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MEDICAID DATA

INTRODUCTION

The Medicaid program became part of Federal law in 1965 under Title XIX of the Social Security Act. Title XIX provides for a program of medical assistance to individuals with low incomes, financed by both Federal and state funds. Federal contributions to each state are based on a formula established by statute. The formula is designed to provide higher federal matching funds for states with relatively low per capita income.

States are required to report annual Medicaid program statistics to HCFA. These statistics include state-level summary utilization data on Medicaid recipients and services, and Medicaid recipient drug utilization data. The HCFA Medicaid files described in this chapter contain the statistics, data, and state plan information submitted to HCFA by states.

The Medicaid Data chapter contains three file groups:

- Medicaid Eligibles, Claims, and Utilization Files
- Medicaid Drug Rebate Files
- Medicaid Budget and Expenditure Files

The Medicaid Eligibles, Claims, and Utilization Files group consists of files that provide HCFA with detailed Medicaid claims information for more than half of the states participating in the Medicaid program, and summarized utilization information for all participating states.

The Medicaid Drug Rebate Files group consists of data files developed in response to a Congressionally mandated drug rebate program. These data are gathered by HCFA to track the cost of drugs in each state Medicaid program and to monitor implementation of the rebate program.

The Medicaid Budget and Expenditure Files group consists of data files that contain information on Medicaid-related expenditures and budget projections for each state Medicaid program.

MEDICAID ELIGIBLES, CLAIMS, AND UTILIZATION FILES

The Medicaid Eligibles, Claims, and Utilization Files group includes the following data files:

- Medicaid Valid Tapes Files
- Personal Summary Record File
- State Medicaid Research Files

- HCFA Form 2082 Totals File

States submit annual Medicaid program statistics to HCFA on standard HCFA forms. One such form required from states is the HCFA Form 2082 which contains state-level summary counts for Medicaid recipients and services, categorized by types of service and demographic characteristics. Such information enables HCFA to determine state and national trends in Medicaid enrollment and utilization. States have the option to submit the hard copy Form 2082 or to provide eligibility and claims data to HCFA.

HCFA manages the Medicaid Statistical Information System (MSIS), to collect raw Medicaid eligibility and claims data from states. When a state elects to participate in the MSIS project, it provides a copy of its eligibility and claims data to HCFA on tape. The MSIS processes and edits the data received from the state, and the data are used by HCFA to produce a HCFA Form 2082 for the state. The data provided by the state must pass MSIS edits for a consecutive number of quarters so that a valid Form 2082 is produced from the data submitted. When a valid and acceptable HCFA Form 2082 report is produced, that state is exempt from submitting a hard copy HCFA Form 2082. Until an acceptable Form 2082 report is produced using MSIS data, the state must continue submitting a completed hard copy form in addition to providing the data on tape.

While not all states elected to participate in MSIS prior to 1999, the number of available participants allowed HCFA to build a significant data source for analysis of Medicaid utilization patterns. The Balanced Budget Act (BBA) of 1997 mandated that all states participate in MSIS beginning in 1999.

Medicaid Valid Tapes Files

The Medicaid Valid Tapes Files include the Eligible, Inpatient Claims (Claim-IP), Long-term Care Claims (Claim-LT), and Other Claims (Claim-OT) Files. These files are created from data submitted by states to HCFA as part of the MSIS project. Once submitted, the state tape files are validated by HCFA and become the Valid Tapes Files.

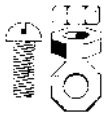
File Creation

Each quarter, states participating in the MSIS project provide HCFA with a tape file that contains information for all persons eligible for Medicaid in their state. This file is called the Eligible File. Participating states also provide quarterly tape files containing all adjudicated claims for medical services reimbursed with Medicaid funds during that quarter. There are three types of claims files, depending on the type of service reported: Claim-IP, Claim-LT, or Claim-OT. HCFA conducts QA edits to ensure that data are within acceptable error tolerance levels. Acceptable data are then recorded in the Valid Tapes Files. For some states, these files are available beginning as early as fiscal year 1985, but the data elements and years of available data vary by state.

