | Risk | INFH | Num | 3 | Infectious, high | CDPS |
| 163 | IP, OT, PS | Risk | EXCL | Num | 3 | Excluded code | CDPS |
| 164 | IP, OT, PS | Risk | HIVM | Num | 3 | HIV, medium | CDPS |
| 165 | IP, OT, PS | Risk | INFL | Num | 3 | Infectious, low | CDPS |
| 166 | IP, OT, PS | Risk | CNSL | Num | 3 | CNS, low | CDPS |
| 167 | IP, OT, PS | Risk | SKNSL | Num | 3 | Skin, super low | CDPS |
| 168 | IP, OT, PS | Risk | PULSL | Num | 3 | Pulmonary, super low | CDPS |
| 169 | IP, OT, PS | Risk | CANM | Num | 3 | Cancer, medium | CDPS |
| 170 | IP, OT, PS | Risk | CANL | Num | 3 | Cancer, low | CDPS |
| 171 | IP, OT, PS | Risk | CANH | Num | 3 | Cancer, high | CDPS |
| 172 | IP, OT, PS | Risk | CANB | Num | 3 | Cancer, benign | CDPS |
| 173 | IP, OT, PS | Risk | CANNWD | Num | 3 | Cancer, not well def | CDPS |
| 174 | IP, OT, PS | Risk | METSL | Num | 3 | Metabolic, super low | CDPS |
| 175 | IP, OT, PS | Risk | DIA2L | Num | 3 | Diabetes, type 2 low | CDPS |
| 176 | IP, OT, PS | Risk | DIA1M | Num | 3 | Diabetes, type 1 medium | CDPS |
| 177 | IP, OT, PS | Risk | DIA2M | Num | 3 | Diabetes, type 2 medium | CDPS |
| 178 | IP, OT, PS | Risk | DIA1H | Num | 3 | Diabetes, type 1 high | CDPS |
| 179 | IP, OT, PS | Risk | METNWD | Num | 3 | Metabolic, not well def | CDPS |
| 180 | IP, OT, PS | Risk | METH | Num | 3 | Metabolic, high | CDPS |
| 181 | IP, OT, PS | Risk | METM | Num | 3 | Metabolic, medium | CDPS |
| 182 | IP, OT, PS | Risk | METVL | Num | 3 | Metabolic, very low | CDPS |
| 183 | IP, OT, PS | Risk | PULVH | Num | 3 | Pulmonary, very high | CDPS |
| 184 | IP, OT, PS | Risk | HEMSL | Num | 3 | Hematological, super low | CDPS |
| 185 | IP, OT, PS | Risk | HEMM | Num | 3 | Hematological, medium | CDPS |
| 186 | IP, OT, PS | Risk | HEMVH | Num | 3 | Hematological, very high | CDPS |
| 187 | IP, OT, PS | Risk | HEML | Num | 3 | Hematological, low | CDPS |
| 188 | IP, OT, PS | Risk | HEMEH | Num | 3 | Hematological, extra high | CDPS |
| 189 | IP, OT, PS | Risk | HEMNWD | Num | 3 | Hematological, not well def | CDPS |
| 190 | IP, OT, PS | Risk | SUBVL | Num | 3 | Substance abuse, very low | CDPS |
| 191 | IP, OT, PS | Risk | SUBL | Num | 3 | Substance abuse, low | CDPS |
| 192 | IP, OT, PS | Risk | PSYNWD | Num | 3 | Psychiatric, not well def | CDPS |
| 193 | IP, OT, PS | Risk | PSYL | Num | 3 | Psychiatric, low | CDPS |
| 194 | IP, OT, PS | Risk | PSYSL | Num | 3 | Psychiatric, super low | CDPS |
| 195 | IP, OT, PS | Risk | PSYH | Num | 3 | Psychiatric, high | CDPS |
| 196 | IP, OT, PS | Risk | PSYM | Num | 3 | Psychiatric, medium | CDPS |
| 197 | IP, OT, PS | Risk | SUBNWD | Num | 3 | Substance abuse, not well def | CDPS |
| 198 | IP, OT, PS | Risk | DDL | Num | 3 | DD, low | CDPS |
| 199 | IP, OT, PS | Risk | DDM | Num | 3 | DD, medium | CDPS |
| 200 | IP, OT, PS | Risk | CNSNWD | Num | 3 | CNS, not well def | CDPS |
| 201 | IP, OT, PS | Risk | CNSSL | Num | 3 | CNS, super low | CDPS |
| 202 | IP, OT, PS | Risk | CNSM | Num | 3 | CNS, medium | CDPS |
| 203 | IP, OT, PS | Risk | CNSH | Num | 3 | CNS, high | CDPS |
| 204 | IP, OT, PS | Risk | CERL | Num | 3 | Cerebrovascular, low | CDPS |
| 205 | IP, OT, PS | Risk | EYESL | Num | 3 | Eye, super low | CDPS |
| 206 | IP, OT, PS | Risk | EYEL | Num | 3 | Eye, low | CDPS |
| 207 | IP, OT, PS | Risk | EYENWD | Num | 3 | Eye, not well def | CDPS |
| 208 | IP, OT, PS | Risk | EYEVL | Num | 3 | Eye, very low | CDPS |
| 209 | IP, OT, PS | Risk | EARSL | Num | 3 | Ear, super low | CDPS |
| 210 | IP, OT, PS | Risk | EARNWD | Num | 3 | Ear, not well def | CDPS |
| 211 | IP, OT, PS | Risk | CARL | Num | 3 | Cardiovascular, low | CDPS |
| 212 | IP, OT, PS | Risk | CARM | Num | 3 | Cardiovascular, medium | CDPS |
| 213 | IP, OT, PS | Risk | CAREL | Num | 3 | Cardiovascular, extra low | CDPS |
| 214 | IP, OT, PS | Risk | RENM | Num | 3 | Renal, medium | CDPS |
