MSIS State Anomalies/Issues: All States

State	File	Record Type	Issue
AK	Claims	All	Alaska is not submitting any service tracking claims.
		Capitation	There aren't any capitation claims as Alaska doesn't have a managed care program.
		Encounter	Except for a few Early and Periodic Screening Diagnosis and Treatment (EPSDT) encounter claims, there aren't any encounter claims as the state doesn't have a managed care program.
		IP	About 20 percent of the claims are Indian Health Service (IHS) and therefore don't have ancillary codes as they are not billed on a Uniform Hospital Bill (UB-92) form.
		LT	At least half the claims have a Type of Service of 04 (Inpatient Psychiatric Facility Services for Individuals Age 21 Years and Under) which is much higher than expected.
			Alaska has a low percentage of Type of Service 07 [Nursing Facility (NF)] claims in the LT files as they have a relatively low senior population and an active waiver program. They also have a state-operated Pioneers Home system, separate from Medicaid, that provides services to many people who might be served by Medicaid NF institutions.
			The average Medicaid Amount Paid per day is about two times higher than expected, but is consistent across years.
			Some diagnosis codes are padded with zeros on the right as this is how providers formatted them on their submitted claims. The most common code with padded zeros is 311 (31100 and 3110). This situation was significantly improved starting with Quarter 2 (Q2) 2003.
			There is a lower than expected percent of claims with Patient Liability.
			There aren't any claims with a Type of Service of 05 [Intermediate Care Facilities for the Mentally Retarded (ICF/MR)] or 02 (Mental Hospital/Aged) as these are not covered.
		RX	Date Prescribed is always missing.
			There aren't any claims with a Program Type of 2 [Family Planning (FP)].
			A small percentage claims have a HCPCS Service Code instead of an NDC code in the NDC field.

State	File	Record Type	Issue
AK	Claims	RX	A small percent of NDC fields are 0-filled.
			There are only a few claims with Other Third Party Payment, also known as Third Party Liability (TPL).
			The Point of Service (POS) system results in few adjustments.
			Alaska started reporting IHS as a Program Type in Q2 2003.
	Eligibility	CHIP Code	Alaska reports its M-CHIP eligibles in MSIS. The state does not have an S-CHIP program.
			Beginning in FY 2001, there is a higher than expected discrepancy between MSIS and SEDS CHIP counts. It appears that the SEDS data are more reliable. The data become comparable in Q3 FY 2003, then differ again in Q1 FY 2004, due to an increase in SEDS reporting that quarter.
			Roughly 400 to 1000 M-CHIP eligibles under age 21 are mapped to MAS/BOE 35 each month. This could be an age sort issue.
			AK's MCHIP population with income 151% - 175% FPL will be reported to MASBOE 54 beginning Q1 FY05. These children are deemed eligible under AK's 1115 waiver guidelines - unlike children <150% FPL, they are subject to a 1yr "waiting period" without insurance.
		County Code	Alaska's county codes do not follow the usual pattern of three-digit odd numbers. However, they are correct.
		Dual Eligibility Flag	FY 2000: Alaska reports very few QMB and SLMB onlies (dual flags 01 and 03, respectively). In Alaska, the state supplement income standard is approximately 110 percent of poverty for a single individual, and 122 percent of poverty for a couple. Hence, the vast majority of QMB and SLMBs are eligible for full Medicaid benefits by virtue of their eligibility for the state supplement to SSI.
			We agreed that Alaska could assign dual code 99 to enrollees whose Medicare status is unknown. In Q1 FY 2003, no enrollees received dual code 99. Alaska reports very few QMB and SLMB onlies (dual flags 01 and 03, respectively). In Alaska, the state supplement income standard is approximately 110 percent of poverty for a single individual, and 122 percent of poverty for a couple. Hence, the vast majority of QMB and SLMBs are eligible for full Medicaid benefits by virtue of their eligibility for the state supplement to SSI.
			FY 2000:About 85 percent of persons age 65 and older are dual eligibles. This is a lower proportion than expected.

State	File	Record Type	Issue
AK	Eligibility	Health Insurance	More than 40 percent of Alaska's Medicaid population is enrolled in a private health insurance plan. This is much higher than we see in other states. It happens because of a high percentage are Native Americans and eligible for coverage under the IHS.
		Managed Care	No one in Alaska's Medicaid population is enrolled in a managed care plan.
		MAS/BOE	Alaska has a six months continuous eligibility guarantee for children. New enrollment for children is highest in the fall (August and September). July is a peak employment time in Alaska, contributing to a decrease in Medicaid enrollment each July. Alaska's data show a seam effect, with enrollment lowest in month 1 of each quarter.
		TANF/1931	There appear to be problems with the TANF flag, particularly in FY2001 and FY2002, when the state reports many more TANF enrollees than ACF data suggest. There was a smaller, though still considerable, discrepancy in FY1999 and FY2000. The state will begin 9-filling its TANF data in FY2003. Once the state's new system (the contract for which is currently under protest) is in place, the state will be able to report TANF data reliably.

State	File	Record Type	Issue
AL	Claims	IP	Alabama includes global payment claims for people enrolled in prenatal/delivery managed care. They generally represent about 75 percent of the IP claims. Alabama requested they be coded as FFS claims as they are based on services provided. They can be identified by a "58" in the first two positions of the Provider ID field. These claims are not billed on the UB-92 and so are missing data elements such as UB-92 Revenue Codes, patient status, and procedures.
			There is a high proportion of crossover claims because most non-crossovers are enrolled in managed care.
			Patient status is frequently missing.
		IP, LT, OT	On some claims in Q1 1999, the diagnosis codes are padded with an extra zero.
		IP/LT/OT	Between Q2 2000 and Q4 2002 Alabama coded most credit claims as crossovers (by 0-filling the coinsurance/deductible fields).
		LT	Very few LT claims have Other Third Party Payment (or Third Party Liability/TPL).
			There aren't any claims with a Type of Service of 04 (Inpatient Psychiatric Facility Services for Individuals Age 21 Years and Under).
			No claims have Leave Days in 1999. Starting in 2000 they are reported, but the percentage of claims with leave days varies widely by quarter, from 3 percent to more than 25 percent. Alabama reports this is correct.
			Only about one third of the claims have Nursing Facility Days in 1999. They are reported starting in 2000.
			Some facilities bill for more than a month, resulting in some claims having more than 31 covered days.
		Managed Care	Alabama has a prenatal/delivery managed care type program. They are not submitting capitation payments for people enrolled in this program. They pay global fees that are included in the IP file as Fee for Service (FFS). They can be identified by the first two bytes in the provider ID number (58). These claims should be in the OT file as capitation claims. But the state prefers to submit them in the IP file.
		MSIS ID	In 1999 to 2000, some of the adjustment claims had an extra character in the 20th position of the MSIS ID. This extra character needs to be removed in order to link the eligibility with the claims files. This situation was fixed starting with Q1 2001.

State	File	Record Type	Issue
AL	Claims	OT	The state did not start submitting individual PHP capitation claims until 2001. However, those PHP capitation claims contain the managed care plan beneficiary ID and not the MSIS ID. The state will have to resubmit these files correcting this problem. The credit adjustment claims do not include the Service Code, making it very difficult to properly adjust the claims. AL has under reported individual capitaion payments since Q1 1999. In 1999 HMO and PCCM capitations were reported as Service Tracking claims and there were no PHP payments although there was PHP enrollment. In 2000 individual PCCM capitation claims were submitted and the HMO and PHP capitation payments were submitted as service tracking claims. Also there were some PCCM Service Tracking payments as well. In Q1-3 2001 they only submitted some individual PHP and PCCM capitation claims and also Service Tracking claims for HMO, PHP and PCCM. Starting in Q4 2001 the file had a few individual HMO claims. During 2002-2003 there were individual PHP and PCCM payments and Service Tracking claims for HMO, PHP and PCCM.
		RX	RX claims with a Type of Service of 19 (Other Services) are for Clozapine Support System; this is a kit used to monitor the blood of individuals using Clozaril (a drug with significant potential negative side-effects). The NDC code on these claims is "CLOZSS." NDC's are not reported on credit claims. Very few RX claims have Other Third Party Payment (or Third Party Liability/TPL) in 1999.
	Eligibility	1115 Waiver	Alabama had an 1115 Waiver program (the Mobile County BAY Health Plan) that was active in FY99. The program was terminated, however, on 9/30/99. Beginning in FY2000 Q4, Alabama implemented a new 1115 Waiver. This 1115 welfare waiver provides family planning services for Plan First families.
		CHIP Code	Alabama reported its M-CHIP children, but did not report any of its S-CHIP children (a much larger program). In FY 2001, M-CHIP enrollment declined and enrollment phased out by Q1 FY 2003. Alabama did not ever report its M-CHIP program in SEDS.
		Correction Records	Through FY02 Q4, the state sent in correction records that erroneously made each person eligible for one month of the quarter automatically eligible for all 3 months. Invalid correction records caused monthly enrollment to be overstated in 99 MAX. Correction records should be ignored for 2000-2002 MAX.

State	File	Record Type	Issue
AL	Eligibility	County Code	Alabama assigns county code 100 to its Foster Care recipients.
		Dual Eligibility Flag	There appears to be a switch for duals with code 01 and 02 (QMB onlies and QMB pluses) between FY1999 Q1 and Q2. Roughly 5,000 duals who are reported with dual flag 01 in Q1 are reported with dual flag 02 in Q2 and beyond. There are no dual eligibles with dual flag 04 (SLMB plus full Medicaid) in FY1999 Q1. Beginning in FY1999 Q2, about 5,500 individuals with dual code 04 are reported each quarter. More than 16,000 eligibles in Q1 FY 1999 incorrectly received the dual code 08. They should have been coded as 09s. This change was made in subsequent quarters. Through September 2002, Alabama assigned dual flag 00 ("not Medicare eligible") to approximately 5,000 persons in MAS/BOE 31 - 32. These persons should have received dual flag 07 ("QI-2"). Not until Q103 were a substantial number of duals assigned code 07. The QI-2 program was discontinued in December 2002, although this is not reflected in MSIS files until February 2003. Through FY02, Alabama assigned dual flag 02 ("QMB & full Medicaid coverage") and 04 ("SLMB & full Medicaid coverage") to about 18,000 persons in MAS/BOE 32. These persons should have been assigned dual codes 01 ("QMB-only") and 03 ("SLMB-only"). The state fixed this problem beginning in FY 2003.
		Managed Care	More than 300,000 eligibles received Plan Type 08 each month. These persons were enrolled in what Alabama refers to as its "PHP Network." This is not a comprehensive managed care plan. Rather, the PHP Network provides only inpatient care for persons who do not have Medicare Part A coverage. In Q1 FY 2000, about 40,000 eligibles were no longer enrolled in a comprehensive managed care plan. According to the state, these persons were children in Mobile County who were enrolled in the Bay Health Plan. The plan was discontinued and the children moved into Primary Care Case Management (PCCM) plans. Although disparities exist between CMS and MSIS Medicaid managed care counts (between 8 and 20% discpancy in PCCM counts), Alabama assures us that the MSIS counts are more accurate. The United Medicare Complete is classified by the state as a Health Maintenance Organization (HMO) for dual eligibles. But the average capitation rate is only $15 indicating that it is very limited coverage. This plan does not include drug benefits. GA ended its PCCM "Patient First" program in Q2 FY04. All recipients were disenrolled from the program as of 3/1/04 forward.

State	File	Record Type	Issue
AL	Eligibility	MAS/BOE	Enrollment in MASBOE 14 declined by 8% from June to July 2004. AL has confirmed that this drop was due to changes in Medicaid redetermination responsibilities for TANF recipients. The drop occurred when many TANF recipients did not recertify their children.
			There were nearly 800 persons in state-specific eligibility group "L" who were incorrectly mapped to MAS/BOE 11 and 12 in Q1 FY 1999. They should have been mapped to MAS/BOE 31 and 32. This problem was corrected in subsequent quarters.
			AL reports almost no one to MASBOE 44-45 due to state coding limitations. Presumably TMA enrollees are included in the MASBOE 14-15 counts, as well as other 1913 enrollees.
			In the first month of Q1 FY 2001, enrollment in MAS/BOE 35 increased by about 5,000 before returning to its previous level in the following month. The jump in enrollment represented the added enrollment of about 5,000 women into a family planning program. Most of the women elected not to remain enrolled beyond the first month.
		Restricted Benefits	Effective Q4 FY 2000, persons in MAS/BOE 54-55 only qualify for family planning benefits. These persons are assigned restricted benefits code 4.
		SSNs	In Q4 FY 2001, about 850 Social Security Numbers (SSNs) were assigned to more that one person. This occurred because both correct and incorrect MSIS ID numbers were submitted with the same SSN. This problem cannot be fixed without resubmission of the entire file.
		State-Specific Eligibility Group	Alabama reports a four-byte state-specific eligibility group. Beginning in FY 2000, the deprivation code (bytes 3-4) became unreliable for eligibles in MAS/BOE 14 - 15. The information in these bytes comes from an external department in the state (DHR). These problems do not affect MAS/BOE mapping during the year.
		TANF/1931	Alabama experienced major problems with its TANF flag in FY 2000 and FY 2001. As a result, the monthly TANF information was not reliable. The state fixed the flag in FY 2002.

State	File	Record Type	Issue
AR	Claims	Adjustments	Claims that are voided and resubmitted may not always be tied to original claims so that sometimes both originals and resubmission are left in the file. ??Is this a MAX comment instead of an MSIS comment??
		IP	There aren't any claims with a Program Type of 2 (Family Planning).
			Each claim can only have a maximum of two diagnosis codes.
			Arkansas doesn't use Diagnosis Related Groups (DRGs).
		LT	Patient Liability is not shown on any LT claims.
			There aren't any claims with a Type of Service of 02 (Mental Hospital Services for the Aged), as is appropriate since this is not a covered service in Arkansas.
		OT	In 1999 to 2002, Arkansas submitted one Primary Care Case Management (PCCM) capitation payment claim per month for everyone enrolled in Medicaid, not just for the PCCM enrollees. This will be corrected starting with the Q1 2003 file.
			There is a big increase in the number of transporation claims starting in Q3 2004. However, since there is a big decrease in the average expenditure per claim, it appears that they are now billing separately for line items instead of span bills.
		RX	The few FFS debit claims appear to be all, or mostly, service tracking claims while credit adjustments are all individual claims.
			A larger than expected percent of claims have days supply greater than 30.
			Both the Fill Date and Prescribed Date fields contain the Fill Date through 2003 Q4. The state will '9' fill the Prescribed Date in future submission as it is not available.
	Eligibility	1115 Waiver	Arkansas has an 1115 Waiver program called ARKIDS B (called ARKIDS First when implemented in 10/97) and is reporting many of its poverty-related children into MAS/BOE 54. The adults in MAS/BOE 55 only qualify for family planning benefits.
		CHIP Code	AR had an M-SCHIP program until September, 2003. This program covered older children to 100 percent FPL. Age data suggest some of the persons being assigned M-SCHIP codes were over age 18 in FY02. By FY03, all persons with M-SCHIP codes were over age 18. AR reported more M-SCHIP children that were reported into the CMS SEDS system through 2002. No M-SCHIP children were reported to SEDS in 2003, even though they continued to be reported in MSIS.

State	File	Record Type	Issue
AR	Eligibility	CHIP Code	As of FY04 Q1, AR has been approved to establish an S-SCHIP program using 150 to 200 percent FPL, but it is not clear when this program will be implemented, or if it will be reported to MSIS. If the S-SCHIP program is implemented, the ARKIDS 1115 child coverage will be reduced from 200 to 150 percent FPL, except for children who do not meet the S-SCHIP requirements (for example, children of state employees).
		County Codes	Before Q1 FY03, the AR county code data are not valid.
		Dual Codes	Through Q1 FY03, AR dual eligible data were not fully reliable. AR did not report about 9,000 enrollees who had a Medicare match as duals. The state also reported approximately 7,500 false duals who did not have a Medicare match. The state does not have the original data required to improve its data for this earlier period.
		Health Insurance	AR's insurance data were not reliable until Q1 FY03. Until Q1 FY 2002, less than 50 eligibles are reported to have private health insurance each month. The level increased to over 1000 enrollees per month in Q1 to Q2 FY 2002, before dropping to about 200 per month in Q3. In Q1 FY01, it increased dramatically to 20,000/month, 3.8% of current enrollees.
		Managed Care	Until Q1 FY03, Arkansas reported PCCM enrollment in MSIS; however, it only reported PCCM enrollment for children in its ARKids program (MAS/BOE 54). This is a significant under-count (about 20 percent of total PCCM enrollment). This was not corrected until Q1 FY03. The state is not reporting any transportation-related managed care in its MSIS data. In Q3 FY02, CMS managed care data showed over half of Arkansas Medicaid enrollees participating in PCCMs and half in a transportation PHP.
		MAS/BOE	After Q3 FY 2000, Arkansas' enrollment data are always highest in month 1 of each quarter and then declines in months 2 to 3. Recent discussion with the state has indicated that they are not submitting retroactive records, as expected. Roughly three percent of the eligibles in BOE 1 are younger than age 65. Similarly, roughly 25 percent of eligibles in BOE 5 are younger than 21. Both proportions are greater than expected. In Q1 FY03, AR data show a large increase in enrollment (7% from September 2002). This occurred in part because the file was resubmitted late in 2004. SSI disabled enrollment in particular showed a big increase
		Restricted Benefits	Most adults in MAS/BOE 55 should have been assigned restricted benefits code 5 (other) since they only qualify for family planning benefits. This was fixed in Q1 FY03.

State	File	Record Type	Issue
AR	Eligibility	TANF/1931	The TANF flag is 9-filled for all eligibles.

State	File	Record Type	Issue
AZ	Claims	All	Since most people are enrolled in capitated managed care plans, FFS distributions are not always as expected.
			It is possible that all mental health claims may not be in file. Some IP psych claims may be in the IP and not the LT file.
		Crossovers	There are very few crossover FFS claims. This is because most dual eligibles are enrolled in managed care.
		IP	There aren't any claims with a Program Type of family planning due to special population in FFS.
			About one quarter of the claims are missing UB-92 revenue codes as they are Indian Health Service claims.
		LT	Arizona started reported the Program Type of Indian Health Service in Q2 2004.
			The percent of claims with Patient Liability is lower than expected.
			Beginning in 2001 all LT claims were mostly only paid in month 3. The state has no explanation, but believes all claims paid in each of those quarters are included in the files.
			Beginning Q2 2002, Arizona is unable to provide the IP covered days for Type of Service 04 (Inpatient Psychiatric Services for those Under Age 22). There are very few claims with this Type of Service.
			There aren't any claims with Other Third Party Payment (or Third Party Liability/TPL) due to the small FFS population.
			In the 2004 Q1-4 files only, the state does not report covered days on LT claims. The files were approved as AZ said it would be very difficult to fix due to system changes. Also the FFS claims are only slightly more than 10% of the file as it is a mostly managed care state. They are reported again beginning with Q1 2005.
		OT	There aren't any Federally Qualified Health Center (FQHC) claims because Arizona doesn't have a FQHC program.
			There are very few claims in the OT file with a Program Type of 5 (I.H.S.) prior to Q2 2004, but there are many people covered by the Indian Health Service
			The percent of outpatient hospital claims with UB-92 Revenue Codes codes went from almost 100 percent in 2000 to 36 percent in 2001.
			All capitation payment claims are coded as crossovers until Q1 2003.

State	File	Record Type	Issue
AZ	Claims	OT	The percent of local Service Codes went from 25 percent in 2000 to 50 percent in 2001.
			Up until 2003, Arizona was putting the total Medicaid Amount Paid from the claim header for OPD claims on each line item claim. This results in overstating the amount paid. Beginning in 2003, they created a summary OPD claim with the Medicaid Amount Paid for all line items, but without the line item service codes. The line item claims will show the details of the services, but the Medicaid Amount Paid will be $0 on each line item claim. There are lots of OPD claims.
			Arizona sometimes makes multiple capitation payments per person/month/plan to cover different plan services.
			The amount charged is mostly missing.
			There was a big increase in the percent of claims with Type of Service of 11 (Outpatient Hospital) from 2000 to 2001. Arizona investigated and has no explanation.
			The error tolerance is set at 100 percent for Diagnosis 1 but 95 percent or more of the claims actually have a diagnosis.
			There was a big increase in the average amount paid between 2000 and 2001 for Physician and outpatient hospital services. The state hasn't any explanation except volatility probably due to most people being enrolled in managed care.
			There aren't any FFS or encounter claims with a Program Type of Waiver Services. Arizona says that waiver services are being provided as part of managed care.
			There are large supplemental payment in some quarters of the OT file that are for transplant reinsurance.
		RX	The Other Third Party Payment (TPL) amount is always missing.
	Eligibility	CHIP Code	Arizona is not reporting S-SCHIP population in MSIS. The state does not have an M-SCHIP program.
		County Code	County Code 012 is the proper FIPS code for La Paz county, which was formed out of Yuma county in the early '80's.
		Dual Eligibility Flag	Arizona shifted many dual eligibles from 01 (QMB-only) to 02 (QMB-plus, or full Medicaid) between Q2 and Q3 FY 2001. Specified Low-Income Medicare Beneficiary (SLMB) only (dual code 03) and QI enrollees (dual codes 06 - 07) were generally not included in MSIS reporting until Q1 FY 2003.
		Foster Care	Arizona under-reported foster care enrollment in Q1 and Q2 1999. The problem was fully corrected in subsequent quarters.

State	File	Record Type	Issue
AZ	Eligibility	Health Insurance	In FY 1999, Arizona acknowledged that the number of persons with private health insurance was lower than it should be. They are making improvements to their TPL file, and the reporting increased somewhat in FY 2000.
		Managed Care	Arizona did not report enrollment in Behavioral Health Plans from FY 1999 to FY 2002. According to CMS data, there were about 50,000 BHP enrollees in Arizona in June 2002. The state began reporting BHP enrollment in FY 2003. However, the state had been submitting BHP Claims to MSIS all along. In Arizona, Plan Type 08 is used primarily to cover new eligibles who have not yet selected a managed care plan. In FY 2001, CMS Medicaid managed care data showed higher HMO enrollment than MSIS; however, the CMS data included S-CHIP managed care enrollment, while S-CHIP children were not included in the MSIS counts. In addition, many LTC plans appear to be reported as HMOs in the CMS data. In FY 2002, the variation between the sources is within the expected range.
		MAS/BOE	Durring 2001, Arizona also extended full Medicaid benefits to the aged and disabled with income <100 percent FPL (reported in group 372). However, this was not done under the OBRA 86 option, but instead AZ used an 1115 expansion. Generally, AZ MASBOE counts show a seam effect, with enrollement higher in Month 1 and declining in months 2 and 3. Hopefully correction records smooth out enrollment. State groups 585 (<100 percent FPL), 587 (<40 percent FPL) and 595 (spenddown to 100 percent FPL or less) are for adults with no children who are not otherwise eligible for Medicaid. These groups are part of the 1115 expansion waiver.
		MAS/BOE 2000	Effective Q3 FY 2000, each eligible in Arizona was assigned one and only one BOE during the year. Thus, enrollees who aged out of BOE 4 are not moved into BOE 5. Arizona reported increased enrollment in MAS/BOE 14 - 15 during FY 2000, attributable to a rapidly growing number of 1931 eligibles not receiving TANF benefits.
		MAS/BOE 2001	Beginning in April 2001, Arizona extended full Medicaid coverage to single adults and childless couples in MAS/BOE 55.
		MAS/BOE 2001-2002	Between Q3 and Q4 FY 2001, Arizona had a considerable amount of shifting between MAS/BOE groups. The shifts stemmed from the introduction of new Key Codes, as well as a new hierarchy for determining Medicaid eligibilty. During FY02 Q1-3, growth continued across several of the child and adult groups.

State	File	Record Type	Issue
AZ	Eligibility	Private Health Insurance	In Q4 FY04, the number of enrollees with third party health insurance dropped one third from 46,000 to 32,000. In October 2004, AZ verified the private medical coverage of enrollees, and found that many enrollees third party coverage had been terminated.
		Restricted Benefits	Arizona extends family planning only benefits to some persons in group 960. However, the state did not assign restricted benefits code 5 to these individuals until FY 2003.
		Retro/Correction Records	AZ data show some seam effect issues, but these are generally resolved with retro/correction records.
		TANF	Almost no one was flagged as a TANF recipient from Nov. 99 to Sept. 00. The state corrected this problem in FY01.

State	File	Record Type	Issue
CA	ALL	MSIS ID	There are about 500,000 people in the Calendar Year (CY) 1999 MSIS files that have claims, but no EL record. These are mostly preemptively eligible pregnant women. If they are later deemed to be eligible for Medicaid, they are assigned a new Medicaid ID that does not link back to the Temp ID.
	Claims	All	MSIS ID is missing on a few claims
		Capitation	The capitation claims for the hybrid PCCM program are reported with a Type of Service of 22 (PCCM capitation payment), even though California is now reporting that enrollment as "Other Managed Care." The capitation payment is $2.
		IP	A large % than expected of UB-92 Revenue Codes are not reported because of Short/Doyle and LA (Los Angeles) waiver hospitals. Claims may belong in LT file.
			DRG is missing as it is not used for reimbursement.
			Procedure codes 3 to 6 are not available from the state.
			There is a maximum of two diagnosis codes on IP claims.
			The percent of claims with a Patient Status of "still a patient" is higher than expected. This is perhaps due to the inclusion of Short/Doyle facilitates.
		LT	Diagnoses 2 to 5 are not available in the state source file, and therefore are not on the MSIS file.
			The percent with Patient Liability is lower than expected.
		OT	Outpatient hospital claims have Service Codes, not UB-92 revenue codes
		RX	There are many claims in the RX file with state-defined service codes (with a length of seven bytes or fewer) in the NDC field. Those are valid codes defined in California's MSIS application's attachment on service code definitions.
			The NDC field is 12 byte 8-filled for crossover drug claims as the NDC in unknown. This is the case for all CA files from 1999 through 2004.
		Waiver	Very few waiver claims, but state confirms that is correct. Detailed services not included.
	Eligibility	1115 Waiver	California introduced a very large 1115 Welfare Waiver program Family Planning, Access, Care and Treatment (FPACT) in December 1999, which covers family planning benefits for working age women. Enrollment immediately exceeded one million persons.

State	File	Record Type	Issue
CA	Eligibility	BCCA	Effective Q2 02, California begins to report women in the Breast and Cervical Cancer Treatment Act (BCCA) group.
		CHIP Code	California reports its M-CHIP enrollees, but not its S-CHIP population. Additionally, some M-CHIP enrollees in state-specific eligibility groups 7C, 8N, and 8T are correctly mapped to MAS/BOE 44. These children are undocumented aliens eligible for emergency services only.
		Date of Death	All dates of death are 8-filled or 9-filled
		Dual Eligibility	Until Q2 of FY03, CA mistakenly coded its 100% FPL group (state group IH) to dual code 04 (because special income disregards up to 33% of FPL allowed actual income to exceed 100% FPL). CA switched to using dual code 02 effective Q2 FY03. This dual code 02 includes persons whose income can exceed 100% FPL. This also explains why CA does not use dual code 04. CA had no SLMB's (Dual Code 04) in Q's 2-4 FY03. These individuals were recorded as 'Other' (Dual code 08). This will be corrected starting in FY04 Q2.
		Foster Care	In July and August 2001, there is an unusual dip in foster care enrollment.
		HIC Number	In FY 1999, about 10,000 dual eligibles have missing Medicare Health Insurance Claim (HIC) numbers. This field should be 9-filled in the event that the HIC Number is missing. This problem was corrected in FY 2000.
		Managed Care	California reports four to five million enrollees in dental PHPs each month. Only about 300,000 of these enrollees are reported in CMS counts, however. As it turns out, a small portion of California's dental enrollees are enrolled in "true blue" dental PHPs. These are the persons that appear in the CMS PHP data. The remaining enrollees participate in a hybrid FFS/PHP dental plan. The CMS data do not count these plans as PHPs, but MSIS does. In addition, beginning with FY 2000, California reports enrollment in several hybrid PCCM plans in plan type 8 (other) since these are limited risk contracts and not true PCCMs. However, these are reported as PCCMs in the CMS report. The number of personal plan type 08 - other decreased to under 1000 per month in Q4 FY03 compared to over 30,000 in previous quarters. CA eliminated two plans at this time. (Pacer County Managed Care Network, and Sonoma Partners for Health MC).

State	File	Record Type	Issue
CA	Eligibility	MAS/BOE	1931 changes, beginning in FY 2000, are significant. First, California stopped reporting eligibles into MAS/BOE 16 - 17 as part of its 1931 changes. Instead, persons who would have been in these groups are reported into MAS/BOE 14 - 15. Second, some groups previously reported into MAS/BOE 24 - 25 were moved to MAS/BOE 14 - 15 as a result of the 1931 changes. Over FY 2000 and 2001, 1931 enrollment grew, while enrollment in MAS/BOE 24/25 declined.
		MASBOE	CA covers all aged and disabled to 100% FPL.
		Race Code	The race field is unknown for four to ten percent of the Medicaid population.
		Restricted Benefits Flag	The one million FPACT eligibles are only eligible for family planning benefits.
		SSN	Roughly one quarter to one third of eligibles have 8-filled SSNs each quarter. This results in part from the fact that SSNs are not reported for the 1+ million persons who are 1115 FPACT Waiver eligibles. In addition, SSNs are often not available for unborns, newborns, undocumented aliens, and immigrants.
		TANF	TANF status is reported as "unknown" for about 100,000 to 150,000 eligibles beginning in Q1 FY 2000. L.A. county was unable to report TANF status. This continues through FY 2004.

State	File	Record Type	Issue
CO	Claims	Adjustments	There are both some positive credits and negative debits because the copay is deducted from line items. ??header copay deducted from first or several line items??
		IP	Colorado recodes CMS DRGs into state DRGs
		LT	The lower than expected percent claims with Patient Liability is due to switch from monthly to weekly billing
		OT	The Service Code is missing on numerous claims because the UB-92 is used for Home Health (HH), waiver, hospice and outpatient hospital.
			Colorado purchases private health insurance for some enrollees. The premium payments are Type of Claim (TOC) 2 and Type of Service 19
			There are several clms with amount paid = $99,999. This is a valid amount, not an improperly 9-filled field
			There are more claims than expected with $0 because of the way cost sharing is applied
			Lab/X-ray claims have diagnosis codes as that is how they receive them from providers.
			In December 2003, Colorado's fiscal agent reported that the state has been "redefining" national HCPCS and CPT codes to meet its own needs for many years. Requested copy of redefined codes, as yet not received.
			There are very few claims with place of Emergency Room/Emergency Department (ER) in Q1 1999 because Colorado didn't start reporting ER separately until Dec 1998.
			Colorado stopped paying PCCM capitation payments on June 30, 2004.
		RX	There are a lot of apparent duplicate claims in the 1999 RX files
			All compound drugs are coded as "COMPOUND" in the NDC field.
	Eligibility	CHIP Code	Colorado's separate State Child Health Insurance Program (S-SCHIP or S-CHIP) program is not reported in MSIS data. Colorado does not have an Medicaid expansion Child Health Insurance Program (M-SCHIP or M-CHIP) program.
		County Code	In Nov 2001, Broomfield county, FIPS code 14 was officially created in Census. The new county took parts of Boulder County (013), Jefferson County (059), and Weld County (123).
		Date of Death	The state does not report dates of death for any eligibles.

State	File	Record Type	Issue
CO	Eligibility	Dual Eligibility Flag	Prior to FY03 Q1, a specific dual eligibility flag code could not be assigned to about 20 percent of the dual population. These persons received dual flag "09."
		HIC Number	HIC numbers are 9-filled for about five percent of dual eligibles.
		Managed Care	There is an unusual drop in all types of managed care enrollment (comprehensive, PCCM, and behavioral) in Q2 FY 2001, compared to Q1, Q3, and Q4 FY 2001 and FY 2002. The state could not explain why this occurred. In 11/1/02, the United Healthcare and Kaiser HMOs were shut down. Effective 2/03, community Health Plan of the Rockies was terminated as well. In June 2002, there is a discrepancy between the BHP enrollment count in MSIS compared to the CMS managed care report. Colorado reports that this discrepancy was caused by the state's failure to include two of its BHP plans (Jefferson Center for Mental Health and Access Behavioral Care: Pikes Peak) in the CMS managed care report. However, the FY03 data showed a 26% discrepance in BHP counts. Nevertheless, the state asserts that its MSIS data are accurate. Effective July 2004, CO terminated its PCCM program.
		MAS/BOE	FY02, FY03, FY04: Each month, 50 to 100 persons were mapped to the invalid MAS/BOE combinations of 19, 39, or 49. CO shows many more SSI recipients in MAS/BOE 11 - 12 than SSA data, but this may relate to a state-administered SSI supplement. During FY 1999 and FY 2000, Colorado mapped about 4,000 to 5,000 disabled individuals into MAS/BOE 32 inappropriately, since they are reported to qualify for full Medicaid benefits.
		Retroactive Records	Colorado decided in April 2000 that they would use the delayed submission, rather than submitting retroactive records. They had initially elected to report retroactive eligibles in their MSIS application.
		SSN	About eight to ten percent of eligibles have the SSN field 9-filled.

State	File	Record Type	Issue
CT	Claims	Crossover	All crossover claims (IP/LT/OT) are in the OT file for FY 1999. Connecticut corrected the problem beginning with FY 2001.
		IP	In Q1 2003, 75 percent of the claims are adjustments, due to a rate change.
			The DRG and DRG grouper are missing as they are not used for reimbursement.
			Chronic disease hospital claims are in the IP file. This impacts UB-92 Revenue Codes, Patient Status codes and LOS
		LT	The Admission Date is always missing.
		OT	The percent with Place of Service of 11 (Office) is lower than expected because Place of Service is not reported on Home Health claims and there are a large number of those claims.
			The MSIS ID on HMO capitation claims do not match the EL file from 2000 through Q2 2002. The state resubmited the Q1 2002 and forward OT files with the MSIS ID corrected. According to the state, the MSIS ID on the HMO capitation claims is the same as on the EL file, except that in the OT file, it is right justified with leading zeros and in the EL file it is left justified.
			In 2004 Q1 there is a big drop in the average Medicaid Amount Paid on original, FFS, non-crossover claims with Types of Service of 15 (Lab/Xray), 10 (Other Practitioners), 19 (Other Services) and also Program Type Home- and Community-Based Services (HCBS). That was the first quarter of a new system.
			The percent of HH claims is high because the state is able to submit line item services instead of just a summary bill.
			There are a few state-specific codes that have more than one definition, but the state only uses one Service Code Indicator so the correct definition for those codes can't be determined.
		RX	Date Prescribed is always missing.
	Eligibility	CHIP Code	CT has an S-SCHIP program, but they are not reported in MSIS.
			Connecticut is not able to identify M-CHIP eligibles. M-CHIP children belonged to certain state specific groups that also include non-CHIP children. As a result, these state-specific groups are coded as 9 (CHIP status unknown) for the CHIP indicator. The M-CHIP program phased out over time. In Q4 FY02, M-CHIP enrollment according to SEDS was 1,273 personmonths. There was no enrollment reported in SEDS FY03.
		Dual Eligibility Flag	In FY2001, enrollment in QMB only, SLMB only, and QI programs increased, following a special outreach effort.

State	File	Record Type	Issue
CT	Eligibility	Foster Care	Until Q2 FY 2002, a higher than expected proportion of foster care children were older than age 20.
		MAS/BOE	In FY04 Q3, CT changed how it counts income, shifting some aged/disabled from MASBOE 21-22 to MASBOE 41-42. In FY 2001, enrollment in MAS/BOE 34 declined, while MAS/BOE 44 - 45 enrollment increased. This was due in part to changes in financial rules. CT exhibits a "seam effect" between the third month of a quarter and the first month of the next quarter. The state reports a large number of retroactive eligibles, however, which presumably smooths out the seams. From Q1 to Q2 FY02, foster care (MASBOE 48) enrollment declined by 18% for an unknown cause. According to MAX data, correction records made this reduction effective in January, 2001 (Q2 FY01).
		Retroactive/Correction Records	Connecticut had an unusually high number of retroactive and correction records in Q1 and Q2 FY 2003 when it made some system adjustments.
		SSI	Connecticut is a 209(b) state and only reports about half of the SSI population in MAS/BOE 11 - 12. Part of the problem is that the state does not report disabled children who quality for Medicaid in MAS/BOE 12.
		SSN	In each quarter of 1999, a few Social Security numbers are "0-filled" or "8-filled." They should be "9-filled" if unknown. CT reports about 600 duplicate SSN's each quarter.
		TANF/1931	Connecticut cannot identify its TANF population. The field is 9-filled for all eligibles.