The data contained in the Valid Tapes Files are limited to MSIS participating states and may vary because of varying state programs. The differences in the state programs complicate analysis of the data across states. As more states comply with MSIS participation, the amount of beneficiary and claim level data available will increase. As of 1998, 32 states were participating in the MSIS project:

Alabama	Minnesota
Alaska	Mississippi
Arkansas	Missouri
California	Montana
Colorado	Nevada
Delaware	New Hampshire
Florida	New Jersey
Georgia	North Dakota
Hawaii	Oregon
Idaho	Pennsylvania
Indiana	Rhode Island
Iowa	Utah
Kansas	Vermont
Kentucky	Washington
Maine	Wisconsin
Michigan	Wyoming

File Maintenance



When the new quarterly Valid Tapes Files are created by HCFA, existing files are updated with corrections. As the files are created and updated, basic edits are performed to ensure data quality. The edits performed on the eligible and claims files fall into four categories:

- Tests for numeric fields that contain non-numeric data
- Tests for 8- and 9-filling of fields, which indicate that a field was not applicable
- Tests for values outside established allowable ranges
- Relational tests for inconsistencies between two or more data elements

MSIS evaluates the first 500 records in each state's eligible tape to ensure that the current quarter records fall within the reported quarter. If more than 50 percent do not fall within the current quarter, the file is rejected and returned to the state without further evaluation.

MSIS also evaluates the first 600 records of a state's claim tape file for inconsistencies in payment date. If more than 50 percent of the current quarter claims have a payment date that is not consistent

with the reporting quarter, the file is rejected without further evaluation. States are required to sort their tape files by beneficiary. Improperly sorted eligible and claims files are also returned to the state.

Documented error tolerance levels for each data element in the eligible and claims files describe the maximum allowable percentage of records that may have missing, unknown, or invalid code combinations. Error rates in excess of the error tolerance level for any field cause the entire file to be rejected.

File Structure and Usage

States submit eligible and claims files each quarter. The Valid Tapes Eligible File contains one record for each person who was eligible for Medicaid for at least one day during the reporting quarter, one record for each individual who was determined to be eligible during the reporting quarter for a previous quarter, and records that correct previously submitted records.

The Medicaid Valid Tapes claims files contain several record types such as current claims for medical services, adjustments to previously paid claims, premium payments, and dummy claims. Dummy claims simulate claims that would have been generated for Health Maintenance Organization (HMO)/Prepaid Health Plan (PHP) patients if they were billed on a fee-for-service basis. Additionally, some states use zero-dollar claims for special purposes such as tracking individual services covered in a lump sum billing.

Three distinct claims files are created each quarter: the Claim-IP, Claim-LT, and Claim-OT. Each file reports detailed information for a different group of services. The Claim-IP File contains records for inpatient hospital services claims. The Claim-LT File contains records of claims for long-term care received in an institution. Long-term care includes services rendered in SNFs, ICFs for persons who are mentally retarded, psychiatric hospitals, and independent (free-standing) psychiatric wings of acute care hospitals.

The Claim-OT File contains all Medicaid claims not included in either the Claim-IP File or the Claim-LT File. These claims include the following:

- Provider payments for all non-institutional Medicaid services
- Provider claims for all services received in hospitals, SNFs, or ICFs that are not billed as part of long term or inpatient care such as physician visits and prescription drugs (Beginning in 1999, prescription drugs are submitted in a separate claim RX file.)
- HMO/PHP premium payments

- Claims for medical and non-medical services received under an approved Medicaid plan

The claims files are used for health care research and evaluation activities, program utilization and expenditure forecasts, analyses of policy alternatives, program management support at both the Federal and state levels, responses to Congressional inquiries, and longitudinal tracking of enrollees and services.

Because participation in the MSIS project was voluntary until January 1999, the data maintained in the Valid Tapes Files are limited to participating states, and vary from state to state.

Data Structure and Usage

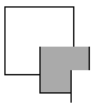
The Valid Tapes Files are stored at the HDC. The Eligible File contains personal characteristics information and monthly enrollment data for each Medicaid recipient. The monthly enrollment data are present for each month of the reporting quarter in which the individual is eligible for Medicaid. Each fixed length record contains approximately 20 data elements including general demographic information such as date of death, date of birth, sex, race, and county code as well as information regarding basis of eligibility and maintenance assistance status. The 1994 Valid Tapes Eligible File contains approximately 62 million records.

The claims files contain data elements that describe dates and place of service, payment amounts, and primary diagnosis. The Claim-IP File contains claims for inpatient hospital services. There are approximately 30 data elements on each fixed length record, including beneficiary identification, admission and discharge date, and procedure code data. The 1994 Claim-IP File contains approximately five million records.

The Claim-LT File contains claims for long-term care services received in an institution. The fixed length records have approximately 20 data elements that include beneficiary identification, diagnosis, and number of days of care. The 1994 Claim-LT File contains approximately 15 million records.