| 215 | IP, OT, PS | Risk | CARSL | Num | 3 | Cardiovascular, super low | CDPS |
| 216 | IP, OT, PS | Risk | PULH | Num | 3 | Pulmonary, high | CDPS |
| 217 | IP, OT, PS | Risk | CARNWD | Num | 3 | Cardiovascular, not well def | CDPS |
| 218 | IP, OT, PS | Risk | CERNWD | Num | 3 | Cerebrovascular, not well def | CDPS |
| 219 | IP, OT, PS | Risk | CERSL | Num | 3 | Cerebrovascular, super low | CDPS |
| 220 | IP, OT, PS | Risk | GIM | Num | 3 | Gastro, medium | CDPS |
| 221 | IP, OT, PS | Risk | PULNWD | Num | 3 | Pulmonary, not well def | CDPS |
| 222 | IP, OT, PS | Risk | PULM | Num | 3 | Pulmonary, medium | CDPS |
| 223 | IP, OT, PS | Risk | SKCVL | Num | 3 | Skeletal, very low | CDPS |
| 224 | IP, OT, PS | Risk | GISL | Num | 3 | Gastro, super low | CDPS |
| 225 | IP, OT, PS | Risk | GIH | Num | 3 | Gastro, high | CDPS |
| 226 | IP, OT, PS | Risk | RENL | Num | 3 | Renal, low | CDPS |
| 227 | IP, OT, PS | Risk | RENVH | Num | 3 | Renal, very high | CDPS |
| 228 | IP, OT, PS | Risk | RENNWD | Num | 3 | Renal, not well def | CDPS |
| 229 | IP, OT, PS | Risk | RENSL | Num | 3 | Renal, super low | CDPS |
| 230 | IP, OT, PS | Risk | GENEL | Num | 3 | Genital, extra low | CDPS |
| 231 | IP, OT, PS | Risk | GENSL | Num | 3 | Genital, super low | CDPS |
| 232 | IP, OT, PS | Risk | PRGCMP | Num | 3 | Pregnancy, complete | CDPS |
| 233 | IP, OT, PS | Risk | PRGINC | Num | 3 | Pregnancy, incomplete | CDPS |
| 234 | IP, OT, PS | Risk | SKNVL | Num | 3 | Skin, very low | CDPS |
| 235 | IP, OT, PS | Risk | SKNNWD | Num | 3 | Skin, not well def | CDPS |
| 236 | IP, OT, PS | Risk | SKNL | Num | 3 | Skin, low | CDPS |
| 237 | IP, OT, PS | Risk | SKNH | Num | 3 | Skin, high | CDPS |
| 238 | IP, OT, PS | Risk | SKCL | Num | 3 | Skeletal, low | CDPS |
| 239 | IP, OT, PS | Risk | CANVH | Num | 3 | Cancer, very high | CDPS |
| 240 | IP, OT, PS | Risk | SKCNWD | Num | 3 | Skeletal, not well def | CDPS |
| 241 | IP, OT, PS | Risk | SKCSL | Num | 3 | Skeletal, super low | CDPS |
| 242 | IP, OT, PS | Risk | SKCM | Num | 3 | Skeletal, medium | CDPS |
| 243 | IP, OT, PS | Risk | BABY4 | Num | 3 | Other perinatal problems | CDPS |
| 244 | IP, OT, PS | Risk | BABY3 | Num | 3 | Serious perinatal problem | CDPS |
| 245 | IP, OT, PS | Risk | BABY1 | Num | 3 | Extremely low birth weight | CDPS |
| 246 | IP, OT, PS | Risk | BABY2 | Num | 3 | Very low birth weight | CDPS |
| 247 | IP, OT, PS | Risk | CARVH | Num | 3 | Cardiovascular, very high | CDPS |
| 248 | IP, OT, PS | Risk | E\_EXCL | Num | 3 | Excluded E code | CDPS |
| 249 | IP, OT, PS | Risk | BABY5 | Num | 3 | Normal, single birth | CDPS |
| 250 | IP, OT, PS | Risk | VNWD | Num | 3 | V code, not well def | CDPS |
| 251 | IP, OT, PS | Risk | PSYML | Num | 3 | Psychiatric, medium low | CDPS |
| 252 | IP, OT, PS | Risk | RENEH | Num | 3 | Renal, extra high | CDPS |
| 253 | IP, OT, PS | Risk | GENNWD | Num | 3 | Genital, not well def | CDPS |
| 254 | IP, OT, PS | Risk | NOCDPS | Num | 8 | Bene has no diagnoses in CDPS Categories | CDPS |
| 255 | IP, OT, PS | Risk | CCARVH | Num | 8 | Childrens CARVH | CDPS |
| 256 | IP, OT, PS | Risk | CCARM | Num | 8 | Childrens CARM | CDPS |
| 257 | IP, OT, PS | Risk | CCNSH | Num | 8 | Childrens CNSH | CDPS |
| 258 | IP, OT, PS | Risk | CPULVH | Num | 8 | Childrens PULVH | CDPS |
| 259 | IP, OT, PS | Risk | CPULH | Num | 8 | Childrens PULH | CDPS |
| 260 | IP, OT, PS | Risk | CGIH | Num | 8 | Childrens GIH | CDPS |
| 261 | IP, OT, PS | Risk | CMETH | Num | 8 | Childrens METH | CDPS |
| 262 | IP, OT, PS | Risk | CHIVM | Num | 8 | Childrens HIVM | CDPS |
| 263 | IP, OT, PS | Risk | CINFM | Num | 8 | Childrens INFM | CDPS |
| 264 | IP, OT, PS | Risk | CHEMEH | Num | 8 | Childrens HEMEH | CDPS |
| 265 | IP, OT, PS | Risk | MRX1 | Num | 3 | Anti-coagulants | CDPS (MRX-R) |
| 266 | IP, OT, PS | Risk | MRX2 | Num | 3 | Cardiac | CDPS (MRX-R) |
| 267 | IP, OT, PS | Risk | MRX3 | Num | 3 | Psychosis/Bipolar/ Depression | CDPS (MRX-R) |