State	File	Record Type	Issue
DC	Claims	All	Other Third Party Payment (or Third Party Liability/TPL) is missing on all claims, except a very few in the RX file
		Crossovers	There are fewer than expected percent of crossover claims.
		IP	The average amount paid per IP claim has always been higher than expected. Prior to 2003 it was around $10,000 and by 2003 Q1 it increased to about $12,000.
			Up until 2002 Q4 some claims do not have UB-92 for accommodations due to partial hospitalizations, according to the state.
			DRGs are not included on about one-third of the claims until Q4 2002 when they were reported on most IP claims.
			The average length of stay is about eight days which is higher than expected. The state confirms it is correct.
			There is a higher percentage of claims than expected with a Patient Status of 30 (Still a Patient).
		LT	In 2003 Q3, Washington DC was unable to identify crossover claims and, since most claims in the LT files are non-crossovers, all the LT claims are reported as non-crossovers.
			There are no crossover claims in Q4 2002.
			Other Third Party Payment (or Third Party Liability/TPL) is not reported in the LT files.
			Most LT claims had a diagnosis code of 799.9 until Q4 2002 when they are converted to "unknown."
			The percent of claims with Type of Service 02 (Mental Hospital Services for the Aged) and 04 (Inpatient Psychiatric Facility Services for Individuals Age 21 and Under) is quite variable from quarter to quarter, probably because there are so few of them and also the billing cycle.
		OT	All claims with a Type of Service of 11 (Outpatient Hospital) have Service Codes instead of UB-92 Revenue Codes as they bill using the CMS-1500 claim form.
			There are fewer waiver claims then expected in 1999, but the percent increased slightly in 2000.
			There aren't any claims with a Program Type of 4 (FQHC).
			The percent of claims with a Place of Service of 99 (Unknown) dropped from about 40 percent in 1999 to under 20 percent in 2002.

State	File	Record Type	Issue
DC	Claims	OT	The average amount paid on clinic claims doubled in Q1 2003 as there were over 61,000 old (1999 to 2002) Washington DC Family Service claims paid in that quarter. The amount paid on those claims were either $452 or $646. There were about 100,000 more claims in Q2 FY 1999 than in the other three quarters of the year. In Q4 2000 the state starting submitting claims with state-defined Service Codes. The distribution and payment for services varies widely from quarter to quarter. In Q1 2000 one provider submitted lots of old claims. There are very few claims with Type of Service of 09 (Dental) in the OT file. Washington DC confirms that is correct. There is an increase of about 200,000 claims in Q1 2000. They are mostly clinic claims and the state has no explanation.
		RX	There are very few claims with a Program Type of 2 (Family Planning).
	Eligibility	CHIP Code	DC is reporting its M-CHIP data. DC does not have an S-CHIP program. From Q1 FY 2000 through Q2 FY 2002 (except Q1 FY 2001, when the numbers compared well), more M-CHIP children were reported in MSIS that the CMS SEDS system, however, DC maintains that the MSIS numbers are more reliable.
		Dual Eligibility Flag	Before Q1 FY 2002, only 85 percent of DC's aged Medicaid population were reported as being dually eligible for Medicaid and Medicare. In addition, DC was not able to assign a specific dual eligibility code to 60 to 65 percent of its dual population. Instead, these eligibles were assigned dual code value 09. Also, until Q1 FY 2002, DC did not include the following groups of duals in its MSIS data: SLMB-only, QI, QII, QWDI. Information on these eligibles was not retained in DC's MMIS until Q1 FY 2002. DC provides full Medicaid benefits for the aged and disabled up to 100 percent FPL. As a result, there are hardly any QMB-Only eligibles (about 100).
		Dual Eligiblity Flag	In FY2002 Q1-2, DC's dual reporting correctly uses dual code 08. In FY02 Q3-4, DC did not use dual code 08, and erroneously used dual code 09. From FY03 Q1 forward, DC's dual reporting correctly uses dual code 08, and does not report any individuals to dual code 09. This inconsitency in reporting occurred because DC resubmitted its FY02 Q1-2 data to correct an MSIS ID problem, and simultaneously updated its dual reporting. FY02 Q3-4 data were not resubmitted because the MSIS ID problem had already been corrected.

State	File	Record Type	Issue
DC	Eligibility	Health Insurance	DC reported a lower than expected proportion of eligibles with private health insurance (1.3 to 1.4 percent) until Q1 FY 2002.
		HIC Number	About 20 to 25 percent of the dual eligible population did not have valid HIC numbers until Q1 FY 2002.
		Managed Care	MSIS reports the "Health Services for Children with Special Needs" plan as an HMO. However, this plan is reported as a "Medical-Only PHP" in the CMS managed care report.
		MAS/BOE	A noticeable increase in aged enrollees occurred in Q1 FY 2002 when DC began reporting several restricted benefit dual groups for the first time. The state provides full Medicaid benefits for the aged and disabled up to 100 percent FPL.
		MSIS ID	DC changed its MSIS ID numbering scheme in Q1 2002.
		SSI	Relative to the number of aged and disabled SSI recipients, DC reported 25 percent to 30 percent more eligibles under MAS/BOE 11 and 12 through FY 2000. Effective Q4 FY 2001, this problem begins to subside. In FY 2003 and FY 2004, MSIS counts were 14 percent higher. Part of the discrepancy may be due to the fact that DC has a state-administered supplement.
		SSN	About 3 percent of eligibles do not have valid SSNs.

State	File	Record Type	Issue
DE	Claims	Adjustments	There are very few adjustments (less than one percent). Delaware confirms this is correct.
			There are no adjustment claims in the Q4 2002 or Q1 2003 IP file due to system changes.
		All	Delaware changed systems in Q4 2002. There are problems with claims for that quarter. Mostly, there is a shortfall of claims and a significant shift in the Types of Services reported and average amount paid for some services. Delaware believes that this will be remedied in future submissions.
		Capitation	There aren't any PCCM capitation claims because PCCM providers are paid on the basis of services provided, not a capitated rate.
			There aren't any PCCM capitation claims in the OT file as case management is paid on a FFS basis and not a monthly payments.
		Crossovers	Beginning with Q4 2002, Delaware will begin submitting OT XO claims with one record per line item, without Medicaid Pd, Coinsurance/Deductibles, and Charge as those amounts are only carried on the header. They will submit a separate header claim with those summary amounts.
		IP	The state pays for bundled services for Services for Children, Youth and their Families (DSCYF) that includes inpatient care. These claims do not have UB-92 revenue codes, Patient Status or Admission Date. The number of these bundled claims nearly doubled between Q1 and Q2 1999.
			There weren't any claims with a Patient Status of 30 (Still a Patient) until 2002.
			DRGs are not included as they aren't used for reimbursements.
			There aren't any claims with Program Type of 2 (Family Planning).
			The percent of claims without UB-92 Revenue Codes declined in 2000.
		LT	Other Third Party Payment (or Third Party Liability/TPL) is missing on all claims.
			There are no covered days on claims with a Type of Service of 04 (Inpatient Psychiatric Facility Services for Individuals Age 21 and Under).
			There was a big increase in adjustments in Q2 1999 as that is when the claims are adjusted to accommodate rate changes.
			Leave days are not reported in the Q1 2003 LT file due to a system change.

State	File	Record Type	Issue
DE	Claims	LT	There are no claims with a type of service of IP Psych < 21 years starting with Q4 2003.
		OT	Payments for PCCM services are service based and not paid as capitation claims.
			In the 2003 Q2-4 OT files, about 50% of the claims have a type of service of 'other services'.
			Starting with Q4 2002, the state began submitting Home Health services at the line item level resulting in more Home Health claims with a lower Medicaid Amount Paid.
			Place of service is missing on the majority of claims.
			There is very large increase in the number of OT claims in 2003 Q3 as the state was catching up with a delay in processing due to a system change.
			There was a change in the distributions on some types of service from Q1 to Q2 1999 due to inconsistencies in submission of bills. Also, prior to January 2000, people with private health insurance were not allowed to enroll in managed care. About 2000 people were moved to managed care as a result of the rule change.
			For some reason, the average expenditure for clinics doubled in Q4 2000.
			Claims with a Type of Service of 26 (Transportation) make up between 26 to 40 percent of all services. Starting with Q1 2003, there will be a transportation managed care program.

State	File	Record Type	Issue
DE	Claims	OT TOS	claims from school districts that have been providing a high volume of services from school nurses, school psychologists, PT/OT/ speech therapists,and transportation providers to Medicaid children. These claims were being assigned to about four State service categories (Other Practitioner, PT/OT/Speech, Other and Transportation) and the equivalent MSIS service types until we switched from locally assigned State codes to regular HCPCS/CPT-4 codes around the end of 2003.. When this happened the new codes did not automatically map to the internal or State service categories used for the old codes. They went to unknown in our State category of service crosswalk. And, these claims have stayed in the Unknown category until March 2005 when we added the new codes to the State category of service crosswalk. claims from school districts that have been providing a high volume of services from school nurses, school psychologists, PT/OT/ speech therapists,and transportation providers to Medicaid children. These claims were being assigned to about four State service categories (Other Practitioner, PT/OT/Speech, Other and Transportation) and the equivalent MSIS service types until we switched from locally assigned State codes to regular HCPCS/CPT-4 codes around the end of 2003.. When this happened the new codes did not automatically map to the internal or State service categories used for the old codes. They went to unknown in our State category of service crosswalk. And, these claims have stayed in the Unknown category until March 2005 when we added the new codes to the State category of service crosswalk. Switch to national HCPCS codes in late 2003 caused Delaware to lose the ability to easily report claims for therapy services provided by school districts into separate MSIS Types of Service -- PT/OT, Other Practitioner, and Transportation were all used for these services before. Until the end of 2005, Delaware will report all these services in TOS 19 because they don't have the resources to code each procedure code separately. This causes TOS 19 to greatly increase as a percent of the OT file.
		RX	Some drug expenditures are bundled as part of the NH bundled rate and information about those specific drugs are not available in the MSIS files. New Refill Indicator is always missing. Date Prescribed is always missing. Some drugs are included in the NH bundled rate and not as individual drug claims.

State	File	Record Type	Issue
DE	Claims	RX	All compound drugs are coded as "COMPOUND" in the NDC field.
		TPL	There aren't any claims with Other Third Party Payment (or Third Party Liability/TPL) as Delaware is a "pay and chase" state
	Eligibility	CHIP	In Q4 FY 2002, Delaware added an M-CHIP program for infants 186 to 200 percent FPL. This program was not reported to the CMS SEDS system until FY04.
			Deleware's S-CHIP program is not being reported into MSIS.
		Dual Eligibility Flag	Delaware moved to a new MMIS system in Q3 FY 2002 with EDS. They hope to be able to report QI1s consistently by FY 2004.
			Initially, Delaware had difficulty coding the dual eligibility flag at the level of detail requested. Qualifying Individuals (QI1s and QI2s) were reported as SLMB onlies (dual code = 03), although some sporadic QI reporting occurred in FY 2000 to FY 2002. Also, Delaware has had difficulty identifying some full QMBs and full SLMBs. Prior to Q1 FY03, these dual eligibles were categorized using dual code 09; in Q1 FY03 on, the state began using to dual code 08 for these enrollees.
		Managed Care	In Q1 FY03 the state began to report enrollment in a transportation PHP. This transportation plan is not reported in CMS MC data.
			In Q4 FY 2002, the number of HMOs dropped to one.
			From FY 1999 to FY 2002, the majority of eligibles were enrolled in two HMOs as part of the state's 1115 demonstration. Delaware began to report PCCM enrollment as well in Q4 FY 2002, however, this is not reported in CMS managed care data.
		MAS/BOE	Effective 1/02, Delaware began to change its coding so that only TANF and 1931 eligibles (state group 71) were reported to MAS/BOE 14 and 15, while transitional assistance eligibles (state group 81) went to MAS/BOE 44 and 45. Since transitional assistance eligibles were previously reported to MAS/BOE 14 - 15, this caused an increase in MAS/BOE 44 - 45 enrollment in Q2 FY 2002. However, in Q3 and Q4, enrollment in MAS/BOE 14 - 15 expanded due to growth in the 1931 program.
			Delaware's 1115 Waiver program extends full Medicaid benefits to adults with income to 100 percent FPL. It also extends family planning benefits (only) for 24 months to women leaving Medicaid (State Specific Group F3).

State	File	Record Type	Issue
DE	Eligibility	MAS/BOE	Initially, a few groups could not be correctly mapped to MAS/BOE due to coding constraints. These include eligibles in 1619(b), some foster care children, and some 1931 eligibles. However, the state fixed its 1931 reporting effective 1/02 and began to report 1619(b) eligibles (state group 20) in Q4 FY 2002. During FY 1999, several changes occurred in eligibility mapping and eligibility policy which make it difficult to track Delaware?s eligibility counts by MAS/BOE group for FY 1999. For Q1 1999, Delaware reported some 1931 eligibles to MAS/BOE 44/45 since they were included with transitional assistance eligibles in aid category 81 (all 1931 eligibles should have been reported into MAS/BOE 14/15). Then, effective 1/99, the state started using a new classification approach for eligibility. In the new classification approach, all 1931 eligibles were correctly reported into MAS/BOE 14/15. However, transitional assistance eligibles were also reported into MAS/BOE 14/15 effective 1/99 (instead of MAS/BOE 44/45). As a result of these changes, the number of eligibles in MAS/BOE 44/45 sharply declined in Q299. Researchers should be aware then that the types of eligibles mapped into MAS/BOE 14/15 and 44/45 are not consistent during 1999. Further complicating any analysis, the state expanded its interpretation of 1931 eligibility rules beginnning in 1999. As a result, the number of children and adults reported into MAS/BOE 34 and 35 declined somewhat in Q2, while the numbers in MAS/BOE 14 and 15 appeared to grow by a commensurate amount. The patterns finally stabilize in Q3 and Q4 1999. Over time in FY 1999 and 2000, as a result of the 1931 expansion, we see an increasing number of eligibles in MASBOE 14-15 who are not TANF eligibles.
		Restricted Benefits	Enrollees in state group F3 (in MAS/BOE 54 - 55) are assigned restricted benefits code 5 (other). They only qualify for family planning benefits.
		SSN	A few SSNs were 0-filled in FY 1999 and FY 2000. They should be 9-filled.
		TANF	Beginning with Q4 FY 2000, Delaware 9-fills TANF status.

State	File	Record Type	Issue
FL	All	MSIS ID	The MSIS IDs on the claims and most of the EL records are nine bytes, with a check digit in the 10th position. There are a few EL records with a nine-byte MSIS ID. The check digit was not always set the same between claims and eligibility. Since the nine-byte MSIS ID uniquely identifies enrollees, the EL file can be unduplicated by dropping the 10th byte, sorting the file by the nine-byte MSIS ID and dropping the duplicate records. The claims files can be made to link correctly with the EL files by dropping the 10th byte as well.
	Claims	IP	Large expenditures are reported on service tracking claims - often amounting to more than is reported on FFS claims.
			There are a very large percentage of adjustment claims in most quarters, possibly due to frequent rate changes.
			Florida does not report DRGs.
			In 2003, the percent of claims without ancillary codes is higher than expected.
		LT	Admission Date are missing on nearly all of the claims.
			Patient Status is missing on nearly all of the claims.
			Diagnosis codes are missing on many claims.
			There continues to be a small percentage of LT claims with an unknown Adjustment Indicator
			There aren't any claims with a Type of Service 04 (Inpatient Psychiatric Services for those Under Age 22) as Florida does not cover these services.
		OT	There is a problem with the reporting of non-crossover FQHC claims in the Q3 2003 file. It appears that it is a problem with the reporting of crossovers and not FQHCs. Florida plans to fix and resubmit.
	Eligibility	1115 Waiver	In 8/02, FL began to implement a Pharm Plus Waiver extending RX benefits to aged with income from 88% -120% FPL..
			Florida's Family Planning Waiver ended 9/30/03. However, the state began a new Family Planning Waiver beginning in May 2004. The new waiver allowed retroactive enrollment back to December 2003, explaining low levels of enrollement from Dec. 2003-May 2004.
		CHIP Code	Florida reports enrollment in its M-CHIP and S-CHIP programs. The enrollment reported in its S-CHIP program, however, is incomplete and only for eligibles ages 1 to 5 who have transferred from Medicaid. The M-CHIP program appears to be phasing out.

State	File	Record Type	Issue
FL	Eligibility	County Code	Florida used state county codes instead of Federal Information Processing Standards (FIPS) county codes in FY1999 and FY 2000. The state has supplied MPR with a crosswalk that links together their state codes with the FIPS codes.
		Dual Eligibility Flag	Florida extends full Medicaid benefits to the aged and disabled with income below 90 percent FPL, accounting for the somewhat lower than expected proportion of QMB-only dual eligibles. Florida has a slightly lower than expected proportion of aged dual eligibles until FY03. Use of Dual Code 09 is approved for FL's Pharm Plus enrollees.
		Eligibility Group	Enrollment in the SLMB state-specific eligibility groups "SLMBA," "SLMBD", and "SLMB" drops from about 21,000 total at the end of FY 1999 to 14,000 total at the beginning of FY 2000. Enrollment stays at this level until the beginning of FY 2001 when it jumps to around 30,000. The state acknowledges this problem, but is unable to explain it.
		HIC Number	Roughly 3,300 dual eligibles have blank HIC numbers in Q1 FY 1999.
		Managed Care	Florida generally codes enrollees in its MediPass plan to Plan Type 07 (PCCM). However, enrollees with mental health MediPass providers are coded to Plan Type 03 (BHP). This can be confusing, since these BHP/PCCM providers are listed on the PCCM Provider ID file, not the regular Managed Care Provider ID file. MSIS reports fewer enrollees in Plan Type 03 than CMS reports in its PHP count, but the state has assured us that the MSIS figure is accurate. Each month in FY1999, a few hundred ineligible persons (who are mapped to MAS/BOE 00) received PLAN TYPE = "88" and PLAN ID = "88888888888". Persons who are ineligible for Medicaid during a month should receive PLAN TYPE = "00" and PLAN ID = "000000000000."
		MAS/BOE	In FY 1999 and FY 2000, the age sort for MAS/BOE 31 was not working properly and about 8,000 individuals under age 65 were mapped to MAS/BOE 31 who should have been mapped to MAS/BOE 32. In FY02 through Q1 FY04, some persons 65+ were mapped to MASBOE 22, 23 and 42. The state provides full Medicaid benefits for the aged and disabled up to 90 percent FPL. Effective 8/02, Florida began to implement an 1115 Pharm Plus waiver demonstrating for the elderly called SilverStar Pharmacy. These persons only qualify for pharmacy benefits.

State	File	Record Type	Issue
FL	Eligibility	MAS/BOE	Florida reports roughly 10 to 15 percent more SSI eligibles (in MAS/BOE 11 and 12) than does SSA over the same period of time.
			Children and adults in MAS/BOE 54 - 55 (state-specific group FP) only qualify for family planning benefits. In Q4 FY01, enrollment in MASBOE 55 Dropped by over 25% (cause unknown).
			In Q3 FY02 persons in state group MX_D were mismapped to MASBOE 94 instead of 44. Women with breast cancer (state group MB_C) were mismapped to MASBOE 95 in Q3 FY02 and MASBOE 35 in Q4 FY02. They should be mapped to MASBOE 3A. This was fixed in FY03. In July and August 2002, enrollment in MASBOE 22 surged. The state had reduced its income thresholds for the aged and disabled, but litigation forced FL to reinstate individuals who lost eligibility for two months. They were reported into state group NS_D. In all disabled MASBOE groups (12,22,32 and 42), a sizeable proportion of enrollees are over age 65. Researchers may want to remap these individuals to the aged groups (11,21,31 and 41).
		Restricted Benefits	Children and adults in MAS/BOE 54 to 55 (state-specific group FP) only qualify for family planning benefits (reported under the "other" code, 5). In addition, persons qualifying through the medically needy provisions are usually assigned the "other" restricted benefits code.
		TANF/1931	Florida cannot identify TANF recipients. All eligibles receive TANF = 9, indicating that their TANF status is unknown.
	Eligibilty	Header	Quarterly Backups and Valids EL files contain more than one (3) header records.

State	File	Record Type	Issue
GA	All	All	Some claims don't link with the MSIS ID in the EL file. This is under investigation.
		MSIS ID	The state assigned new MSIS IDs, provider IDs, case numbers and provider specialty codes beginning with Q3 2003. GA replaces the new MSIS ID's with the old ID's on the MSIS files before submitting them to CMS. People who enrolled for the first time after the new MSIS ID system was implemented will only have the new ID's.
	Claims	All	Georgia submitted claims for S-CHIP enrollees even though there weren't supposed to be included in MSIS. They can be identified using the eligibility codes.??this is an error, or at least unlike other states, right??
			Adjustments are not properly coded from Q1 1999 - Q2 2003. During that time all adjustments had an Adjustment Indicator of Void regardless of the type of adjustment. The Medicaid Amount Paid field on those claims had either negative or positive amounts.
		IP	There are very few claims with a Program Type of 2 (Family Planning)
			Georgia submitted the DRGs as character instead of numeric. During the Valids edits, if the DRG is character, it is converted to 0. This should be corrected starting with the 2003 files. The DRG codes are on the state backup files, just not the Valids.
		LT	The percent of claims with Patient Liability is lower than expected.
			There is no reported Other Third Party Payment (or Third Party Liability/TPL).
			There are no diagnosis codes on the file prior to Q3 2003. Also, very few claims have Leave Days.
			There are no claims with a Type of Service of "02" or "04" as Georgia does not cover either IP Psychiatric Care for those Under 22 nor IMD services for those Over 64.
			Over 10 percent of the claims have a Medicaid Amount Paid of $0 until Q4 2003. It is unusual for such a high percentage of original non-crossover claims to have a zero Medicaid Amount Paid. The state has no explanation.
		OT	Capitation claims for non-emergency transportation are not included in the OT files. The state plans to add them sometime later (date??)
			There aren't any claims with a Type of Service of 30 (Personal Care Services) as Georgia does not cover these services in its state plan.

State	File	Record Type	Issue
GA	Claims	OT	Over one quarter of the original, FFS claims have a Place of Service of 99 (Unknown).
		RX	NDC code is missing on a few void claims in 1999 and 2000, making those claims difficult to adjust properly. That field is either blank-filled or 11-byte 9-filled (instead of 12 bytes).
			There aren't any Family Planning claims.
	Eligibility	CHIP Code	Numerous problems occurred with SCHIP coding during the FY00-FY02 period. First, the numbers of children assigned to the S-SCHIP state groups (state codes 90-91) were not consistent month-to-month over this period. Second, S-SCHIP code 3 was not consistently assigned to persons in the S-SCHIP groups. In some quarters, all Medicaid enrollees were assigned S-SCHIP code 3. In other quarters, S-SCHIP children were mistakenly assigned SCHIP code 0. In addition, regular Medicaid children (in state group 71) were sometimes erroneously assigned S-SCHIP code 3.
			Georgia uses Dental Health Administrative Consulting Services (DHACS) to manage its S-CHIP program (called Peach Care). DHACS submits enrollment information on S-CHIP children (in groups 90 and 91) to the state's MMIS system (managed by EDS through FY02 and then ACS effective FY03). In addition, DHACS submits enrollment information on children who apply for S-CHIP, but are found to be eligible for regular Medicaid (group 71). The children in this Medicaid group are called Peach Care Plus, since they qualify for the regular Medicaid benefits package. In FY 2001, two errors occurred in the DHACS reporting to the MMIS. First, monthly enrollment information was not reported. Instead, DHACS reported children who were ever enrolled during the quarter. In MSIS data, these children were shown as enrolled all 3 months of the quarter. Second, children in group 71 identified by DHACS were erroneously counted as S-CHIP children, not regular Medicaid children. In MSIS, they were assigned to MAS/BOE 00 and CHIP code 3, when they should have been assigned MAS/BOE 34 and CHIP code 1. As a result of these errors, Medicaid enrollment is undercounted and S-CHIP enrollement is overcounted in FY 2001. In addition, children in groups 71, 90 and 91 identified by DHACS are reported as enrolled in all three months each quarter, when they may not have been enrolled the entire quarter. The number fo children in group 71 who were erroneously reported as S-CHIP instead of Medicaid ranged from 200 in Q1 FY2001 to almost 46,000 per month by Q4 FY 2001.

State	File	Record Type	Issue
GA	Eligibility	CHIP Code	Georgia does not have an M-SCHIP program. Its S-SCHIP program began in FY99, but was not reported into MSIS until FY2000. However, there were problems of data reliability until FY2003. As a result, researchers should not use the S-SCHIP data or rely on the state specific codes 90 and 91 used for S-SCHIP until FY03. Beginning with FY03 data, S-SCHIP enrollment appears to be correctly coded. There are still some problems of consistency with SEDS; however, the state asserts the MSIS S-SCHIP data are more reliable.
		County Code	In Q1 FY 2000 to Q3, Georgia over-reported enrollees of state codes 90 and 91 (the state CHIP groups) into county code 009. The reported enrollment levels in 009 returned to normal in Q4 FY 2000. The state claims to have resolved the problem through correction records. From Q1 FY02 through Q4 FY02, GA erroneously stopped using FIPS county codes. The state was asked to submit a list of the codes they used during this time period; however, they were not able to figure out what coding scheme was used. Thus, county code data during this period are not reliable.
		Dual Eligibility Flag	Until Q1 FY03 GA coded about 72 to 90 percent of its dual eligible population with Dual Eligibility Flag = 09 (individual is entitled to Medicare, but reason for Medicaid eligibility is unknown). In addition, dual eligibility was undercounted until Q1 FY03 (when ACS took over GA's MMIS). SLMB and QI's were not reported until then. GA does not automatically code dually eligible SSI recipients as QMB plus duals (code 02). Most SSI reciprients are coded as dual code 08. The state has determined that it is more affordable to pay for Medicaid coverage than Medicare Part A premiums for duals who do not automatically qualify for Part A coverage. The state requires dual SSI recipients to apply for QMB or SLMB status, but this status has no effect on the coverage/services received by SSI recipients.
		HIC Number	Roughly six to ten percent of non-dual eligibles have valid HIC numbers. This is a higher proportion than expected.
		Managed Care	Through FY02, there was a seam effect problem with PCCM enrollment data, with enrollment lowest in month one and highest in month 3. Then, PCCM enrollment falls in month one of the next quarter.

State	File	Record Type	Issue
GA	Eligibility	Managed Care	In FY01 through FY03, GA's managed care data were not always consistent with the CMS managed care data. The CMS managed care reports in 2001 and 2002 included 3,000 individuals in a Mental Health PHP that was reported to MSIS because it was a 1915c waiver program. CMS managed care data thoughout this period showed one million plus enrollees in a NET (transportation) PHP. This program was not reported to MSIS. The state is working toward its inclusion for Q1 FY04. In addition, PCCM counts were not always consistent between MSIS and the CMS reports. In FY02, for example, CMS showed 1,043,154 PCCM enrollees, compared to 677,148 in MSIS.
			Georgia's Grady Memorial Hospital HMO ceased 1/00.
			In FY03 and FY04 there were also larger monthly fluctuations in PCCM enrollment, suggesting this data may not be reliable.
			Each month in FY 1999, some eligibles with Plan Type = 01 (comprehensive managed care) have 8-filled Plan IDs.
		MAS/BOE 1999-2003	From FY99 through Q2 FY03, Georgia exhibits a seam effect between the last month of one quarter and the first month of the next quarter. Generally, enrollment is highest in month one of each quarter and lowest in month three. This problem also affects other fields, most notably Plan Type. It is improved somewhat by their submission of retroactive eligibles, but not entirely resolved.
		MAS/BOE 2000	In Q4 2000, a few individuals were assigned an invalid MAS of 6 or 7.
			In FY00 and FY01, some persons in state group 90 (S-SCHIP) were erroneously mapped to MASBOE 32.
		MAS/BOE 2001	Increases in state groups 19 (TANF MAO child/MASBOE 44) and 24 (foster care TANF/MASBOE 48) in the summer of 2001 are probably related to the TANF reinstatement in January-April 2001.
			GA Medicaid enrollment is undercounted in FY2001 for reasons explained above under "CHIP Code".
			During January to April of 2001, GA reinstated a large group of former TANF recipients into Medicaid in MAS/BOE 14-15, accounting for a short-term dramatic increase in enrollment.
			In August 2001, GA terminated its special family planning program (state specific group 77), causing an abrupt decline in MAS/BOE 35. In Q4 FY01 and in FY02, GA mistakenly 0-filled the Plan ID, Plan Type, and restricted benefits fields for about two thousand persons (per month, per field) who were assigned a MAS/BOE other than 00.

State	File	Record Type	Issue
GA	Eligibility	MAS/BOE 2003	In 2004, ACS became GA's MMIS contractor, replacing EDS. As a result, the state specific coding system was changed effective Q1 FY03. This had little effect on MAS/BOE with two exceptions: In Q1 FY03 GA included SLMB and QI enrollees for the first time, thus increasing enrollment in MASBOE 31-32. In addition, enrollment in several of the disabled groups increased noticeably. This may have occurred because the file was cut at a later date.
		Restricted Benefits	Effective Q3 FY03, restricted benefits code 4 (Pregnancy related) was only assigned to presumptively eligible pregnant women in MASBOE 35. Beginning in Q4 FY00 through July 2001, many persons in state group 77 mapped to MASBOE 35 were assigned restricted benefits flag 9 (unknown). They were family planning enrollees. All persons in state group 77 should have been assigned restricted benefits code 5 (other). This program was terminated in July 2001.
		Retroactive Records	Georgia decided to report retroactive records, despite the fact that they said they were going with the delayed submission in their MSIS application.
		SSN	Until Q1 FY03, Georgia had a problem with SSNs assigned to more than one enrollee (for example, 33,677 in Q1 FY 2001) that appears to be caused by outside agencies providing data for the MMIS.
		TANF/1931	Georgia cannot accurately identify TANF recipients. The field is 9-filled for all eligibles.

State	File	Record Type	Issue
HI	Claims	All	From Q1 2000 - Q4 2002, some eligibility files have the wrong MSIS ID, resulting in a failure to link with claims. This was corrected beginning with Q1 2003.
			Arizona is creating the Hawaii MSIS files. They took over what HMSA had in their legacy files for 1999 to 2002 and there are many problems/missing information in those files. Starting with 2000, Arizona took over the MMIS processing as well and they expect all these problems to be fixed.
			The 1999 to 2001 files contain very few adjustment claims and they are all voids with $0 paid. The files that Arizona received from Hawaii were supposedly mostly adjusted. They believe that the $0 paid voids, actually had a negative amount paid that wasn't allowed in their system, so they were converted to $0. For this reason, it isn't possible to create correctly adjusted claims. The 2002 files have negative amounts paid on void claims, but the resubmittal claims still have $0 paid. This was fixed starting with the 2003 files.
		IP	2000: Medicaid Amount Paid on resubmittal adjustments is somethimes $0.
			Other Third Party Payment (or Third Party Liability/TPL) is basically not reported in the 1999 files.
			Very few of the IP claims in the 1999 to 2001 files are flagged as crossovers. Hawaii believes the crossover claims are in the file, but just not identified as such. The Medicare Coinsurance Payment and Medicare Deductible Payment amounts are carried as separate line items. This was corrected starting with the 2002 files.
			The state does not report DRGs.
			Covered days are not reported in the 1999 files.
			There are a few claims in the 1999 files with an invalid Patient Status.
			2000: It appears that there may be some claims from long stay hospitals in the IP file, as about 15 percent of the claims show Patient Status 30 (Still a Patient) and they are missing UB-92 Revenue Codes for ancillary services. Also, the average number of days stay is 9 which is higher than expected.
			2000 to 2001: There are about 50 percent fewer IP claims based on comparison to the Q1 2003 file.
			From 1999 to 2004 there is a higher than expected percentage of claims without UB-92 Revenue Codes and a slighter longer length of stay. This appears to reflect the inclusion of some long stay hospital claims in this file.

State	File	Record Type	Issue
HI	Claims	IP	There are a few claims with an invalid Patient Status. This will be fixed in the 2000 files.??was it??
		LT	There are no Leave Days in the 1999-2001 files.
			2000: There are very few resubmittal claims and the amount paid is $0. ??see different wording on this LT comment vs. on OT comment and make consistent??
			In 2002 there was a huge increase in the number of LT claims without covered days and with a Patient Status of 01 (Discharged to Home). This is a result of the conversion process and are actually old claims for non-bundled services that were not previously included in the file.
			1999 to 2001: Leave days are not reported.
			2000: There are no claims with a Type of Service of 02 (Mental Hospital Services for the Aged) or 04 (Inpatient Psychiatric Services for those Under Age 22).
			2000: There are no crossover claims.
			There are no claims in the file with a Type of Service of IP Psych < 21 although the state covers that service.
			Charge is always missing in the 1999 files.
			Patient Liability is missing in the 1999 to 2001 LT files. In 2003 it is mostly a negative amount.
			No covered days are reported in the 1999 files.
		OT	Quantity of Service is always missing in the 1999 files. This will be fixed in the 2000 files.
			Amount Charged is always missing in the 1999 files.
			All capitation payment claims are coded as crossovers from 1999 to Q1 2003.
			About 25 percent of the claims do not have a Medicaid Amount Paid because they are line item claims for OPD and the amount paid is available only on the header summary claims. The line item claims are in the file, but with $0 Medicaid Amount Paid.
			Hawaii outpatient hospital claims will be handled the same way as the Arizona claims since Arizona is doing the MSIS file creation for Hawaii. That is, there will be a summary outpatient hospital claim with the total Medicaid Amount Paid for all line item services and then individual line item claims with $0 paid. This means that there will be a higher percent of claims with $0 paid.

State	File	Record Type	Issue
HI	Claims	OT	The outpatient hospital claims don't have UB-92 Revenue codes, even though they are billed on a UB-92 in the 1999 files. This will be fixed in the 2000 files.
			1999 to 2002: The files do not include claims with Program Type of 6 or 7 (Home and Community Based Waivers) or 3 (Rural Health Clinic).
			In 1999 there are very few claims with a Program Type of 4 (FQHC). However HI has FQHCs.
			The files do not include waiver claims as they are processed by a different state agency in 1999. Since 1999, they are supposed to be in the files, but HI can not identify them as waiver claims.
			Some of the CPT-4 codes have an invalid length of seven in 1999.
			The most frequent Service Code in the OT file is Z9020 (taxes). The taxes are carried as separate line items on Hawaii claims. These claims will be included in the 1999 files, but should be ignored except for reporting expenditures. This will be fixed in the 2000 files. ??was it fixed??
			There is a separate line item for taxes on and they are included in the 1999 files as separate claims. This will be fixed in 2000.??fixed??
			There aren't any claims with a Type of Service of 13 (Home Health) in 1999.
			2000: The amount paid on adjustment claims (resubmittals) is usually $0.
			In 2003 there was a switch in reporting OPD claims. Prior to 2003 the Medicaid Amount Paid on the header was repeated on each line item, over stating the expenditures. Beginning in 2003, HI began submitting a header claims with the total amount paid and line item claims with services but no amount paid.
		RX	The fill date is reported in both the Fill and Prescribed Date fields. The state will correct starting with Q2 2005.
			Quantity of Service is often missing in the 1999 files.
	Eligibility	CHIP Code	Hawaii has an M-CHIP program, but no S-CHIP program. The M-CHIP program did not begin enrollment until January 2000 and didn't appear in MSIS until July 2000.
			From FY02 forward, HI reports more M-SCHIP enrollees than SEDS. The state cannot explain this discrepancy.