The Claim-OT File contains all Medicaid claims not included in either the Claim-IP File or the Claim-LT File. The fixed length records have approximately 20 data elements including number of units of service, state-specific service, and drug codes. The 1994 Claim-OT File contains approximately 540 million records.

Migration of Data



The Medicaid Valid Tapes Files have not been affected by the changing HCFA data processing environment.

List of Data Elements

A list of data elements contained in the Eligible File, along with brief definitions and coding schemes, will be included in the future on the HCFA web site at www.hcfa.gov. The data elements for the claims files are divided as follows: data elements in all claims files, data elements in both the Claim-IP and Claim-LT Files, data elements in the Claim-IP File only, data elements in the Claim-LT File only, and data elements in the Claim-OT File only.

Medicaid Personal Summary Record File

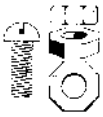
The Medicaid Personal Summary Record File was designed to provide a single source of data for Medicaid eligibles by state and fiscal year and to facilitate efficient analysis of state supplied eligible, recipient, and paid claims data. The file summarizes paid Medicaid claims data at the person level.

File Creation

The Personal Summary Record File is created only for states that submit data through MSIS. A list of participating states is contained in File Creation in the Medicaid Valid Tapes Files discussion. As more states participate in the project, more person-level data will be available. The Personal Summary Record File is created using quarterly validated eligible and claims files, any prior year fourth quarter Personal Summary Record File, and the prior quarter of the current year Personal Summary Record File. These files are merged to create a new quarterly year-to-date Personal Summary Record File. The Personal Summary Record File is available for some states beginning as early as fiscal year 1985.

When claims data are summarized for an individual who was eligible during the prior year but not the current year, the individual's demographic information is derived from the prior year Personal Summary Record File. Claims that cannot be linked to eligible data records are assigned a "dummy" MSIS identification number. All claims associated with a dummy MSIS identification number are summarized into a single record. Attempts are made to link these records to eligibility information obtained in future processing quarters.

File Maintenance



The Personal Summary Record File is updated quarterly throughout the fiscal year as described under File Creation. The annual file is a fourth quarter year-to-date file. Validated eligible and claims files used to populate the Personal Summary Record File may contain data errors that are identified

as a result of QA checks. Flags indicating the presence of these errors are coded within each eligible and claim file. Error flags can be assigned for incorrect data type, format, or logical relationship. These flags identify data that should not be included in the summarization of claims records into a Personal Summary Record File.

File Structure and Usage

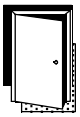
The Personal Summary Record File contains one summary record for each person participating in a state Medicaid program. The MSIS eligibility and claims data are summarized to provide eligibility and utilization information by individual. Each Personal Summary Record File contains one record for each unique MSIS identification number assigned to a Medicaid recipient. The records are sorted by identification number within a state.

As with the Valid Tapes Files, the Personal Summary Record File contains information for only those states participating in the MSIS project and years in which the state submitted tape data. The file can be used to study Medicaid utilization at the person-level.

Data Structure and Usage

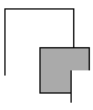
The data contained in the Personal Summary Record File include eligibility and utilization data summarized at the person-level. The data are used to analyze Medicaid utilization (e.g., cost by age group within states and services rendered to subsets of recipients) and are also used for program and policy evaluations. The 1994 file contains approximately 16 million fixed length records. Each record contains approximately 75 data elements including demographic information such as date of birth, age group, date of death, sex, and county code, basis of eligibility and maintenance assistance status; claims data such as total number of claims, total dollars paid for claims, and coinsurance flag; and type of coverage at the person-level. The file is available for some states as early as 1985.

Methods of Access



HDC users may access the Personal Summary Record File data directly through the menu-driven M204 Medicaid User Interface (MUI) Subsystem.

Migration of Data



The Personal Summary Record File has not been affected by the changing HCFA data processing environment.

List of Data Elements

A list of data elements contained in the Personal Summary Record File, along with brief definitions and coding schemes, will be included in the future on the HCFA web site at www.hcfa.gov.