| 268 | IP, OT, PS | Risk | MRX4 | Num | 3 | Diabetes | CDPS (MRX-R) |
| 269 | IP, OT, PS | Risk | MRX5 | Num | 3 | ESRD / Renal | CDPS (MRX-R) |
| 270 | IP, OT, PS | Risk | MRX6 | Num | 3 | Hemophilia/von Willebrands | CDPS (MRX-R) |
| 271 | IP, OT, PS | Risk | MRX7 | Num | 3 | Hepatitis | CDPS (MRX-R) |
| 272 | IP, OT, PS | Risk | MRX8 | Num | 3 | HIV | CDPS (MRX-R) |
| 273 | IP, OT, PS | Risk | MRX9 | Num | 3 | Infections, high | CDPS (MRX-R) |
| 274 | IP, OT, PS | Risk | MRX10 | Num | 3 | Inflammatory /Autoimmune | CDPS (MRX-R) |
| 275 | IP, OT, PS | Risk | MRX11 | Num | 3 | Malignancies | CDPS (MRX-R) |
| 276 | IP, OT, PS | Risk | MRX12 | Num | 3 | Multiple Sclerosis / Paralysis | CDPS (MRX-R) |
| 277 | IP, OT, PS | Risk | MRX13 | Num | 3 | Parkinsons / Tremor | CDPS (MRX-R) |
| 278 | IP, OT, PS | Risk | MRX14 | Num | 3 | Seizure disorders | CDPS (MRX-R) |
| 279 | IP, OT, PS | Risk | MRX15 | Num | 3 | Tuberculosis | CDPS (MRX-R) |
| 280 | IP, OT, PS | Risk | AID | Char | 2 | CDPS Aid Category | Codes:  AA- TANF adults (age > 18 and not disabled)  AC- TANF children (age <= 18 and not disabled)  DA- Disabled adults (age > 18 and disabled)  DC- Disabled children (age <= 18 and disabled).  A bene is considered disabled if their latest MAX eligibility code (EL\_MAX\_ELGBLTY\_CD\_LTST) in the PS file =12, 22, 32, or 42 or if DUAL\_IND=1. |
| 281 | IP, OT, PS | Risk | cdps\_con\_wgt | Num | 8 | CDPS Concurrent weight | CDPS |
| 282 | IP, OT, PS | Risk | cdps\_pro\_wgt | Num | 8 | CDPS Prospective weight | CDPS |
| 283 | PS | Elg | el\_rsdnc\_fips\_cd\_ltst | Char | 5 | FIPS Code of residence- state & county |  |
| 284 | PS | Elg | el\_rsdnc\_pcsa\_cd\_ltst | Char | 5 | PCSA of residence | Method: Merged ZIP to ZCTA and then ZCTA to PCSA.  Sources: zip2zcta07.dbf,uszcta2pcsav21.xls (from: [www.dartmouthatlas.org](http://www.dartmouthatlas.org) ) |
| 285 | PS | PCSA Chars | PUNIS0\_64 | Num | 6 | PCSA-Uninsured 0-64 (2006 est) | Source: 2006 Population Estimates by Insurance Type, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 286 | PS | PCSA Chars | PMCD0\_64 | Num | 6 | PCSA-Medicaid Pop 0-64 (2006 est) | Source: 2006 Population Estimates by Insurance Type, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 287 | PS | PCSA Chars | POINS0\_64 | Num | 6 | PCSA-Other Insurance 0-64 (2006 est) | Source: 2006 Population Estimates by Insurance Type, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 288 | PS | PCSA Chars | PMDR65UP | Num | 6 | PCSA-Medicare 65+ (2006 est) | Source: 2006 Population Estimates by Insurance Type, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 289 | PS | PCSA Chars | PNMDR65UP | Num | 4 | PCSA-Non-Medicare 65+ (2006 est) | Source: 2006 Population Estimates by Insurance Type, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 290 | PS | PCSA Chars | ppunis0\_64 | Num | 8 | PCSA-% of total pop-Uninsured 0-64 | Source: 2006 Population Estimates by Insurance Type, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 291 | PS | PCSA Chars | dpunis0\_64 | Num | 8 | PCSA-Uninsured 0-64/land area | Source: 2006 Population Estimates by Insurance Type, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 292 | PS | PCSA Chars | ppmcd0\_64 | Num | 8 | PCSA-% of total pop-Medicaid Pop 0-64 | Source: 2006 Population Estimates by Insurance Type, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 293 | PS | PCSA Chars | dpmcd0\_64 | Num | 8 | PCSA-Medicaid Pop 0-64/land area | Source: 2006 Population Estimates by Insurance Type, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 294 | PS | PCSA Chars | ppoins0\_64 | Num | 8 | PCSA-% of total pop-Other Insurance 0-64 | Source: 2006 Population Estimates by Insurance Type, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 295 | PS | PCSA Chars | dpoins0\_64 | Num | 8 | PCSA-Other Insurance 0-64/land area | Source: 2006 Population