State	File	Record Type	Issue
HI	Eligibility	CHIP Code	In Q1 FY01, HI erroneously reported that M-SCHIP child enrollment dropped to about 500 per month, compared to 3,000-4,000 per month in previous and subsequent quarters. However, this appears to be fixed with correction records.
			Eligibility codes for MCHIP changed from H55 and H58 to H71 and H72 effective 12/01/03.
		Dual Eligibility Flag	The state provides full Medicaid benefits for the aged and disabled up to 100 percent FPL.
			Roughly 80 percent of aged eligibles are reported as being duals in FY 2000. This improved to 86 percent by FY 2003. We generally expect 90% or more of eligibles aged 65 and older to be dually eligible.
			In FY 1999, roughly 50 percent of dual eligibles in Hawaii received flags 08 or 09. This proportion fell to less than 10 percent in FY 2000.
			Between four and five percent of persons in BOE 4 - 8 are reported as dual eligibles in FY 1999. We generally don't expect to see any duals in these BOEs. The state corrected this problem in FY 2000.
		Foster Care	In FY00 Q4, foster care enrollment averaged about 3850 children/month (these children are reported into state groups H41 and H42 and mapped to MASBOE 48). However, in FY01 Q1, foster care enrollement drops to less than 300 children/month. Then, in Q2 FY01, foster care enrollement rebounds, with 3,984 children reported in January 2001.
		HIC Number	In FY 1999, between 54 to 57 percent of Hawaii's dual eligibles had valid HIC numbers. This problem was corrected in FY 2000.
		Managed Care	MSIS MC data show lower HMO enrollment than CMS MC data. The state explained that this occurs because state-only enrollees were mistakenly included with the CMS managed care data.
			HI's PACE program is not a full PACE, rather it is a "Pre-PACE" program operating under a waiver, it is not reported as managed care type 06 (PACE). It is correctly reported to managed care plan type 01 (HMO).
			The Queens HMO ended in 4/02, and the Kapiolani HMO ended in 7/02.
			Most dental managed care ended 10/01, with only low levels of dental managed care reported subsequently.

State	File	Record Type	Issue
HI	Eligibility	Managed Care	Each month in FY99, 100-400 eligibles with Plan Type 88 (Not Applicable) receive valid Plan IDs. Persons with Plan Type 88 should receive Plan ID 888888888888. During FY02, HI incorrectly reported enrollees to MC codes '03' and '08'." These enrollees should have been reported to '88' as HI's dental programs are all FFS as of 10/01. From Q1 FY03 forward, persons are assigned the following plan ID's: DEN001, DEN003, EMGSVC, NONPAY, QMBONY, QNAFFS, TRANSP. However, these are all FFS, so the plan type field is 8-filled. HI has been asked not to report individuals to these Plan ID's from FY04 Q2 forward.
		MAS/BOE	The state provides full Medicaid benefits for the aged and disabled up to 100 percent FPL. Since FY 2000, Hawaii enrollment data have shown a seam effect, with enrollment the highest in month one of each quarter and the lowest in month three. Generally, enrollment rises significantly in month one of each quarter.
		MAS/BOE -2003	Through Q4 FY03, many persons over age 65 were reported to MASBOE 32.
		MAS/BOE-1999	Each month in FY 1999, 100-200 eligibles in valid state-specific eligibility groups are mapped to MAS/BOE 00. These eligibiles should be mapped to a valid MAS/BOE group. In the third month of FY99 Q4, enrollment drops by about 8,000 in MAS/BOE 14 and rises by the same amount in MAS/BOE 34. According to the state, this is a correction of problems in FY99 Q1-3. The data in FY00 should be consistent with what we see at the end of FY99.
		MAS/BOE-2001	In FY01 Q1, HI erroneously reported enrollment levels of 43,00 in HI QUEST(H03), compared to levels of 35,000-39,000 in previous and subsequent quarters. It appears that foster care and M-SCHIP children may have been reported to H03 by mistake in FY01 Q1. In FY01 Q1, HI erroneaouly reported that enrollment in MASBOE 48 dropped to less than 300 per month, compared to about 4,000 per month in previous and subsequent quarters.
		MAS/BOE-2002	From FY02 Q1- FY02 Q4, persons in state groups H48 and H50 (BCCPTA enrollees) should have been mapped to MASBOE 3A, not MASBOE 31. From FY02 Q1 forward, enrollment is no longer reported to MASBOE 35, since the H03 group includes both pregnant women and adults covered under the 1115 waiver. This group is now mapped to MASBOE 55.

State	File	Record Type	Issue
HI	Eligibility	MASBOE 2004	From FY04 Q1 forward, HI reports 50-60 persons to MASBOE 99 who have some monthly data elements with values >0.
		MASBOE-03	In Q1 FY 2003, child and adult enrollment shifted somewhat from MAS/BOE 34 - 35 to MAS/BOE 14 - 15, when HI corrected the reporting for 1931-related groups H45 and H61. This will be fixed in MAX effective Q1 FY 2002. In Q1 FY 2003, enrollment is no longer reported to MAS/BOE 35, since the H03 group includes both pregnant women and adults covered under the 1115 waiver. This group is now mapped to MAS/BOE 55.
		SS code	In Q1 FY01, enrollment in HI Quest, SS group H03, increases by 8,000 to more than 43,000/month. In Q2 FY01, H03 enrollment drops back down to 39,000/month. This level is steady, and increases somewhat in Q3 and Q4 in FY01. We think that foster care and M-SCHIP children may have been included in this group for this quarter.
		TANF/1931	Hawaii 9-fills the TANF field for all eligibles.
	Eligibilty	SLMB/ QI's	Recipients who are QI-1 or QI-2 (discontinued since 1/03) are tracked in HAWI (EL system) as MO/SL recipients. They are entered into HAWI as a SLMB with a deduction on EXPE under the PI code that accounts for income over 120% FPL. Eligibility Workers (EW) complete a worksheet that is sent to MedQUEST Program and Policy Office(PPDO). PPDO then has the Member File Integrity Section (MFIS) Buy-In staff change the Buy-In group code from a SLMB to a Qi. In HPMMIS, because their program/categroy is MO-SL, they are being reported as SLMB under SS code H39.

State	File	Record Type	Issue
IA	Claims	IP	There are no claims with a Program Type 2 (Family Planning) because family planning is billed as on an outpatient basis on a HCFA-1500.
		LT	Diagnosis Codes are missing on most claims.
	Eligibility	CHIP Code	Iowa reported its M-CHIP children in MSIS. The state did not report its S-CHIP children, however.
		Dual Eligibility Flag	Roughly 85 percent of Iowa's MAS/BOE 11 eligibles (aged SSI recipients) were reported to be dual eligibles. This is a lower than expected proportion.
			Effective Q2 FY04, IA will no longer use Dual Code 09. All 09's will be reported as 02, 04, or 08 (Full Duals).
		Health Insurance	Roughly 15 percent of Iowa's Medicaid population was reported to have private health insurance. This is a greater than expected proportion.
		Managed Care	In 2003, several HMO's were terminated, with many (but not all) enrollees shifting to PCCM's.
		MAS/BOE	In Q1 FY 1999, between 100 to 180 CHIP eligibles (state eligibility group 920) were mapped to MAS/BOE 64. This problem was corrected in subsequent quarters.
			Prior to Q2 FY04, IA had a recurring problem with reporting enrollees under age 65 to BOE '1'. All of these individuals <65 should have been mapped to BOE '2'.
		TANF	Effective FY 2001, Iowa began 9-filling the TANF flag. TANF data for earlier quarters are not reliable.

State	File	Record Type	Issue
ID	All	All	There was a change in the MSIS IDs just prior to FY Q1 1999. Therefore, the linkage with claims and eligibility records from prior quarters will be incomplete.
	Claims	IP	DRGs are not reported in the IP files.
		LT	Almost 20 percent of the claims have a Type of Service of 05 (ICF/MR), which is much higher than expected.
	Eligibility	CHIP Code	Idaho reports its M-CHIP enrollment.
			Effective Q4, FY04, ID began an S-SCHIP program, and reports this S-SCHIP group into MSIS.
		County Code	Until Q1 FY03, ID failed to report any enrollees in Blaine County (013). About 900 enrollees per month were reported beginning with Q1 FY03 data. It is not clear what county code assignment these enrollees received prior to Q1 FY03.
		Dual Code	Dual Codes 03, 06 and 07 are not included in ID MSIS records, from FY99-Present. These individuals are not eligible to receive Medicaid benefits other than Medicare cost-sharing, so they were not included in Idaho's MMIS. Idaho plans to include these dual codes beginning in 2007 when they implement a new MMIS.
		Dual Eligibility Flag	Until FY03, Idaho reported that only 50 to 60 percent of eligibles ages 65 and older were dually eligible for Medicare and Medicaid. This increased to 90 percent in Q1 FY03. Similarly, 22 to 26 percent of disabled eligibles in BOE 2 were reported as dual eligibles until Q1 FY03, when the proportion increased to 36%.
		Health Insurance	Idaho reports that about 18 to 25 percent of eligibles have private insurance. This proportion is much higher than in other states.
		HIC Numbers	Because Idaho is an auto accrete state, there is fluctuation in the percentage of duals with valid HIC numbers. The percentage typically ranges from 91% to 97%, but was 83% in FY03 Q1.
		Managed Care	The state does not have any fully capitated managed care. They do have PCCMs, however.
		MAS/BOE 1999	In FY 1999, the number of eligibles in MAS/BOE 11 and 12 was roughly half of the number of SSI recipients reported by the SSA. Some difference may result because SSI recipients in Idaho have to apply separately for Medicaid. In addition, State-Specific Eligibility Group 54, which includes SSI eligibles (and some non-SSI eligibles, as well) were mapped to MAS/BOE 42. This problem was corrected in FY00.

State	File	Record Type	Issue
ID	Eligibility	MAS/BOE 2000	In FY 2000, the eligibles in state specific eligibility group 54 were moved to MAS/BOE 12. As a result, the number of eligibles in MAS/BOE 11-12 is more equivalent to the number of SSI recipients if state supplements are considered as well.
		MAS/BOE 2001	There was a six percent increase in the number of eligibles in October 2001. The state believes that the increase is the result of economic hardship at that time, however, retroactive coverage and correction records eventually smoothed out this difference.
		MAS/BOE 2001-2002	Periodically, Idaho reported a higher than expected (roughly three to five percent) number of eligibles in BOE 1 who are under age 65. This problem phases out by the end of FY 2001 but reappeared in Q2 FY 2002. FY03 looks ok.
		MAS/BOE 2002	Idaho reported a higher than expected number of enrollees to MAS/BOE 44-45 through FY02. This occurred because many 1931 eligibles were reported to MAS/BOE 44-45. In FY03, state group 53 was remapped to MASBOE 14-15, correcting this problem, and retro-records were submitted.
		MAS/BOE 2003	In 2003, ID had 20% more enrollees in MAS/BOE 11-12 than reported by SSI. This may have occurred because of SSI State Supplement enrollees. Also, State Group S4 may include some enrollees who are not SSI recipients.
		MSIS ID	The state changed their MSIS ID's starting with FY 1999.
		Race Code	In FY03 Q1, Idaho submitted retro records for FY02 Q4 which changed 6000 individuals from "hispanic" to "white." This represents roughly 25% of those individual who were originally coded as hispanic in FY02 Q4. This change was made due to the Census Bureau's change in the definition of hispanic. MSIS coding will be changing to incorporate multiple races and ethnicities in Q1 FY05.
		Retroactive Records	Before Q1 FY 2002, ID had a technical problem that prevented their submission of retroactive records. The state submitted a high volume of retroactive records in FY 2002 (about 100,000 each quarter) to compensate. IDs procedure for submitting retroactive and correction records results in lower levels of retros in quarters run shortly after the previous quarter and higher levels when a large time span elapses between submissions. This does not impact data quality, simply the flow of when retros are submitted.
		TANF/1931	Idaho 9-fills the TANF flag for all eligibles.

State	File	Record Type	Issue
IL	Claims	Adjustments	There are no crossover adjustment claims due to the way the Illinois system processes crossover claims.
		All	The number of claims varies by month and quarter due to state billing cycles. There is an especially big drop in the number of claims in the Q1 and Q2 2003 files due to a state budget problem that delayed the payment of claims.
		IP	The adjustment sets need to be linked together using Beginning Date of Service instead of Ending Date of Service.
			The number of covered days equals the length of stay on only about 17 percent of the records.
			Procedure Code Modifiers 1 through 6 are always missing, but this is reasonable since modifiers are rarely applicable for IP procedure codes.
		LT	Other Third Party Payment (or Third Party Liability/TPL) is always missing.
			Up until Q3 2001, Illinois incorrectly classified claims for Inpatient Psych Under age 21 with a Type of Service of 07 (Nursing Facility).
			The average Medicaid Amount Paid per day for Mental Hospital for the Aged claims was very high in early years (probably because some of these claims were actually service tracking claims). However, at least by 2003, these claims show a low daily rate, more similar to standard nursing facilities than to other psychiatric hospitals or institutions.
			Patient Status is always missing
		OT	There are no dental capitation payment claims in any files in 1999. There are very few FFS dental claims until 2002 when they increased to about three percent.
			In 2001, the State of Illinois began to process Delta Dental claims through the MMIS system rather than through the C-13 voucher system. In their 2002 January to March and April through June claims there will be a big increase in Type of Service 09 (Dental) claims because of the Department processing back-dated claims for Delta Dental (back to 3/99). These claims do not have a Diagnosis Code. After the April through June quarterly tape, the level of claims for Type of Service 09 should level off.
		RX	There are no adjustment claims in 1999.
			There are no NDC codes on credit adjustment claims, making it difficult to properly adjust the files.

State	File	Record Type	Issue
IL	Eligibility	CHIP Code	In Q1 FY 2003 Illinois implemented adult coverage under its SCHIP program (SEDS reporting for adults did not begin until Q4 FY 2003). From the start, there have been differences in M-SCHIP and S-SCHIP reporting for MSIS and SEDS. The state has been working on this and hopes the two systems will show comparable data in the future. The state says MSIS data are more reliable than SEDS. See correspondence file (10/04) for more detailed discussion.
			IL is reporting both its M-CHIP and S-CHIP programs.
		Correction Records	In FY 2001, Illinois submitted about 1800 correction records each quarter that disenrolled persons in the file seven quarters prior. This problem was resolved in Q1 FY 2002. Thus, Q1 FY 2000 is the last quarter to have enrollees erroneously disenrolled through correction records. In Q3 to Q4 FY 2002, some correction records on the file were lost (about 70,000 per quarter). These records were primarily for Q1 to Q3 FY 2002. The state was not able to provide any explanation about the content of these records.
		Dual Eligibility Flag	In FY 2002, Illinois did not have reliable dual status data for enrollees in its 1115 senior care waiver. However, these enrollees were assigned dual code 00 rather than 99. In FY 2003, dual code 09 was used for most Pharmacy Plus enrollees, but some were still assigned dual code 00. This causes the percent of >64 yrs duals to be lower than expected.
			Illinois does not have Qualified Disabled Working Individuals (QDWIs). In July 2002, approximately 6000 persons moved to QMB + from QMB only when the state increased its medically needy eligibility level from 85 percent to 100 percent FPL for aged and disabled enrollees.
		Family Planning	Family planning program -MB55- added in Q4 FY04.
		HIC numbers	The percentage of duals with valid HIC numbers dropped to 70 percent when Illinois began its prescription drug waiver in Q3 FY 2002.
		Managed Care	Illinois reports enrollment in Plan Type 08 (Other). These plans consist of Primary Health Providers and Managed Care Community Care Networks (MCCN). These plans provide different services than comprehensive managed care plans. Enrollment in these plans declined by about 7,000 in Q1 FY 2000 when the County Care Total Health Plan closed. These plans appear to be reported as HMOs (not PHPs) in CMS managed care data.

State	File	Record Type	Issue
IL	Eligibility	MAS/BOE	Enrollment in MAS/BOE 14-17 and MAS/BOE 44-45 declined across FY01, but was offset by increases in MAS/BOE 34 and 25. This shift was a result of a Department of Human Services initiative to redetermine eligibility. Many recipients were moved from MAS 1 and MAS 4 to either MAS 2 (primarily adults) or MAS 3 (primarily children). In FY2002, IL experienced several shifts in MASBOE enrollment, which the state believes are the result of its move to a new database. The shifts included a decline in MASBOE 14-17, which was offset by increases in other groups, particularly MSBOE 44-45. In addition, there were some increases in 41-42 due to a more accurate reporting of waiver participants. It appears that enrollment in MAS/BOE 31-32 decreased in FY00 Q4 and FY01, in spite of these expansions, but picked up in later quarters. There was some offset in MAS/BOE 21-22, however. MASBOE 21-22 enrollment may continue to increase in the future. State law requires that the Medically Needy standard be raised to 100% FPL effective 7/02.
		MAS/BOE 1999	Because Illinois is a 209(b) state, the number of persons reported into MAS/BOE 11 and 12 is lower than ordinarily expected. Also relevant, Illinois reports SSI recipients who do not qualify for a state supplement into MAS/BOE 21 and 22 effective Q3 FY 2001.
		MAS/BOE 2000-2001	There were two expansions in Q4 of FY 2000 in Illinois -- a Medically Needy Expansion and an OBRA 86 expansion (the OBRA 86 expansion covered aged and disabled eligibles to 70 percent FPL; this was later raised to 85 percent, and then to 100 percent in FY 2003). The codes for expansion were not ready by Q4, however, so those eligibles are lumped in with the Medically Needy expansion eligibles. Beginning in FY 2000 q1, new groups 11EXP1 and 23 EXP1 are mapped to MAS/BOE 31 and 32; groups 11EXP2, 22EXP2, and 23EXP2 are mapped to MAS/BOE 21 and 22. It appears that enrollment in MAS/BOE 31 to 32 decreased in Q4 FY 2000, in spite of these expansions. There was some offset in MAS/BOE 21 - 22, however. MAS/BOE 21 - 22 enrollment may continue to increase in the future. State law requires that the Medically Needy standard be raised to 100 percent FPL effective 7/02. Enrollment in MAS/BOE 14 - 17 and MAS/BOE 44 - 45 declined across FY 2001, but was offset by increases in MAS/BOE 34 and 25. This shift was a result of a Department of Human Services initiative to redetermine eligibility. Many enrollees were moved from MAS 1 and MAS 4 to either MAS 2 (primarily adults) or MAS 3 (primarily children).

State	File	Record Type	Issue
IL	Eligibility	MAS/BOE 2002	Effective FY 2002, Illinois implemented two new types of coverage in an 1115 waiver. In the summer of 2002, Illinois began enrollment in a Senior Care program, extending drug benefits to aged to 200 percent FPL. In the fall of 2002, Illinois extended coverage to several groups of children and adults. Many of the newly covered children buy into employer-sponsored or private insurance. Plus, the state added new S-SCHIP groups (MAS/BOE 00). In FY 2002, Illinois experienced several shifts in MAS/BOE enrollment, which the state believes are the result of its move to a new database. The shifts included a decline in MAS/BOE 14 to 17, which was offset by increases in other groups, particularly TMA enrollees in MAS/BOE 44 to 45. In addition, there were some increases in 41 to 42 due to a more accurate reporting of waiver participants. In Q4 FY 2002 and Q1 FY 2003, there are major shifts in MAS/BOE enrollment for aged and disabled, as the state implemented coding changes with its new system. The eventual impact is a major increase in MAS/BOE 31-32 and declines in MAS/BOE 21-22 and 41-42.
		MAS/BOE 2003	Effective November 2002, Illinois began to cover adults under its S-SCHIP program. In July of 2003, Illinois provided full benefits to the aged and disabled to 100 percent FPL.
		MAS/BOE 2004	In Q2 FY04, IL had an abrupt decrease in MASBOE 45 with a commensurate increase in MASBOE 25. This was caused when the state caught up on redeterminations for persons ending TMA coverage.
		Restricted Benefits Flag	Until FY 2002, between 80 to 93 percent of eligibles with RBF = 4 (restricted benefits on the basis of being pregnant) are mapped to MAS/BOE 34, 35, 44, and 45. We generally expect that at least 95 percent of eligibles with RBF 4 will be mapped to those MAS/BOE groups. By FY 2002, the reporting was in the expected range most months. Also, RBF 4 is always highest in month three of each quarter and then drops abruptly in the first month of the next quarter -- an RBF "seam effect."
		Retroactive Records	Illinois decided to report retroactive records, despite the fact that they said they were going with the delayed submission in their MSIS application.
		SSN	Illinois reports about 5500 SSNs with duplicate records (i.e., two records with the same SSN) in Q4 FY 2001. This problem likely existed prior to this quarter, but we do not have data for those time periods. The level of duplicates reached 20,000 by the end of FY 2004. The state is aware of the problem, but unable to correct it.

State	File	Record Type	Issue
IN	Claims	IP	The percent of claims without ancillary UB-92 revenue codes has been increasing over time. It was two percent in Q1 2000 and seven percent in Q4 2000 and nine percent in Q4 2002.
			The average number of covered IP days jumped to 8 days from 4 days in prior and subsequent quarters. The state has no explanation.
			There aren't any claims with a Program Type of 2 (Family Planning).
		RX	The Date Filled is also in the Date Prescribed field.
	Eligibility	CHIP Code	In some quarters during FY03 and FY04, MSIS S-CHIP counts were 13-14% lower than S-CHIP counts in SEDS. The state was not able to explain why this level of difference occurred. M-CHIP counts were ok.
			Indiana is reporting M-CHIP into MSIS. Its S-CHIP program was implemented 1/1/2000 and reported into MSIS effective FY 2000Q2. In Q4 FY 2002, there is a 25 percent discrepancy between MSIS and SEDS S-CHIP counts. The two sources compare well in other quarters. The state believes that the SEDS numbers are erroneous and is working towards correcting them.
		Correction Records	In some quarters, Indiana has a large volume of correction records. Analysis of Q2 and Q4 FY 2002 corrections showed that the majority of the correction records did not change any key data elements.
		County Code	Indiana submitted files using state county codes instead of FIPS county codes in FY 1999. The state gave us a crosswalk that links together state codes and FIPS codes. This problem was fixed in Q1 FY 2000.
		Dual Eligibility Flag	Indiana assigned dual flag 08 to about 22 percent (21,000 persons) of its dual population. Indiana explained that these persons have Medicare Part B, but don't fall into one of the other dual categories.
		Health Insurance	Indiana reported about 12 percent of its eligibles with private health insurance which is higher than other states report. The state confirmed that this proportion is correct.
		HIC Number	Just over five percent of the dual eligible Medicaid population do not have a HIC number.
		Managed Care	In January 2001, two new HMOs were introduced, causing a shift in HMO enrollment by plan.

State	File	Record Type	Issue
IN	Eligibility	MAS/BOE	Indiana is a 209(b) state. This explains why the total number of SSI eligibles reported into MAS/BOE 11 and 12 is lower than the number reported by the Social Security Administration. Indiana reports the SSI disabled over age 64 into MAS/BOE 11.
		MAS/BOE 2000	During FY2000, about 500 people were incorrectly mapped to MAS/BOE 01 and 04.
		MAS/BOE 2001	In Q4 FY2001, Indiana began enrolling women in MAS/BOE 3A under the BCCPTA provisions.
		MAS/BOE 2003	IN's Q1 FY03 file shows a larger than usual increase in enrollment across several MAS/BOE groups. This resulted from the delayed submission of FY03 data as a result of the MMA.
		Restricted Benefits	Approximately 10 percent of aliens with restricted benefits are assigned MAS 4. Typically, we expect at least 95 percent of restricted aliens to appear in MAS 4. Indiana reports roughly 10,000 restricted aliens each quarter.
		TANF	In FY02, there is an 18% discrepancy between MSIS and ACF TANF counts. In FY03 Q1, this discrepancy is 28%. EDS responded that the ACF counts include some assisted guardianship enrollees that are not reported in MSIS data, as well as other enrollees in families where someone is getting SSI.

State	File	Record Type	Issue
KS	Claims	All	KS included state-only claims in the MSIS files from 1999 Q1 through 2002 Q4. These state only claims can not be identified in the remaining files, but are among those claims that don't link the the eligibility files.
		Crossovers	There are some claims where the Medicaid Coinsurance/Deductible amounts but the Medicaid Amount Paid field is $0.
		LT	There is a higher percent of claims with $0 Medicaid Amount Paid than expected due to the application of spend-down. The file contains mostly weekly bills. The expected percent of claims with Patient Liability is lower than expected, but state verifies that it is correct. If the state does not pay for all covered days on the claim, the number of covered days is not reduced to reflect the days paid.
		OT	There were very few HMO capitaion claims in Q1-3 2002. They started reporting them again at the expected level in Q4 2002. Kansas uses some local diagnosis codes. The state system does not carry UB-92 Revenue Codes on outpatient hospital claims, but all outpatient hospital claims have Service Codes.
		RX	The date filled is also reported in the date prescribed field.
	Eligibility	CHIP Code	Kansas is not reporting their S-CHIP children. The state does not have an M-CHIP program.
		Dual Eligibility Flag	Until Q1 FY03, dual eligibles were somewhat undercounted in Kansas due to a reporting quirk. With correction records, the state sometimes 0-filled the dual flag for dual eligibles who had died to include the period when they were alive. Kansas uses the dual flag 08 for persons whose income and resources are too high to qualify for QMB plus, or SLMB plus, but who still receive full Medicaid benefits. Some persons in MAS/BOE 41 - 42 are reported to have restricted benefits related to their dual status (QMB-only, SLMB-only, or "other" dual eligibles). These are potential spend-downers who are incorrectly mapped, as discussed below.
		Foster Care	Foster care is under-reported in MAS/BOE 48 prior to February 2000 when the number of foster care children almost doubles.
		Managed Care	Kansas officials have acknowledged that they overcounted managed care enrollment in MSIS for FY 1999 to FY 2002 data. MSIS managed care data, effective FY2003 are more reliable.

State	File	Record Type	Issue
KS	Eligibility	Managed Care	Managed care enrollment patterns changed during FY 1999. To start, from Q1 to Q2, two of the three HMOs in Kansas withdrew from Medicaid. Then, in April, 1999 (the start of Q3), the remaining HMO changed ownership, meaning that a large group of eligibles had to be reassigned to a new plan ID#. In December 2003, KS increased access to PCCM providers by changing the distance parameters of participation. This resulted in a large (9%) increase in enrollement.
		MAS/BOE 1998-1999	From 12/98 through 4/99, Kansas had problems distinguishing between children in MAS/BOE 14 and 34. The state reports that this was related to implementation of their S-SCHIP program (they were trying to make sure children leaving welfare would not be inappropriately terminated from Medicaid). As a result, some children (about 12,000 by 4/99) were mapped to MAS/BOE 34 who should have been mapped to MAS/BOE 14. This problem was corrected effective 5/99.
		MAS/BOE 1999-2001	From October 1999 through November 2001, Kansas reported QMB-only and SLMB-only eligibles who were potential spend-downers to MAS/BOE 31 - 32. Then, beginning in December 2001, through FY02, these potential spend-downers were mapped to MAS/BOE 41 - 42, a mistake. Since potential spend-downers are not considered Medicaid eligibles, these individuals should not have been reported as enrolled in Medicaid with full benefits. Persons in this group are reported in state-specific codes MSSDOA, MSSDAB and MSSDAD. With the implementation of its new system in FY 2003, Kansas will map potential spend-downers in these groups to MAS/BOE 31 - 32. Potential spend-downers who do not qualify for restricted Medicaid benefits related to Medicare cost-sharing will not be included in MSIS reporting.
		MAS/BOE 2000	Beginning in April 2000, Kansas changed their nursing home criteria. Rather than using the Medically Needy criteria, the state used the 300 percent institutional rules. As a result, enrollment increased in MAS/BOE 41, 42, and 44 and fell in MAS/BOE 21, 22, and 24.
		MAS/BOE 2001	During FY01 Q2, Kansas took steps to reinstate Medicaid coverage to persons inappropriately terminated during welfare reform. These persons were mapped to MAS/BOE 24/25. This coverage only lasted three months unless persons were otherwise eligible.
		MAS/BOE 2002	During FY2002, KS changed how it reported its Work Transition program, so that more eligibles qualified under the 1931 provisions, causing a shift in enrollment from MASBOE 44-45 to MASBOE 14-15 during FY2002.

State	File	Record Type	Issue
KS	Eligibility	MAS/BOE 2002	The state believes enrollment was under-counted in Q1 to Q3 FY 2002 due to a problem with the submission of retroactive and correction records. During FY 2002, Kansas changed how it reported its Work Transition program, so that more eligibles qualified under the 1931 provisions, causing a shift in enrollment from MAS/BOE 44 - 45 to MAS/BOE 14 - 15 during FY 2002.
		MAS/BOE 2003	Effective Q1 FY03, KS made several MASBOE changes. First, SSI disabled >64 years are mapped to MASBOE 11, not MASBOE 12. Second, some children and adults previously mapped to MASBOE 24-25 are now mapped to MASBOE 44-45. KS believes MASBOE 24-25 enrollment was higher than it should have been in the past. Third, potential spend-downers who were also QMB-only were previously mapped to MASBOE 41-42 in error. This was fixed beginning Q1 FY03, and caused an increase in MASBOE 31-32.
		Private	Prior to Q1 FY03, KS under-reported private insurance recipients.
		Race	Beginning in Q1 FY03, KS began reporting Hispanic enrollees to Race Code 7 (Hispanic/Latino and 1+ races) instead of Race Code 5 (Hispanic/Latino). KS also began using Race Code 8 (more than 1 race, not Hispanic/Latino)
		Retroactive Records	During FY 2001, Kansas implemented retroactive enrollment to previous quarters for many persons inappropriately terminated during welfare reform.
		TANF/1931	The state reports that they did not correctly implement 1931 rules. There are relatively few non-TANF 1931 eligibles. During FY2001, the state started to implement changes. Effective Q1 FY 2002, Kansas TANF data are not reliable. The reported number in MSIS is below the number of expected recipients.
	Eligiblity	Managed Care	KS has a BHP - ASO (Administrative Services Only) benefit which covers only administrative costs of coordinating mental health benefits, not benefits themselves. This plan is not recorded in Claims or Eligibility data.

State	File	Record Type	Issue
KY	Claims	IP	DRGs are not reported in the IP files.
		LT	The state does not pay for leave days.
			The state does not pay for leave days.
			The number of covered LT days exceeds the days of enrollment.
		OT	Dental codes are flagged as state-specific. They can be converted into HPCPS by replacing the leading "0" with "D."
			The 1999 files do not include PCCM capitation claims. They are reported beginning with 2000 but are somewhat under reported.
			Dental service codes are flagged as state specific. They can be converted to HCPCS by replacing the leading '0' with a 'D'.
			There are many claims without Service Codes as Kentucky uses the UB-92 claim form for HH, hospice, and outpatient hospital billing.
			The Q1 1999 to Q2 2002 files do not include individual PCCM capitation claims.
			In 1999 the file does not include capitation claims.
			There are no claims with Program Type 2 (Family Planning).
	Eligibility	CHIP Code	Kentucky reported only M-CHIP enrollment in FY 1999. Beginning in FY 2000, the state also reported their S-CHIP data.
			There is a discrepancy between the MCHIP and SCHIP counts in MSIS 2001 data and SEDS 2001 data. The state expects that their MSIS correction records will eliminate this discrepancy.
		Dual Eligibility Flag	From FY03 Q1 through FY04 Q1, roughly 20,000 individuals with MASBOE 00 were assigned a dual code, generally '08'. These individuals should not be counted when determining the number of duals.
			Prior to FY2001 Q4, Kentucky's dual eligibility data are incorrect and should not be used. The state was over-reporting the number of disabled and children who were dually eligible.
		HIC Number	Kentucky fixed its dual eligibility flag in Q4 FY 2001. After that time, about 12 percent of the state's non-dual eligibility population have valid HIC numbers.

State	File	Record Type	Issue
KY	Eligibility	Managed Care	Beginning in Q4 of FY 2000, Kentucky phased out the use of Kentucky Health Select (Plan ID 9690005500), a comprehensive managed care plan. The individuals were moved into the state's Medicaid PCCM. Kentucky added a new region to its transportation plan '08' in July 2002. However, MSIS reporting did not reflect this new region (about 100,000 enrollees) until October 2002. Then, from December 2002 to April 2003, the state temporarily shut down the transportation plan for this region, before returning services in May 2003.
			By Q4 FY99 Kentucky had reported that about one-third of eligibles each month are enrolled in Plan Type 8, which is a special capitation plan for transportation services. By Q4 FY02 two thirds of eligibles each month were in the transportation plan, following a sharp increase in July 2002.
		MAS/BOE	Throught FY02, Kentucky exhibited a seam effect from quarter-to-quarter, whereby enrollment declined from the first month in the quarter until the last, and then jumped in the first month of the next quarter. The state submits a significant proportion of retroactive eligibles and correction records, however, which may smooth out enrollment trends.
		SSN	About four percent of eligibles don't have valid SSNs.
		Various Fields	In FY2000, between 200 - 400 persons each month in MAS/BOE 00 have the following fields blank-filled: TANF, Restricted Benefit Flag, Plan Type 1-4, Plan ID 1-4, and CHIP Code.
	Encounter	IP	There are no Procedure Codes on encounter records.
			There is only one Diagnosis Code per encounter record.
		OT	There are no encounter records for waiver services.
			Service Codes are missing on about nine percent of the encounter records.

State	File	Record Type	Issue
LA	All	MSIS ID	Louisiana converted to a new eligibility system in mid-1999. Prior to that time, SSNs were not verified and the state used a Medicaid ID numbering scheme that included county and aid code. As a result there is a mis-match between the EL and claims files. Louisiana believes this was corrected in late 1999.
		SSN	Louisiana is an SSN state, but prior to mid 1999 they did not verify SSN and were internally using a Medicaid ID number that contained county code, EL group, etc. The new EL system checked the accuracy of the SSN. As a result, there are some people in the PSF with more than one MSIS ID and some claims had an MSIS ID not found in the EL file.
	Claims	Encounter	Louisiana currently doesn't have a managed care program.
		IP	There are more claims than expected with Patient Status of 30 (Still a Patient) because they generate lots of interim bills.
			There is a large percent of crossover claims. Louisiana verifies that this is correct.
			The file does not contain DRGs.
			The Procedure Date Principal (that goes with the Procedure Code Principal) is missing.
		LT	The Admission Date is missing on most records.
			There are diagnosis codes on less than 75 percent of the claims.
			Diagnosis Codes are missing on most claims.
		OT	Beginning in 2003, the state is paying a fixed rate for FQHC/RHC visits. They will submit claims for line-item services with a Medicaid Amount Paid of $0 and a summary claim with the visit rate paid, but no services.
			Louisiana will no longer be able to report Place of Service for HH claims due to Health Insurance Portability and Accountability Act (HIPAA) form changes.
	Eligibility	CHIP code	Louisiana reports its M-CHIP children in MSIS. The state does not have an S-CHIP program. The M-CHIP data differed greatly from the numbers in SEDS until FY 2001, but the state assured us that MSIS data were more reliable. There was a discrepancy between SEDS and MSIS M-CHIP counts, again, in Q4 FY 2001 and Q1 FY 2003; the rest of the FY03 data look fine. The state generally insists that MSIS counts are more reliable than SEDS.
			Louisiana plans to expand its CHIP program to cover pregnant women to 200 percent FPL beginning 1/03.

State	File	Record Type	Issue
LA	Eligibility	County Code	From FY1999 to FY2000 Q1, Louisiana incorrectly used a state-specific county code. This problem was corrected in FY2000 Q2. The state supplied MPR with a crosswalk, linking together the state and FIPS county codes.
		Dual Eligibility Flag	Louisiana has a somewhat lower than expected proportion of disabled eligibles who are duals. From Q1 FY1999 to Q3 FY 2000, Louisiana's MMIS system did not include the following groups: SLMB, QI1, QI2, QDWI. Beginning in Q3 FY 2000, these groups are included in the state's EL file.
		Managed Care	Louisiana did not report any managed care enrollment in FY 1999, although the state was running a PCCM plan at this time (enrollment in the plan in June 1999 was approximately 44,000, according to CMS managed care data). Beginning in Q1 FY 2000, the state reported PCCM claims in its OT file for this group, but the state did not begin reporting PCCM enrollment in its EL file until Q2 FY 2000. In the latter half of FY 2002, Louisiana MSIS data shows significant growth in PCCM enrollment. This growth is also reflected in CMS managed care data.
		MAS/BOE	Most poverty-related infants are reported in MAS/BOE 44 instead of MAS/BOE 34, because the state deems these newborns are covered until age 1.
		Private	In Q1 FY 2003, Louisiana corrected some problems with how it coded private insurance. This resulted in a 13 percent reduction in the number of people reported to have private coverage.
		Restricted Benefits	Most of the enrollees assigned restricted benefits code 5 (other) are eligible through the medically needy provision. However, some persons assigned code 5 are in the poverty-related pregnant woman group 35. These women may have restrictions related to substance abuse. Most of the women in MAS/BOE group 35 are assigned restricted benefit code 4.
		TANF/1931	Q1 FY04 TANF data look ok, but declined rapidly between Q2-Q4 FY04. Recheck in Q1 FY05.