State Medicaid Research Files (SMRF)

The State Medicaid Research Files (SMRF) are the Medicaid Eligibles, Claims, and Utilization files reformatted into file structures requested by researchers to facilitate the use of Medicaid data. The files are sorted by calendar year and by date of service. Adjustments have been applied, and new type of service and eligibility codes have been added. The Inpatient file contains stay records with maternal and neonatal claims separated where possible. A separate drug file has been created that includes injectables. The specific SMRFs are listed below:

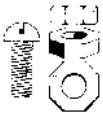
- Drug Claims Files
- Inpatient Claims Files
- Long Term Care Claims Files
- Other (Ambulatory) Claims Files
- Person Summary Files

File Creation

The SMRF data are created nine months after the end of the calendar year. The MSIS eligibility data for each state from the study year plus two quarters of the following year are processed to create a base eligibility record for the SMRF Person Summary File. This record is updated as each claim file is processed so that the Person Summary File is completed when the last claim file is processed.

The SMRF Drug, Ambulatory, Inpatient, and Long Term Care files are created separately for the MSIS Claims data. Adjustments are applied and some additional variables are created.

File Maintenance



SMRFs are created from the quarterly MSIS Valid Tapes. Because the MSIS files are by date of payment and because of payment lag time, SMRFs are created using seven quarters of MSIS data - the four quarters of the calendar being created and three quarters of the following year.

After the file has been created, the data are given a "preliminary review," which searches for programming errors and obvious data errors. Data dumps and SAS distributions are reviewed. The processing of adjustment records and the crosswalking to new data fields are scrutinized. Significant problems are corrected and the data files are recreated. Smaller problems and/or uncorrectable problems do not cause the files to be recreated but are noted in the data documentation.

The data are further reviewed in the Data Verification Phase and analyzed in depth using a number of statistical tools. Any anomalies and data quality problems are documented. The data summaries, distributions, and statistics are saved for researchers who need to perform further analysis of data patterns.

File Structure and Usage

While the data is essentially the same as the MSIS data, the file structure has been changed to accommodate researchers. The files are sorted by calendar year and by date of service with adjustments applied.

The MSIS Other (OT) files have been divided into Ambulatory and Drugs. The Drug file contains all drugs including injectables.

The MSIS Inpatient (IP) claims have been combined to form Stay records in the SMRF IP files. Maternal and neonatal are kept separate, if possible. States report these claims in various ways.

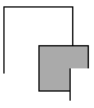
With the exception of adjustments, the MSIS and SMRF Long Term Care (LT) files should be virtually identical.

Data Structure and Usage

The SMRF Files mirror the MSIS Valid Tapes Files except they are consolidated based on date of service rather than date of payment. Furthermore, the following data are added:

- Neonate Indicator
- Delivery Indicator
- Additional Types of Service
- Additional Eligibility Codes

Migration of Data



The development of Medicaid SMRF files for calendar years 1996, 1997 and 1998 was delayed by Y2K priorities in HCFA. These files are now in production. Changes in MSIS reporting requirements were implemented for Medicaid agencies in fiscal year 1997 and 1998. Then, the BBA mandated reporting by all states beginning in 1999. As the BBA was mandated, additional changes in MSIS reporting requirements were implemented for fiscal year 1999. Each round of changes had an impact on selected SMRF data elements and their code values. Beginning in November 1999, new specifications for the 1996, 1997 and 1998 SMRF files were being developed.

List of Data Elements

A list of data elements contained in the SMRF Files, along with brief definitions and coding schemes, will be included in the future on the HFCA web site at www.hcfa.gov. The data elements for the claims files are divided as follows: data elements in all claims files; data elements in both the Claim-IP and Claim-LT Files; data elements in the Claim-IP File only; data elements in the Claim-LT File only; and data elements in the Claim-OT File only.

Medicaid HCFA Form 2082 Totals File

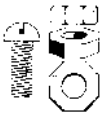
The Medicaid HCFA Form 2082 Totals File contains summarized eligible, recipient, and claim expenditure information similar to the information provided by the HCFA Form 2082 report.

File Creation

The HCFA Form 2082 Totals File contains summary counts of Medicaid recipients and services, categorized by type of service within states. The Medicaid HCFA Form 2082 Totals File is created from both hard-copy Form 2082 reports and MSIS data. The process by which these reports are submitted by the states or prepared by HCFA is described in the introduction to this file group. As more states participate in the MSIS program, and thus eventually become exempt from submitting hard-copy forms, the source of data for the HCFA Form 2082 Totals File will shift to the MSIS files submitted by states.

Each annual HCFA Form 2082 Totals File covers one fiscal year and is usually available in May of the following year. A HCFA Form 2082 Totals File is available for each fiscal year beginning in 1987.

File Maintenance



Preliminary versions of the HCFA Form 2082 Totals File are available almost immediately after the file is updated. A final version of the file is generally available in May of the following fiscal year. HCFA Form 2082 data are subjected to a series of arithmetic checks to ensure data accuracy and consistency. MSIS data are subjected to the verification process described in File Creation in the Medicaid Valid Tapes Files discussion.