Estimates by Insurance Type, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 296 | PS | PCSA Chars | ppmdr65UP | Num | 8 | PCSA-% of total pop-Medicare 65+ | Source: 2006 Population Estimates by Insurance Type, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 297 | PS | PCSA Chars | dpmdr65UP | Num | 8 | PCSA-Medicare 65+/land area | Source: 2006 Population Estimates by Insurance Type, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 298 | PS | PCSA Chars | ppnmdr65UP | Num | 8 | PCSA-% of total pop-Non-Medicare 65+ | Source: 2006 Population Estimates by Insurance Type, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 299 | PS | PCSA Chars | dpnmdr65UP | Num | 8 | PCSA-Non-Medicare 65+/land area | Source: 2006 Population Estimates by Insurance Type, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 300 | PS | PCSA Chars | PARG\_ALOC | Num | 8 | PCSA-Adj. rate:allocated primary care physicians clinically active | Source: HRSA AMA Data Dictionary 0509, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 301 | PS | PCSA Chars | PFQHC07 | Num | 3 | PCSA-Number of FQHCs | Source: Update CHC/FQHC/RHC location data, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 302 | PS | PCSA Chars | PCHC09\_ALL | Num | 3 | PCSA-Number of grant funded HC service delivery sites | Source: Update CHC/FQHC/RHC location data, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 303 | PS | PCSA Chars | PAREA\_SM | Num | 8 | PCSA-Land Area-Square Miles (2008 est) | Source: 2008 PCSA Population Estimates, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 304 | PS | PCSA Chars | PP001001 | Num | 6 | PCSA-Pop from 2000 Census | Source: 2008 PCSA Population Estimates, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 305 | PS | PCSA Chars | PTOTPOP\_08 | Num | 6 | PCSA-Pop (2008 est) | Source: 2008 PCSA Population Estimates, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 306 | PS | PCSA Chars | PAGE65\_UP | Num | 6 | PCSA-Pop Age 65+ (2008 est) | Source: 2008 PCSA Population Estimates, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 307 | PS | PCSA Chars | PMALE | Num | 6 | PCSA-Pop Male (2008 est) | Source: 2008 PCSA Population Estimates, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 308 | PS | PCSA Chars | PFEMALE | Num | 6 | PCSA-Pop Female (2008 est) | Source: 2008 PCSA Population Estimates, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 309 | PS | PCSA Chars | PWHITE | Num | 6 | PCSA-Pop White (2008 est) | Source: 2008 PCSA Population Estimates, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 310 | PS | PCSA Chars | PBLACK | Num | 6 | PCSA-Pop Black (2008 est) | Source: 2008 PCSA Population Estimates, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 311 | PS | PCSA Chars | PNATIVE | Num | 6 | PCSA-Pop American Indian & Alaskan (2008 est) | Source: 2008 PCSA Population Estimates, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 312 | PS | PCSA Chars | PASIAN | Num | 6 | PCSA-Pop Asian (2008 est) | Source: 2008 PCSA Population Estimates, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 313 | PS | PCSA Chars | PISLAND | Num | 4 | PCSA-Pop Hawaiian & Pacific Islander (2008 est) | Source: 2008 PCSA Population Estimates, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 314 | PS | PCSA Chars | P1OTHER | Num | 6 | PCSA-Pop Some Other Race (2008 est) | Source: 2008 PCSA Population Estimates, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 315 | PS | PCSA Chars | P2MORE | Num | 6 | PCSA-Pop 2 or More Races (2008 est) | Source: 2008 PCSA Population Estimates, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 316 | PS | PCSA Chars | POTHER | Num | 6 | PCSA-Pop Other Non-White & Non-Black (2008 est) | Source: 2008 PCSA Population Estimates, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 317 | PS | PCSA Chars | PMA65\_UP | Num | 6 | PCSA-Pop Male 65+ (2008 est) | Source: 2008 