State	File	Record Type	Issue
LA	Eligibility	TANF/1931	Across time, TANF enrollment in MSIS and ACF are diverging. The numbers are very similar in FY 1999, but by FY 2001, the ACF numbers are much smaller than those in MSIS. This problem results from the fact that DHH does not automatically disenroll TANF individuals when notified by DSS. The DHH policy is to extend eligibility for TANF individuals until they are able to determine an appropriate Medicaid disposition. DHH policy requires the individuals to remain in their Aid-Category/Type-Case classification (03/01) for up to six months until they can be re-classified. In Q1 FY 2003, ACF and MSIS data on TANF enrollment were very close again.

State	File	Record Type	Issue
MA	Claims	Capitation	Capitation payments to plans are made on a quarterly, not monthly, basis. Even so, there appears to still be a shortfall of capitation payment claims as there are fewer capitation claims than quarterly enrollment in managed care. PCCM payments are only made if there is actually a PCCM visit, so there are very few PCCM capitation payments (after Q1 1999). In Q1 1999 Behavioral Health Organization (BHO) capitation claims are incorrectly shown as Type of Service 22 (PCCM capitation claims).
		LT	There are no leave days on the files. There are very few Diagnosis Codes on the files.
		OT	The number of Home- and Community-Based Services (HCBS) claims (identified by Program Type 6 and 7) vary considerably by quarter due to the billing and submission cycle. Most services to children under age 21 have a Program Type of 1 (EPSDT). About 1/3 of the original, non-crossover claims do not have a Place of Service. Most of these claims are outpatient hospital department claims (Type of Service 11) or Lab and X-ray (Type of Service 15) claims.
	Eligibility	1115 Waiver	Massachusetts operates an 1115 waiver program for the disabled, children, and adults.
		CHIP Code	In Q2 FY 2002, persons in state-specific eligibility groups AA01AA, AA01BA, and AA01CA (all mapped to MAS/BOE 44 - 45) were incorrectly assigned a CHIP code of 2 (M-CHIP) when the code should have been 1 (no CHIP). The state addressed this problem through correction records. Massachusetts reports children in both its M-CHIP and S-CHIP programs. The MSIS data are close, but do not exactly track, SEDS data. The state insists that the MSIS data are more reliable. Until Q2 FY03, a small group of CHIP children were reported in MAS/BOE 35 who may have aged out of coverage; the state is supposed to fix this problem with correction records. Some M-CHIP children are also correctly reported to MASBOE 52.
		Dual Eligibility Flag	Massachusetts reports very few eligibles with dual code 01, since the state provides full Medicaid benefits to all aged/disabled up to 100 percent FPL. Also, because Massachusetts provides full Medicaid benefits to all blind/disabled up to 133 percent FPL in its 1115 Waiver program, the state reports very few blind/disabled with dual codes 01 or 03.

State	File	Record Type	Issue
MA	Eligibility	Dual Eligibility Flag	The majority of the dual eligibles population receives the flag 08 (09 before Q1 FY03). Many of these 08 duals probably belong in 02 or 04, but the state can not determine. MA will work on this in the future.
		Foster Care	Massachusetts is under-reporting the children in foster care.
		MAS/BOE	In FY03 Q2, MA corrected its MASBOE mapping, moving all enrollees in MASBOE 35 to MASBOE 55. Enrollees mapped to MASBOE 35 in all previous quarters were incorrectly mapped. In FY03 Q2, MA corrected its MASBOE mapping, moving 20,000 individuals from MASBOE 14 to MASBOE 34. The state provides full Medicaid benefits for the aged up to 100 percent FPL and the disabled up to 133 percent FPL.
		MAS/BOE 2003	Between March 2003 and April 2003, MA dropped 32,000 enrollees previously coded to MASBOE 55. This was part of a cost savings project.
		Race	More than 20 percent of eligibles are coded with an unknown race.
		Restricted Benefits	25,0000 to 75,000 persons in MASBOE 44 and 45 are assigned the "other" restricted benefits flag. MPR has requested clarification from the state about this.
		Retroactive Records	Massachusetts decided to report retroactive records, despite the fact that they said they were going with the delayed submission in their MSIS application.
		SSI	Enrollment in MASBOE 11 is about 2/3 of the SSI aged enrollment reported in SSA administrative data. MPR has repeatedly requested clarification from the state about this.
		SSN	Massachusetts has roughly 1,000 SSNs assigned to more than one record. The state reduced this problem in Q4 FY 2002 to fewer than 500.
		TANF/1931	Until Q2 FY03, the number of monthly TANF recipients reported in MSIS is considerably higher than ACF administrative data on TANF for the same period. Until Q1 FY03, then the MSIS TANF counts are lower. Effective Q2 FY03, TANF counts in MSIS were lower that ACF administrative data, but were within the 10% margin.

State	File	Record Type	Issue
MD	Claims	All	MD reports Medicaid expenditures on encounter claims through Q1 2004.
			Nearly two-thirds of the Medicaid recipients are enrolled in the HealthChoice Program. The remaining one-third tend to be either sicker (many institutionalized) or covered by Medicare. As a result, the distribution of Maryland's FFS claims may seem quite different from the distribution for other states.
		IP	In FFY 1999, a higher than expected percentage of original, non-crossover FFS claims have a Patient Status of 30 (Still Patient) because the IP file contains Chronic and Rehab hospitals in addition to acute-care hospitals.
			A higher than expected percentage of original, non-crossover FFS claims do not have ancillary codes in the UB-92 Revenue Code fields. This higher percentage is due to a high percentage of per-diem hospitals that remain ??what does the term remain mean here?? for the sicker population. These hospitals only receive a room and board charge.
			Because nearly two-thirds of Medicaid recipients are enrolled in managed care, the fee-for-service hospital costs tend to be higher than for other states with less Medicaid managed care. See above comment about types of enrollees included in FFS.
			Maryland does not use DRGs (there are no DRGs on the IP file). The State reimburses in state acute general hospitals using a percent of charges for rates established by the Health Services Cost Review Commission (HSCRC) under a Medicare waiver. Out-of-state hospitals are reimbursed according to that state Medicaid Programs reimbursement principles. Other hospitals in the state are reimbursed on a per-diem basis and many are subject to cost settlement.
		LT	Maryland does not report leave days.
			The Admission Date is not a required field on continuing stays. As a result, the Admission date is missing on 18 percent of the original, non-crossover FFS claims.
			Most LT claims do not have diagnosis codes.
			No one has a Patient Status of 20 (Expired/Died).
			There are no crossover LT claims.
		OT	There was a large increase in the number of outpatient hospital claims in Q4 1999.

State	File	Record Type	Issue
MD	Claims	OT	There was an increase of almost one million claims in the Q2 FY 1999 file over the number of claims in the Q1 OT file. This was the result of another agency sending in a large batch of old mental health claims in Q2. Most of these claims have a Type of Service of 33 (Rehabilitation Services). The distribution of claims, by Type of Service, is unusual due to the high percentage of individuals enrolled in managed care. Most of the original, non-crossover FFS claims are for Home Health, Physical/Occupational Therapy or Rehabilitation.
		RX	There are no Family Planning claims.
	Eligibility	CHIP Code	Maryland reports its M-CHIP eligibles, however until Q3 FY 2001 M-CHIP children in state groups P11 and P13 were not counted. This problem was fixed using correction/update records. In Q4 FY 2001 the state began to identify its S-CHIP children (in state groups DO1, DO2, DO3, and DO4).
		County Code	Maryland reports eligibles with County Code = 510. These are residents of the city of Baltimore. While this FIPS code is technically correct, documentation for the Area Resource File suggests that researchers might want to recode these persons into county "007."
		Dual Eligibles	In MD's 1115 pharmacy program, dual status information was not available in FY03 for most persons in State group S09, they were assigned dual code 99. Most of the enrollees in S09 are <65. In addition, in Q1 FY03, most enrollees in S09 were incorrectly assigned dual coade 00. This error was fixed through correction records (dual code status was changed to dual code 99). 1115 enrollees in State groups S08 and S10 were reported to dual codes 01, 03, 06 and 07.
		HIC Number	Almost 27,000 non-duals have HIC numbers (about six percent of the non-dual population).
		Managed Care	Some persons have the PLAN ID field 9-filled.
		MAS/BOE	Maryland reports more SSI recipients (MAS/BOE 11 and 12) each month than expected, based on a comparison to federal SSI administrative data. However, the state administers a SSI supplement program.
		MAS/BOE 2000	During the second and third months of Q1 FY 2000, enrollment jumps by over 50,000 in MAS/BOE 22. The state reinstated these eligibles after improperly terminating their Medicaid benefits. They are mapped to an incorrect MAS/BOE group, however, and the state used correction/update records in Q4 FY 2000 to resolve the problem.

State	File	Record Type	Issue
MD	Eligibility	MAS/BOE 2002	In October 2002, MD converted its state pharmacy plan to a 1115 waiver program. This plan covers children and adults, as well as aged and disabled individuals. MD covers FP only services as part of its 1115 waiver.
		MASBOE 2003	Correction records were submitted for Q1 FY03 to fix an age sort problem in MASBOE 51.
			In Q1 FY03, persons <65 in the state group S09 were incorrectly mapped to to MASBOE 51. This problem was fixed with correction records.
		Restricted Benefits	Many of the poverty-related women in MAS/BOE 35 only qualify for restricted benefits (Code 5) related to family planning (State Group P10 and S12).
		SSN	More than 23,000 persons have the SSN field 9-filled (four to five percent of the population).
		TANF	TANF figures are higher than reported by ACF due to the fact that individuals enrolled in TANF but who may not have received cash benefits are counted by MD. ACF counts only those who receive cash benefits.

State	File	Record Type	Issue
ME	Claims	Adjustments	There are very few adjustment claims on the files and they do not conform to the MSIS specifications. Maine has indicated that the number of adjustment claims is accurate.
		IP	There aren't any DRGs.
			Family Planning is not reported.
			Maine stopped paying Medicare coinsurance and deductibles as part of an agreement with the hospital association, so there are very few crossover claims in the IP file.
		LT	The state doesn't report leave days.
		OT	Some of the Service Code Indicators do not match the format of the Service Codes.
			Maine creates a summary bill on outpatient department claims with separate line items. Each line item should be included as a separate claim without the TPL, and then an additional claim should be included that has only the TPL amount. The TPL amount would be a negative dollar value matching the positive value in the Other Third Party Payment field. As a result, there are original and resubmittal claims with a negative Medicaid Amount Paid.
			Maine discontinued its one HMO around the beginning of 2001.
		RX	There are no adjustment claims on the file. Maine has indicated that this is OK, because drug claims are Point of Service.
	Eligibility	CHIP Code	Maine has both M-CHIP (state code 3P) and S-CHIP (state code 000000) programs, and both are reported into MSIS.
		County Code	In Q3 FY 2001, the number of enrollees with county code 999 increased to 13,000 (from 1,000 in Q2), presumably caused by enrollees in the new prescription drug program.
		Date of Death	Dates of death are 8-filled for all eligibles.
		Dual Eligibles	Part A coverage: FY03 Q1. There is a persistant problem that a small percent of dual code 02's do not have Medicare Part A coverage. The state believes that all of these duals should and do have Part A coverage, but because of coordination issues, these individuals may get their Part A coverage retroactively.

State	File	Record Type	Issue
ME	Eligibility	Dual Eligibles	When the 1115 prescription drug program started in Q3 FY01, many of the enrollees in the program were assigned dual code 00 and 08, in addition to 01, 03, 06 and 07. In Q1 FY03, all 1115 prescription drug enrollees were assigned dual code 02, 04 or 08, in compliance with new CMS MMA criteria. This caused enrollment in dual code 01, 03, 05 , 06, and 07 to decline. Many of the 1115 persons assigned 00 were probably duals. Effective Q2 FY03, enrollment in dual codes 01, 03, 05 and 06 rebounded when the 1115 program ended in december 2002; however, overall dual enrollment dropped 43%. Maine extends full Medicaid benefits to the aged and disabled with income <100% FPL, accounting for the somewhat lower than expected proportion of QMB only dual eligibles. In Q1 FY01, enrollment declined in QMB only (Code 1) and increased by about the same number in Qualified Individual (Code 6).
		HIC Number	In, FY 1999 to FY 2000, 91 to 93 percent of dual eligibles had a valid HIC number. This proportion dropped to 69 percent with the implementation of the new prescription drug program in Q3 FY 2001 and continued to decline in FY 2002. From Q2 FY03 forward, the percent of duals with a valid HIC number improved, with 89% of duals having a valid HIC number.
		Managed Care	During FY2000, comprehensive managed care declined and PCCM enrollment increased. This shift happened as the state phased out its managed care contract with Aetna and increased its PCCM enrollment.
		MAS/BOE	Maine's counts of SSI recipients in MASBOE 11-12 are somewhat higher than those reported in SSI administrative. This probably occurs because Maine has a state-administered SSI supplement. The state provides full Medicaid benefits for the aged and disabled up to 100% FPL.
		MAS/BOE 1999-2000	Each month in FY1999 and FY2000, roughly 4-5 percent of the persons in BOE 1 are younger than 65. This is a higher-than-expected proportion. Additionally, in BOE 4 each month, roughly 7 percent of the enrollees are older than age 20. This, too, is a higher-than-expected proportion. In Q2 FY 2000, the state began to separate out the unemployed adults and their children. They had previously been enrolled in MAS/BOE 14 - 15, but are now reported separately into MAS/BOE 16 - 17.

State	File	Record Type	Issue
ME	Eligibility	MAS/BOE 1999-2000	In September 2000, the state implemented a new program to cover the parents of CHIP eligibles from 100-150% FPL. The state tried to get a waiver through to make these adults eligible for the higher CHIP matching rate, but were unsuccessful. Throughout FY1999 and FY2000, Maine had an age-sort problem in MAS/BOE 44 and 45. There were also age sort problems in MASBOE 24-25 in FY1999. Only persons older than age 20 should have been mapped to MAS/BOE 45 (or 25). Persons under age 21 should have been mapped to MAS/BOE 44 (or 24).
		MAS/BOE 2001-2002	During FY 2001, child enrollment shifted between MAS/BOE 34 and MAS/BOE 44 in January. Adult enrollment shifted between MAS/BOE 45 and MAS/BOE 15 in July, 2001 when ME expanded its Section 1931 Eligibility provisions to include parents with income to 150% FPL (SS group 4Y). In June 2001, the state launched a Medicaid prescription drug program for the aged and disabled under an 1115 waiver. This program was shut down as a result of a court ruling in January 2003. In the six months prior to the waiver's start, about 1500 persons were mapped to MASBOE 51-52 due to programming complexities. They should have been mapped to MASBOE 31-32. In October 2002, a new 1115 waiver extended Medicaid to childless adults under 100% FPL (MASBOE 55). In FY 2002, state group 53 (disabled boarding home enrollees) began to be reported, but was mismapped to MAS/BOE 21, instead of MAS/BOE 22. They should have been reported to MSIS all along, but were ommitted from earlier data by mistake. In July of 2002, enrollment in MAS/BOE 14/15 dropped due to a decline in welfare enrollment (ss groups 04 and 05), while there was an increase in MASBOE 44/45 through TMA (SS groups 15 and 16), as well as "eligible" for AFDC, but not receiving (group 67). Increases in these groups reported to MASBOE 44-45 continued in FY03 and FY04.

State	File	Record Type	Issue
ME	Eligibility	MAS/BOE 2003	In FY03, ME began to report some disabled SSI recipients over age 65 to MASBOE 11, who were previously reported to MASBOE 12. In addition, groups 54000 and 62000 (nursing home enrollees who qualified for SSI) were moved to MASBOE 11-12 from MASBOE 41-42. In Q1 FY03, enrollment in MASBOE 48 increased significantly as a result of a coding change. Prior to this point, foster care children were underreported. In FY03 Q1, ME reported 500 persons to MASBOE 54 (1115 children) who should have been reported to MASBOE 55. This problem was greatly reduced in Q2 FY03. In Q2 FY03, ME's 1115 prescription drug program ended, causing over 90,000 aged and disabled to disenroll from Medicaid.
		MAS/BOE 2004	Almost no children are reported to MASBOE 14. Instead, ME primarily relies on the poverty-related group for child coverage (MASBOE 34). This shift began in FY03.
		Private	FY02 Q3-4 data is inaccurate - 9,000 (33%) of enrollees who should have been reported to private insurance were not. In Q1 FY03, private insurance patterns returned to normal.
		Restricted Benefits Flag	In some quarters prior to Q1 FY 2003, not all the persons assigned dual codes 01 and 03 were assigned restricted benefits flag 3. Aged and disabled persons enrolled in the 1115 prescription drug program (MAS/BOE 51 - 52) should have been assigned restricted benefits code 5, instead of restricted benefits code 1 (full benefits). The state correced this problem beginning in FY 2003.
		TANF/1931	Prior to FY03, Maine's TANF numbers were consistently higher than ACF numbers. The state believes MSIS overcounted TANF enrollees, and may not be reliable. TANF was 9 filled beginning in FY03 Q1.
	Eligibilty	MAS/BOE 2003	In Q1 FY03, ME corrected a long-standing programming error that had caused them to under-report foster care children. The children were still reported, but not to the appropriate category (MASBOE 48).
	Eligiblity		In FY03 Q2, MAS/BOE 51-52 should disappear, as the state's drug waiver program ended in 1/03. Most of the 100,000 are no longer eligible. Only enrollees who are SLMB only, QMB only, or QI's will continue to be enrolled in Medicaid. They will be reported to MASBOE 31-32.

State	File	Record Type	Issue
MI	Claims	Capitation	The BHO capitation claims are reported as service tracking claims in the 1999 to 2002 OT files. The state started submitting them Q1 2003.
		IP	The number of claims decreased from Q1 to Q4 1999.
		LT	Prior to Q2 2003, MI did not report covered days on most claims with a Type of Service of Mental Hospital for the Aged. This resulted in the average paid per covered day being very high in the MSIS validation tables. The large number of service tracking claims are gross adjustment payments known as QAS (Quality Assurance Supplement). It is related to the provider tax program. Prior to Oct 2003, these payments were part of the NF per diem. After that, the payments were pulled of of the per diem and paid as gross adjustments. Due to a delay in the approval of the new state plan, a 9 month catchup payment was made in 2004 Q3. Normally the payments are monthly.
		OT	Only about 80 percent of claims have a Service Code. This may be due primarily to outpatient hospital claims billing on a UB-92. The outpatient hospital claims do not have either a Service Code or revenue code. There was a sudden shift from state to HCPCS codes between Q3 and Q4 2001. Place of Service of ER is not reported until Q4 2001.
		TPL	Other Third Party Payment (or Third Party Liability/TPL) is missing on all claims.
	Eligibility	CHIP Code	Beginning in Q2 FY 2002, the state changed its SEDS reporting to accurately report enrollees that have aged out of the M-CHIP group. However, MSIS data do not yet reflect this change. Thus, there is an overcount of M-CHIP eligibles beginning in Q2 FY 2002. The state plans to implement new coding to improve reporting for its M-SCHIP children in FY02 Q2. Michigan reports its M-CHIP enrollment. It does not report its S-CHIP enrollment, however.
		Date of Death	All dates of death are "8-filled".
		Dual Eligibility Flag	Over half of Michigan's dual eligible population are reported with dual code 09 each quarter (dual code 08 effective Q1 FY03). Also, Michigan reports relatively few eligibles with dual code 01, since the state provides full Medicaid benefits to all aged/disabled up to 100 percent FPL.

State	File	Record Type	Issue
MI	Eligibility	Dual Eligibility Flag	In Q1 FY03, the distribution by dual code changed somewhat, although the total duals was about the same. In particular, enrollment shifted from dual code 02 to dual code 08.
			The state provides full Medicaid benefits for the aged and disabled up to 100 percent FPL.
		Managed Care	In each quarter, a few Plan IDs are used that do not appear in the crosswalk. In addition, many Plan IDs are 10 bytes long, with three leading zeroes, while others are seven bytes long with no leading zeroes.
			Michigan underreported enrollees in its BHP managed care plans in FY 1999. This problem was corrected in FY 2000 files.
			Michigan reports PCCM enrollment in Q1 to Q2 FY 1999, but enrollment phases out in Q3 FY 1999. Beginning in Q3 FY 2000, the state reports enrollment in a dental managed care plan. Dental plan enrollment is not included in the CMS managed care report for Michigan.
		MAS/BOE	Until FY 2003, SLMB-only and QI 1and Q2 eligibles older than 65 in state codes M2H and M2J were erroneously mapped to MAS/BOE 32. They should have been mapped to MAS/BOE 31. This problem was corrected in FY 2003.
			Michigan has a higher than expected number of enrollees younger than age 16 in BOE 5. This is likely tied to the fact that the state maps its state-specific eligibility groups directly to MAS/BOE groups, rather than using any sort of age sort.
			In Q1 FY 2003 Michigan shifted to MAS/BOE 31 about 4500 persons over age 64 who were previously reported to MAS/BOE 32.
		Race Code	The number of eligibles with "unknown" race codes varies between two and six percent.
		TANF/1931	Michigan is unable to provide TANF flags for its Medicaid population. All eligibles receive a TANF flag of 9, indicating their TANF status is unknown.
	Encounter	All	They are submitting line item claims and often each line has the same diagnosis code. Michigan thought that the diagnosis code probably applied to all lines, but were concerned that if there were, for example, 11 line items for an abortion all with an abortion diagnosis, it would be counted as 11 abortions.
			Most encounter claims have the regular encrypted Medicaid ID for the MSIS ID, but Judy Moran thought that some claims were coming in with the SSN. However, she believes that these SSNs are being crosswalked to the MSIS ID. Need to check when we start receiving encounter data.

State	File	Record Type	Issue
MI	Encounter	IP	The procedure code is missing on 95 percent of the claims.
		LT	75 percent of the claims have only one covered day.
			The only Type of Service is NF.
		OT	The billing provider ID is not always included on encounter claims and the servicing provider ID may be the provider tax ID or the provider ID assigned by the plan.
			Michigan will not be able to assign Type of Service for many encounter records because the plans often do not submit the information needed for Type of Service classification and use plan-specific provider types, making it impossible for the state to identify the type of provider. The claims have some non-specific types of service like "critical care."
			The state can't distinguish between FQHC and RHC claims in their managed care data.

State	File	Record Type	Issue
MN	Claims	IP	There aren't any family planning claims. The state said none meet the definition. The professional component is billed in the OT file.
			Service tracking claims have been reported with Type of Claim 5 (Supplemental Payment) from Q1 1999 to Q4 2003. These are mostly adjustment claims.
		IP/LT	Starting in Q3 2001 Minnesota moved their chemical dependency claims from IP to LT.
		LT	The diagnosis code is "00000" on most claims from Q1 1999 through 2004.
			The percent of ICF/MR claims is greater than expected.
			The ICF/MR days are missing on many ICF/MR claims.
		OT	Specialty Code is missing on most claims.
			The distribution of OT claims paid each month is uneven.
			The percent of lab claims is lower than expected in 1999.
		RX	The distribution of RX claims paid each month is uneven.
			Date Prescribed is always missing.
	Eligibility	1115 Waiver	MN has approved a FP only 1115, but has not implemented it. Implementation is not expected until Jan. 2006.
		CHIP Code	Minnesota is reporting its M-CHIP children. The state did not have an S-CHIP program until Q4 FY 2001, when it transferred adults from its 1115 waiver to S-CHIP. Then S-CHIP enrollees are included in MSIS under MAS/BOE 00. SEDS data in FY 2002 are not reliable. SEDS data is reliable for FY03 forwards.
			Minnesota has a very small M-CHIP program that covers only infants with income from 275 to 280 percent FPL.
		Managed Care	The number of enrollees with state-purchased health insurance declined from 8,000 in Q4 FY 2000 to 5,600 in Q1 FY 2001. The drop was the result of Minnesota's deletion of a number of records that had been found to be erroneous.
		MAS/BOE	MN is a 209 (b) state, causing the number of SSI recipients in MAS/BOE 11-12 to differ somewhat from SSI enrollment data. In addition, disabled SSI enrollees > 64 years appear to be reported to MAS/BOE 11.

State	File	Record Type	Issue
MN	Eligibility	MAS/BOE 1999-2000	In FY99 and FY00, the assignment of enrollees to MAS 2, 3, and 4 was not reliable in Minnesota, except to the extent that individuals were identified as aged, disabled, children, or adults. As an example, "children" at a general level were appropriately identified, but the sorting of children by medically needy, poverty-related, or other status had many errors. Only the MASBOE 11-15, 48, and 54-55 designations are reliable. Until FY01, the state had an MSIS coding mistake related to income -- and income is a critical variable to the assignment of individuals across MAS 2, 3, and 4.
		MAS/BOE 2001	Effective FY 2001, Minnesota reported almost all of its poverty-related children and adults into MAS/BOE 54 and 55 as a part of its MinnesotaCare 1115 Waiver Program. About 24,000 adults transferred out of MAS/BOE 55 to the S-CHIP parent program in Q401. In July 2001, MN exercised the OBRA 86 option, extending full Medicaid benefits to the aged and disabled to 95% FPL. However, these individuals were not assigned a special eligibility code and were not identified in MSIS data until Q4 FY03. They were probably reported to MASBOE 21-22. In addition, in FY01, MN began extending "access" services to aged persons whose eligbility was not yet finally established.
		MAS/BOE 2001-2003	From FY01 through Q3 FY03, MN reported many children and adults to MAS 2,3 and 4 who should have been reported to MAS 1 as a result of the state's expanded 1931 criteria. This problem was corrected in Q4 FY03.
		Restricted Benefits	Persons assigned restricted benefits code 5 only qualify for "access" services, since their eligibility has not yet been fully established.
		TANF/1931	Eligibles reported as TANF recipients in Minnesota's data are actually recipients of the Minnesota Family Income Program. For their Medicaid population, this is nearly equivalent of the TANF code and is of greater interest to the state (from a data feedback perspective). In FY 1999 and FY 2000, 99 percent of children and adults in MAS/BOE 14 - 15 are TANF recipients. In Q1 FY 2001, the TANF numbers in MSIS were 15 percent higher than the TANF administrative data. This discrepancy increased to 45 percent in Q1 FY 2002.

State	File	Record Type	Issue
MO	Claims	IP	DRG is not on the file
			There is a higher than expected percent of records with a Patient Status of 30 (Still a Patient).
			There is a much larger than expected percent of crossover claims, but the amount paid on those claims make them appear to truly be crossovers.
		LT	The Admission Date is missing.
		OT	Outpatient hospital claims have Service Codes rather than UB-92 revenue codes.
			There aren't any claims with a type of service of sterilization or abortion.
			33 percent of claims have Type of Service 19 (Other Services). Missouri says these are mostly claims for homemaker chores
			The Servicing ID is mostly missing
		RX	All compound drugs are coded as "COMPOUND" in the NDC field.
			New Refill Indicator is always missing.
	Claims/FFS	IP	One of most frequent diagnosis code - Y85 is not a ICD-9 code
		RX	Date Prescribed is always missing.
	Eligibility	CHIP Code	Missouri is reporting M-CHIP eligibles into MSIS. The state does not have an S-CHIP program. The data differs from SEDS through FY 2001, but the state insists their MSIS data are correct.
		County Code	Missouri reports eligibles with County Code = 510. These are residents of the city of St. Louis. While this FIPS code is technically correct, documentation for the Area Resource File suggeests that researchers might want to recode these persons into county "191."
			Through FY02, MO used improper FIPS code 193 for Ste. Genevieve county. They should have used code 186. The state corrected this problem beginning in Q1 FY03.
		Dual Eligibility Flag	According to the state, these are eligibles that might qualify under QMB or SLMB rules, but pay for their own Part B premiums as a part of their spend down. The state also indicated that dual eligibles have to apply for QMB/SLMB coverage.
			Missouri differs from most other states in its dual eligibles policies. About 45 percent of the total dual population (61,000 persons) are assigned dual code 08.

State	File	Record Type	Issue
MO	Eligibility	Health Insurance	In Missouri's Q1 FY 1999 file, roughly 5,000 persons who were ineligible for Medicaid during the month (i.e., those in MAS/BOE 00) received HEALTH INSURANCE flags, indicating that they were eligible for Medicaid during the month. This problem was corrected in Q2.
		Managed Care	Missouri was under-counting managed care enrollment in FY 1999. This problem was corrected in FY 2000.
		MAS/BOE	Enrollment in MAS/BOE 14 - 15 jumps by roughly 40,000 persons in July 2000. This shift is caused by the reinstatement of persons who lost Medicaid because their welfare benefits were terminated. This special initiative ended in March 2001. Effective Q2 FY 2002, Missouri increased its 1931 income threshold to 100 percent FPL, causing many children to transfer from MAS/BOE 34 to 14 and many adults to transfer from MAS/BOE 55 to 15. Effective Q4 FY 2002, the 1931 threshold was lowered to 77 percent FPL, causing many adults to disenroll and some children to transfer from MAS/BOE 14 to MAS/BOE 34. Also, in Q4 FY 2002, Missouri cut back eligibility for 1115 enrollees in MAS/BOE 55, reducing TMA coverage for state groups 76C and 80R from 24 months to 12 months. In Q3 to Q4 FY 2002, approximately 2,000 enrollees in state-specific eligibility group 11M (Medical Assistance -- Old Age assistance) were falsely reported to MAS/BOE 41 rather than MAS/BOE 11 and about 4,500 enrollees of group 13M (Medical Assistance-Old Age assistance) were falsely reported to MAS/BOE 41 rather than MAS/BOE 11 and about 4,500 enrollees of group 13M (Medical Assistance --Aid to Disabled) were falsely reported to MAS/BOE 42 rather than MAS/BOE 12. This error was resolved by FY03 Q1 and FY02 Q3-4 were fixed through correction records. Effective Q2 FY 1999, Missouri extended full Medicaid benefits to adults in its 1115 program (MAS/BOE 55). In addition, some adults in MAS/BOE 55 only qualify for family planning benefits. Children were already covered.

State	File	Record Type	Issue
MO	Eligibility	MAS/BOE	Through Q1 FY02, Missouri reports a larger than expected number of persons younger than age 65 in BOE 1. Eligibles in state-specific eligibility groups AALN00, BBLN00, and CCLN00 are mapped only to MAS/BOE 31. Eligibles in these groups that are younger than 65 should be mapped to MAS/BOE 32. The state corrected this in Q3 FY 2002. Towards the end of Q1 FY03, MO added coverage for the working disabled, resulting in increased enrollment in MASBOE 42. In July 2003 there was a noticeable increase in enrollment in MASBOE 34 and 55 when some families transferred out of MASBOE 14-15 when they hit the standard 12 month TMA time limit. BCCPTA coverage was added for Q1 FY04. Missouri does not provide medically needy coverage. Missouri is a 209(b) state. This explains why the number of SSI eligibles reported into MAS/BOE 11 and 12 is lower than the number reported by Social Security Administration. TMA enrollees are included in the 1931 group mapped to MASBOE 14-15.
		Restricted Benefits	Some presumptively eligible pregnant women in MAS/BOE 34 (state code 58PL00) are assigned restricted benefits code 4 (pregnancy related). In addition, adults in state code 80R000 (mapped to MAS/BOE 55) only qualify for family planning benefits; however, they were not assigned restricted benefits code 5 until Q1 FY03. In Q1 FY03, some persons in MASBOE 31-32 were incorrectly assigned restricted benefit flag 1. This was corrected in Q2 FY03 forward.
	Encounter	IP	In 2003 about three percent of the IP encounter claims have an invalid Type of Service. In 2002, only 30 percent of the claims had UB-92 Revenue Codes for ancillary services, and 13 percent have procedures.

State	File	Record Type	Issue
MS	Claims	All	Mississippi will start including claims with invalid IDs, but with payment amounts, in Q1 2005. They realize these could fail an edit check (the numbers are usually 0s or 9s), but feel their inclusion provides a truer portrayal of claims activity.
			Mississippi will start including $0 paid claims (previously not included) with 2005 Q1. These claims sometimes have TPL amounts.
		Capitation	The Mississippi HMO program ended 10/99, however, there are some lagged capitation claims and around 8,000 HMO enrollees listed in the Q1 and Q2 2000 EL files.
			The HMO capitation void claims in Q1 to Q3 1999 appear to be lump sum adjustments.
		IP	The IP file has a large percentage of adjustment claims in Q1 1999. Mississippi has confirmed that this is accurate.
			Family Planning is not reported.
			Mississippi does not report DRGs.
		IP/LT/OT	MS went to a new claims system starting with Q1 2004. Because they knew there would be a delay in paying claims at first, they made large advance lump sum payments to providers. As the providers submit claims, those amounts are deducted from their financial system. However, the claims will show up with $0 until the advance payments are exhausted. This continued on throughout FFY 2004 but tapered off during the year.
		LT	There aren't any claims with a service type of 02 (Mental Hospital for the Aged) as this is not covered in the Mississippi state plan.
		OT	The state has put revenue codes into the Service Code field on about 25,000 original non-crossover claims in Q1 1999.
			There are no PCCM claims in the 1999 files. The state starting including these claims in the FFY 2000 files.
		RX	Quantity of Service is not reported on most drug claims from Q3 2000 to Q4 2003. It appears again starting with the 2004 files.
	Eligibility	1115 waiver	MS had an 1115 FP waiver approved for implementation in July 2002. MSIS reporting did not begin until Q1 FY04.

State	File	Record Type	Issue
MS	Eligibility	CHIP Code	Until October 2002, Mississippi's state-specific eligibility group "91" encompassed M-CHIP children, non-CHIP poverty-related children and poverty-related pregnant women. The state could not accurately determine which individuals in state group "91" were M-CHIP children, however. Thus, Mississippi elected to assign CHIP code "9" (CHIP status unknown) to all individuals under age 19 in "91." The state erroneously continued this practice in Q1 to Q3 FY 2003 after the M-CHIP program had been discontinued. These individuals should have been assigned CHIP code 1 ("eligible and no chip") after the program ended. Effective 1998, Mississippi had both an M-CHIP and an S-CHIP program. The M-CHIP program phased out in FY 2002. The S-CHIP program is not reported in MSIS.
		Contractor	MS switched from EDS to ACS as its MMIS contractor effective Q1 FY04.
		Dual Eligibility Flag	Effective Q2 FY04, MS revised its dual coding in MSIS to conform with its MMA dual coding. Many persons previously reported to dual code 02 are now reported to dual codes 04 and 08. In Q4 FY 2000, the state began to disregard income between 100 to 135 percent FPL, in effect providing full benefits to 135 percent FPL. As a result of this change, the number of SLMB-only dual eligibles dropped from more than 8,000 in Q3 to around 1,000 in Q4. In FY 2003, Mississippi assigned dual code 02 to all full benefit duals, rather than distinguishing between QMB fulls (02s), SLMB fulls (04s) and other full duals (08s). This occurs because the state disregards income between 100-135 percent FPL.
		Foster Care	Mississippi reports a smaller proportion of children in foster care than we generally expect.
		Managed Care	The PCCM program was discontinued April 2002. Beginning in November 1999, Mississippi stopped reporting any eligibles with comprehensive managed care.
		MAS/BOE	Through Q3 FY 2000, the state provided full Medicaid benefits for the aged and disabled up to 100 percent FPL. In Q4 FY 2000, the state began to disregard income between 100 to 135 percent FPL, in effect providing full benefits to 135 percent FPL. In Q1 FY04, aged enrollment increased substantially. Some, but not all, of this increase resulted when some shifts were made in the age sort for aged and disabled. However, some persons 65+ continue to be reported to BOE 2.