File Structure and Usage

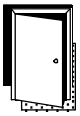
The HCFA Form 2082 Totals File contains total dollars expended or number of patients treated by Medicaid covered services; the file does not contain claim- or recipient-level data. The data are used

to determine trends in Medicaid coverage and utilization at the state and national level. The HCFA Form 2082 Totals File data are limited to what is reported by states in the HCFA Form 2082 report. The HCFA Form 2082 was supplemented in 1987 and 1989 to cover additional Medicaid eligible groups created by legislation. Subsequent changes in 1997 modified the eligibility categories, and in 1998, the service categories were updated.

Data Structure and Usage

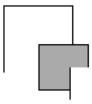
The HCFA Form 2082 Totals File is an annual statistical abstract of state Medicaid program characteristics. The file consists of a SAS table with approximately 7,000 data cells that include information on payment amounts, numbers of individuals enrolled and served, and service units. These cells are categorized by basis of eligibility, maintenance assistance status, demographic characteristics, and type of service. The data contained in the table correspond to the hard copy Form 2082 reports submitted by states. General state and national trends in Medicaid enrollment and utilization can be tracked with the data contained in this file. The years of data available vary by state, starting in 1987.

Methods of Access



The HCFA Form 2082 Totals File is available in hard copy or on diskette. Tables are created from the file and are available at the state or national level. The national level tables are available as a PUF. The summarized MSIS data used to create the file can be accessed through the menu-driven M204 MUI Subsystem. Additional information about the PUF is provided in the Public Use Files Data chapter. An online version of the HCFA Form 2082 Totals File that contains data only for MSIS participating states is also maintained.

Migration of Data



The HCFA Form 2082 Totals File has not been modified as a result of the changing HCFA data processing environment.

List of Data Elements

A list of data fields contained in the HCFA Form 2082 Totals File, along with brief definitions and coding schemes, will be included in the future on the HCFA web site at www.hcfa.gov.

MEDICAID DRUG REBATE FILES

The Medicaid Drug Rebate Files group includes two files maintained by HCFA to assist in the administration of the Medicaid drug rebate program mandated by Congress:

- Medicaid Drug Rebate Product Description File
- Medicaid Drug Rebate Utilization File

The Medicaid Drug Rebate Initiative (MDRI) was enacted as part of the Omnibus Budget Reconciliation Act of 1990. Effective January 1, 1991, drug manufacturers provide quarterly rebates to states for drugs dispensed to state Medicaid recipients. Manufacturers who want to participate in the Medicaid drug rebate program must sign a rebate agreement. The majority of the products produced by participating manufacturers are included in this rebate agreement.

States report Medicaid recipient drug utilization data to HCFA and to drug manufacturers approximately 60 days after the end of each quarter. Manufacturers must pay any undisputed rebate claims to the states within 30 days of receiving the drug utilization data. In addition, manufacturers must supply HCFA with the average manufacturer price (AMP) and best price for all their drugs in each calendar quarter. The AMP is the average unit price paid for a drug sold to retail pharmacies. The best price is the lowest price (excluding certain types of buying arrangements) for brand name drugs sold to any purchaser in the United States.

HCFA assists states by calculating individual drug rebate amounts that states can use to invoice drug manufacturers (each quarter). HCFA operates an MDRI information management system to perform this function.

Medicaid Drug Rebate Product Description File

Drugs that qualify for Medicaid vendor payment (i.e., provider, reimbursement) and for a manufacturer rebate are described and individually identified by National Drug Code (NDC) in the Medicaid Drug Rebate Product Description File. The NDC identifies the drug manufacturer, drug product, and package size. There is one NDC for each size drug package available from each manufacturer. The product descriptions contained in the file are provided by participating drug manufacturers.

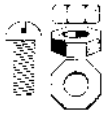
File Creation

Approximately 570 drug manufacturers submit product data to HCFA each quarter through one of three transmission forms: electronic transfer, microcomputer diskette, or hard copy. Manufacturers with very large product lines use the electronic transmission option. The diskette program option, which was designed by HCFA specifically for manufacturer data submission, is used by over 400 manufacturers. These manufacturers have from 15 to 2500 products. Hard copy data submission is a temporary option only for companies with very few products.

Hard copy submissions are entered online by HCFA staff. Electronic transmissions and data submitted on diskette are input into the MDRI System. As data are processed by the system, QA

edits are performed to verify field values. The Medicaid Drug Rebate Product Description File is updated quarterly.