PCSA Population Estimates, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 318 | PS | PCSA Chars | PFA65\_UP | Num | 6 | PCSA-Pop Female 65+ (2008 est) | Source: 2008 PCSA Population Estimates, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 319 | PS | PCSA Chars | PWA65\_UP | Num | 6 | PCSA-Pop White 65+ (2008 est) | Source: 2008 PCSA Population Estimates, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 320 | PS | PCSA Chars | PBA65\_UP | Num | 6 | PCSA-Pop Black 65+ (2008 est) | Source: 2008 PCSA Population Estimates, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 321 | PS | PCSA Chars | POA65\_UP | Num | 6 | PCSA-Pop Other Non-White & Non-Black 65+ (2008 est) | Source: 2008 PCSA Population Estimates, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 322 | PS | PCSA Chars | PPAGE65\_UP | Num | 8 | PCSA-% Pop 65+ (2008 est) | Source: 2008 PCSA Population Estimates, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 323 | PS | PCSA Chars | PPFEMALE | Num | 8 | PCSA-% Pop Female (2008 est) | Source: 2008 PCSA Population Estimates, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 324 | PS | PCSA Chars | PPWHITE | Num | 8 | PCSA-% Pop White (2008 est) | Source: 2008 PCSA Population Estimates, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 325 | PS | PCSA Chars | PPBLACK | Num | 8 | PCSA-% Pop Black (2008 est) | Source: 2008 PCSA Population Estimates, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 326 | PS | PCSA Chars | PPOTHER | Num | 8 | PCSA-% Pop Other Non-White & Non-Black 65+ (2008 est) | Source: 2008 PCSA Population Estimates, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 327 | PS | PCSA Chars | PHISPANIC | Num | 8 | PCSA-Pop Hispanic (2008 est) | Source: 2008 PCSA Population Estimates, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 328 | PS | PCSA Chars | PNON\_HISP | Num | 8 | PCSA-Pop Non-Hispanic (2008 est) | Source: 2008 PCSA Population Estimates, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 329 | PS | PCSA Chars | PHH\_08 | Num | 6 | PCSA-Number of Households (2008 est) | Source: 2008 PCSA Population Estimates, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 330 | PS | PCSA Chars | PMHI\_08 | Num | 8 | PCSA-Median Household Income (2008 est) | Source: 2008 PCSA Population Estimates, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 331 | PS | PCSA Chars | page0\_64 | Num | 8 | PCSA-Pop 0-64 (2008 est) | Source: 2008 PCSA Population Estimates, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 332 | PS | PCSA Chars | pma0\_64 | Num | 8 | PCSA-Pop Male 0-64 (2008 est) | Source: 2008 PCSA Population Estimates, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 333 | PS | PCSA Chars | pfa0\_64 | Num | 8 | PCSA-Pop Female 0-64 (2008 est) | Source: 2008 PCSA Population Estimates, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 334 | PS | PCSA Chars | pwa0\_64 | Num | 8 | PCSA-Pop White 0-64 (2008 est) | Source: 2008 PCSA Population Estimates, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 335 | PS | PCSA Chars | pba0\_64 | Num | 8 | PCSA-Pop Black 0-64 (2008 est) | Source: 2008 PCSA Population Estimates, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 336 | PS | PCSA Chars | poa0\_64 | Num | 8 | PCSA-Pop Other Non-White & Non-Black 0-64 (2008 est) | Source: 2008 PCSA Population Estimates, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 337 | PS | PCSA Chars | ppage0\_64 | Num | 8 | PCSA-% Pop 0-64 (2008 est) | Source: 2008 PCSA Population Estimates, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 338 | PS | PCSA Chars | ppma0\_64 | Num | 8 | PCSA-% Pop Male 0-64 (2008 est) | Source: 2008 PCSA Population Estimates, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 339 | PS | PCSA Chars | ppfa0\_64 | Num | 8 | PCSA-% Pop Female 0-64 (2008 est) | Source: 2008 PCSA Population Estimates, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 