State	File	Record Type	Issue
MS	Eligibility	MAS/BOE	Beginning June 2001, Mississippi changed its reporting system as part of the welfare delinking process so that now state group 85 includes 1931 eligibles AND TMA enrollees. As a result, TMA enrollees were no longer separately identifiable and no longer reported to MAS/BOE 44 - 45. They are now mapped to MAS/BOE 14 - 15. Only a small group of hospice recipients remain in MAS/BOE 45 in FY 2001. No one is assigned to MAS/BOE 45 in FY 2002.
			State groups 10 and 21 (300 percent nursing home, and illegal aliens) were mistakenly mapped to MASBOE 32 from Q1 FY01 to Q4 FY03; they should have been mapped to MASBOE 41 or 42. State groups 12 and 22 (same groups) were mistakenly mapped to MASBOE 34 from Q1 FY01 to Q4 FY03; they should have been mapped to MASBOE 42.
		Private Health Insurance	In April 2003, Mississippi reported a surge in private health insurance of about 4,000 (16 percent). The state believes they had been under-reporting private health insurance enrollment prior to this time.
		SSN	Roughly 5 percent of Mississippi's eligibles did not have SSNs. Many of these eligibles have been identified as "K Babies" (state-specific eligibility group "KK"). These eligibles are newborns who have yet to receive SSNs.
		TANF	In Q1 FY 2002, the number of TANF recipients was about 20 percent less than the number reported in ACF administrative data. Data from the two sources began to converge in Q2 and the discrepancy was within the expected range by Q3; however, in FY 2003 discrepancies reappeared.
			In Q2 FY04, MS began 8-Filling its TANF indicator. Prior TANF data is not reliable.

State	File	Record Type	Issue
MT	Claims	IP	There weren't any claims paid in Month 3, Q3 FY 2000, but there wasn't a drop in the claim count for the quarter, so it doesn't appear that the state failed to submit a month's worth of claims.
			There are few claims with a Program Type of Family Planning. The incomplete reporting is the result of the exclusive use of service codes to define it, rather than family planning status being reported on the MMIS claims.
			The DRGs appear to be CMS DRGs, but they are reported as state-specific.
		LT	There are no crossover claims on the file. Montana does not process long term facility claims as crossovers.
			1999 to 2001 files: Montana reports that mental health services are entirely state-funded and therefore not included in MSIS.
			1999 to 2005 files: Patient Status is not available on most claims even though it was submitted on 1998 MSIS files. Montana claims that only a few facilities ever report anything in the field, and that when something is reported it is almost always 99 (Unknown).
			The TPL amount is mostly combined with the Patient Liability field due to system reporting.
		OT	The percent of lab claims is lower than expected in 1999.
			Q4 2004 - the percent of claims with a Type of Service 19 (Other Services) is increasing over time. By Q4 2004 it is up to 42%.
			Some original, non-crossover FFS claims have a negative Medicaid Amount Paid. This is correct because Montana needed to create dummy bills in cases where they had summary bills. On the summary bills, the state assigned the allowed amount on each line item into the Medicaid Amount Paid field, and then created a dummy claim which had cost-sharing. The cost-sharing (e.g., copayments, TPL) was included as a negative Medicaid Amount Paid on the dummy record.
			There are some debit adjustment claims with a negative Medicaid Amount Paid
	Eligibility	Age Sort	Montana had an age calculation problem until Q3 FY 2002. In Q1 to Q2 FY 2002, three to four percent of enrollees in BOE 4 were over age 20.
		CHIP Code	Montana begins reporting its S-CHIP data in FY 2000.

State	File	Record Type	Issue
MT	Eligibility	CHIP Code	There was a considerable discrepancy between SEDS and MSIS S-SCHIP counts in FY2002 Q3. According to the state, the SEDS numbers are incorrect. Subsequent SEDS data is comparable to MSIS data.
		Dual Eligibility Flag	Dual eligibility groups QDWI, QI1, and QI2 are not included on Montana's MSIS files. In June 2003, MT stoppped reporting dual code 03 by mistake, and persons who should have been reported to dual code 04 were converted to dual code 08. MT says they will be fixing this.
		Managed Care	MSIS and CMS data are generally consistent on managed care enrollment in PCCMs (HMO enrollement ceased effective Q4 FY00). However, the June 1999 CMS data show 70,000 persons in PHPs. According to state officials, this was an error. No PHP enrollment is shown in MSIS.
		MASBOE	MT appears to report many of disabled SSI >64 years of age to MASBOE 11. Until Q1 FY03, MT reported a small group of enrollees to MASBOE 99 each month. Most appear to be children in the "M1" state group who would ordinarily be mapped to MASBOE 34
		Restricted Benefits Flag	Montana's welfare reform program, called "FAIM," extends reduced Medicaid benefits to some adult eligibles. These persons appear to be assigned restricted benefits code 5 and are mapped to MASBOE 45. MT also assigned restricted benefits code 5 to its BCCPTA enrollees.
		TANF/1931	Montana cannot identify TANF recipients. All eligibles are coded with TANF = 9, indicating that TANF status is unknown.

State	File	Record Type	Issue
NC	Claims	Adjustments	There are fewer than expected adjustment claims because many adjustments are done as cost settlements and not as adjustments to individual claims.
		IP	Some claims have procedure dates after the date of the file because this field is not validated by the state MMIS system.
		LT	A slightly higher than expected percent of claims are for ICF/MR services which the state has confirmed is correct.
		OT	The Place of Service is missing or has invalid codes on most claims in 1999. The percent with valid codes has increased somewhat over time. About 60 percent of the OT claims have valid codes in the 2002 files.
			The Service Code Indicator was not set correctly on some claims prior to Q2 2004.
			There are a few adjustment claims with the incorrect sign.
		RX	The file contains non-standard NDC codes that start with "0A" in 1999.
			The prescribing physician ID is missing.
			The state has been reporting the fill date in both the Fill Date and Prescribed Date fields.
	Eligibility	CHIP Code	North Carolina has opted to report its S-CHIP group. The state does not have an M-CHIP program.
		Correction Records	NC almost completely replaced its Q3 04 and Q2 04 files with correction records in Q4 04, most did not involve actual changes.
			Analysis of North Carolina correction records in the Q1 FY 2003 file for Q4 FY 2002 indicated that 60 percent of the records did not change any key data elements. The records with changes seemed appropriate.
		Dual Eligibility Flag	Effective 1/1/99, the state extended full Medicaid benefits to aged and disabled, up to 100 percent FPL. This is reflected in changing dual flags and restricted benefits for persons in MAS/BOE 31 and 32 beginning in Q2 FY 1999. This also caused some enrollment to shift from MAS/BOE 21/22 to 31/32.
			The state assigns dual code 99 to aged and disabled persons who appear to be duals but for whom the state is not yet showing a buy-in.
			About 11 percent of persons age 65 and older are not reported to be dually eligible for Medicare in Q1 FY 1999 a somewhat higher proportion than expected. This issue was corrected in subsequent quarters.

State	File	Record Type	Issue
NC	Eligibility	Managed Care	The number of enrollees in a comprehensive health plan (Southern Coventry Health Care of the Carolinas, Inc.) spiked in January 04 (Q2, month 1 FY 2004) and returned to an expected level by September 2004. This is likely due to a managed care reporting error.
			In October 2001, the Wellness Plan of North Carolina was terminated, causing a noticeable drop in HMO enrollment. In December 2002, United Health Care was terminated, also causing an enrollment drop.
			North Carolina was reporting its 1915b health plan (CALTERN) as a comprehensive managed care plan (Plan Type 01), while it was reported as a PHP in the CMS managed care system. Enrollment in the plan expired at the end of June 1999.
		MAS/BOE	Effective 1/1/99, the state extended full Medicaid benefits to aged and disabled to 100 percent FPL. This caused some enrollment shifts from MAS/BOE 21/22 to 31/32.
			Beginning in Q1 FY 2001, North Carolina reinstated a large group of former AFDC welfare enrollees in to MAS/BOE 14 - 15. These enrollees may have been inappropriately terminated from Medicaid as a result of welfare reform. At the peak in April 2001, this reinstated group more than 70,000 persons. By October 2001, it had dropped to about 10,500, according to the data provided by the state. This policy accounts for the increase in MAS/BOE enrollment in FY 2001.
			About 700 refugees were mapped to MAS/BOE "**" each month in Q1 FY 1999.
			Effective 11/1/99, North Carolina eliminated their UP Policy. After that date, no eligibles are reported into MAS/BOE 16 or 17.
			Prior to 9/1/03, enrollees losing TANF coverage were provided an additional 12 months of Medicaid coverage before they were moved to traditional transitional Medicaid coverage. After 9/1/03, this 12-month extended coverage was ended by the state resulting in a portion of state group MAFCN being moved into traditional transitional coverage (state group AAFCN). Hence, there was a transfer of enrollees from MASBOE 14-15 to MASBOE 44-45 in September 2003.
			Roughly 2,000 eligibles were mapped to MAS/BOE 46 and 47 each month in Q1 FY 1999. These persons should have been mapped to MAS/BOE 44 and 45. In the remaining quarters of FY 1999, this number was down to a few hundred per month. By the end of Q1 FY 2000, this problem disappeared.

State	File	Record Type	Issue
NC	Eligibility	MAS/BOE	Effective 11/1/99, North Carolina expanded their 1931 eligibility rules to cover eligibility for 12 months after termination of TANF benefits. These enrollees would otherwise have received transitional Medicaid (MAS/BOE 44 - 45). As a result, enrollment increased in MAS/BOE 14 - 15 in FY 2000, while it fell in MAS/BOE 44 - 45. North Carolina's count of SSI recipients is somewhat different from SSA data for two reasons. First, North Carolina administers its own SSI Supplement program. Second, the state appears to report most disabled persons over age 64 to MAS/BOE 11. Enrollment in several of the MAS/BOE groups shows a seam pattern each quarter, with enrollment highest in Month 1 and lowest in Month 3, but increasing in Month 1 of the next quarter. This may be smoothed out over time by retroactive and correction records.
		Restricted Benefits Flag	The women in MAS/BOE 35 who receive RBF = 2 (restricted benefits on the basis of alien status) are aliens who receive coverage for emergency services, including labor and delivery. Persons with restricted benefits code 5 (other) are generally medically needy enrollees.
		TANF	In FY 2000 through FY 2002, TANF counts in MSIS were 13 - 14 percent higher than ACF TANF counts. In FY 2003, MSIS counts were 19 percent higher.

State	File	Record Type	Issue
ND	Claims	Capitation	There are very few HMO capitation claims until Q1 2000.
		IP	A slightly higher than expected percentage of the claims do not have UB-92 Revenue codes for ancillary services. This is because mental health and rehabilitation claims are billed using the comprehensive UB-92 revenue code that includes accommodations and ancillary services. This percentage decreases over time, probably because these claims were moved to he LT file.
		LT	There are almost no crossover claims in the LT files.
			Two thirds of the original claims have an admission year prior to 1997. This percentage is higher than expected.
			Nearly all of the claims do not have diagnosis codes.
		OT	North Dakota has state specific Service Codes that are a single letter (e.g., 'M', 'L', or 'E'). The state has been asked for the definitions, but so far they have not been provided.
			The percent of claims with Other Third Party Payment (or Third Party Liability/TPL) is higher than expected
			The provider ID servicing number is missing on some claims.
	Eligibility	CHIP Code	North Dakota reports its M-CHIP children. The state has an S-CHIP program, but did not start reporting those children in the file until 10-99. In Q2 to Q4 FY 2002, there is a discrepancy between MSIS and SEDS data. The state believes the MSIS data are more accurate. The two sources compare well in FY 2003. Beginning in Q2 FY 2002, the state reports M-SCHIP enrollees with multiple state-specific eligibility groups and MAS/BOE codes. Through Q1 FY 2002, all M-SCHIP enrollees were mapped to MAS/BOE 34 and state group 33. However, the M-SCHIP program in ND is very small (fewer than 1,000 enrollees per month) and we chose not to question the state about this.
		Correction Records	Until Q2 FY 2002, a sizable proportion of retroactive and correction records were for 6+ months ago, a somewhat unusual pattern. From Q2 FY 2002 forward, the state only submits correction and retroactive records for the prior three quarters. The state discovered a problem with its system of correction and retroactive records that particularly impacted dual coding and appeared to date back to FY 1999. The state fixed the programming for Q1 FY 2002 forward. The number of correction records increased in Q2 FY 2001 due to changes in the state's reporting system. There was also a high volume of correction records in Q3, as the state changed the way that it reported the "days of eligibility" data element in order to comply with CMS standards. This change did not effect the value of any data elements, just the way that it is reported.

State	File	Record Type	Issue
ND	Eligibility	Dual Eligibility Flag	Most dual eligibles receive the dual flag 09 (08 effective FY 2003), including SSI recipiants. ND asserts that SSI duals should not be required to apply for QMB or SLMB status sinse they are already getting premiom payments and cost-sharing.
		Health Insurance	North Dakota reports that about 18 percent of its eligibles have private insurance, a higher than expected proportion.
		Managed Care	The provider ID of the state's only HMO (Altru Health Plan) changed from "0006900" to "MCO" in FY 2002.
		MAS/BOE	In September 2003, ND reduced the earned income disregards used for Section 1931 enrollees. As a result, enrollment declined in MASBOE 14, 15, 16, and 17. At the same time, child enrollment increased in MASBOE 34, while adult enrollment increased in MASBOE 25 and 35. Because North Dakota is a 209(b) state, they report a somewhat lower proportion of SSI recipients in MAS/BOE 11 and 12 than usually expected. In addition, it appears that disabled SSI recipients over age 64 are reported to MASBOE 11. In Q4 FY 2001, ND made changes to its 1931 policies that resulted in increased enrollment in MAS/BOE 14 - 17, with declines in other child/adult groups. In FY 2002 increases occurred in MASOBE 44 - 45 as a result of growth in TMA (state-specific groups 26 and 27). In January 03, there was a decline in MAS/BOE 16 - 17(SS code 37 and 38) and a comensurate increase in MAS/BOE 44 - 45(SS code 09 27 and 28). This resulted from a more stringent definition in underemployment, on accounting for income and number of hours per month worked, instead of only accounting for income. The enrollees who had been on the plan for at least three months were moved to transitional coverage, hence the change in MAS/BOE. For those who did not qualify for transitional coverage, the children were able to qualify under the poverty-related provisions, while the adults became ineligible for Medicaid.
		Retroactive Records	Until Q2 FY 2002, a sizable proportion of retroactive and correction records were for 6+ months ago, a somewhat unusual pattern. From Q2 FY 2002 forward, the state only submits correction and retroactive records for the prior three quarters. The state discovered a problem with its system of correction and retroactive records that particularly impacted dual coding and appeared to date back to FY 1999. The state fixed the programming for Q1 FY 2002 forward.

State	File	Record Type	Issue
NE	Claims	OT	In the 1999 and 2000 files, Nebraska will include a lump sum claim in each quarter for their waiver, transportation, and targeted case management claims. Most of these claims are processed outside of Nebraska's MMIS, and the State has indicated that it will not be able to create line item claims. The State notes that when their methodology for creating line item claims is complete, they will be able to create historical records. The BHO case management capitation claims are reported as individual claims through Q1 2002. From Q2 2002 through Q3 2003 they were not included in the file in any form. Starting in Q4 2003 they are reported as service tracking claims with a Type of Service of PCCM. They don't expect to be able to send individual BHO capitation claims until June 2005.
		RX	The following data elements are not available: Days Supply, Date Prescribed, and New Refill Indicator.
		Waiver Claims	The 1999 to 2004 OT files include some of the waiver services as individual claims and some as service tracking. The percent varies across quarters with a drop in Q1 2003. Nebraska is working on changing their system so they can report all waiver services as individual claims.
	Eligibility	CHIP Code	Nebraskas MSIS data include their M-CHIP enrollees (the state does not have an S-CHIP program).
		DOB	See Unborn Child note.
		Dual Eligibility Flag	Nebraska assigns dual flag 09 to 100 to 200 enrollees per quarter. In addition, the state does not use dual flags 04, 06, and 07. The state has agreed to work towards eliminating dual flag 09 and including dual flag 06 beginning in Q2 FY 2004. Nebraska does not report any eligibles with the dual code 01, since the state extends full Medicaid to all aged/disabled <100 percent FPL. In Q1 FY 2002, SLMB-only dual eligibles were mistakenly excluded from MSIS. This resulted in a dip in MAS/BOE 31 - 32 that rebounded in Q2. Through FY04, about 80 percent of eligibles in MAS/BOE 11 (Aged-cash) are reported as dually eligible. This is lower than generally expected, but the overall dual rate for BOE 1 is 95 percent.
		Managed Care	There was no behavioral managed care reported in MSIS in Q4 FY 2002. The state failed to report this enrollment as Nebraska moved from the Value Options BHP plan to the Magellan plan. BHP reporting was returned to the data in Q1 FY 2003 and the state fixed Q4 FY 2002 through correction records. Nebraska did not enter a PCCM plan ID through Q1 FY 2004.

State	File	Record Type	Issue
NE	Eligibility	MAS/BOE	Nebraska requires SSI recipients to separately apply for Medicaid, accounting for the somewhat lower-than-expected count in MAS/BOE 11 and 12. Because Nebraska has converted to a new eligibility system, they are having difficulty placing roughly 5,000 - 6,500 eligibles into MAS/BOE groups each month. HCFA has increased the error tolerance to 3%, allowing these eligibles to be mapped to MAS/BOE 99. This problem will disappear as the state more fully adopts the new eligibility system. In Q4 FY 2000, Nebraska begins to correctly re-map eligibles who had been mapped to MAS/BOE 99 in previous quarters. At the same time, the state is refining its state-specific eligibility code. These changes result in uneven enrollment patterns, but the state insists they are correct and that they will smooth out over time. See note about unborn children, which complicates reporting into MAS/BOE 35. In FY 2003, Nebraska imposed cuts in eligibility for working families, causing major declines in child and adult enrollment.
		Retroactive Records	Nebraska decided to report retroactive records, despite the fact that they said they were going with the delayed submission in their MSIS application.
		Sex	See Unborn Child note.
		TANF/1931	Over time, TANF enrollment in MSIS has been about 15 - 25 percent higher than ACF data. The state believes this is because there is a separate TANF plan that is not reported to ACF. Nebraska is not reporting any non-TANF eligibles in MAS/BOE 14 - 17, contrary to expectations. Additionally, until FY 2001, there were 3,000 persons receiving TANF outside of MAS/BOE 14 - 17. As the state more fully adopts their new eligibility system, it expects these problems to disappear.
		Third Party Liability	Nebraska had a significant drop in the number of people with private health insurance from Q4 1999 to Q1 2000.
		Unborn Children	Pregnant women who are only eligible for Medicaid as a result of their unborn child are not entered into the MSIS system. Instead, an MSIS ID is assigned to the unborn child. The unborn child's SSN is 9-filled and the sex is Unknown. The DOB is the expected DOB. After birth, the SSN, sex, and DOB fields are corrected. Most of these unborn children are initially mapped to BOE 5, although some are mapped to BOE 4.

State	File	Record Type	Issue
NH	Claims	LT	There is a large shortfall of LT claims in Q2 1999 due to a mass adjustment that was done to most claims. Since these files were created more than a year after the time of the file and quarter, the state just dropped the original/void pairs, keeping the resubmissions as originals, but recording them in the subsequent quarter (Q3 1999). The Admission Date is missing on most claims as that information is not collected on the New Hampshire claim form. Some adjustment claims are not properly reported. There are sets of original and resubmissions without voids, probably resulting in duplicate claims. The days are on all adjustment and supplemental claims so they are over reported. There aren't any claims with a Type of Service of mental hospital for the aged, even though that service appears in the state crosswalk.
		RX	Credit adjustment claims are reported as original claims from 2003 Q4-s004 Q1. Credit claims are reported as originals from 2003 Q4-2004 Q1.
	Eligibility	CHIP Code	New Hampshire operates both M-CHIP and S-CHIP programs, but it only reported its M-CHIP eligibles in MSIS initially. S-SCHIP reports began in Q1 FY03. In Q4 FY 2002, there is a 13 percent discrepancy between MSIS and SEDS M-CHIP counts. The state says that this occurred because the state submitted its MSIS files before all of the CHIP data had been received. The state has been asked to delay submission in the future. The SEDS and MSIS M-SCHIP and S-SCHIP data were comparable in Q1 FY03.
		Dual Eligibility Flag (DUAL	New Hampshire incorrectly reported in Q1 to Q2 FY 1999 that all dual eligibles in MAS/BOE 31 and 32 were QMBs with full Medicaid FLAG = 02). In subsequent quarters this problem was corrected, and the vast majority of dual eligibles in MAS/BOE 31 and 32 were reported as QMB onlies (DUAL FLAG = 01). New Hampshire did not report dual eligibles in the SLMB only, QI-1, QI-2, and QDWI groups in its MSIS data until Q1 FY03. In addition, NH reported all full benefit duals to code 02 until Q1 FY03.

State	File	Record Type	Issue
NH	Eligibility	Managed Care	New Hampshire is reporting comprehensive managed care (Plan Type 01) enrollment of 2,172 in its June 1999 MSIS data. The CMS data for the same time period indicate that enrollment was more than double that -- 5,872. The state explored this issue, but was unable to find an explanation. They guessed it could have resulted from the fact that MSIS data contained only the managed care enrollment of case heads. The gap between the two counts converged by June 2001. In February 2002, NH switched from Matthrew Thorton HMO to Anthem/BCBS. The dental managed care NH began reporting in Q1 FY03 is not reported in CMS managed care data in Q3 FY03. In July 2003 (Q4 FY03) NH terminated its only HMO managed care program, but its dental managed care program continued.
		MAS/BOE	Because New Hampshire is a 209(b) state, the number of eligibles reported in MAS/BOE 11 and 12 is lower than the number receiving SSI, according to the SSA. In addition, it appears SSI disabled >65 years are reported as SSI aged.
		Restricted Benefits Flag	In Q1 to Q2 FY 1999, all persons in MAS/BOE 31 and 32 are correctly reported to have restricted benefits related to dual status, even though they are reported under dual code 02.
		TANF/1931	From FY 1999 forward, all persons in MAS/BOE 14 - 17 are reported to be TANF eligibles. It is unclear whether any persons other than TANF recipients qualified for Medicaid under 1931 rules.

State	File	Record Type	Issue
NJ	Claims	Adjustments	Because of reimbursement system, there are a few original and resubmittals claims with negative amount pd, particularly in the LT file.
		Crossovers	There was a drop in the percent of crossovers from 9.1 percent in Q1 1999 to two to three percent in subsequent quarters. This is due to the processing cycle. In Q1 1999 they were catching up from the 2 previous quarters when there was a shortfall.
		LT	The claims from five or six inpatient psych hospitals were inadvertently left out of the files prior to FY 2002. This was fixed starting with Q1 2003. New Jersey doesn't know how long those claims were omitted.
			A small percentage of the adjustment claims have the wrong sign on the amount paid field.
		OT	There aren't any claims with a Type of Service of 34 [Physical Therapy (PT), Occupational Therapy, Speech Pathology and Language Therapy].
			The Service Code Flag is not always correct in Q1 1999.
		RX	All compound drugs are coded as "COMPOUND" in the NDC field.
			Date Prescribed is always missing.
	Eligibility	CHIP Code	Beginning in January 2001, New Jersey added coverage for M-SCHIP and S-SCHIP parents under an 1115 waiver. However, there were problems with MSIS reporting for these enrollees. M-SCHIP parents (state group 380) began to be reported in MSIS current records in Q2 FY 2001, but they were mapped to MAS/BOE 15 (they should have been mapped to MAS/BOE 55), and they were assigned SCHIP code 01 (they should have been assigned SCHIP flag 02). The correct coding for M-SCHIP parents did not appear in current MSIS records until Q1 FY 2003. S-SCHIP parents (state groups 497,498, and 499) were not reported in MSIS current records until Q1 FY 2002, when they were correctly reported to MAS/BOE 00 and assigned SCHIP code 03. In Q1 FY 2002, there were about 184,000 correction records in SCHIP for state group 380 (M-SCHIP parents); so some of the reporting problems for M-SCHIP parents may have been corrected for MAX.
			New Jersey reports both its M-CHIP and S-CHIP enrollees into MSIS.
		Dual Eligibility Flag	New Jersey does not report any eligibles with dual eligibility flag 01, since the state extends full Medicaid benefits for all aged/disabled up to 100 percent FPL.

State	File	Record Type	Issue
NJ	Eligibility	Dual Eligibility Flag	Between Q1 FY 2000 and Q2 FY 2000, the number of dual eligibles with flag 02 dropped by about 7,000 and increased by roughly the same amount for duals with flag 09. The state assured us that this was not a coding error; however, they could not explain this shift. CMS approved NJ to use dual code 09 in FY03 for aged/disabled medically needy duals in nursing homes who do not get drug benefits (<800 enrollees/month).
		Managed Care	In New Jersey's MSIS files, about 30,000 persons receive the Plan Type value 08 (Other) in the first month of each quarter. These persons are residents of long term care facilities, and are receiving capitated payments for the costs associated with dispensing prescription drugs. The actual drugs are paid FFS. Due to a reporting lag, no one receives this flag in months two and three of any quarter. Data for the second and third months of the quarters are supposed to be reported in subsequent quarters as correction/update records. However, this correction has proved to be problematic. Related to this issue, we do not have Plan IDs for these capitated pharmaceutical plans since the payments are made to pharmacies, not nursing home providors. In addition, Q2 data for this plan were problematic FY 1999 - FY 2001. There is lag in reporting people enrolled in the nursing facilities drug managed care program, because they first have to be verified as residing in the NF that month. This lagged MC enrollment will show up in the retroactive or correction records. This plan type 08 enrollment is not reported in the CMS June managed care each year.
		MAS/BOE	New Jersey provides full Medicaid benefits for the aged and disabled up to 100 percent FPL. NJ has an 1115/HIFA waiver for SCHIP parents. Until FY 2002, some aged and disabled waiver enrollees were mistakenly mapped to MAS/BOE 45, instead of MAS/BOE 41 and 42. The state believes that the 2001 mapping problem was fixed through correction records. New Jersey's MAS/BOE data appear to have a "seam effect," but this is supposedly remedied by retroactive coverage and correction records.
		MMIS	NM will start a new MMIS system in June 2005.

State	File	Record Type	Issue
NJ	Eligibility	Race Code	Between Q1 and Q4 FY 2002 there was a considerable change in the distribution of enrollees by race, especially for whites and Hispanics/Latinos. In Q1, 31 percent of enrollees were coded as white and 25 percent were coded as Hispanic/Latino, whereas, in Q4, 36 percent were coded as white and 20 percent were coded as Hispanic/Latino. The state was unable to explain this shift. New Jersey reports about 12 percent of its eligibles with an unknown race.
		Restricted Benefits	Persons with restricted benefits flag 5 are generally in waivers and do not qualify for full Medicaid benefits.
		TANF/1931	Some persons in MAS/BOE 44 receive TANF. This is not an error. The state reports that they do receive TANF, but that they are not 1931 eligibles (I.e. they are mapped correctly, and do not belong in MAS/BOE 14). In December 2001, MSIS data report 20 percent more TANF enrollees than data from the Administration for Children and Families. The state was unable to explain this discrepancy.

State	File	Record Type	Issue
NM	All	All	About 10 percent of the people with claims, did not link with the MSIS EL file prior to 2003. They resubmitted their 2003 and forward files to correct the IDs.
	Claims	IP	Approximately one quarter of the original, non-crossover claims do not have UB-92 Revenue Codes for ancillary services. These include Indian Health Service (IHS) inpatient per-diem claims.
			Approximately one quarter of the claims do not have DRGs. These include Indian Health Service (IHS) inpatient per-diem claims.
			There are no family planning claims until Q1 2003.
			50 percent of Q1 1999 claims are adjustment claims, due to a DRG reprocessing for Grouper 12 recovery conducted during the quarter.
			There are more crossover claims than expected. This is probably due to the enrollment of mostly non-duals in managed care.
		LT	The diagnosis code is missing on nearly all claims.
			There are not any claims with a Type of Service of Mental Hospital for the Aged. KFF says NM covers this group but not IP Psych <22. However there are many IP Psych < 22 claims in the LT file.
		OT	About 25 percent of the claims had CPT Service Codes in Q1 to Q3 1999. This jumped to 45 percent in Q4 99. There was an similar drop in local Service Codes in Q4 99.
			Approximately one third of the Q1 to Q3 FY 1999 original, non-crossover claims had a Type of Service of 12 (Clinic); this is higher than expected, but New Mexico verified this was correct. However, the percent dropped to 11 percent in Q4 1999 and then back up to 32 percent in Q1 2000.
			New Mexico does not currently have a separate Place of Service code for ER. For a UB-92 invoice, any line item with a rev code of 450, 451, or 452 is reported as an emergency room Place of Service. The State does not have the information needed to capture ER Place of Service on their physician/clinic claims. Therefore ER is under reported.
			Adjustment claims that are resubmittals are reported as original claims.
			An increase in the number of Indian Health Service and waiver claims in the Q4 2000 file impacted the Type of Service distribution.

State	File	Record Type	Issue
NM	Claims	OT	The percent of clinic claims fluctuates considerably across quarters, probably reflecting billing cycles. In Q4 2001, there was a big increase in the average amount paid for all OT services. New Mexico has no explanation.
	Eligibility	CHIP Code	Enrollment in New Mexico's M-CHIP program is first reported in Q2, month 3 FY 1999. Enrollment from Q2 FY 1999 to Q3 FY 2000 are somewhat inconsistent with SEDS, but the state assures us that the data are correct. By Q4 FY 2000, the data in the two systems are comparable. The state does not have an S-CHIP program. M-CHIP children are mapped to MAS/BOE 54.
		County Codes	NM has two even-numbered county codes --06 and 28-- that are legitimate FIPS codes.
		Dual Eligibility Flag	New Mexico does not report persons in dual flags 03 - 07 because these enrollees are not part of the MMIS. The state has been asked to include this information beginning in FY04 Q2.
		MAS/BOE	In Q2 to Q4 FY 2002, between 200 and 400 persons age 19 or older each month in state groups 032 (133 percent FPL kids) and 036 (185 percent FPL kids) were mapped to MAS/BOE 99, because they had aged out of coverage. New Mexico implemented an 1115 waiver in March 1999 for its M-CHIP program, covering children from 185 to 235 percent FPL. An 1115 was used to facilitate the use of copayments. Persons in state group 29 mistakenly mapped to MAS/BOE 45 only qualify for family planning benefits. This group should be mapped to MASBOE 54-55. In Q1 FY 2002, state-specific eligibility group 074 ("working disabled") was incorrectly moved from MAS/BOE 32 to MAS/BOE 15. The group was returned to MAS/BOE 32 in Q2 FY 2002. New Mexico's SSI counts in MAS/BOE 12 exceeded the SSA counts by 11 percent; however, this may occur because NM has a state-administered SSI supplement for residential care. In Q1 FY04 there is an enrollment shift from state specific eligibility code 036 to 032 because the state altered the definition of code 036. Previously, the code included children 0-185% FPL for some ages. Effective Q1 FY04, 036 only included children from 133-185% FPL. NM does not include SLMB-only, QI, and QDWI enrollees in MSIS. New Mexico implemented an 1115 waiver in March 1999 for its M-CHIP program, covering children from 185 to 235% FPL. An 1115 was used to facilitate the use of copayments.
		Restricted Benefits	Persons (in state group 29) with restricted benefits code 5 only qualify for family planning benefits.

State	File	Record Type	Issue
NM	Eligibility	TANF	Beginning in FY01, the state reported that systems problems led to discrepancies between MSIS and ACF TANF counts in some months. The discrepancy was particularly pronounced in December 2001, when the MSIS count dropped close to 0. We will monitor this discrepancy in future files. New Mexico TANF data are not reliable. The state began 9-filling the TANF FLAG in Q1 FY 2003.

State	File	Record Type	Issue
NV	Claims	All	NV is a SSN state, but has not been providing the link between the Temp ID and SSN when a SSN is assigned to an enrollee. The main impact is in the IP file for newborns. The claims are submitted with the Temp ID, but often, by the time the EL file is submitted a SSN has been assigned and the record does not include the Temp ID. NV has agreed to fix this beginning with Q2 2004.
		IP	The DRG code is always missing as they don't use DRGs for hospital reimbursement.
			Nevada has state-defined codes in the IP procedure code field from Q1 1999-S4 2003; these codes are quite general, and report the type of hospital stay, such as medical/surgical one- to five- days' stay. They switched to standard procedure codes in 2004 Q1.
			There are no UB-92 Revenue Codes on the IP file because Nevada's system does not capture the revenue codes.
			Diagnosis Code fields 2 to 9 are blank, because Nevada does not collect this information in its existing system.
		IP, LT, OT	In 1999 the diagnosis codes are padded with zeros. As a result, all diagnosis codes are five-digit codes. This was fixed, for the most part, starting with Q1 2000.
		IP/LT	There are some FFS adjustments that are probably really service tracking claims since the Medicaid Amount Paid on them is very large.
		LT	Medicaid IP Covered Days are missing (Type of Service of Aged MH and IP Psych < 21.
			Diagnosis codes were missing on most claims in 1999, but are reported, for the most part, starting with the 2000 files.
			The files do not include leave days.
			In Q1 1999 on original claims, the admission year is 1997, 1998, or 1999. These dates are the beginning date of service in most cases, so the field should be 9-filled instead. In Q4 1999, the field is mostly 9-filled. ??and now??
			There are very few claims with a Type of Service 02 (Mental Hospital for the Aged) or 04 (Inpatient Psychiatric Services for those Under Age 22).
		OT	Only four percent of the original claims are physician claims (Type of Service of 08); this is a low percentage.
			Specialty codes are missing.

State	File	Record Type	Issue
NV	Claims	OT	Nevada has had a transportation managed care waiver since October 2003. The have not been reporting either the capitation claims, service tracking claims with the expenditures or enrollment.
			In the 2000 Q1 file the most frequent diagnosis is '42' which is not a valid code.
			Provider ID Servicing Number is missing.
			14 percent of the original claims with a Type of Service of 08 (Physician), 11 (Outpatient hospital department), 12 (Clinic), 36 (Nurse Midwife), or 37 (Nurse Practitioner) are missing diagnosis codes.
			About 40 percent of the original claims are for Type of Service of 15 (Lab/X-ray Services); this is a high percentage.
			Nevada's state-specific service codes are really six bytes long, with one alpha followed by five numeric. However, on the OT files, they seem to have been submitted as five-digit numeric codes, with a Service Code Flag of 10. Since they therefore look just like CPT-4 codes, it is important to use the flag before determining each code's meaning
			Place of service is missing, or invalid on about 20 percent of the original claims.
			Starting with FFY 2004, NV will submit individual transportation capitation claims. There will be a mix of service tracking and capitation claims in Q1.
			There are no UB-92 Revenue Codes on outpatient hospital department claims, but the claims do have Service Codes.
			There isn't any PHP enrollment, but there are a few PHP capitation claims in the file with unexpected payments in Q1 to Q3 2000.
		RX	All compound drugs are coded as "COMPOUND" in the NDC field.
			New Refill Indicator is always missing (so CMS reset the error tolerance at 100 percent for this field).
			Date Prescribed is always missing.
	Eligibility	CHIP Code	Nevada does not report its S-CHIP enrollment. The state does not have an M-CHIP program.
		County Code	Nevada reports eligibles with County Code = 510. These are residents of Carson City. While this FIPS code is technically correct, documentation for the Area Resource File suggests that researchers might want to recode these persons into county "025."

State	File	Record Type	Issue
NV	Eligibility	County Code	Effective FY04, NV added new FIPS county codes. County code 03 (Clark) is now reported as 703 (Urban Clark) and 803 (Rural Clark). County code 31 (Washoe) is now reported as 731 (Urban Washoe) and 831 (Rural Washoe).
		Dual Eligibility Flag	In FY02, about five percent of enrollees reported as QMB+ (dual code 02) are not receiving Medicare Part A coverage. This is due to a lag in the payment of Part A premiums for these enrollees by the state. The state assures us that these persons are eventually provided with Part A coverage once the state has fully processed the eligibility information. Nevada reports all its full benefit dual eligibles as full benefit QMBs (dual code 02). QI-1 and QI-2 enrollees (dual codes 06-07) are reported as SLMB onlies (dual code 03). The state began to report to dual codes 04 through 08 in FY 2004. Through FY03, the following dual eligibility groups were not included on Nevada's MSIS file: QDWI (05), QI-1 (06), or QI-2 (07). In FY04, the state began reporting to code 06.
		HIC Number	In FY01, between 74 to 76 percent of NV's dual eligibles had HIC numbers. We generally expect that at least 95 percent of dual eligibles will have valid HIC numbers. This was corrected in FY02.
		Managed Care	In June 2001, there is a 24 percent discrepancy between the CMS managed care count and the MSIS managed care count. Generally, we expect no greater than a 10 percent discrepancy between the figures. The discrepancy may be partially explained by unusually low reporting for total enrollment in Q3 FY 2001. In 10/03 (Q1 FY04), a non-emergency transportation waiver went into effect. Enrollees are reported to play type code 08. Mandatory HMO enrollment in the northern region became effective 2/1/04. We expect to see an increase in managed care enrollment in February. Until Q3 FY 2003, Nevada incorrectly identified about 30 Hospice care enrollees as receiving comprehensive managed care. Beginning in Q4 FY 2003, they received plan type code 88: not applicable, as required. In June 2002 managed care reporting in MSIS was 12% lower than CMS data. However, in July 2002, HMO enrollment in MSIS increased considerably, bringing MSIS data much closer to CMS reporting. The state did not provide an explanation for this change.