File Maintenance



The Medicaid Drug Rebate Product Description File is a snapshot that is produced 45 days after the start of each quarter. Batch and online edits are performed as the file is updated to check for valid values in each field. Product reports are generated to show any discrepancies in unit type fields and to rank drugs according to Drug Efficacy Study Implementation (DESI) rating. Error reports are generated for invalid values. Error reports of rejected records are sent to manufacturers so that data can be corrected and resubmitted. The content of the descriptive drug product fields, which are submitted by manufacturers, are assumed by HCFA to be accurate and complete.

File Structure and Usage

The Medicaid Drug Rebate Product Description File contains individual drug product description information such as NDC code, product name, and Food and Drug Administration (FDA) information. There is one product record per NDC.

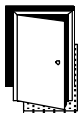
The file is used to identify all drugs that qualify for Medicaid vendor payment by a state and qualify for Medicaid drug manufacturer rebates to states. The Medicaid Drug Rebate Product Description File is also a valuable source of information on drug product attributes.

Data Structure and Usage

The Medicaid Drug Rebate Product Description File contains over 65,000 fixed length records. Each record contains the full product name as registered with the FDA, NDC code; identification of the drug as a single source, innovator multiple source, or non-innovator (generic) drug; type of unit used as a basis for rebate calculation and utilization measurement; DESI rating assigned by FDA to rate effectiveness and the FDA therapeutic equivalency code; FDA approval date; prescription or over-the-counter product; first full month product entered the market; and date product is no longer distributed by manufacturer.

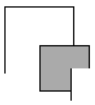
The drug rebate product description data are used within HCFA to operate the Drug Rebate Program and to develop legislatively mandated quarterly and annual reports to Congress.

Methods of Access



HCFA users may obtain browse-only access to the file data through the MDRI System. The Medicaid Drug Rebate Product Description File is also available in flat file format as a PUF. Additional information about this file is discussed in the Public Use Files Data chapter.

Migration of Data



The Medicaid Drug Rebate Product Description File has not been modified as a result of the changing HCFA data processing environment.

List of Data Elements

A list of data elements contained in the Medicaid Drug Rebate Product Description File, along with brief definitions and coding schemes, will be included in the future on the HCFA web site at www.hcfa.gov.

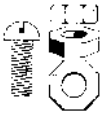
Medicaid Drug Rebate Utilization File

The Medicaid Drug Rebate Utilization File contains detailed, NDC-level Medicaid drug utilization data submitted to HCFA by states. The file consists of product description data for each drug dispensed to Medicaid recipients, the quarterly total Medicaid utilization of each drug, and total reimbursements (i.e., Medicaid vendor payments) made by the state for each drug.

File Creation

States submit data on tape to HCFA. The data include records for each NDC reimbursed under their Medicaid programs. As these data are input into the MDRI System, QA edits are performed to verify field values. Quarterly files are created from these data and are available beginning in 1991.

File Maintenance



Medicaid Drug Rebate Utilization files from previous quarters are updated continually as data for those quarters are received from states. QA range and format edits are performed that check for valid values in each field.

As part of the update process, HCFA sends letters to each state acknowledging receipt of data, detailing invalid values, and indicating whether the data were accepted or rejected. Utilization reports track state data submissions by quarter and the action taken on tapes that cannot be processed.

File Structure and Usage

The Medicaid Drug Rebate Utilization File contains one record for each drug reimbursed by a state Medicaid program within a quarter. Each record includes the total reimbursement amount derived from all individual claims paid by a state during the covered quarter.

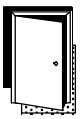
File information is based on date of state payment, not date of service. The file is used to generate reports to Congress to monitor the Drug Rebate Program. Private companies also purchase the file to determine how many units were sold under the Medicaid program each quarter and for marketing purposes.

The drug utilization data gathered in the file are limited to those states that report quarterly utilization information. All states, except Tennessee and Arizona, report this information. Also, due to the lag before data are received from the state, data are input into the system on a continuous basis. Beginning in fiscal year 1994, states began to incur penalties for late or incomplete data. At that time, data reporting became more timely.

Data Structure and Usage

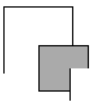
Each quarter the Medicaid Drug Rebate Utilization File contains about 20,384,900 fixed length records. The data elements contained in these records include drug product information identifying the individual drug; the number of units reimbursed (a unit is the smallest dispensable amount of a drug); the total reimbursement amount paid by the state including the dispensing fee; the total rebate amount claimed; and the number of prescriptions filled. Quarterly files are available beginning in 1991.