340 | PS | PCSA Chars | ppwa0\_64 | Num | 8 | PCSA-% Pop White 0-64 (2008 est) | Source: 2008 PCSA Population Estimates, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 341 | PS | PCSA Chars | ppba0\_64 | Num | 8 | PCSA-% Pop Black 0-64 (2008 est) | Source: 2008 PCSA Population Estimates, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 342 | PS | PCSA Chars | ppoa0\_64 | Num | 8 | PCSA-% Pop Other Non-White & Non-Black 0-64 (2008 est) | Source: 2008 PCSA Population Estimates, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 343 | PS | PCSA Chars | ppma65\_up | Num | 8 | PCSA-% Pop Male 65+ (2008 est) | Source: 2008 PCSA Population Estimates, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 344 | PS | PCSA Chars | ppfa65\_up | Num | 8 | PCSA-% Pop Female 65+ (2008 est) | Source: 2008 PCSA Population Estimates, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 345 | PS | PCSA Chars | pppwa65\_up | Num | 8 | PCSA-% Pop White 65+ (2008 est) | Source: 2008 PCSA Population Estimates, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 346 | PS | PCSA Chars | ppba65\_up | Num | 8 | PCSA-% Pop Black 65+ (2008 est) | Source: 2008 PCSA Population Estimates, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 347 | PS | PCSA Chars | ppoa65\_up | Num | 8 | PCSA-% Pop Other Non-White & Non-Black 65+ (2008 est) | Source: 2008 PCSA Population Estimates, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 348 | PS | PCSA Chars | PAR\_PC05 | Num | 8 | PCSA-Adj. Rate:Primary Care visits (2005 Medicare Part B & OPT) | Source: 2005 AMA Physician Workforce and Medicare Utilization Data - ZCTA and PCSA Layers, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 349 | PS | PCSA Chars | PAR\_AM05 | Num | 8 | PCSA-Adj. Rate:Ambulatory visits (2005 Medicare Part B & OPT) | Source: 2005 AMA Physician Workforce and Medicare Utilization Data - ZCTA and PCSA Layers, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 350 | PS | PCSA Chars | PAR\_ED05 | Num | 8 | PCSA-Adj. Rate:ER visits (2005 Medicare Part B) | Source: 2005 AMA Physician Workforce and Medicare Utilization Data - ZCTA and PCSA Layers, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 351 | PS | PCSA Chars | PAR\_RHC05 | Num | 8 | PCSA-Adj. Rate:RHC Primary Care visits (2005 Medicare OPT) | Source: 2005 AMA Physician Workforce and Medicare Utilization Data - ZCTA and PCSA Layers, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 352 | PS | PCSA Chars | PAR\_FQHC05 | Num | 8 | PCSA-Adj. Rate:FQHC Primary Care visits (2005 Medicare OPT) | Source: 2005 AMA Physician Workforce and Medicare Utilization Data - ZCTA and PCSA Layers, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 353 | PS | PCSA Chars | PHOS\_05 | Num | 6 | PCSA-All Discharges (2005 MedPar) | Source: 2005 AMA Physician Workforce and Medicare Utilization Data - ZCTA and PCSA Layers, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 354 | PS | PCSA Chars | PARHOS\_05 | Num | 8 | PCSA-Adj. Rate:All Discharges (2005 MedPar) | Source: 2005 AMA Physician Workforce and Medicare Utilization Data - ZCTA and PCSA Layers, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 355 | PS | PCSA Chars | PARREIM\_05 | Num | 8 | PCSA-Adj. Rate:All Reimbursement (2005 MedPar) | Source: 2005 AMA Physician Workforce and Medicare Utilization Data - ZCTA and PCSA Layers, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 356 | PS | PCSA Chars | PAS\_PC05 | Num | 8 | PCSA-SE of Adj. Rate:Primary Care visits (2005 Medicare Part B & OPT) | Source: 2005 AMA Physician Workforce and Medicare Utilization Data - ZCTA and PCSA Layers, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 357 | PS | PCSA Chars | PAS\_AM05 | Num | 8 | PCSA-SE of Adj. Rate:Ambulatory Care visits (2005 Medicare Part B & OPT) | Source: 2005 AMA Physician Workforce and Medicare Utilization Data - ZCTA and PCSA