State	File	Record Type	Issue
NV	Eligibility	Managed Care	Through FY 2000, Nevada reported all HMO enrollees into one managed care Plan ID in MSIS. CMS managed care data show three managed care plans in Nevada. The state MSIS staff has now identified distinct plans and assigned each a distinct plan ID. This fix was implemented in the FY 2001 files. In the three months of FY99 Q1, there are 2,841, 1,304, and 47 persons who are mapped to MAS/BOE 00 and incorrectly receive Plan Type 88 and Plan ID 88888888. This problem was corrected in FY99 Q2. In FY2001, there is a 15% discrepancy between the CMS managed care count and the MSIS managed care count. Generally, we expect no greater than a 10% discrepancy between the figures.
		MAS/BOE	A recurring problem in Nevada until FY04 was that there are between five and 30 persons each month with invalid MASBOE combinations. In FY02, the number of records with this problem was several thousand each month. THese records should have been coded as MASBOE 00. In FY03, this problem stopped, but a few individuals (<10) were assigned MAS 4 but a BOE of 6 or 7. Nevada began a BCCPTA program in July 2002. They hope to begin reporting these individuals to MASBOE 3A in October 2004. Although all SSI recipients would qualify for Medicaid, Nevada requires them to apply separately for Medicaid coverage. Monthly data show enrollment in MAS/BOE 11 - 12 about 10 percent below SSI enrollment levels. In FY1999-FY2001, roughly 27-28 percent of eligibles in BOE 5 are younger than 21.
		MASBOE	During FY 2001, total enrollment drops from Q2 to Q3 by about 4,000 and then it increases by about 10,000 from Q3 to Q4. There is an especially dramatic drop in the number of infants: 5,000 in Q3 compared to 9,000 in both Q2 and Q4. There appears to have been a reporting problem in Q3 FY 2001.

State	File	Record Type	Issue
NV	Eligibility	MASBOE	In FY02, NV underreported persons in state group '48 105' (approximately 15,000 persons). Some, but not all, of these persons were included in MSIS reporting, but mapped to MASBOE 04-05. Persons in '48 105' should have been mapped to MASBOE 14-15, dependent on age, through FY02. The state corrected the mapping starting in FY03. This caused much of the enrollment increase from FY02 to FY03. It was also determined that NV had been inappropriately mapping all the other state groups with '48' and '49' in bytes 1-2 since MSIS began. Persons with '48' and '49' in bytes 1-2 should be mapped to MASBOE 14-15, dependent on age. This problem was fixed in FY03 forward for '48' and contributed to the enrollment increase in FY03. The problem was fixed from FY04 forward for '49' (although eligibility codes changed in FY04--see below). This caused MASBOE shifts in FY04. As a result of these reporting errors, NV was undercounting enrollment in MASBOE 14-15 and overcounting enrollment in MASBOE 44-45 until FY04. In addition, NV moved to a new crosswalk effective FY04 when the state moved to a new system and changed the eligibility codes assigned to state groups. In addition, NV corrected some errors in past reporting.
		Private	Prior to FY04, NV was undercounting the number of enrollees with private insurance.
		Race/Ethnicity	In FY04, NV began reporting to race code 07 (Hispanic/Latino & more than one race) and code 08 (not Hispanic/Latino and more than one race).
		TANF/1931	In FY02 and FY03, NV's TANF enrollment data in MSIS are overreported. In FY04, the state corrected its TANF reporting in MSIS which brought the data consistent with ACF data.

State	File	Record Type	Issue
NY	Claims	IP	There are a large number of service tracking claims in the 1999 IP files. These are probably the Lombardi program payments. The Type of Claim was changed to 9 (Unknown) during the Valids processing because the MSIS IDs did not start with an "@" as required for service tracking claims. These claims can be identified with a Type of Claim of 9 and an Adjustment Indicator of 5 (Gross Adjustment). NY switched to reporting these claims as supplemental claims in 2004.
			New York uses a DRG reimbursement methodology except for certain psychiatric and rehabilitation services that NY pays using per diem.
			The percent of claims with a Patient Status is around 10% which is higher than expected. NY does not have an explanation.
			40 percent of the claims do not have an Amount Charged in 1999. New York notes that this is correct: "Our claims processing and payment system often utilizes our Procedure File fee schedules and Provider Rate File amounts to determine payments and not the "Amount Charged" entered by provider. For our rate-based service categories, i.e. Clinics, we simply pay the rate amount on our files and do not necessarily validate the "Amount Charged" amount, if any, is entered."
		IP/LT/OT	On some original and resubmittal claims, the Medicaid Amount Paid is negative. Likewise, on some voids and credit adjustments, the Medicaid Amount Paid is positive. This is OK according to the state, who notes: "Under our system, Long Term Care claims may be negative due to presence of a patient participation amount on our recipient master file. The patient participation amount is the amount a recipient is responsible for toward payment of his long term care services. If, for example, a nursing home submits a claim for $500 and the patient participation amount on our file is $600, the paid claim amount will be a negative $100. The same applies to resubmittals and debit adjustments. As far as voids and credit adjustments, we agree that they should generally be negative, but there may be some exceptions with long term care claims."
		IP/OT	The New York State Medicaid program does not utilize the UB-92 Claim Form for Hospital Inpatient services nor the HCFA-1500 Claim Form for Hospital Outpatient services. Instead the state uses the EMC Version 4.0 or 5.0. The state has its own rate codes (definitions for the rate codes are in the MSIS documentation). Therefore, there are no UB-92 Revenue Codes on the IP or on Outpatient Hospital Department claims on the OT file.
		LT	The admission year is not available on these claims.

State	File	Record Type	Issue
NY	Claims	LT	The percent of claims with Patient Liability is much lower than expected.
			Some LT claims properly do not have covered days as they are claims for non-bundled services.
			Most supplemental claims are for non-bundled services starting with 2001. In prior quarters these supplemental claims are reported as service tracking claims.
			The New York bundled nursing home rate includes maintenance drugs. Therefore claims for those drugs do not appear separately in any file.
			Starting in 1999 there is only a small percent of LT claims have a diagnosis code, but it is increasing over time. By 2005 it is at 95%.
		OT	New York only reports a small percentage of FQHC claims in the 1999 to 2003 files.
			Over 80% percent of the claims have local codes. Most of these are state-specific rate codes.
			AIDS case management expenditures were reported as PCCM capitation claims in 1999. The average payments is quite high as it includes some AID services. In 2000 there claims were reported as PHP capitation claims, having the impact of higher expenditures starting with 2000.
			The Place of Service is 12 (Home) on 44 percent of the claims, which appears to be correct since most of these claims are for Home Health and Personal Care Services.
		RX	In Q2 to Q3 1999, the NDC field has leading zeros when it contains a HCPCS code.
	Eligibility	CHIP	New York reported its M-CHIP eligibles when the program was active, but does not report its S-CHIP eligibles.
			New York's M-CHIP data in MSIS differ from SEDS numbers through Q1 FY 2001. After that, they are generally consistent in FY 2001. In FY 2002, M-SCHIP enrollment declined throughout the year, with no enrollment by September 2002. No M-SCHIP enrollment is reported in SEDS for FY 2002 forward. Medicaid officials believe the MSIS data are more reliable.

State	File	Record Type	Issue
NY	Eligibility	County Code	New York did not use FIPS for the County Code in Q2 FY 1999. This problem was corrected in Q3 FY 1999. The state also provided us with a crosswalk, which included information on the state codes that were in use in Q2, as well as the corresponding FIPS Codes. Additionally, from Q3 FY 1999 forward, all New York Cities are mapped to one state county code "61." This includes persons residing in 005 (Bronx), 047 (Kings), 081 (New York), and 085 (Richmond). Until Q1 FY03, enrollment in county code 007 (Broome County) was incorrectly reported as enrollment in county code 005 (Bronx). Therefore, researchers may want to recode.
		Date of Birth	New York usually reported 90,000-100,000 enrollees with no date of birth. Most, but not all, of these enrollees were reported into child eligibility groups. The state believes that most of the enrollees who do not have dates of birth are unborn children. The state assigns ID numbers to unborn children to make sure that they are eligible for services at birth.
		Dual Eligibility Flag	New York has relatively small QMB-only (Dual eligible flag = 01) and SLMB-only (Dual eligible flag = 03) populations. Until Q1 FY03, New York coded over 60 percent of its dual eligible population with dual flag = 09 (individual is entitled to Medicare, but reason for Medicare eligibility is unknown). This was switched to 08 in Q1 FY03.
		HIC Number	New York is unable to report HIC numbers for its dual eligibles.
		Managed Care	During FY 1999, there were major shifts in the number of eligibles with comprehensive managed care plans and PCCMs. During FY99, there were major shifts in the number of eligibles with comprehensive managed care plans and PCCMs. While New York's comprehensive managed care enrollment compares favorably with CMS data, there was a problem with PCCM and PHP enrollment in FY 1999 and FY 2000. The state assured us that the MSIS data are correct and seemed to think that the CMS data flip-flopped PCCM and PHP enrollment. New York's Senior Care Plan is reported as "other" in CMS data, but as "comprehensive" in MSIS.

State	File	Record Type	Issue
NY	Eligibility	MAS/BOE	From FY97 forward, New York has an 1115 demonstration extending full Medicaid benefits to childless adults. More groups were added over time. In Q1 FY02, major increases in child and adult enrollment (MAS/BOE 24-25) occurred as a result of the September 11 terrorist attack. These persons were reported to state code 36. This continued through April 2002, then state group 80 (Disaster Relief) began to be used for September 11th coverage. Beginning in Q3 FY01, several new state groups were added to MSIS including 74, 75, 78, 79, 80, and 81. SOme of these will be added to FY02 data eventually (through resubmitted files). In addition, many corrections to the MASBOE crosswalk were made, moving many children and adults from MASBOE 24-25 to 14-15 and 44-45. Large state groups whose MABOE mapping was changed included 17, 18, 19, 21, 32, 68, 69, 70, 72, and 76. Other changes occurred as well. These changes mean that FY99-FY02 had some MASBOE reporting problems. See 10/04 crosswalk for correct mapping. Until FY03, the number of poverty-related children and adults mapped to MAS/BOE 34 and 35 is lower than expected. Similarly, the number of eligibles in MAS/BOE 24 and 25 is higher than expected. Finally, until FY03 no one is being reported into MAS/BOE 31-32 or MAS/BOE 45.
		Race Code	More than 20 percent of eligibles in New York have an unknown race code. This increased to almost 30 percent during FY 2002 as a result of increases in enrollment due to the September 11 terrorist attack.
		Restricted Benefits Flag	New York has a large group of enrollees (over 40,000 each month in Q4 FY 2001) assigned restricted benefits flag 5. Most of these enrollees are reported into MAS/BOE 21 - 25. Some others only qualify for family planning benefits, while others are legal aliens who should have been assigned restricted benefits flag 2 instead. This error was corrected in FY 2003 data.
		Sex	Each year a large group of eligibles (more than 50,000) are reported with an "unknown" sex code. These are probably in the unborn group.
		SSI	Relative to the number of aged SSI recipients, New York is reporting about 15 to 20 percent more eligibles under MAS/BOE 11. NY has a state administered SSI suppliment program to provide emergency assistance to SSI recipients, which may account for the difference.

State	File	Record Type	Issue
NY	Eligibility	SSN	New York assigned over 25,000 SSNs in FY 2001 through FY 2003 to more than one MSIS record. In FY 2002, the proportion of enrollees with SSNs dropped to 84 percent as a result of increases in enrollment due to the September 11 attack

State	File	Record Type	Issue
OH	Claims	LT	Patient status is missing on most claims.
			Admission date is missing.
			Leave days are missing on most claims
			Diagnosis codes are missing.
		OT	Physcian specialty codes are missing on all claims.
			The Provider ID Number Servicing fields are not filled in.
		RX	New Refill Indicator is missing.
			Other Third Party Payment (or Third Party Liability/TPL) is missing.
			Days supply is missing in the 1999-2001 files.
	Eligibility	CHIP Code	Ohio has an M-CHIP program, but no S-CHIP program. Ohio is somewhat unusual in that some M-CHIP children are reported into MAS/BOE 12. Since Ohio is a 209(b) state, some disabled children do not quality for Medicaid through the SSI-related provisions. However they are able to quality for CHIP coverage.
		County Code	Ohio incorrectly used state-specific county codes in their FY 1999 to FY 2002 files. The state has supplied MPR with a crosswalk, linking together their state county codes with FIPS county codes. This problem was corrected in FY 2003 when OH started using FIPS codes in MSIS.
		Date of Birth	In Q1 1999 1,675 eligibles have birth dates claiming that the person was born in 1999.
		Dual Eligibility Flag	Until FY03, Ohio was only able to code 2 values for dual eligibles; 01 (QMB-only) and 09 (eligible is entitled to Medicare, but reason for Medicaid eligibility is unknown).
		Foster Care	Through Q3 FY 2001, a higher-than-expected proportion of Ohio's foster care children are over age 21. The percentage reaches as high as seven percent in FY 2001, but is within the expected range of less than one percent by Q4 FY 2001. Several thousand children in foster care have two records with different MSIS IDs and the same social security number. The state has been asked to fix this.
		MAS/BOE	In January, 2001, child and adult enrollment increased by about 172,000 for an overall gain of 15 percent. About 133,000 recipients were added through a Medicaid Reinstatement project (in response to problems with Medicaid disenrollment related to welfare reform) that ran from January 2001 through March 2001. As a result, MSIS data show a dramatic increase in enrollment in January 2001 and a dramatic decrease in April 2001.

State	File	Record Type	Issue
OH	Eligibility	MAS/BOE	OH has an unusually large proportion of children and adults in MASBOE 44-45, raising the possibility that some 1931 enrollees are being reported there in error. We have questioned the state about this and gotten no response. Ohio is a 209 (b) state. As such, the number of SSI eligibles reported into MAS/BOE 11 and 12 is lower than the number reported by the Social Security Administration. In addition, most SSI disabled over 65 appear to be mapped to MASBOE 12. In FY02 (and FY01 to some extent) enrollment seems to decline for the aged and disabled month one to month three of each quarter and then increases noticeably in month one of the following quarter. Through Q1 FY03, there also seems to be a surge in enrollment in month one of each quarter for adults and in month two for children. From Q4 FY02 to Q1 FY03, there is a noticeable increase in enrollment across all MASBOE groups, probably related to the last submission of this data for purposes of the MMA. In addition, the increase in MASBOE 32 occurred.
		Restricted Benefits	Ohio has a sizeable group of eligibles (about 3000) in MAS/BOE 11 - 12 with restricted benefits related to Medicare, which seems odd. This may be related to the state's 209(b) coverage.
		SSNs	OH has several thousand foster care children with two MSIS records, but the same SSN. Researchers might want to combine these records.
		State-Specific Eligibility Group	Through FY02, a handful of eligibles are missing state-specific eligibility codes in each quarter.
		TANF/1931	As a result, if eligibles leave TANF and move from MAS 1 to MAS 3 or 4 during the quarter, they will still be coded as receiving TANF benefits. That explains why quite a few MAS 3 and 4 persons have TANF. The TANF flag for Ohio has some limitations. Ohio is only able to update this data element quarterly, not monthly.

State	File	Record Type	Issue
OK	All	All	Starting with Q3 2003, Oklahoma reported that they began using new MSIS IDs. Oklahoma has been asked to convert the "old" MSIS IDs to the new ones, starting with Q1 2003. Prior to that, the MSIS files will contain the old MSIS IDs. The state has submitted a cross-reference file of old and new MSIS IDs. However, there are some 'new' MSIS ID's in the 1999-2002 files. So the crosswalk may be needed.
	Claims		The state terminated their HMO contracts in December 2003, but there were some outstanding capitation payments that occur in the next quarter. Also they continue to pay HMO's for some deliveries that occur after that time.
			The date of payment on voids is the date of payment of the original claim, not the date is was adjusted. This means that many of the void claims have payment dates prior to the quarter.
		IP	Program Type of 5 (Indian Health Service) appears to be under-reported in the IP file.
			There aren't any DRGs as Oklahoma does not use them for reimbursement.
			A higher than expected percent of claims do not have UB-92 Revenue Codes. This is because claims from the Indian Health Service and residential treatment centers are not billed on a UB-92. However, the Program Type of Indian Health Service appears to be under-reported in the IP file. The residential treatment center claims should be reported in the OT file.
		IP/LT	The dates of payment on voids are often prior to the quarter as they contain the Date of Payment/Adjudication/Adjudication of the original claim, rather than the date of adjustment.
		LT	Most claims do not have a diagnosis code until Q2 2003.
			Patient Status is missing on most claims until Q1 2003.
		OT	About 25 to 30 percent of claims have a Type of Service of 19 (Other Services).
			Some of the diagnosis codes may have an extra zero or two because this field is not edited by the state. MPR checks only the 50 most frequent diagnosis codes, and these appeared to be correct.
			In Q1 to Q2 2003 there is a significant decrease in the average paid for HCBS claims.
			PCCM is covered under PHP plans for most people, so what appears to be a shortfall of PCCM capitation claims in some quarters is reasonable.

State	File	Record Type	Issue
OK	Claims	OT	The Type of Service on capitation claims is PHP for people flagged as enrolled in a PCCM because it is a "PCCM plus" program and includes some other services.
		RX	The file only has three claims with a Program Type of Family Planning
	Eligibility	CHIP Code	Oklahoma reports its M-CHIP children in MSIS. The state does not have an S-CHIP program. From Q2 FY 2001 through Q1 FY 2002, there was a considerable discrepancy between SEDS and MSIS M-CHIP counts. The state believes the SEDS numbers to be inaccurate. The state is looking into correcting the SEDS numbers. However, systems problems may prevent such corrections. In March 2003, some persons in state groups 14A8, 15A8, and 17A8 were inadvertently dropped as M-SCHIP enrollees and mapped to MASBOE 14. They should have been mapped to MASBOE 34 and given a SCHIP flag=2. Reporting was corrected in April 2003.
		Dual Eligibility Flag	Effective 11/99, OK covered all aged and disabled up to 100% FPL. Oklahoma does not report any QDWIs, QI-1s, or QI-2s until FY03. Information on these groups is stored in a separate manual system. Beginning January 2003, the state implemented a new system that allowed them to begin reporting QI's.
		Managed Care	The number of enrollees in plan type 08 showed significant increases in Q2 FY03 when the state added a non-emergency transportation (NET) waiver in January 2003 with Metropolitan Tulsa Transit as the provider. Another provider, Logisticare, began providing services in 8/1/03. These clients are enrolled in both the hybrid and the transportation plans, so they have two plan 08's. In Q4 FY 2001, OK began a more traditional PCCM program for Native Americans. By Q4 FY 2002, enrollment had reached about 2,000 per month. Enrollees of this plan are reported into plan type 07 (PCCM). In Q2 FY04 HMO enrollment ceased (185,000 persons in Q1 04), accompanied by a major increase in NET (plan 08) and the hybrid PCCM (plan type 08) in Q2 and Q3 FY04.

State	File	Record Type	Issue
OK	Eligibility	Managed Care	Oklahoma reports a significant number of eligibles with Plan Type = 08 (other) which is used for two different types of managed care plans. The first one is a hybrid managed care program that combines capitated and case management services. Under the plan, physicians are capitated for a limited number of common office procedures and lab work. Additional services are provided on a FFS basis. Physicians also provide a case manager role by referring eligibles to specialists, as needed. These individuals are reported under PCCM in the CMS enrollment report.
		MAS/BOE	Oklahoma is a 209(b) state, using more restrictive rules for Medicaid than SSI. Oklahoma's MAS/BOE 14 - 15 and 44 - 45 enrollment fluctuated greatly during Q4 FY 1999 and Q1 FY 2000. We suspect this was caused by difficulties with TANF delinking. Effective 11/99, OK provides full benefits to 100% FPL for aged and disabled. Oklahoma cannot identify Title IV-E foster care children for MASBOE 48. In addition, until Q1 FY03, non-Title IV-E foster care children were undercounted. Finally, there was a system problem in MASBOE 48 counts in October 2002, causing an overcount for that month. Researchers should probably only use foster care data with caution. From FY 1999 through FY 2002, individuals in state-specific eligibility groups CB__00 and KB__00 were incorrectly assigned to MAS/BOE 11 and 12 when they should have been assigned to MAS/BOE 31 and 32. These are persons newly covered under the OBRA 86 provisions allowing coverage for full Medicaid benefits to 100 percent FPL. The state began covering this group in November, 1999. The state fixed this problem in its FY 2003 files.

State	File	Record Type	Issue
OK	Eligibility	MAS/BOE	Until Q1 FY03 some 1931 eligibles are mapped to groups other than MAS/BOE 14 and 15, explaining why enrollment in MAS/BOE 14 - 15 is lower than TANF. All 1931s were not mapped to MAS/BOE 14 and 15 until Q1 FY03. In Q1 FY03, some significant corrections were made to OK's MASBOE crosswalk. These changes resulted in shifts by MASBOE from FY 2002. In particular, many enrollees were moved from MASBOE 34 and 45 to MASBOE 14-15 and 48. OK phased out its medically needy program in FY03. There were also some changes in enrollment by MASBOE group from Q1 to Q2 FY03 when the state transitioned to a new reporting system. The state believes they were underreporting enrollment in MASBOE 12 prior to this change. OK had an 1115 waiver for FP services approved 11/04.
		Restricted Benefits Flag	Most medically needy enrollees have restricted benefits code 5 (other).
		SSNs	Beginning in FY1999, about 3,000 to 5,000 SSNs were assigned to more than one record each quarter. However, this problem was down to about 500 per quarter by Q3 FY02, but increased to 1,700 in Q4 FY02. The state agreed to work on this problem in future files. The state believes that these duplicates primarily involve newborns, twins, and mothers and their children. The state is unable to correct all the duplicate SSNs, but believes that many of the duplicates assigned to newborns are resolved in future files.
		TANF/1931	Oklahoma TANF data were not reliable until Q2 FY03.

State	File	Record Type	Issue
OR	Claims	All	Because so many people are enrolled in managed care, the distribution of FFS services is sometimes unusual.
		IP	There are nine state-specific DRGs that aren't flagged as state codes.
			There aren't any claims with a Patient Status of 30 (Still a Patient).
		LT	The Patient Liability field contains both TPL and Patient Liability. This can't be corrected until the whole system is revised
			In Q1 FY 1999 files, the beginning date of service was put in the Admission Date field as admission date was not available. After Q1, the field will be coded as missing.
			There are no crossover claims in 2003.
		OT	There is a low percentage of dental claims as most people are enrolled in dental managed care.
			There aren't any FFS claims with Program Type of 4 (FQHC) although Oregon has an FQHC program.
			About one third of the claims have a Type of Service of 26 (Transportation).
			Specialty Code is missing on about half the claims on which it is expected to be reported.
		RX	There are only original and credit adjustments in the file. The credits are used to void originals. Resubmitted claims are coded as originals.
			The Fill Date and Prescribed Date fields both contain the Fill Date. The state will '9' fill the Prescribed Date field in future submission as it is not available.
	Eligibility	CHIP Code	Oregon reports its child S-CHIP data in MSIS. Its adult S-SCHIP program, which began in 2/03 is not being reported to MSIS. The state does not have an M-CHIP program.
			About 60 persons in October 2003 who were reported to a valid MASBOE group were assigned SCHIP code 0, indicating they were not enrolled that month. They should have been assigned SCHIP code 1. In addition, about 216 persons assigned to MASBOE 00 in October 2003 are assigned SCHIP code 1. We assume they should have been assigned SCHIP code 0. The state will fix this problem in Q2 FY04.
		County Codes	Prior to FY03, OR's county code data were not reliable.
			The state does not have the FIPS codes for about 6,000 - 8,000 persons and reports them to county code '0' each quarter.

State	File	Record Type	Issue
OR	Eligibility	Dual Eligibility Flag	In Q2 FY 2000, Oregon reviewed the dual eligibility status of their eligibles. They discovered that many were coded incorrectly. As a result, we observed a shift from dual flag = 02 to dual flag = 09. Until FY03, dual codes 03, 06, and 07 were not reported to the correct MASBOE groups.
		Health Insurance	Each month, a couple of thousand people ineligible for Medcaid received a Health Insurance Flag of "1" or "4". All persons who are ineligible each month should have a health insurance code value of "0". In addition, some persons who are current enrollees have the health insurance field 0-filled starting with Q1 FY01.
		HIC Number	In Q1 FY 1999, Oregon 0-filled the HIC code for about 12,000 persons who were eligible for Medicaid, but not Medicare. This problem was resolved in Q2 to Q4 FY 1999, when the field was correctly 8-filled for these eligibles. In FY 2001, several thousand dual eligibles were added. Many of these had only 9-digit HIC numbers, resulting in an increase in the percentage of dual eligibles with invalid HICs. This remains a problem through FY 2003.
		Managed Care	Managed care enrollment declined in FY03 due to decline in eligibility (medically needy program ended 1/03) and reductions in services (e.g., mental health and dental services). A large disparity exists between the June 1999 CMS and MSIS PCCM enrollment. It appears as if there was an error in the data reported to CMS. The MSIS numbers are consistent with data from the state's website in FY 1999. Additionally, the MSIS, CMS, and state data are consistent in FY 2000 and FY 2001. However, there may be a slight overcount in managed care enrollment for Q1 FY 2001 due to reporting problems.

State	File	Record Type	Issue
OR	Eligibility	MAS/BOE	A handful of people in FY 1999 and FY 2000 were incorrectly mapped to MAS/BOE 99. Oregon maps most SSI disabled >64 years to MASBOE 11. Oregon's Medically Needy Program ended 1/31/2003. At that time some recipients were determined eligible for other programs and shifted to MASBOE 31-32 (poverty-related aged and disabled) and some to MASBOE 42 (other disabled). Throughout FY03 and in Q1 FY04, OR reports from 17 to 370 persons to MASBOE 99. In OR's FY03 and Q1 FY04 data, OR has entries other than "0" in the monthly fields for many individuals in MASBOE 00. In November 2003, some reprogramming by the state caused a shift in enrollmen from MASBOE 16-17 to MASBOE 14-15.
		Restricted Benefits Flag	In Q1 FY 1999 about 3,000 people in MAS/BOE 21 and 22 received a restricted benefit flag of 3. This error was resolved in Q2 to Q4 FY 1999 when these eligibles were correctly assigned the restricted benefit flag of 5. Until 1/03, persons with restricted benefits code 5 (other) were generally medically needy enrollees. There was a decline in full benefit dual eligibles after 1/31/03 when the medically needy program ended.
		SSNs	Each quarter, several hundred SSNs are assigned to more than one record.
		State Specific Eligibility	The state reports about 5,000 - 7,000 persons to a blank state specific eligibility code each quarter. This is a group of SLMB-only's and QI's that are extracted from a file that does not contain eligibility group information.
		TANF	Oregon's TANF data are overreported from FY 2002 to October 2003. New program logic fixed this problem in November 2003.

State	File	Record Type	Issue
PA	Claims	All	The percent of claims paid each month is uneven because the adjudication flow is not always even.
			The PA MMIS include claims for both Medicaid and State Only programs. Claims are selected for MSIS based on the value in the FFP field. Sometimes people are enrolled into Medicaid who were on General Assistance retroactively (such as a delivery). When this happens the FFP on the claim(s) are not changed in the state MMIS, so they will not be included in MSIS. The state is working on a way to solve this problem.
		Delivery cap claims	Starting with Q1 04, PA will report maternity care payments to managed care plans as cap claims (type of claim 2), and TOS 21. These claims are essentially a global payment to the managed care plan for any live delivery, and include 5 months of prenatal care and 2 months of post-natal care as well as the delivery. The plan ID will be included, as will their system's provider ID. State proc codes of W1871 and W1872 identify these semi-service semi-cap claims.
		IP	In Q1 2004 the percent of claims with Family Planning dropped from 1% to 0.
			The Charge on void adjustment claims is positive instead of negative.
		LT	Patient status is missing on most LT claims until Q1 2004 as it was not available in the state system.
		OT	Outpatient hospital claims are not billed on a UB-92, so there aren't any UB-92 Revenue Codes on those claims.
			The Maternity Care payment is for each live birth outcome. A live birth outcome is defined as one or more live deliveries. For example, if a recipient of a managed care plan delivers twins, the managed care plan is paid for one live birth outcome. Each managed care plan is paid an amount that is negotiated in advance between the Commonwealth and each managed care plan. The negotiated rate must be within the rate range of actuarially sound rates that the Commonwealth's actuary develops. These rate ranges are developed for different geographical rating areas in which the managed care plans operate. The rate ranges cover dates of service for a given length of time, typically in increments of 1 year. The rate ranges are based on an estimate of the costs the managed care plan can be expected to incur for a pregnancy, with an additional allowance for administrative costs and profit. Separate claims must be submitted by the managed care plan for each live birth outcome. The payment is to compensate the managed care plan for all services received by the woman during the period 5 months prior to delivery, the delivery itself, and 2 months after the delivery. These payments are reported as capitation payments.

State	File	Record Type	Issue
PA	Claims	OT	Pennsylvania believes that the 1999 to 2002 OT files contain waiver claims, but they all can not be identified by Program Type. There are a large number of claims with a Type of Servicde of 19 (Other Services) and a Place of Service of 12 (Home). According to Pennsylvania, these are not Home Health services. Specialty Code is not available for most physician claims. In 2004 Pennsylvania is transferring to a new processor (EDS) and they should be better able to report waiver claims. The diagnosis code on some EPSDT screens is "EPSDT." There aren't any individual PCCM claims until 2003 Q1. Previously they were submitted as service tracking claims. Until Q2 2004 all PACE capitation claims were reported with a type of service of 20 (HMO capitation payment). However, there are 2 levels of PACE - full PACE and partial or pre-PACE. Starting with Q2 2004 the full PACE capitation claims will have a type of service of 20 and the partial PACE capitation payments will be reported with type of service 21.
		RX	The Fill Date is reported in both the Fill and Prescribed Date fields. Beginning with Q2 2004 the state will '9' fill the Prescribed Date field as it is not generally available. There are a few claims in Q1 1999 with a Type of Service of 12 (Clinic). Amount Charged is missing on some claims.
	Eligibility	CHIP Code	Pennsylvania has an S-CHIP program, but no M-CHIP program. The state does not report its S-CHIP enrollment.
		Dual Eligibility Flag	The dual eligibility flag was 9-filled for all dual eligibles until Q4 FY 2000. In Q4 FY 2000, the eligibles assigned dual flags 8 and 9 were reversed by mistake. This was corrected Q1 FY 2001.
		Health Insurance	In FY 1999 through Q3 FY 2000, about 17 to 20 percent of Pennsylvania's Medicaid population had private insurance, which is greater than expected. In Q4 FY 2000, the number of eligibles with private insurance dropped dramatically. Prior to this time, Pennsylvania officials indicated they were probably overcounting private insurance eligibles, since persons with Black Lung benefits and Workers' Comp benefits were being counted. In addition, they continued to count persons with private insurance who became Medicare eligible as continuing to have private insurance (when that insurance probably expired).

State	File	Record Type	Issue
PA	Eligibility	Managed Care	Pennsylvania shows a substantial increase in enrollment in managed behavioral health care plans across FY 1999, as Pennsylvania incrementally moved counties into the managed care system. In Q1 FY 2000 to Q3, the increase continued, but was more gradual. Pennsylvania did not report the approximately 125,000 enrollees of Magellan Behavioral Health that are included in the CMS managed care count until Q4 FY 2000. In addition, Pennsylvania did not report PCCM enrollment in MSIS until Q4 FY 2000 (152,000/month according to CMS data). Managed care enrollment in Pennsylvania appears to have been under-counted until July 2000. Until then, the state failed to report any PCCM enrollment. In addition, HMO and BHP enrollment was lower than CMS managed care reports until July 2000.
		MAS/BOE	Pennsylvania provides full Medicaid benefits for the aged and disabled up to 100 percent FPL, (state groups PS40, PS70, PS90, PH00, PH80), explaining why many people in MASOBE 31 - 32 have full Medicaid benefits. In addition, SSI disabled >64 years are mapped to MASBOE 11. In Q1 FY 1999, about 700 foster care/adoption assistance children in state groups PC34, TC 33, and TC 34 are incorrectly reported in to MAS/BOE 44, causing an under-count in MAS/BOE 48. This problem was corrected in Q2 FY 1999. In Q1 FY03, PA corrected a mapping error. Prior to this time, state group PU27 was incorrectly mapped to MAS/BOE 15, instead of MAS/BOE 17. This caused the upward shift in MAS/BOE 17 enrollment in Q1 FY03. In Q2 FY03, PA added byte 3 information to its state specific eligibility codes. Byte 3 data identifies LTC residents and HCBC waivers. Also in Q2, PA shifted some of its state specific eligible codes, but this did not affect MASBOE patterns. In Q4 FY00, PA made several changes to its MSIS MASBOE reporting. Some groups were dropped as part of the change, meaning that they were incorrectly reported prior to this period. For other groups, MASBOE mapping changed. As a result, overall enrollment dropped by about 112,000 from Q3 FY00 and there were major shifts by MASBOE group. Declines in MASBOE 14, 15, 21, 32, 35, and 42 were only partially offset by increases in MASBOE 41, 44, and 45. The attached chart shows the mapping changes from Q3 FY00 to Q4 FY00.

State	File	Record Type	Issue
PA	Eligibility	MAS/BOE	During the first two months of Q4 FY 1999, there was an increase in enrollment of about 37,000 persons in MAS/BOE 14 - 15. This change reflects the fact that Pennsylvania had to reinstate some people who improperly were terminated from Medicaid because they no longer received welfare. Enrollment returned to its original level during the third month of the quarter. In Q4 FY 2000, Pennsylvania made several changes to its MSIS MAS/BOE reporting. Some groups were dropped as part of the change, meaning that they were incorrectly reported prior to this period. For other groups, MAS/BOE mapping changed. As a result, overall enrollment dropped by about 112,000 from Q3 FY 2000 and there were major shifts by MAS/BOE group. Declines in MAS/BOE 14, 15, 21, 32, 35, and 42 were only partially offset by increases in MAS/BOE 41, 44, and 45. The attached chart shows the mapping changes from Q3 FY 2000 to Q4 FY 2000.
		Plan ID	PA uses different Plan ID's in its Claim and EL files. The state has submitted a crosswalk matching the two sets of ID's. Beginning in FY04, the state will use only one plan ID in both EL and Claims files.
		Restricted Benefits	Pennsylvania's RBF data are unreliable in FY99 through Q3 FY02.. In Pennsylvania's Q4 FY 2000 through Q3 FY 2002 files, the restricted benefits flag is miscoded for many dual eligibles in MAS/BOE 21 - 22, 31 - 32, and 41 - 42. In Q3 to Q4 FY 2002, most of the problems are resolved; however, about 2,000 persons in MAS/BOE 31 - 32 still receive restricted benefits flag 0. The state fixed this in FY 2003. Until Q3 FY 2002, about 18,000 persons in MAS/BOE 45 mistakenly received restricted benefits flag 5: other. They should have received RBF 1: full benefits. Effective FY03, PA assigned restricted benefits flag 5 to all medically needy aged, disabled, and adults (but not children)

State	File	Record Type	Issue
RI	Claims	Adjustments	When a claim is adjusted, Rhode Island voids the original claim itself and therefore there isn't any original claim. If a claim is adjusted in the same quarter as the original, then Rhode Island will create a "dummy" original claim. If the claim is adjusted in a later quarter, the original claim will be have been submitted in the MSIS files, so the state will not need to create a "dummy" original. The voided original claims will be flagged as "voids" and the Medicaid Amount Paid will be a negative amount.
		All	The date of payment on void adjustments is the date of payment of the original and not the date the void was adjudicated.
			The 1999 claims files have serious problems that can't be fixed due to the limitations of the source files (MARS). Rhode Island will have to change their system in order to fix most of these problems.??have they fixed stuff??
		IP	There is only one UB-92 Revenue Code on each claim because that is all that is available in the source files. Most of claims have an accommodation code and a few have only a ancillary code.
			There are no DRGs.
			Very few procedure codes are included in the file as they are not required to be included by the providers, even though they use the UB-92 form.
		LT	The diagnosis code is missing on most LT claims until Q1 2004 when they are reported on 100% of the claims.
			There are not claims with a Type of Service of Mental Hospital for the Aged in Q1 1999.
			The file does not contain leave days.
		OT	About 30 percent of the claims in the OT file have a Type of Service of 19 (Other Services).
			2004 Q1-2 - the date of payment on voids is the date of payment on original claims. This will be fixed starting with 2004 Q3.
			Many claims with a Type of Service of 11 (Outpatient Hospital) have a pharmacy revenue code.
			In 1999 and 2000, there are some very large Medicare Coinsurance and Deductible payments that can't possibly be correct. Rhode Island was unable to fix them. They should be ignored.??Fys or calendar years??
			There aren't any claims with a Type of Service of 34 (PT and other therapies).