Methods of Access



HCFA users may obtain browse-only access to the Medicaid Drug Rebate Utilization File data through the MDRI System. The file is also available in flat file format as a PUF. Additional information about the public use version of the file can be found in the Public Use Files Data chapter.

Migration of Data



The Medicaid Drug Rebate Utilization File has not been modified as a result of the changing HCFA data processing environment. Utilization data are now available and are summarized by NDC and by state.

A list of data elements contained in the Medicaid Drug Rebate Utilization File, along with brief definitions and coding schemes, will be included in the future on the HCFA web site at www.hcfa.gov.

Medicaid and Children's Health Insurance Budget and Expenditure Files

Title XIX and XXI of the Social Security Act authorizes federal funding of the Medicaid and Children's Health Insurance Program (CHIP). To ensure that states receive an adequate amount of money to properly administer their programs, states are required to report budget estimates prior to the beginning of each quarter. They must also track and report Medicaid and CHIP related expenditures quarterly.

Title XXI of the Social Security Act authorizes federal funding of CHIP. The purpose of CHIP, enacted under the Balanced Budget Act of 1997 (BBA) and technical Amendments made by Public Law 105-100, is to provide federal matching funds to states to enable them to extend coverage to uninsured, low-income children in an effective and efficient manner. Under the BBA and technical amendments made by Public Law 105-100, states are allowed to provide federal matching funds to extend coverage to uninsured, low-income children in an effective and efficient manner through the Medicaid program.

HCFA collects state budget and expenditure data through the Medicaid and Children's Budget and Expenditure System (MBES/CBES). Budget information is reported on Form HCFA-37 and HCFA-21, the Medicaid Program Budget Report. This form provides a statement of the state's funding requirements for the upcoming quarter and certifies the availability of the requisite state and local funds. In addition, it provides both the state's budget estimates and the assumptions that underlie its projections for two fiscal years. This information is needed by HCFA to formulate and execute the national Medicaid budget as well as forecast the potential impact of proposed legislation on the Medicaid program. Further, the first quarter submission of the HCFA-37 and HCFA-21 serves as the basis in formulating Medicaid's portion of the President's budget.

Expenditure information is collected on Form HCFA-64, the Quarterly Medicaid Statement of Expenditures for the Medicaid Assistance Program. Form HCFA-64 is a statement of expenditures for which a state is entitled to federal reimbursement. This form also reconciles the monetary advancement made on the basis of the HCFA-37 and HCFA 21B filed previously for the same quarter. It is the vehicle by which states track and adjust overpayments and under payments made by the federal government.

CHIP expenditure information is collected on Form HCFA-21, the Quarterly Statement of Expenditures for the Children's Health Insurance Program. Form HCFA-21 is the state's accounting statement of actual recorded expenditures and the disposition of federal funds. It also reconciles the monetary advances made on the basis of the Form HCFA-21B.

The Quarterly Medical Assistance expenditures by Children's Health Insurance Program (Form HCFA-1) is the state's accounting statement of actual recorded expenditures and the disposition of federal funds which, in accordance with sections 2105(e) and 2107(b)(1) of the Act, must be submitted each quarter for Medicaid expansion.

MEDICAID BUDGET AND EXPENDITURES FILES

Title XIX of the Social Security Act authorizes federal funding of the Medicaid program. To ensure that states receive an adequate amount of money to properly administer their programs, states are required to report budget estimates prior to the beginning of each quarter. They must also track and report Medicaid-related expenditure quarterly.

HCFA collects state budget and expenditure data through the Medicaid Budget and Expenditure System (MBES). Budget information is reported on Form HCFA-37, the Medicaid Program Budget Report. This form provides a statement of the state's funding requirements for the upcoming quarter and certifies the availability of the requisite state and local funds. In addition, it provides both the state's budget estimates and the assumptions that underlie its projections for two fiscal years. This information is needed by HCFA to formulate and execute the national Medicaid budget as well as forecast the potential impact of proposed legislation on the Medicaid program. Further, the first quarter submission of the HCFA-37 serves as the basis in formulating Medicaid's portion of the President's budget.

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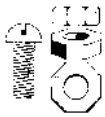
File Creation

The 50 states, District of Columbia, Guam, Northern Mariana Islands, Puerto Rico, American Samoa, and the Virgin Islands submit their Medicaid budget and expenditure data electronically through MBES/CBES directly to the HCFA Data Center quarterly. The HCFA-37 and HCFA-21B data is submitted on a November-February-May-August cycle; the HCFA-64 and HCFA 21 is submitted on an October-January-April-July cycle. As these reports are input into MBES/CBES, Quality Assurance edits are performed to verify the field values.