Layers, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 358 | PS | PCSA Chars | PAS\_ED05 | Num | 8 | PCSA-SE of Adj. Rate:ER visits (2005 Medicare Part B) | Source: 2005 AMA Physician Workforce and Medicare Utilization Data - ZCTA and PCSA Layers, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 359 | PS | PCSA Chars | PAS\_RHC05 | Num | 8 | PCSA-SE of Adj. Rate:RHC Primary Care visits (2005 Medicare OPT) | Source: 2005 AMA Physician Workforce and Medicare Utilization Data - ZCTA and PCSA Layers, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 360 | PS | PCSA Chars | PAS\_FQHC05 | Num | 8 | PCSA-SE of Adj. Rate:FQHC Primary Care visits (2005 Medicare OPT) | Source: 2005 AMA Physician Workforce and Medicare Utilization Data - ZCTA and PCSA Layers, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 361 | PS | PCSA Chars | PASHOS\_05 | Num | 8 | PCSA-SE of Adj. Rate:All Discharges (2005 MedPar) | Source: 2005 AMA Physician Workforce and Medicare Utilization Data - ZCTA and PCSA Layers, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 362 | PS | PCSA Chars | PASREIM\_05 | Num | 8 | PCSA-SE of Adj. Rate:All Reimbursement (2005 MedPar) | Source: 2005 AMA Physician Workforce and Medicare Utilization Data - ZCTA and PCSA Layers, [www.pcsa.dartmouth.edu](http://www.pcsa.dartmouth.edu) |
| 363 | PS | PCSA Chars | HC\_Users\_All | Num | 6 | PCSA-Ravi-Total Number of HC users | Source: PCSA level data from Ravi Sharma |
| 364 | PS | PCSA Chars | TotPop | Num | 6 | PCSA-Ravi-Total Pop | Source: PCSA level data from Ravi Sharma |
| 365 | PS | PCSA Chars | Penetration\_TotPop | Num | 8 | PCSA-Ravi-Pop Penetration | Source: PCSA level data from Ravi Sharma |
| 366 | PS | PCSA Chars | Unserved\_TotPop | Num | 6 | PCSA-Ravi-Unserved Pop | Source: PCSA level data from Ravi Sharma |
| 367 | PS | PCSA Chars | POVERTY\_LOW\_INCOME\_pop | Num | 6 | PCSA-Ravi-Low Income Pop | Source: PCSA level data from Ravi Sharma |
| 368 | PS | PCSA Chars | Penetration\_LowInc | Num | 8 | PCSA-Ravi-Low Income Penetration | Source: PCSA level data from Ravi Sharma |
| 369 | PS | PCSA Chars | Unserved\_LowInc | Num | 6 | PCSA-Ravi-Unserved Low Income | Source: PCSA level data from Ravi Sharma |
| 370 | PS | PCSA Chars | Users\_1PY | Num | 6 | PCSA-Ravi-previous year HC users | Source: PCSA level data from Ravi Sharma |
| 371 | PS | PCSA Chars | User\_1Yr\_Diff | Num | 4 | PCSA-Ravi-difference current & previous year HC users | Source: PCSA level data from Ravi Sharma |
| 372 | PS | PCSA Chars | Prcnt\_1Yr\_Diff | Char | 12 | PCSA-Ravi-% difference current & previous year HC users | Source: PCSA level data from Ravi Sharma |
| 373 | PS | PCSA Chars | Users\_2PY | Num | 6 | PCSA-Ravi-2 years previous HC users | Source: PCSA level data from Ravi Sharma |
| 374 | PS | PCSA Chars | User\_2Yr\_Diff | Num | 4 | PCSA-Ravi-difference current & 2 years HC users | Source: PCSA level data from Ravi Sharma |
| 375 | PS | PCSA Chars | Prcnt\_2Yr\_Diff | Char | 12 | PCSA-Ravi-% difference current & 2 years HC users | Source: PCSA level data from Ravi Sharma |
| 376 | PS | FIPS Chars | PRCNT\_HS\_UP\_25\_UP | Num | 8 | FIPS ACS 5-yr est-High School+ 25+ | Source: 2006-2010 American Community Survey 5 year estimates |
| 377 | PS | FIPS Chars | PRCNT\_HS\_UP\_25\_UP\_MOE | Num | 8 | FIPS ACS 5-yr est-MOE-High School+ 25+ | Source: 2006-2010 American Community Survey 5 year estimates |
| 378 | PS | FIPS Chars | PRCNT\_BD\_UP\_25\_UP | Num | 8 | FIPS ACS 5-yr est-Bachelors Degree+ 25+ | Source: 2006-2010 American Community Survey 5 year estimates |
| 379 | PS | FIPS Chars | PRCNT\_BD\_UP\_25\_UP\_MOE | Num | 8 | FIPS ACS 5-yr est-MOE-Bachelors Degree+ 25+ | Source: 2006-2010 American Community Survey 5 year estimates |
| 380 | PS | FIPS Chars | PRCNT\_HS\_UP\_65\_UP | Num | 8 | FIPS ACS 5-yr est-High School+ 65+ | Source: 2006-2010 American Community Survey 5 year estimates |