State	File	Record Type	Issue
RI	Claims	OT	A large percent of claims are for Type of Service 33 (Rehabitation Services), and most of these have a Place of Service of 53 (Community Mental Health Center).
		RX	The Quantity of Service on most claims is 0.
			There aren't any claims with a Program Type of 2 (Family Planning). ??check that this is right since this actually said a Type of Service of FP??
			Date Prescribed is always missing.
	Eligibility	1115 Waiver	Beginning in 1994, Rhode Island had an 1115 program for children and adults. This 1115 plan has always covered infants 185-250% FPL, children 1-5 years 133-250%, children 6-7 years 100-250% FPL, and family planning only recipients 250%. Until 1/97, it also covered children 8-19 years 100-250%, but then that group became the first M-SCHIP population. Until 1/01, it also covered children pregnant women 185-250% when this group was transferred to M-SCHIP as well. Finally, from 1/98 to 1/01, RI covered parents 110-185% FPL under the state's 1931 provisions; however, this group was transferred to the 1115 program and M-SCHIP effective 1/01.
		CHIP Code	Beginning 1/97, Rhode Island covered children 8-19 years 100-250% FPL as an M-SCHIP group. Then, in 1/01 it added pregnant women 185-250% FPL and parents 110-185% FPL as M-SCHIP groups. The child M-SCHIP groups were all previously covered as expansion populations under the state's 1115 program while the parents were previously covered under the state's 1931 provisions. Then, effective 11/02, RI added an S-SCHIP program covering unborn children up to 250% FPL (including undocumented aliens). S-SCHIP children are not reported to MSIS.
			The MSIS CHIP count differs from SEDS in some quarters, but the MSIS numbers appear to be more reliable.
		Correction Records	Beginning in FY 2001, Rhode Island submits an unusually high number of correction records. The state explains that, prior to FY 2001, a programming error caused only 1/5 of their correction records to be included in MSIS. Analysis of Rhode Island's corrections shows that most are not changing key data elements.
		County Code	Rhode Island has a larger than expected number of persons with County Code = 000. These individuals live out of state, so do not receive a valid FIPS code.
		Dual Eligibility Flag	Prior to Q2 FY 2002, more than 95 percent of Rhode Island's dual eligible population receive the dual flag 09.

State	File	Record Type	Issue
RI	Eligibility	Managed Care	Some people with PLAN TYPE = 01 (comprehensive) have 8-filled PLAN IDs. This is caused by a problem with the program used to generate MSIS data. The problem will be fixed in FY 2000.
		MAS/BOE	In July 2000, Rhode Island increased its income threshold for the aged and disabled reported into MAS/BOE 41 and 42. This caused many enrollees previously enrolled in MAS/BOE 21 and 22 to move. In Q2 FY 2001, Rhode Island moved a large group of adults previously reported in MAS/BOE 45 to MAS/BOE 55 (state group CN) as it implemented M-CHIP coverage for adults. In FY 2002, Rhode Island reported about 12 percent more SSI enrolled than SSA. This increased to 16 percent in FY 2003. Rhode Island is not able to report all of its 1931 eligibles into MAS/BOE 14 and 15. Some are currently mapped to MAS/BOE 44 and 45. This is an important data problem since Rhode Island greatly expanded eligibility for adults under its 1931 program. Until Q2 FY04 almost 100-350 persons were incorrectly included in MASBOE 44-45 (state groups GA & GC) who were state only enrollees, not title XIX enrollees.
		Private	In Q1 FY 2002, there was a noticeable increase in insurance coverage. This was likely an error, since the Q1 FY 2003 rates returned to the previous levels.
		Restricted Benefits	Women in state groups 71, 73, and 74 only qualify for family planning services. They are assigned restricted benefits flag 04, as are pregnant women. Medically needy enrollees are assigned restricted benefits code 5 ("other"). By mistake, M-CHIP parents in MAS/BOE 55 were assigned restricted benefits flag 9. They should have been assigned flag 1 ("full benefits"). Fixed FY 2002. However, about 2k persons in other groups receive flag 9 throughout FY 2002. In FY 2000, a MAS/BOE coding flaw resulted in a lower than expected proportion of person with restricted benefits code 3 being reported to MAS/BOE 31 - 32. Women in state groups 71, 73, and 74 only qualify for family planning services. They are assigned restricted benefits flag 04, as are pregnant women.
		TANF	MSIS showed 13 to 14 percent more TANF recipients than ACF in Q1 FY 2002 to Q1 FY 2003.
		Waivers	RI can't identify the portion of the 1115 waiver for family planning, and will report all enrollment just as an 1115. However, they are able to identify those with restricted benefits, and will report them with the right restricted benefits flag.
	Encounters	IP	In 2002, UB-92 Revenue Codes are missing on most IP encounter records.

State	File	Record Type	Issue
RI	Encounters	IP	In 2002, Patient Status is missing on most IP encounter records.

State	File	Record Type	Issue
SC	Claims	Adjustments	The files do not contain any IP/LT/OT adjustment claims. South Carolina expects to be able to start submitting them at the end of 2004.
		Crossovers	Starting in 2003, South Carolina's crossover claims will be reported with a summary record with the coinsurance and deductible amount for all line items and then separate line items with the coinsurance and deductible fields 0-filled.
		IP	The average Medicaid Amount Paid on crossover claims is higher than expected in some quarters.
			A large percent of the claims are for crossovers
			There aren't any claims with a Patient Status of 30 (Still a Patient).
		IP/LT	In Q3 2004, South Carolina made Disproportionate Share Hospital (DSH) payments for two prior quarters in addition to the current quarter, so the DSH amounts appear to be very large for Q3 2004.
		LT	Admission date is usually missing.
			Leave days are usually missing. The field is usually '0' filled instead of '9' filled when the days are unknown.
			Patient Status is missing on most LT claims.
			On the South Carolina LT files, diagnosis codes are only available on claims for Type of Service 04 (IP psych claims).
			Through 2001 submission 1, over 13 percent of claims are for ICF/MR
			Patient liability has an ETR of 100percent, but is actually present in the file.
		OT	The number of PCCM capitation claims is somewhat lower than expected based on the person months of enrollment in PCCM managed care.
			Q1 FY 1999 file has over a thousand FFS claims with a Type of Service of 21 (PHP Capitation Payment). This problem was corrected in Q2 to Q4
			Through 2001 submission 1, very rich list of places of service (lots of detail)
		RX	Date Prescribed is always missing.

State	File	Record Type	Issue
SC	Eligibility	CHIP Code	South Carolina reports its M-SCHIP enrollment. The state does not have an S-SCHIP program. M-SCHIP enrollment dropped about 6% in the first month of FY00 and about 10% in the first month of FY01. The state reported that it moved older children from M-SCHIP to Medicaid at these times.
		County Code	South Carolina submitted files using state county codes instead of FIPS county codes from Q1 FY 1999 to Q2 FY 2001. The state has submitted a crosswalk of state codes to FIPS.
		Date of Birth	South Carolina had some problems with their date of birth variable in 1999 Q2. Some of their records have "9-filled" DOBs. A few other records indicate, implausibly, that the eligible was born in 2000.
		Dual Eligibility Flag	In FY 1999, about 13 percent of duals were coded with 09. The proportion of duals with 09 grew throughout FY 2000, however. By Q4 of FY 2002, 34 percent of duals received code 09. Dual coding was greatly improved in Q1 FY 2003. Generally, no one was assigned dual code 09 after 2003, except for persons in the Silver RX program. South Carolina does not report any eligibles with dual code 01, since the state extends full Medicaid benefits to all aged/disabled up to 100 percent FPL. Beginning in Fy99, South Carolina generally reported only two values for dual eligibles -- 02 (QMB plus full Medicaid) and 09 (eligible is entitled to Medicare, but reason for Medicaid eligibility is unknown). However, in Q3 FY 2002, SC reported a few enrollees (fewer than 50) with dual eligibility flags 03, 06, and 07. In Q4 FY 2002, all enrollees were in dual eligibility groups 02 and 09 again. In FY 2003, fuller dual reporting began. For its 1115 Silvercard drug program (also referred to as "SilveRxCard"), which began in 2003, SC defaulted to dual code 00 in cases where the state could not determine whether an individual was Medicare eligible. Dual code 09 is used if the state knows the Silver Rx enrollee is dual eligible, since this is a Pharmacy Plus program.
		Managed Care	South Carolina's Physician's Enhanced Program (PEP) is a hybrid PCCM program. In MSIS, it is coded as Plan Type 08 ("other"). In CMS data, it has been reported in several categories over time, including "other" (6/99), PCCM (6/00 and 6/02), and BHP (6/03). In 2001, CMS also reports 4,000 enrollees in a "high-risk channeling project" as an other managed care plan. The enrollees in this project are not reported in MSIS as a managed care plan. According to state officials, this plan terminated August 2002.

State	File	Record Type	Issue
SC	Eligibility	MAS/BOE	Beginning in May 2001, South Carolina reinstated approximately 45,000 persons whose Medicaid eligibility was improperly terminated when they lost welfare benefits. In Q1 FY 2000 and Q1 FY 2001, South Carolina categorized disabled SSI beneficiaries aged 65 and older as "disabled." That is, they were mapped to BOE 2. In FY 1999 and the remaining quarters of FY 2000 and FY 2001 to FY 2003, these individuals were categorized as aged (BOE 1). SC has a large group of enrollees (about 80,000) MAS/BOE who are enrolled in a 1115 family planning waiver, under to state-specific eligibility code 3055. These family planning enrollees have been incorrectly mapped to MASBOE 44-45 instead of MASBOE 54-55 though FY04. Generally, these enrollees were assigned restricted benefits flag 5. In the summer of FY 2003, child and adult enrollment dropped in SC, as the state implemented a new automated eligibility redetermination system. This system seems to have reduced participation (see Kaiser article). South Carolina exhibits a seam effect between the last month of one quarter and the first month of the next quarter. This problem also affects other fields, most notably Plan Type. It is resolved by their submission of retroactive eligibles. South Carolina provides full Medicaid benefits for the aged and disabled up to 100 percent FPL. In the fall of 2002, SC implemented a SLMB-only program for 135 to 175 percent FPL (state code 1049 mapped to MAS/BOE 31). However, this program only lasted until December 2002. Then, in January 2003, SC implemented a prescription drug only program for low income seniors up to 200 percent FPL. This program -- called the SilveRxCard program -- is reported as state-specific eligibility code 1092 and is mapped to MAS/BOE 51. Many of the eligibles also qualify for Medicare cost-sharing as SLMB-only enrollees. To be on Silvercard, an individual must be over 65 and not have any other pharmacy coverage through private health insurance. Some SLMB and QI persons fall in this category and remain with a dual code =03 or 06.
		Race Code	In each quarter, about four percent of South Carolina's eligibles have an "unknown" race.

State	File	Record Type	Issue
SC	Eligibility	Restricted Benefits	A subset of enrollees in MAS/BOE 44 - 45 are assigned restricted benefit flag code 5 (other) since they only qualify for family planning benefits. These individuals should be mapped to MASBOE 54-55. Beginning in FY 2003, restricted benefits flag 5 will also be assigned to enrollees in MAS/BOE 51 - 52, who receive prescription drug benefits only through South Carolina's 1115 waiver for low income seniors.
		TANF	Effective Q2 FY 2002, South Carolina no longer reported TANF data. However, the state 1-filled this data element, instead of 9-filling it. The state will 9-fill this data element in the future.

State	File	Record Type	Issue
SD	Claims	Encounter	There are no encounter data in Q1 1999. However, the state in its application stated that managed care encounter data would be included in the claims files. South Dakota only has one plan.
		IP	In Q1 to Q4 1999, South Dakota mapped Crippled Children's Hospitals to the IP file with Type of Service 01 (Inpatient Hospital). They can be identified with a provider ID in the format of 021xxxx.
		LT	The IP covered days are mostly missing on claims with a Type of Service 04 (Inpatient Psychiatric Services for those Under Age 22) KFF says SD does not cover this service.
			There are no original, non-crossover claims in Q1 1999 with Other Third Party Payment (or Third Party Liability/TPL).
			There are very few diagnosis codes on the file.
		OT	Virtually everyone is enrolled in Delta Dental managed care. In 1999 the PHP capitation claims are actually encounter claims from Delta Dental with the Medicaid Amount Paid by DD to their providers. Starting in 2000, this problem is straightened out and the file contains the true dental capitation claims with a Type of Service 21 (PHP).
			IHS claims are billed on a UB-92, with a Type of Service of 12 (Clinic). These claims have revenue codes, but do not have Service Codes.
			In 1999, some lab claims are incorrected reported with a Type of Service of Physican. This was corrected starting in 2000.
		RX	The state put the fill date in both the Fill and Prescribed Date fields.
	Eligibility	CHIP Code	South Dakota reports its M-CHIP children and S-CHIP children. However, the S-CHIP program was not implemented until Q4 2000.
		County	25 to 30 persons are being assigned county code 131, an invalid FIPs entry. In addition, 7200 persons each quarter are assigned county code 999. In Q1 FY 2003, SD curtailed the use of county code 131. They also drastically cut the number assigned to county code 999.
		Dual Eligibility Flag	Until Q1 FY 2003, South Dakota assigned the dual flag 09 to over 50 percent of their dual eligibles, because they could not correctly identify the dual groups to which these people belong. In Q1 FY 2003, the dual coding was improved, although the state slightly reduced the number iof full benefit duals.

State	File	Record Type	Issue
SD	Eligibility	Health Insurance	More than 10 percent of the persons in the file are coded as receiving third party insurance. This number is higher than expected, but the state confirms that it is correct.
		Managed Care	South Dakota began reporting dental managed care enrollment in FY 2000. By mistake, this enrollment was not reported in FY 1999.
		MASBOE	Children in state-specific code 53 (Non IV-E foster care children) were reported to MAS/BOE 44 in error until Q1 FY 2003. They should be reported to MAS/BOE 48.
		Retroactive Records	South Dakota decided to report retroactive records, despite the fact that they said they were going with the delayed submission in their MSIS application.
		SSN	South Dakota has between 400 to 600 records on each file with duplicate SSNs. The state is aware of the problem and has a process in place to correct it, however most of the process is done manually and takes time. They are a non-SSN state.
		TANF/1931	South Dakota cannot identify their TANF recipients. This field is 9-filled for all eligibles.

State	File	Record Type	Issue
TN	Claims	All	Starting in July 2002 and continuing on Tennessee has been paying the managed care plans a $10 administrative fee and then paid the plans on a FFS basis for services provided to their members. These FFS claims are being produced from the plans encounter data systems but include the Medicaid Amount paid. Two of the managed care organizations (MCOs) have been working under that arrangement since July 2001. The MSIS claims files for July 2001 - June 2002 will not be corrected.
			Starting prior to 1999, virtually everyone was enrolled in an HMO, except the LTC is carved out. The IP/LT/OT files have crossover claims with Medicare Coinsurance and Deductibles.
		Capitation	There was a massive adjustment to capitation claims in August 1999. Until the state becomes current with their submissions, they will only submit original and debit adjustment capitation claims. When an original claim is adjusted in the Tennessee system, the original is replaced with a credit claim, voiding the original and the original no longer exists in their files. In Q3 1999 when the massive adjustment took place, in the state system there are only credit and debit claims that cancel each other out. We requested that until they become current, that they not submit the credit capitation claims.
		Dental	Dental services were also carved out the managed care plans starting with July 1 2002 and they were included in the MSIS files as encounters with $0 paid. Tennessee has been asked to resubmit these claims properly flagged as FFS with the Medicaid Amount Paid.
		IP	TN does not report covered days on all claims.
			TN does not report DRGs.
			The IP file only contains encounter and FFS crossover claims due to managed care enrollment from Q1 1999 through Q2 2002.
			There aren't any claims with a Type of Service 02 or 04 in the LT file. However, there are some Type of Service 04 encounter claims in the IP and OT files. The state has been asked to move them to the LT file in future submissions.
		LT	There is a shortfall of claims in Q4 1999 because state did massive adjustments. They will occur in later quarters.
			There is an increase from about 10,000 FFS claims in Q1 to Q3 2000 to about 50,000 in Q4 2000.
			There is a big drop in the percent of Type of Service 05 (ICF/MR) claims in Q4 2000.

State	File	Record Type	Issue
TN	Claims	LT	There is a shortfall of claims in Q4 1999 because Tennessee did massive adjustments. The claims will show up in later quarters. ??did they??
			LTC services are carved out of managed care so the LT file contains only FFS claims.
		OT	All pharmacy services were carved out of managed care beginning with July 1, 2003. The claims for these services also show up in the MSIS files as encounter claims with $0 Medicaid paid. Tennessee will convert these records to FFS with the Medicaid Amount Paid added. BHO pharmacy claims have been carved out of managed care since July 1996. Tennessee will not fix and resubmit the MSIS claims files prior to Q1 2003. Finally, the pharmacy claims for dual eligible were carved out of managed care starting with July 2000 and will not be corrected prior to Q1 2003.
			Starting with Q3 2002 with the switch from encounter to FFS claims, the Program Types of FQHC and RHC are not reported and there is a big drop in the number of waiver claims.
			During the time when the managed care plans are providing services on a FFS basis, the state submits HMO capitation claims for about $10 per person per month as an administrative fee. This fee does not include any medical services.
			Dental services were carved out from the managed care organizations (MCOs) starting with October 2002 and administered by a Dental Benefits Manager (DBM). Claims for those services were also included in the MSIS claims files, but again as encounter claims, not FFS. These claims will be converted to FFS and the Medicaid Amount Paid included and resubmitted to CMS starting with Q1 2003 (Oct. 2002).
		RX	Starting in 7/96, all BHO pharmacy services were carved out of managed care and starting with July 2000 the pharmacy claims for duals were carved out. Tennessee began carving out all the remaining pharmacy services starting with July 2003. These services were submitted as encounter claims with $0 Medicaid paid. The expenditures have not been reported as service tracking claims. This results in a vast under-reporting of RX expenditures in the MSIS files. CMS has requested that Tennessee resubmit the MSIS files starting with 2002 Q4 with the corrected Medicaid Amount paid and the claims flagged as FFS, not encounter. Any expenditures they can not report as individual claims will be submitted as service tracking.
			The adjustment claims do not have the NDC.
			The days supply is missing on about 15% of the claims.

State	File	Record Type	Issue
TN	Claims	RX	The Fill Date is also entered in the Prescribed Date field from Q3 2002 forward on FFS claims. The 2002 Q2 and Q3 files are missing the RX claims paid by plans, but wouldn't have been paid by the state. Starting with Q4 2002, all paid claims are included in the file.
	Eligibility	CHIP Code	Tennessee has an M-CHIP program, but no S-CHIP program. During FY 1999 - FY 2002, the data varies widely from CMS' SEDS system. The state could not explain the discrepancy. In addition, the M-CHIP data in MSIS approximately doubles in Q1 FY 2001, due to growth in state group 87 ("TennCare Uninsured"). This increase does not appear in the SEDS numbers. However, MSIS and SEDS are consistent in that both data sets show a gradual decline in M-CHIP enrollment across FY 2001 and FY 2002. The M-CHIP program phased out by FY 2003.
		Dual Eligibility Flag	TN had some major problems with is dual eligible reporting until Q1 FY03. Until Q1 FY03, many duals were incorrectly assigned dual codes 01 and 03, as well as restricted benefits code 3. Instead, they qualified for full Medicaid benefits, and they should have been assigned dual codes 02, 04, or 08 and restricted benefits code 1. When this problem was corrected in Q1 FY03, <10,000 persons were assigned dual codes 01 and 03, plus restricted benefits code 3, compared to 84,000 with this set of codes in Q4 FY02. This gives some sense of the problem's proportion. In Q1 FY03, there was also a major decrease in duals reported to dual code 08, with more going to dual codes 02 and 04. Prior to Q1 FY03, the vast majority of full benefit duals were assigned dual code 08.
		Managed Care	Beginning in July 2002, TN converted its managed care system so that its HMOs were no longer bearing risk. Instead, TN pays them a capitated fee to process FFS claims for their enrollees from their network of providers. Nevertheless, enrollees continue to be reported to MC Plan IDs. Presumably this refers to the network they joined.
		MAS/BOE 2002	After many quarters of growth, child and adult enrollment dropped about four percent in January 2002 (cause unknown). Total reported enrollment declined by 2.5% in March 2002 because the state had not yet received all data before running the MSIS file. This will be corrected through retroactive records.
		MAS/BOE 99	Tennessee reported a much higher number of eligibles in MAS/BOE 11 and 12 than expected, given the number of SSI recipients in the state. This may relate to a long-standing court case, requiring the state to maintain Medicaid eligibility for persons leaving SSI.

State	File	Record Type	Issue
TN	Eligibility	MAS/BOE 99	Since the early 1990's, TN has had an 1115 waiver to enroll the vast majority of its Medicaid population in HMOs. The waiver also greatly expanded eligibility. In FY99 Q1-4, over 4,000 individuals younger than age 65 were reported into MAS/BOE 31. This problem was generally corrected in FY00 Q1.
		MASBOE 2003	In Q1 Fy03, TN had some major changes to its MASBOE reporting. First, as mentioned in the duals section, the state has been incorrectly reporting many persons to MASBOE 31-32 as restricted benefits dual eligibles. When this problem was corrected, enrollment declined in MASBOE 31-32 and increased in MASBOE 21-22 and 41-42. As a result of a major reverification effort, there were enrollment declines in MASBOE 44-45 and 52-55 in Q1 FY03. Many, but not all, of these enrollees appeared to shift to MASBOE 14-15, 24-25 and 34-35. Nevertheless, there were still noticeable declines in disabled, child and adult enrollment in Q1 FY03. More declines occurred in MASBOE 54-55 in Q3 FY03 as TennCare made another round of eligibility redeterminations, although overall child and adult enrollment rebounded by the end of the year.
		Restricted Benefits	Until Q1 FY03, many more dual eligibles were assigned restricted benefits code 3 than should have been.
		TANF/1931	Tennessee reported that all eligibles in MAS/BOE 14 - 17 were TANF recipients. It is not clear whether any persons other than TANF eligibles qualified under the 1931 rules. Tennessee under-reported the number of TANF recipients in their FY 1999 MSIS files. The state corrected this issue over time, so that by FY 2002 the numbers were close. In Q1 FY03, TANF counts in MSIS were 12% higher than the TANF Administrative Data.
	Encounter	OT	Type of Service is missing on about 10 percent of the claims and there are very few different Type of Service codes. file contains about 4,000 claims with a Type of Service of Inpatient Psychiatric Services for those Under Age 22. These claims should be reported in the LT file.
		RX	The NDC is missing on adjustment encounter records. The Fill Date is missing, only the Prescribed Date is populated from 1999 Q1 - 2002 Q2. The Type of Service is missing on most RX encounter records.

State	File	Record Type	Issue
TX	Claims	All	The provider ID numbering system was changed Q3 2001. The old and new IDs need to be crosswalked in order to adjust claims. In Q4 2002, Texas started a patient co-pay program. These payments can only be reported in the LT file in the Patient Liability field. Texas has a large number of state agencies responsible for the administration and processing of Medicaid claims for different parts of the program, making it difficult for them to collect and report Medicaid services uniformly in MSIS Texas initiated a co-payment program for Medicaid in December 2002. These co-payments can not be included in the IP, OT or RX files as there isn't a Patient Liability variable.
		Crossover	There are a few crossover claims with very large Medicare Coinsurance and/or Deductible Amounts Paid. Texas will code the Coinsurance field as 99996 and put the Medicaid Amount Paid in the Deductible field.
		IP	Texas uses the following procedure codes: "MXXX" and "KXXX"; these are codes on the National Heritage Insurance Company (NHIC) Procedure Master File. NHIC previously used these codes for: MXXX: Medicaid prior approval; KXXX: Chronically Ill Disabled Children (CIDC) Inpatient Prior Authorization.
		IP/OT	Texas sometimes receives claims with erroneous Other Third Party Payment (or Third Party Liability/TPL) amounts that are so large they won't fit in the Other Third Party Payment (or Third Party Liability/TPL) field. Texas will 9-fill the field and it will be converted to "0" in the MSIS Valids file, appearing that there wasn't any Other Third Party Payment (or Third Party Liability/TPL) paid.
		LT	The diagnosis codes are missing on many claims and is inconsistantly reported quarter to quarter. Some resubmittal adjustment claims are reported as originals.

State	File	Record Type	Issue
TX	Claims	LT	From Q1 1999 to Q4 2000 the, LT files are missing the following data elements: Admission Date, Patient Liability, and TPL. The following variables are missing in the Q1 1999 file: Diagnosis and Covered Days. The following variables are missing in the 1999 files, but are reported starting with Q1 2000; Charge, Leave Days, Patient Liability. The state had to build the Q1 1999 file from very incomplete old records. NHIC's new claims system promises much more complete data starting Q3 2000. from a Long Term Care claims history file that did not contain data essential to MSIS reporting. This was due to a new Long Term Care Claims Management System that was developed, however, the history data was not available for MSIS processing." Texas expects to have these data for FY 2000 because their system will have captured these data.
			Patient Status is missing on most LT claims.
		OT	The OPD claims do not have UB-92 revenue codes.
			There is a big change in the distribution of claims by Type of Service starting with Q3 2001 because the state changed its system and in the process reviewed how they were assigning Type of Service. The revised hierarchy they began using in Q3 2001 results in many more lab/Xray services being pulled out of physician, clinic, etc. claim and being put in lab/xray where they belong. Currently their Q3 2001 claims from NHIC does not have any claims reported with a Type of Service of 19. This is clearly an error and they are investigating.
			In Q2 1999, five percent of the services codes aren't valid.
			Capitation claims from the NorthStar managed care program (BHO) are reported with a Type of Service of 20 (HMO) instead of Type of Service 21 (PHP). Texas will fix this in the future.
			About 8 percent of the claims have the invalid combination of an 8 filled Service Code and a Service Code value of 0. Some claims have invalid Service Codes.
			There are very few claims with a Type of Service of 10 (Other Practitioner) and a much higher than expected percent of claims with a Type of Service of 08 (Physician).
			There are a few claims in Q4 1999 with dates of service after the quarter.
			Place of Service is missing or invalid on about 15 percent of the claims.

State	File	Record Type	Issue
TX	Claims	OT	The $3 PCCM fee is included in the Medicaid Amount Paid for medical services during visits and cannot be reported separately because of the adjustment process. Therefore, the only PCCM capitation claims are those for case management only. The combination claims (PCCM and service) are assigned the to a Type of Service based on the medical service. The capitation payments for transportation managed care are paid to providers once a month as a lump sum payment. Other Third Party Payment (or Third Party Liability/TPL) is not on most claims because it is carried at the header level. Texas planned to create a "dummy" claim with the TPL for 2000, but hasn't been able to do it. In Q4 1999 almost two percent of the claims have the invalid diagnosis code of "02." The Q2 and Q4 1999 OT files have some claims with a date of adjudication prior to the quarter.
		RX	No claims have a Other Third Party Payment (or Third Party Liability/TPL). All compound drugs are coded as "COMPOUND" in the NDC field.
	Eligibility	CHIP Code	Texas reported its M-CHIP children until it phased out in Q1 FY 2003. The state's S-CHIP program, which began in April, 2000, is not reported into MSIS.
		Dual Eligibility Flag	In FY03, TX began assigning dual codes 09 and 99 to enrollees in its 1929(b) waiver, since these persons are not QMB-only, SLMB-only, or QI eligibles. They do not qualify for prescription drug coverage most are reported to MASBOE 41-42. Tentatively, TX agreed to use dual code 09 for this group effective Q1 FY04 when the dual status is known. They will use dual code 99 when the dual status is uknown.
		Managed Care	Texas has a PACE program, but PACE enrollment is not included in the EL files. Beginning in Q1 FY 2000, Texas exhibits a significant upswing in PCCM (Plan Type 07), Comprehensive Managed Care (Plan Type 01), and Behavioral Managed Care (Plan Type 03). The numbers in MSIS are consistent with what we see in external CMS data, although there was a PCCM discrepancy in FY 2002 (the state believes the MSIS numbers are more accurate). Enrollment in these groups continues through FY 2002. Texas began to report a behavioral managed care plan in July 1999.

State	File	Record Type	Issue
TX	Eligibility	MAS/BOE	From Q1 FY 1999 - Q2 FY 2002, Texas reports about 2,000 to 3,000 eligibles in MAS/BOE 55. These eligibles are not part of an 1115 Waiver. Rather, the individuals are made eligible through a TANF waiver, which extended Medicaid benefits after the individual's state time limit had expired. The waiver expired 3/31/02, but the eligibility created by the waiver continued. Because the waiver expired, this group was moved to MAS/BOE 45 in Q3 FY 2002. Texas began reporting BCCPTA enrollees under MAS/BOE 3A in Q1 FY 2003. In September 2003, Texas implemented a TANF sanction policy that caused many adults (20,000) to lose Medicaid coverage, but not their children. Enrollment declined in MAS/BOE 14 - 15, but most children appeared to have transferred to MAS/BOE 44. Also in September 2003, TX changed the medically needy financial rules for adults in MASBOE 25, causing an enrollment decline. In effect, the changed rules eliminated spend-downers. Most disabled SSI reciprients age 65 or older are reported to MASBOE 11.
		Private	In July 2002, private health insurance reporting increased to about 147,000 from about 120,000 in June 2002. The state believes this to be correct.
		Restricted Benefits	Texas assigns code 5 ("other") to aged and disabled LTC persons in MAS/BOE 41 - 42 who are living at home, as well as children and adults in MAS/BOE 24 - 25 whose date of initial coverage is complicated by a spend-down liability. However, in September 2003, Texas changed the financial rules for medically needy adults, so that very few adults qualified as a result of spend-down. This caused a reduction in MASBOE 24 enrollees assigned restricted benefits code 5.
		SSN	Texas reports about 500 duplicate SSNs each quarter. The state is aware of the problem and periodically works at reducing it.
		State-Specific Eligibility Group	The state-specific eligibility group field is 8-filled for QI1s, QI2s, and QDWIs.

State	File	Record Type	Issue
UT	All	MSIS ID	From 1999 Q1 forward, about 7-10% of the MSIS OT claims have not matched the MSIS EL files for the same quarter. The state will correct the MSIS ID's starting with Q2 2004. It is not possible to create a crosswalk from the invalid to correct ID's.
			Some foster care children may have a different MSIS ID in the EL files.
			UT asked to change to a new MSIS ID numbering scheme in 2003 Q4, but the request was denied.
	Claims	_All	Starting in FFY 2004 Q1, the HMO's began providing services on a FFS basis. The state reimburses the plans for those services plus a 9% administrative fee and they are reported in the MSIS files as service tracking claims.
		Capitation	There are not any PCCM capitation claims in the OT file as they are paid on a FFS basis.
			There are very few capitation claims for people enrolled in HMOs in 1999 and Q1/Q2 2000. The HMO capitation claims were added starting in Q3 2000. (Utah resubmitted the Q1/Q2 OT file and was unable to include the HMO capitation claims as those source files had been lost in the state system.)
		IP	Starting in 2003, most crossover expenditures are submitted as service tracking claims.
			No claims have a Patient Status of 30 (Still a Patient).
		LT	The "Admission Date" and "Patient Status" are missing on most nursing home/institutional claims because Utah does not retain the data on the input record.
		OT	Physician specialty codes are missing on over 60 percent of the claims.
			There is a shortfall of HMO capitation clamis in Q1 2003 because some of these claims were deleted from their system.
			Place of Service are missing on over 20 percent of the 1999-2001, Original Non-crossover claims. Utah accepts a place-of-Service Code of "other" from providers. Since this cannot be translated, a high number of claims will have the "99" value (unknown or not listed).
			The 2002 Q3/4 OT files do not contain any claims with a Place of Service of ER.
			The average expenditure for claims with a Type of Service 12 (Clinic) jumped from about $400 to $700 in Q3 1999 and continued at the $700+ level in 2000. ??and more recently??
			Most claims for children have a Program Type of 1 (EPSDT).

State	File	Record Type	Issue
UT	Claims	RX	There is a small percentage of claims with a 12 byte NDC. These come from a manual system that is being phased out. The NDC's probably have a leading 0. The fill date is also reported in the prescribed date field. UT will fix starting in 2004.
	Eligibility	1115 Waiver	Utah's 1115 Waiver program is its Primary Care Network, approved for implementation in July 2002. This network provides reduced benefit packages to adults previously ineligible for Medicaid. The program expands Medicaid coverage to cover adults up to 150 percent FPL and pregnant women with assets exceeding the allowable levels for Medicaid. MSIS reporting began in October 2002.
		CHIP Code	Utah reported enrollment in its S-CHIP program in MSIS. The state does not have an M-CHIP program.
		County Code	Utah uses a state-specific county code in FY 1999 and FY 2000, instead of the FIPS county codes. This problem will be corrected in their FY 2001 files. The state supplied MPR with a crosswalk that links together the state county information with the correct FIPS county code.
		Dual Eligibility Flag	Utah provides full Medicaid benefits up to 100 percent FPL for its aged and disabled recipients. As a result, many eligibles in MAS/BOE 31 and 32 receive full Medicaid benefits. Utah reports they do not buy into Part A Medicare coverage for duals. Between 85 - 90 percent of persons older than age 64 are reported as dual eligibles, a somewhat lower than expected proportion. This pattern worsened in FY04, dropping to 80%. UT has been unable to resolve this issue. Some persons in MAS/BOE 21 - 22 and 41 - 42 are reported to have dual codes 01 and 03. State officials say this is due to a timing problem. Both dual eligibles who have to spend down to qualify for full Medicaid benefits (through the medically needy program) and those who contribute to the cost of their institutional care are not initially classified as qualifying for full Medicaid benefits. The number of QMB-only dual eligibles (dual eligibility flag = 01) is much lower in Q1 FY 2000 than in any of the other FY 1999 or FY 2000 quarters. In Q1 FY 2000, there are roughly 250 QMB onlies, whereas there are about 1000 per quarter in the rest of the FY 1999 and FY 2000 quarters. The number of dual eligibles increased by about one-third from Q4 FY02 to Q1 FY03, as the state improved its identification of dual eligibles. Most of the increase occurred with dual code 08.

State	File	Record Type	Issue
UT	Eligibility	Health Insurance	Utah reported about 10 percent of its eligibles with private health insurance, a somewhat higher than expected proportion. The state has confirmed that this proportion is correct.
		Managed Care	Until Q1 FY04, Utah did not report PCCM enrollment or claims or transportation enrollment or claims, even though PCCM and transportation enrollment is reported in CMS managed care reports. PCCM reporting began in Q1 FY04. For the transportation coverage, individual records are not maintained in the MMIS. Enrollment by individual HMOs varies considerably quarter to quarter for FY02 and FY03. The UMed HMO plan phased out effective 10/02, with IHC enrollment picking up. IHC was an HMO until Q1 FY03 when it changed to a PCCM. However, this switch was not corrected in MSIS eligibility data until Q1 FY04.
		MAS/BOE	Prior to Q4 FY 2000, Utah had been under-counting the number of poverty-related children. During this time, roughly 30,000 had been assigned state-specific eligibility codes which caused them to be mapped to MAS/BOE 44. Beginning in Q4 FY 2000, this problem was corrected. These children were correctly assigned to state-specific eligibility codes which are mapped to MAS/BOE 34. In FY 1999, FY 2000, and FY 2001, MAS/BOE was incorrectly assigned for about 36 state-specific groups. Many (but not all) were reported into MAS/BOE 31 - 35 when they should have been reported into MAS/BOE 14 - 15 and 41 - 45. This represented about 15 percent of monthly enrollment in FY 2001. Groups that were mismapped included some 1931 eligibles, some of the institutionalized qualifying under the 300 percent FPL rules, the working disabled, TMA enrollees, and persons meeting AFDC rules, but not qualifying for cash.
		Restricted Benefits Flag	Some eligibles outside of MAS/BOE 31 and 32 receive RBF = 3 (restricted benefits based on dual eligibility status).
		SSI	Utah requires a separate Medicaid application for its SSI recipients. As a result, the number of MAS/BOE 11 and 12 eligibles was lower than the number receiving SSI.
		TANF	The TANF flag was not reliable in FY 2000, but it looks reasonable for FY 2001 forward.