File Maintenance



The Medicaid and Children's Budget and Expenditure files are updated continually by the states and territories. The files may contain errors that are identified as a result of a verification process. Once verification is passed, the file cannot be altered. It is possible to remove the verified status and alter the data; however, the data must be verified again before being transferred to the Master File.

File Structure and Usage

MBES consists of nine Virtual Storage Access Method (VSAM) files. The following list identifies the VSAM files:

- HCFA-64 Transaction File
- HCFA-64 Master File. The HCFA-64 Transaction and Master Files contain the Medicaid expenditure data that are derived from source documents such as invoices, cost reports, and eligibility records. These files contain 11 types of records:

HCFA-64	Summary Data and Certification of the Submission
HCFA-649	Base Data for Medical Assistance Expenditures by Type of Service
HCFA-649	Waiver for Medical Assistance Payments (MAP) by Type of Service
HCFA-649P	MAP Data by Type of Service for Prior Period of Adjustments
HCFA-649O	Medicaid Overpayment Adjustments
HCFA-649A	Third Party Liability Collections and Cost Avoidance
HCFA-6410	Base Data for State and Local Administration Expenditures
HCFA-6410P	Waiver for Adjustments
HCFA-64	Narrative Data for Submission
HCFA-6421	Presumptive eligible Data for M-CHIP by Type of Service
HCFA-6421P	Presumptive eligible Data for M-CHIP by Type of Service-Prior Period
HCFA-6421U	Sec. 1905(u)(2) & (u)(3) Data for M-CHIP by Type of Service
HCFA-6421UP	Sec. 1905(u)(2) & (u)(3) Data for M-CHIP by Type of Service-Prior Period

- HCFA-21 Transaction File
- HCFA-21 Master File. The HCFA-21 Transaction and Master Files contain the Children's Health Insurance expenditure data that are derived from source documents such as invoices, cost reports, and eligibility records. These files contain six types of records:

HCFA-21	Summary Data and Certification of the Submission
HCFA-21Base	Base Data for Medical Assistance Expenditures by Type of Service
HCFA-21P	CHIP Data by Type of Service-Prior Period
HCFA-21L	Calculation 10% Limit for CHIP Expenditures
HCFA-21C	Allocation of Title XIX and Title XXI Expenditures to CHIP Fiscal Year Allotment
HCFA-21B	Estimate of Quarterly and Fiscal year CHIP Expenditures

- HCFA-37 Transaction File

- HCFA-37 Master File. The HCFA-37 Transaction and Master Files contain projected medical assistance payment data. These files contain five types of records:

HCFA-37.1	Estimate of Quarterly Grant Awards
HCFA-37.3	Estimated Medical Assistance Payments by Type of Service
HCFA-37.7	Estimated Average Number of Eligibles During Year
HCFA-37.8	Quarterly Distribution of Funding Requirements

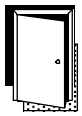
HCFA-37.10	State and Local Administration Payments
HCFA-37.12	Other Narrative Explanations

- Regional Office File contains the Regional Deferral Log and Regional Decision data
- Central Office File contains Deferral, Penalty, Grant Award, Offset, Medicaid Eligibility Quality Control (MEQC) Reduction, Waiver, and Disproportionate Share Hospital (DSH) data
- Federal Security File captures user information including security levels
- DSH Verify File

Data Structure and Usage

The Medicaid and Child Health Budget and Expenditure HCFA-64, HCFA-21, and HCFA-37 files contain approximately 1,200 data elements per state. These elements contain information on total computable and federal share amounts of medical assistance payments and administrative expenditures. Narrative explanations of variances in program expenditures are also captured. There are currently 11 years of data online.

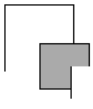
Methods of Access



HCFA users may obtain read access to the Medicaid budget and expenditure data through MBES. The system has a reporting capability that will allow users to print a variety of reports that track each state's expenditures and show national trends by comparing across all states in specific expenditure categories.

Data are available to users outside HCFA in the annual publication, *Medicaid Statistics*, a document that compiles profile data on the Medicaid population and Medicaid expenditures by region, state, and nation.

Migration of Data



MBES has not been affected by the changing HCFA data processing environment.

List of Data Elements

A list of data elements will be included in the future on the HCFA web site at www.hcfa.gov.