| 381 | PS | FIPS Chars | PRCNT\_HS\_UP\_65\_UP\_MOE | Num | 8 | FIPS ACS 5-yr est-MOE-High School+ 65+ | Source: 2006-2010 American Community Survey 5 year estimates |
| 382 | PS | FIPS Chars | PRCNT\_BD\_UP\_65\_UP | Num | 8 | FIPS ACS 5-yr est-Bachelors Degree+ 65+ | Source: 2006-2010 American Community Survey 5 year estimates |
| 383 | PS | FIPS Chars | PRCNT\_BD\_UP\_65\_UP\_MOE | Num | 8 | FIPS ACS 5-yr est-MOE-Bachelors Degree+ 65+ | Source: 2006-2010 American Community Survey 5 year estimates |
| 384 | PS | FIPS Chars | PRCNT\_BPL | Num | 8 | FIPS ACS 5-yr est-Below Poverty Line | Source: 2006-2010 American Community Survey 5 year estimates |
| 385 | PS | FIPS Chars | PRCNT\_BPL\_MOE | Num | 8 | FIPS ACS 5-yr est-MOE-Below Poverty Line | Source: 2006-2010 American Community Survey 5 year estimates |
| 386 | PS | FIPS Chars | PRCNT\_BPL\_65\_UP | Num | 8 | FIPS ACS 5-yr est-Below Poverty Line 65+ | Source: 2006-2010 American Community Survey 5 year estimates |
| 387 | PS | FIPS Chars | PRCNT\_BPL\_65\_UP\_MOE | Num | 8 | FIPS ACS 5-yr est-MOE-Below Poverty Line 65+ | Source: 2006-2010 American Community Survey 5 year estimates |
| 388 | PS | FIPS Chars | PER\_CAPITA\_INC | Num | 8 | FIPS ACS 5-yr est-Per Capita Income | Source: 2006-2010 American Community Survey 5 year estimates |
| 389 | PS | FIPS Chars | PER\_CAPITA\_INC\_MOE | Num | 8 | FIPS ACS 5-yr est-MOE-Per Capita Income | Source: 2006-2010 American Community Survey 5 year estimates |
| 390 | PS | FIPS Chars | MEDIAN\_HOUSE\_INCOME | Num | 8 | FIPS ACS 5-yr est-Median Household Income | Source: 2006-2010 American Community Survey 5 year estimates |
| 391 | PS | FIPS Chars | MEDIAN\_HOUSE\_INCOME\_MOE | Num | 8 | FIPS ACS 5-yr est-MOE-Median Household Income | Source: 2006-2010 American Community Survey 5 year estimates |
| 392 | PS | FIPS Chars | MEDIAN\_HOUSE\_INCOME\_65\_UP | Num | 8 | FIPS ACS 5-yr est-Median Household Income 65+ | Source: 2006-2010 American Community Survey 5 year estimates |
| 393 | PS | FIPS Chars | MEDIAN\_HOUSE\_INCOME\_65\_UP\_MOE | Num | 8 | FIPS ACS 5-yr est-MOE-Median Household Income 65+ | Source: 2006-2010 American Community Survey 5 year estimates |
| 394 | IP, OT\_IP\_ER, OT\_POS\_IP,OT\_LEFT, OT\_ER, OT\_Cap, RX2 | Costs | mdcd\_costs | Num | 8 | Total Medicaid Costs | Total Medicaid Payment Amount. Method of Calculation: Summed Medicaid Payment Amounts from OT\_LEFT, OT\_ER, OT\_Cap, IP, OT\_IP\_ER, OT\_POS\_IP, and RX. |
| 395 | IP, OT\_IP\_ER, OT\_POS\_IP,OT\_LEFT, OT\_ER, RX2 | Costs | tp\_costs | Num | 8 | Total Third Party Costs | Total Third Party Payment Amount. Method of Calculation: Summed Third Party Payment Amounts from OT\_LEFT, OT\_ER, IP, OT\_IP\_ER, OT\_POS\_IP, and RX. |
| 396 | IP, OT\_IP\_ER, OT\_POS\_IP,OT\_LEFT, OT\_ER, OT\_Cap, RX2 | Costs | tot\_costs | Num | 8 | Total Costs | Method of Calculation: Total Medicaid Payment Amount + Total Third Party Payment Amount. |
| 397 | IP, OT\_IP\_ER, OT\_POS\_IP,OT\_LEFT, OT\_ER, RX2 | Costs | php\_val\_costs | Num | 8 | Total Encounter Costs | Total Encounter Costs. Method of Calculation: Summed Encounter Costs from OT\_LEFT, OT\_ER, IP, OT\_IP\_ER, OT\_POS\_IP, and RX. |
| 398 | PS | Elg | chip\_only\_mo\_cnt | Num | 8 | Number of months of CHIP only eligibility | Method:   1. Calculated the number of months of MAX and/or CHIP eligibility. A month X is a MAX and/or CHIP eligible month if MAX\_ELG\_CD\_MO\_*X* not =00 or 99 or EL\_CHIP\_FLAG\_*X* not = 0 or 9, where X=1-12 i.e. January-December, in the PS file. 2. Chip\_only\_month\_cnt=( number of months of MAX and/or CHIP eligibility)- EL\_ELGBLTY\_MO\_CNT (i.e. number of months of MAX only eligibility). |

1. A month is considered a non-managed care month based on Option 4 described in Section 3.1. [↑](#footnote-ref-1)
2. See Section 7 for a description of how the OT file was split into several files. [↑](#footnote-ref-2)