State	File	Record Type	Issue
VA	All		Virginia implemented a new system in March 2003.
	Claims	All	VA has a very small pre-PACE program with only about 20 enrollees. The billing is done outside Medicaid and so there are not any capitation pyament claims.
		Capitation	Update: The date when individual PCCM capitation claims will be available is Q1 2002. (email from R North 1/8/2002)
			PCCM capitation claims are not included in the 1999 to 2000 files.
		IP	Over 20 percent of the 1999 and Q1 2000 claims have a Medicaid Amount Paid of $0 as there is a 21 day limit for adult IP care. Expenditure after 21 days are paid as a cost settlement.
			The state stopped reporting Family Planning in Q4 2003.
			DRGs are not currently available in the claims files as Virginia assigns DRG as a post payment process solely for cost settlement. The state expects to start submitting them beginning with Q2 2000.
			The percent of crossover claims is much higher than expected. For example, in Q1 2005 40% of enrollees are in managed care, but 82% of the claims are crossovers. They appear to be true crossover claims because of the level of reimbursement.
		LT	??KFF says Virginia does not cover IP Psych <22
			The percent of claims with Patient Liability is less than expected. This is because the providers aren't always consistent about including that information on the claims.
			Leave days are not carried in the state's claims files.
		OT	The servicing and billing provider ID numbers are usually the same. When available they are putting the attending provider ID in the servicing field.
			The percent of claims with CPT-4 codes dropped from 81 percent in Q1 1999 to 67 percent in Q4. This is the result of the movement of some FFS recipients to managed care.
			Virginia pays a capitation rate to various county-based agencies for transportation services. The payment is based on the estimated number of Medicaid enrollees, not for specific enrollees. Until Q4 2004 these capitation payments were not in MSIS files either as service tracking or individual capitation claims. People covered by transportation managed care were not flagged in the MSIS EL files as enrolled in Other managed care. Starting with Q4 2004 the transportation capitation claims will be included as service tracking claims and enrollees will be in the EL file in Other managed care.

State	File	Record Type	Issue
VA	Claims	OT	Virginia was unable to submit HMO capitation claims for the first 2 months of Q1 FY 1999 because they had aged off the system.
		RX	Virginia does not have the capacity of using HCPCS inputs on pharmacy claims. Universal codes are used for DMEs without NDCs. Pharmacy claims without NDCs can be compounds or other unidentifiable items.
	Eligibility	CHIP Code	Until the fall of 2002, Virginia only had an S-CHIP program, and was reporting all of its S-CHIP eligibles into MSIS. The numbers in MSIS are greater than in SEDS until Q4 FY 2001. The state assures us that the MSIS numbers are correct; however, there may also have been some problems with double counting. SEDS and MSIS are comparable beginning in Q4 FY 2001. Effective September 2002, the state has an M-CHIP program as well, and many children appear to transfer from S-CHIP to M-CHIP.
		County Code	Virginia assigns county codes 983 - 997 to institutions in the state. List is included in anomalies file. Virginia assigns special FIPS codes 510 - 840 to cities that are independent entities.
		Health Insurance	In Q1 1999, there were about 12,000 Medicaid eligibles each month who were reported as "ineligible" in the HEALTH INSURANCE field. This problem was corrected in the Q299 - Q499 files.
		Managed Care	In Q3 FY 1999, the mix of HMOs changed somewhat and overall HMO enrollment increased, while PCCM enrollment declined. Another shift in managed care enrollment occurred in Q1 FY 2002, with PCCM enrollment declining and HMO enrollment increasing.
		MAS/BOE	Virginia begins reporting BCCA eligibles in Q4 FY 2001. Effective FY2003, Virginia has an 1115 program to extend family planning services to enrollees in MAS/BOE 55. In Q1 FY 2003, a few enrollees were mapped to MAS/BOE 99 by mistake, instead of MAS/BOE 00. Effective FY 2003, Virginia has an 1115 program to extend family planning services to enrollees in MAS/BOE 55 (state group 80). Virginia has an outreach program to children in September of each year. Enrollment is often retroactive three months.

State	File	Record Type	Issue
VA	Eligibility	MAS/BOE	After July 2000, the state began bypassing the 1931 rules for children. Virginia now determines eligibility for children based on the more simplified poverty-related provisions (MAS 3). The state has continued to use the 1931 rules to determine eligibility for adults, but they are unable to separate 1931 eligibles from other transitional assistance recipients. Both groups are under one state-specific eligibility group that is mapped to MAS 4. Virginia is a 209(b) state. As a result, SSI recipients are required to fill out separate applications for Medicaid, and are required to meet stricter standards. Because of this, the total number of persons in MAS/BOE 11 and 12 is less than the number reported by the SSA. Beginning in Q4 FY 2001, Virginia extends full Medicaid benefits to aged and disabled persons to 80 percent FPL (state groups 29, 39, and 49). Many of these persons were incorrectly assigned dual code 01 and restricted benefits code 3. They should have been assigned restricted benefits code 1. The correct dual code would be 02 if they were dual eligibles. This problem was fixed in Q1 FY 2003.
		Restricted Benefits	Persons in state group 80 (Family Planning Waiver) are assigned restricted benefits code 4. In some (but not all) quarters BCCPTA women (state group 66) are assigned restricted benefits code 5. Finally, many medically needy persons are assigned restricted benefits code 5.
		SSN	Virginia put 3 leading 8s and then a date (usually the date of birth) in the SSN field when the SSN is unknown. This caused many records to have duplicate SSNs, plus it was incorrect. Unknown SSNs should be 9-filled. This was corrected starting with Q4 FY 2002, according to the state. However, some level of duplicate SSNs will continue even after 9-filling since people can have more than one MSIS ID if they change cases over time.
		TANF/1931	TANF data are not reliable in Virginia. The state began 9-filling the TANF field in Q1 FY 2003.

State	File	Record Type	Issue
VT	Claims	All	Across the four files, there are fewer than expected adjustment claims. Specifically, less than one percent of the claims are adjustment claims.
		IP	The state does not use DRGs.
			About half the claims are for crossovers in 1999.
		LT	There are no original, non-crossover Q1 1999 claims with a Type of Service of 05, ICF/MR. However, this was a one quarter correction and they occur in subsequent quarters.
		OT	The number of claims jumps from about 482,000 in Q2 2000 to 670,000 in Q3.
			Through 2001, all OT claims, regardless of Type of Service, have something in the diagnosis code field.
			About one third of the 1999 claims have a Type of Service of 19 (Other Services). In 2000 that percent started to decline and in Q3 2000 it was only 19 percent.
			The State has State-specific Revenue Codes for Home Health and Hospice Services.
			Vermont stopped including Specialty Code in Q3 1999.
		RX	The fill date is reported in both the Fill Date and Prescribed Date fields.
			There was a big increase in the number of RX claims between Q1 and Q2 1999.
			All QMB-only, SLMB-only, and QI1 eVermont's 1115 demonstration, these eligibles qualify for pharmacy benefits, but no other Medicaid services (except Medicare cost-sharing expenses, as appropriate).
	Eligibility	CHIP Code	Vermont reports its S-CHIP eligibles into MSIS. The state does not have an M-CHIP program.
		Correction Records	Each quarter, Vermont submits a few correction records that are very old (up to about 20 years old). The number of such records is small and the state does not think this practice has an effect on its data.
		Dual Eligibility Flag	Most QMB only, SLMB only, and QI1 eligibles are reported into MAS/BOE 51 and 52. As part of Vermont's 1115 demonstration, these eligibles qualify for pharmacy benefits, but no other Medicaid services (except Medicare cost-sharing expenses, as appropriate). Other dual eligibles in the 1115 program were assigned dual code 09, beginning in FY03.

State	File	Record Type	Issue
VT	Eligibility	Dual Eligibility Flag	Prior to FY03, dual eligibles in state groups BD, B6, IA, and ID were assigned to incorrect dual codes. Duals in BD and B6 should have been assigned dual code 08, and IA and ID should have been assigned to 04.
		Managed Care	Beginning in FY00Q1, Vermont transitions everyone with Plan Type = 01 (Comprehensive Managed Care) into Plan Type = 07 (PCCM). This change was made because the state's two managed care plans (Blue Cross and Kaiser) left the program.
			PCCM enrollment started Q1 2000.
		MAS/BOE	In FY 1999 through FY 2002, enrollees of state-specific eligibility groups RR and R1 were mistakenly included in MSIS. These are members of the Refugee Resettlement Program. 200 or fewer persons are enrolled in the program each month.
			Relatively few eligibles are mapped to MAS/BOE 31 and 32, because all QMB only, SLMB only, and QI1 eligibles are reported into MAS/BOE 51 and 52. As part of Vermont's 1115 demonstration, these eligibles qualify for pharmacy benefits, but no other Medicaid services (except Medicare cost-sharing expenses, as appropriate).
			In Q1 to Q2 FY 2001, a few hundred persons were reported into MAS/BOE 97. These persons are not Medicaid eligible.
			In FY 2002, approximately ten people each month were mapped to MAS/BOE 39. These are enrollees of state-specific eligibility groups BG and BH. They are BCCPT enrollees and should have been mapped to MAS/BOE 3A.
			In FY 2001, Vermont stopped reporting into MAS/BOE 16 - 17 (optional reporting groups), instead reporting all TANF eligibles into MAS/BOE 14 - 15.
			In FY03 and Q1 FY04, state group 'BD' is incorrectly assigned to MASBOE 52 instead of MASBOE 42.
			Beginning in 1995, Vermont implemented a 1115 waiver program -- Vermont Health Access Plan (VHAP) -- that extends eligibility with full benefits to 300% FPL for children and 185% for parents. Aged and disabled enrollees with income to 175% FPL qualify under the 1115 waiver for prescription benefits. In addition, many of these aged & disabled enrollees also get Medicare cost-sharing benefits under QMB only, SLMB only, or QI provisions.
			Starting in FY 2001, Vermont's counts of aged SSI eligibles are about 20 percent higher than SSA administrative data.
		PCCM	The PCCM program started Q1 2000.

State	File	Record Type	Issue
VT	Eligibility	Restricted Benefits	Restricted benefits flag 5 ("other") is assigned to enrollees of Vermont's 1115 demonstration, which provides aged and disabled enrollees with pharmacy benefits only.
		TANF/1931	Until FY 2000 Q3, everyone in MAS/BOE 14-17 received TANF benefits. There were some 1931 eligibles on the file who did not receive TANF benefits during this period, but those persons were mapped to MAS/BOE 44 and 45 in aid categories TC, T5, TR, and T8.

State	File	Record Type	Issue
WA	ALL	MSIS ID	Washington puts extra "S"s in the MSIS ID field on some records. These need to be dropped in order to properly link claims and eligibility.
	Claims	Capitation	In Q2 to Q4 2000 there are a few capitation claims with a Type of Service of 19.
			There aren't any PCCM capitation claims, although there is some PCCM enrollment.
		Encounters	There is a big drop in OT encounter claims starting with Q2 2001.
		IP	There were no claims with a Program Type of 2 (Family Planning) as FP services are always incidental to other IP services. The professional component is billed in the OT file.
		LT	Washington does not cover Leave Days.
			Washington does not have diagnosis codes on nursing home claims.
			There are no original, non-crossover claims with a Type of Service of 04 (Inpatient Psychiatric Facility Services for Individuals Age 21 Years and Under). According to the State, their Mental Health Division is still working on adding this coding system (having Type of Service 04). Previously, all inpatient psychiatric facility claims were lumped together, not broken out by age category. Diana Reitz expects that in the next twelve months, FY 1999, this issue will be fixed. However, it is possible that Q1 FY 1999 LT file will not have Type of Service 04.
			Over 99 percent of the claims have a Patient Status of 30 (Still a Patient) which is higher than expected. Also, no one has a Patient Status of 20 (Expired/Died).
		Non-MMIS	It has been difficult for WA to include claims in the MSIS files for the six programs that are not processed in the WA MMIS (some waiver, some not) as they are collected and paid in a different manner from the MSIS. As a result thay have been submitted differently in different years as the state attempted to do the best possible job of reporting given the limitations of the external data system. The programs are: 11 - Division of Developmental Disability (a mix of individual and combined data is available), 12 - MH Disabled (only lump sum payments are available) , 13 - Division of Alcohol & Substance Abuse (WA believes that these are actually included as individual claims in MSIS for this time period, 14 - Aging (individual claims are available), 15 - Economic Services Administration (lump sum payments only), 16 - Children's Administration (individual claims available), 17 Juvenile Rehab Administration (these are being provided to the state by another source).

State	File	Record Type	Issue
WA	Claims	Non-MMIS	In 1999, the waiver and BHO capitation expenditures are reported as service tracking claims and the individual claims that were availale are in the OT file as encounter claims, with a program code reported in the Billing Provider ID field (or service code indicator - check)
			In the 2003 Q1-3 files, there are no non-MSIS claims. Starting with Q4, the state is submitting individual claims with expenditures whenever possible and service tracking claims with expenditures for the rest. It is not clear if they are going to fix and resubmit Q1-3 or if all the 2003 information will be in the Q4 file.
			In 2001 and 2002, the waiver services and BHO capitation expenditures are submitted as service tracking claims in Q4 for the entire year.
		OT	WA includes the BHP capitation claims made to their Regional Support Networks with the waiver service tracking claims.
			There are no claims classified as HH in the Q2-4 2004-2005 Q1 OT files due to a state system problem. The state planned to correct this with the 2005 Q1 files, but didn't.
			There are some duplicate state-specific Service Codes with different definitions. They have the same Service Code Indicator. This is under investigation with the state.
			There are the following state-specific diagnosis codes on the file: V950,V990, and V960). According to Washington, "These are valid Washington MMIS codes with the decimal removed as required (i.e. V95.0 -DAY HEALTH CARE; V96.0 -EPSDT/HEALTHY KIDS)."
			Washington did not 8-fill the place of service on the capitation claims on their 1999 files (Q1-Q4). CMS will raise the error tolerance on these files and ask the state to fix the problem in 2000. CMS would like to get their files approved, hence the reason that they are raising the error tolerance vs. asking them to resubmit. CMS will ask the state to properly 8-fill the field on their 2000 files. ??has this happened??
			The capitation payments made to MC plans that use FQHC's do not include the supplemental FQHC payment. That supplemental payment is made directly to the FQHC's and is a monthly rate for everyone enrolled in an FQHC plan. The state will submit those individual supplemental payments with a Type of Claim = 5 (supplemental payment) starting in 2005.
		RX	The Date Prescribed was also put in the Fill Date field on all claims from 1999 to 2002.

State	File	Record Type	Issue
WA	Claims	RX	Drugs provided under the bundled rate for people who are institutionalized under the mental health (MH) and DDD waiver programs are not separately reported. However, the non-bundled drug claims are submitted in the RX files as individual claims.
		Supplemental Cap Claims	Claims with services codes 0351M, 0365M, 0366M, 0367M ??should be or are?? recoded Type of Service 20. The first 0351M is a supplemental premium payment related to newborns. The plans are allowed to use this code for the first 90 days or so of a person's life until they can be officially added to the system. 0365M is a capitation payment related to delivery; 0366M is a managed health care payment related to FQHC or RHC and delivery; 0367M has to do with BHP+ and maternity. Codes appear to be related to compensating plans for adding a newborn.
	Eligibility	CHIP Code	Washington operates an S-CHIP program, but does not report enrollment in MSIS. The state does not have an M-CHIP program. Each month in FY 1999 - FY 2001, 30 - 60 individuals in MAS/BOE 00 were coded with blank CHIP Codes.
		County Codes	Washington's county code data were not reliable until Q1 FY 2002.
		Date of Death	In Q1 FY 1999, 587 individuals were reported to have a date of death before 1998.
		Dual Eligibility Flag	In FY 1999, Washington reported some eligibles with Dual Eligibility Flag = 00 and Dual Eligibility Flag = 02 in MAS/BOE 31 and 32. We generally expect that eligibles in MAS/BOE 31 and 32 would receive Dual Eligibility Flags 01, 03, 05, 06, or 07. This problem decreased substantially across FY 1999, however. Three percent of QMB full enrollees on Washington's Q1 FY 2003 file did not receive Medicare Part A, according to an analysis by CMS. Washington believes this is due to the fact that the state does not pay Part A premiums retroactively when it is not deemed cost-effective to do so.
		HIC Number	More than 96 percent of Washington's non-dual eligibles have the HIC number 9-filled. Technically, the HIC number should be 8-filled for non-dual eligibles.
		Managed Care	Washington was not reporting claims or enrollment information for its behavioral managed care plan in MSIS during FY 1999, FY 2000, and FY 2001. According to CMS data, enrollment in the BHP plan ranged from about 1.4 million in FY 1999 to about 750,000 in FY 2001. BHP enrollment was added for FY 2002. The Department of Social and Health Services administers the BHP program and provides only one plan ID in MSIS in contrast to what is reported in CMS data.

State	File	Record Type	Issue
WA	Eligibility	Managed Care	From FY 1999 to FY 2001, managed care enrollment generally increased from the first month of the quarter to the third. It then decreased somewhat at the beginning of the next quarter.
		MAS/BOE	From FY 1999 forward, enrollment generally declined from month 1 to month 3 in every quarter, and then increased substantially in month 1 of the next quarter, resulting in a "seam effect."
			Enrollment in MAS/BOE 16 - 17 declined from roughly 34,000 in June 1999 to less than 1,000 in FY 2000.
			Washington enrollment data for SSI recipients (MAS/BOE 11 - 12) are higher than expected relative to SSA date; this may occur because of a state-administered SSI supplement.
			Enrollment among children and adults grew by over 70,000 (a 10 percent increase) from March to May, 2000, but then declined by 40,000 by the end of Q4 FY 2000 (cause unknown). Effective Q4 FY 2001, Washington extended family planning benefits to adults in an 1115 demonstration.
			In FY03 and Q1 FT04, some persons were reported to MASBOE 99 by mistake. In addition, a few persons were reported to MASBOE 17 who should have been reported to MASBOE 15.
		Restricted Benefits Flag	Washington assigned restricted benefits flag 5 to persons in the medically needy group and women in MAS/BOE 35 who only qualify for family planning benefits in the post-partum period.
			Until Q1 FY 2002, Washington had a problem with the Restricted Benefit Flag (RBF), as it relates to the Dual Eligibility Flag. Many eligibles with Dual Eligible Flags 01, 03, 05, 06, and 07 are reported to have RBF = 1 (individual is entitled to the full scope of Medicaid benefits). These dual eligibility groups should receive RBF = 3 (individual is eligible for Medicaid, but only entitled to restricted benefits based on dual eligibility status). Some discrepancy between the Dual Eligibility Flag and the RBF is expected, since the Dual Eligibility Flag is a root field, and the RBF is a monthly variable. However, this is a greater difference than we expect to see. There was also a problem with the restricted benefits flag for 1115 enrollees. Even though 1115 enrollees beginning in FY 2001 only qualify for family planning benefits, they are reported to have restricted benefits flag 1, full benefits until Q1 FY 2002 data.
		State Specific Eligibility Code	Effective Q1 FY01, WA switched to using a 4 byte state specific eligibility code. Prior to this, the 6 byte state specific code meant that there were thousands of state specific code combinations making these codes difficult to use.

State	File	Record Type	Issue
WA	Eligibility	TANF/1931	In FY 2002, Washington TANF data are about 15 percent lower than ACF counts (cause unknown), while the FY03 data are 10% lower.
			Almost all eligibles in MAS/BOE 14-17 are TANF recipients.
		Various Fields	Washington's data are not consistent across variables with regard to the number of persons who are ineligible each month. This problem involves fewer than 300 persons each month from Q1 FY 1999 - Q2 FY 2000. Then, in FY 2000Q3 - FY 2000Q4 about 1,200 ineligibles (MAS/BOE 00) each month are not coded as ineligible for the following variables: TANF, RBF, Plan Type 1 - 4, Plan ID 1 - 4, CHIP Code. Many of these problems continue in FY 2001.
	Encounter	IP	Only one UB-92 Revenue Code is reported, so if there is an accommodation code, then there aren't any ancillary codes.
		RX	Days Supply is missing on RX encounter claims.
			NDC code is missing on RX encounter claims.

State	File	Record Type	Issue
WI	All	MSIS ID	Wisconsin is not an SSN state, but submits their MSIS EL files using SSN rules. They assign Temp Ids to people who don't have a SSN (usually babies) and then when the enrollee gets a SSN they use that for the MSIS ID. Wisconsin uses the SSN with an additional byte on the end as their permanent MSIS ID numbers. The extra byte is "0" unless there someone else has previously enrolled in the system with the same SSN.
	Claims	Adjustments	The files may contain some denied claims.
		Capitation	There are two non-comprehensive plan types that appear on the eligibility file with capitation claims with a Type of Service of 20. They are Plan ID 65 (PACE) and Plan ID 66 (Other managed care). Wisconsin will start reporting the capitation claims for Other Managed Care with a Type of Service of 21 (PHP) starting with the 2001 files. The PHP capitation rate is very high as it is used to cover Aged/Blind/Disabled managed care services. Wisconsin changes the date of service to match the date of payment since the HMO capitation claims are made prospectively and their system won't allow payment for a service before it is rendered. This means that if a capitation payment for April is made in March, the dates of service will be changed to March resulting in the capitation payments always being one month prior to the managed care enrollment. Also, this results in the adjustments not linking to the original claims by date of payment.
		IP	There are no claims with a Program Type of Family Planning.
		OT	Wisconsin has two Service Codes that can have different meanings but are not distinguishable on the MSIS claims. These codes are W0500 and W0520. UB-92 code 001 occurs on many outpatient hospital claims as Wisconsin uses it for rate reimbursement. Emergency Room use is under-reported because it is only picked up using UB-92 revenue codes which are not always/often used. Wisconsin plans a system change to pick up ER information for all ER services. ??Have they done this?? ??by place of service or revenue codes?? Wisconsin's system requires diagnosis codes on all claims regardless of Type of Service. The void adjustment claims have the span dates on the claim header, while the originals and resubmissions have the line item service date. Wisconsin does not require Provider ID Number Servicing on outpatient hospital claims

State	File	Record Type	Issue
WI	Claims	OT	There are fewer than expected PHP capitation claims compared to the person months of enrollment in a PHP in 2003.
		RX	Prior authorization drugs have eleven "8"s in the NDC field.
		Waiver	In Q4 FY 2001 OT files, Wisconsin included all the waiver claims going back to service dates in January 2000. These claims have state-specific procedure codes, no diagnoses, and a mean expenditure of $553. Wisconsin submits all the waiver claims for a year in either Q3 or Q4 only due to their processing cycle. The first submission is Q3 2000. This file will probably have some, but not all waiver claims for 1999.
	Eligibility	CHIP Code	Effective Q2 FY 2001, Wisconsin began to cover adults under its CHIP program. M-CHIP adults are reported into MAS/BOE 55. M-CHIP adult counts in MSIS are lower than the SEDS counts because BadgerCare adults with income <100 percent FPL (state group GP) are not considered to be M-CHIP enrollees in MSIS. Wisconsin reported a small number of M-CHIP children until FY1999 Q3, when enrollment increased substantially. M-CHIP children are reported under MAS/BOE 54, since they are part of the state's 1115 Badger Care demonstration. The state does not have a S-CHIP program.
		County Code	For about 10,000 eligibles, Wisconsin reports county codes other than the standard FIPS codes. These codes are for Relief to Needy Indian Person (RNIP) agencies, juvenile correction agencies, Division of Children and Family Services agencies, and Katie Beckett eligibles. Detailed listing in anomaly section.
		Dual Eligibility Flag	Wisconsin assigned dual flag 08 to about 25% (26,000 persons) of its dual population, a higher proportion than expected. Effective Q1 FY 2003, Wisconsin assigned dual code 09 to persons in its Pharmacy Plus Program not qualifying under other dual codes. In addition some disabled duals in MAS/BOE 32 may have full Medicaid benefits. They are in waiver programs allowing them to pay premiums for full Medicaid coverage.
		Health Insurance	Wisconsin reported about 16 percent of its eligibles with private health insurance, which is somewhat higher than other states report. The state has confirmed that this proportion is correct. Effective September, 2002, the proportion increased even more, with the implementation of the Pharmacy Plus Program.

State	File	Record Type	Issue
WI	Eligibility	Managed Care	Each month, several thousand SSI eligibles receive Plan Type 08. These eligibles are enrolled in a voluntary managed care program in Milwaukee County called "The Independent Care Plan" or "iCare." The plan provides medical and social services to individuals with physical, developmental, or emotional disabilities and can also take care of short-term physician-ordered nursing home stays with prior written approval. These stays are typically for rehabilitative purposes. This plan is reported as an HMO in CMS managed care data. A large HMO was terminated in April 2000, causing over 30,000 enrollees to switch to FFS. In June and July 2000, these eligibles enrolled in another HMO.
		MAS/BOE	Beginning in Q3 99, Wisconsin starts to show substantial enrollment for M-CHIP children (MAS/BOE 54) in its 1115 Badger Care program. Enrollment for adults in MAS/BOE 55 generally starts in Q499. Beginning in Q3 99, Wisconsin starts to show substantial enrollment for M-CHIP children (MAS/BOE 54) in its 1115 Badger Care program. Enrollment for adults in MAS/BOE 55 generally starts in Q499. Effective Q2 FY 2001 M-CHIP adults are also reported to MAS/BOE 55. Wisconsin has a state-administered SSI supplement program, which explains why the counts in MAS/BOE 11 - 12 are higher than the number of federal SSI recipients. Effective September 2002, Wisconsin implemented an 1115 SeniorCare program (Pharm Plus) extending prescription drug benefits to low income aged with an income <200% FPL not otherwise qualified for full Medicaid benefits. Wisconsin also has another waiver reported to MAS/BOE 54 - 55 extending FP benefits, effective Q2 FY 2003.
		Race Code	Through Q2 FY 2002, a third of Wisconsin's Medicaid population had the race field coded as "unknown." The proportion is down to one quarter by Q4 FY 2002.
		Restricted Benefits	Wisconsin assigned Restricted Benefits Flag 5 ("other") to enrollees who are infected with TB and eligible for TB-related services only. These persons are assigned state-specific eligibility code TR and are mapped to MAS/BOE 44 - 45. Beginning in September 2002, Flag 5 was also assigned to prescription drug only enrollees in MAS/BOE 51. Beginning in January 2003, Restricted Benefits Flag 5 will be assigned to enrollees of the Family Planning Waiver, who will be mapped to MAS/BOE 54 - 55.

State	File	Record Type	Issue
WI	Eligibility	SSN	Wisconsin 8-fills SSN field when the recipient is assigned a pseudo-MSIS ID. This explains the larger-than-expected number of persons with 8-filled SSNs. The state assigns permanent SSNs and MSIS IDs in the next quarter, using a retroactive change.
		TANF/1931	Wisconsin is unable to identify TANF recipients. The field is 9-filled for all eligibles.
		Waiver	WI says that they will be unable to report waiver enrollment in the MSIS EL files until 2007. CMS has requested that they start in FFY 2005.

State	File	Record Type	Issue
WV	Claims	All	There was a major system change that affected the Q4 1999 files. West Virginia expects to fix shortfalls in subsequent quarters.??Did they fix this??
			Due to billing cycles, files contain some claims from months prior to the quarter and there is a "shortfall" (fewer than expected records) in the last month of the quarter. This also results in very uneven number of claims submitted in each quarter of the MSIS claims files. Major system changes are needed to correct this problem.
			WV did not process any crossover claims from July 2004 - March 2005 due to a system change. Those 'lost' crossover claims will be included in the Q3 2005 MSIS files.
		Capitation	The 1999 and 2000 files do not contain individual HMO capitation claims.
		Crossovers	WV did not process any crossover claims from July1, 2004 to March 2005 as they were changing systems. These missing crossover claims should be included in the 2005 Q3 files.
		IP	There are no claims with Program Type of 2 (Family Planning).
		LT	The percent of claims paid per month were especially uneven - also due to system change. Claims are generally paid once a month, but any particular month's payments schedule can slip into the next month. ??for what time period??
			Diagnosis codes 1 to 5 are missing on most claims.
			There aren't any claims with a Type of Service of 02 (Mental Hospital Services for the Aged).
		OT	The West Virginia system change affected the Q4 1999 average Medicaid Amount Paid. ??how??
			None of the OT claims have state-specific Service Codes.
			UB-92 Revenue Codes are not available for Q2 1999 and mostly missing in Q3 FY 1999.
			There is a big increase in the number of FFS claims in Q3 2000.
			The Place of Service of ER under-reported until Q4 1999.
			In the Q1 FY 1999 file, there are 11 claims flagged as capitation payments that are actually service tracking claims; these claims have an average Medicaid Amount Paid of $1.3 million.
		RX	There are claims with Program Type of 2 (Family Planning) in Q1 to Q4 1999, but not after, due to a system change.

State	File	Record Type	Issue
WV	Claims	RX	Other Third Party Payment (or Third Party Liability/TPL) is missing on all claims.
			Prescribing Physician ID Number is missing on all claims.
	Eligibility	CHIP Code	West Virginia's M-CHIP enrollment phased out at the end of FY 2000, as West Virginia moved to become an S-CHIP only state.
			West Virginia first reported its M-CHIP enrollment in June 1999. The state does not report its S-CHIP enrollment.
		County Code	West Virginia correctly used FIPS for the county codes in Q1 to Q2 FY 1999. In Q3 to Q4 FY 1999, however, the state incorrectly used a state-specific county code. The state used FIPS codes in FY 2000.
		Dual Eligibility Flag	Until Q1 FY03, approximately 75 percent of dual eligibles were coded with dual flag 09. The state was able to identify these individuals as dual eligibles, but could not determine the basis of their dual eligibility. Effective Q1 FY03, all full benefit duals went to dual code 08.
			No dual codes 04 or 06 were reported in MSIS through Q1 FY04. SLMB only and QIs will not be in the system until FY06.
		Health Insurance	From October 1998 to May 1999, no one was reported to have any private health insurance. Beginning in June 1999, between four and five percent of eligibles are reported as having private health insurance.
			MSIS data show a 17 percent increase in the number of enrollees with private health insurance from November 2001 to December 2001. The state believes this data to be correct. In Q1 FY03, private insurance coverage increased. Two factors were involved: (1) the state moved to a new contractor, Unisys, and (2) the Q1 FY03 file was delayed in getting approved, so more retroactive changes may have occurred.
		Managed Care	Because a managed care contract expired at the end of October 1999, managed care enrollment dropped off beginning in November 1999.
			In Q1 FY03, PCCM enrollment dropped by about 10% (cause unknown).
			West Virginia began to use a new set of managed care plans Ids in June 1999.
			In September 1999, 728 enrollees had the managed care plan type field 9-filled by mistake.

State	File	Record Type	Issue
WV	Eligibility	MAS/BOE	Medicaid enrollment declined by about 30,000 persons from October 1998 to November 1998. Enrollment fell in most MAS/BOE groups, but fell most dramatically in MAS/BOE 34.
			In FY 2001 and FY 2002, West Virginia mistakenly mapped 15- to 18-year-olds in state-specific eligibility groups FCDC and FCSC to MAS/BOE 35. These individuals should have been mapped to MAS/BOE 34.
			Enrollment in MAS/BOE 11 and 12 is about 15 percent higher than the number of SSI recipients reported by SSA. This may be caused by persons receiving state supplemental SSI benefits for special needs administered by the state. The state also appears to report most disabled, 65+ years to MASBOE 11. In addition, it was determined in FY03 that WV had been including some aged nursing home enrollees in MASBOE 11 by mistake. This was corrected in Q1 FY03, causing enrollment in MASBOE 11 to drop, with an increase in MASBOE 41.
			Beginning in Q3 FY 2001, West Virginia assigned state code RDF and RDFQ to women in the breast and cervical cancer program (BCCP). However, these eligibles were erroneously mapped to MAS/BOE 35 through Q4 FY 2002.
			Beginning in Q4 FY 2001, West Virginia decided to change how eligibility for children was determined to insure that all children receive a 12-month continuous enrollment guarantee. This change resulted in a substantial enrollment shift from MAS/BOE 14 and 16 to MAS/BOE 34.
			Between the end of FY 2000 and the beginning of FY 2001, West Virginia slightly adjusted their age sort for BOE 4 and BOE 5.
			West Virginia reported a higher than expected (roughly 5%) number of eligibles in BOE 1 who are under age 65. The state believes this is caused by reporting all the persons in long-term care and QMB-only to BOE 1. This policy was corrected beginning in September 2002 data.
		MASBOE	In Q1 FY03, WV began using a new set of state specific eligibility codes as it moved from ACS to a new MMIS contractor, Unisys.
			In Q1 FY03, aged nursing home recipients previously mapped to MASBOE 11 were moved to MASBOE 41.
		TANF/1931	Effective FY 2001, the TANF flag is 9-filled for all eligibles. In FY 1999 and FY 2000, the TANF flag was 9-filled for all eligibles in MAS/BOE 14 - 15. All other eligibles, including those in MAS/BOE 16 - 17, received TANF flag 1, indicating that they did not receive TANF benefits.

State	File	Record Type	Issue
WY	Claims	Capitation	There aren't any capitation claims as Wyoming doesn't have managed care.
		IP	The percent of claims without an accommodation code jumped from 0 percent to 8 percent in Q1 2003.
			Wyoming does not use DRGs for reimbursement.
		LT	There aren't any claims for Type of Service 02 (Mental Hospital for the Aged).??KFF says WY covers this but not IP Psych <22
			Diagnosis Codes are missing on most records prior to Q2 2004.
			The Admission Date is missing frm 1999-2002.
	Eligibility	CHIP Code	Wyoming, which has an S-CHIP program, but not an M-CHIP program, is not reporting its S-CHIP eligibles into MSIS.
		Dual Eligibility Flag	In Q1 to Q3 FY 2002, Wyoming had a lower than expected proportion of Dual Eligibles with valid HIC numbers. The state fixed the problem in Q4 FY 2002.
			From Q1 FY 1999 to Q3 FY 2001, Wyoming assigned dual flag 09 to about 35 percent of its dual population, a higher proportion than expected. Beginning in FY 2001Q4, the state had system enhancements, which allowed them to identify most persons this population as SLMB+ (dual flag = 04).
			In FY03, WY assigned <200 persons to dual code 99 each month. These are persons over age 65 whose eligibility for Medicare could not be confirmed by the state.
		Managed Care	Wyoming has no managed care.
		MAS/BOE	In Q4 FY 2002 and FY03, 1400 enrollees in state group B05 (non-Medicaid Breast & Cervical Cancer program) were assigned to MAS/BOE 35. They should have been assigned MAS/BOE 00. In addition, some individuals in state group D05 (maternal dental care) were mapped to MAS/BOE 51 in error. They should have been mapped to MAS/BOE 00, since this is a state-funded program. Finally, persons in state group B03 and B04 should be mapped to MASBOE 3A, not MASBOE 35.
			In Q1 FY04, WY decided to shift newborn children (state group A53) from MASBOE 34 to MASBOE 44. In addition, the state implemented some improved age sorts for groups mapped to MASBOE 34-35. Finally, the problem related to BCCPTA enrollees was corrected.
			Also, effective Q1 FY04, ACS became the WY MMIS contractor.

State	File	Record Type	Issue
WY	Eligibility	Private	The number of enrollees with private insurance increased in Q4 FY 2002, apparently because the file was submitted later than usual, and more data had become available at the time of submission. In FY03 and FY04, reported private insurance declined.
		TANF/1931	Wyoming TANF data are not reliable. The state began 9-filling the TANF flag in Q1 FY04.