EXHIBIT 51. Service Categories Used to Adjust FY 2022 Medicaid Benefit Spending in T-MSIS to Match CMS-64 Totals

Service category	T-MSIS service types[1]	CMS-64 service types
Hospital	• Inpatient hospital • Outpatient hospital, including mental health other than outpatient substance abuse treatment • Emergency hospital • Critical access hospital • Skilled care, exceptional care, and non-acute care—hospital residing • Electronic health record (EHR) payments to provider (on hospital claim)	• Inpatient hospital non-DSH • Inpatient hospital non-DSH supplemental payments • Inpatient hospital GME payments • Outpatient hospital non-DSH • Outpatient hospital non-DSH supplemental payments • Emergency services for aliens[2] • Emergency hospital services • Critical access hospital base and supplemental payments
Non-hospital acute care	• Rural health clinic • Laboratory • Radiology • EPSDT • Family planning • Physician • Dental • Outpatient substance abuse treatment • Other practitioner • Home health—supplies, equipment, and appliances • Private duty nursing • Nursing, including advanced practice, pediatric, nurse-midwife, and nurse practitioner • Respiratory care for ventilator-dependent individuals • Clinic • Physical, occupational, speech, and hearing therapy • Over-the-counter medications (not on pharmacy claim) • Dentures • Medical equipment and prosthetics (not on pharmacy claim) • Eyeglasses • Hearing aids • Diagnostic and screening services • Preventive services • Well-baby and well-child services • Rehabilitative services • Targeted case management • Other case management • Care coordination • Transportation • Enabling services • Sterilizations	• Physician (including primary care physician payment increase) • Physician services supplemental payments • Preventive services with USPSTF Grade A or B and ACIP vaccines • Dental • Nurse-midwife • Nurse practitioner • Other practitioner • Other practitioner supplemental payments • Non-hospital clinic base and supplemental payments • Rural health clinic • Federally qualified health center • Laboratory and radiology • Sterilizations • Abortions • Hospice • Targeted case management • Statewide case management • Physical therapy • Occupational therapy • Services for speech, hearing, and language • Non-emergency transportation base and supplemental payments • Private duty nursing • Rehabilitative services (non-school based) • School-based services • EPSDT screenings • Diagnostic screening and preventive services • Prosthetic devices, dentures, eyeglasses • Freestanding birth center • Health home with chronic conditions • Health home for enrollees with substance use disorder • Tobacco cessation for pregnant women

EXHIBIT 51. (continued)

Service category	T-MSIS service types[1]	CMS-64 service types
Non-hospital acute care (continued)	• Prenatal care and prepregnancy family planning • Other pregnancy-related procedures • Hospice • Disposable medical supplies • Indian Health Service—family plan • Religious non-medical health care institutions • EHR payments to provider in outpatient setting (not on hospital claim) • COVID-19 in vitro diagnostic products or testing-related services • Medication assisted treatment (MAT) and drugs for evidenced-based treatment of Opioid Use Disorder (OUD) (not on a pharmacy claim) • Residential pediatric recovery center • Other care	• COVID-19 vaccines and administration • MAT treatment services for OUD • Qualified community-based mobile crisis intervention • Care not otherwise categorized
Drugs	• Prescribed drugs • Over-the-counter medications (on a pharmacy claim) • Medical equipment and prosthetic (on a pharmacy claim) • EHR payments to pharmacy provider • MAT and drugs for evidence-based treatment of OUD (on a pharmacy claim)	• Prescribed drugs • Drug rebates (national, state sidebar, ACA offset—fee for service) • MAT drugs for OUD • MAT drug rebates (national, state sidebar, ACA offset—fee for service)
Managed care and premium assistance	Claim type 2 (capitated payment) or type of service: • Capitated payments to comprehensive risk based managed care plans (HMO, HIO, PACE) • Capitated payments to PHP • Capitated payments for PCCM • Premium payments for private insurance • Per member, per month (PMPM) payments for health home services; Medicare Parts A, B, or D premiums; Medicare Advantage dual special needs plans • PMPM payments for other payments	• MCO (i.e., comprehensive risk-based managed care) • MCO drug rebates (national, state sidebar, ACA offset—MCO) • MCO MAT drug rebates (national, state sidebar, ACA offset—MCO) • PACE • PAHP • PIHP • PCCM • MCO, PAHP, and PIHP payments associated with the primary care physician payment increase, Community First Choice option, certified community behavioral health clinic, preventive services with USPSTF Grade A or B, ACIP vaccines, certified community behavior health clinics, and services subject to electronic visit verification requirements • Premium assistance for private coverage

EXHIBIT 51. (continued)

Service category	T-MSIS service types[1]	CMS-64 service types
LTSS non-institutional	Type of service: • Home health, including nursing; home health aide; and physical, occupational, speech, and hearing therapy • Personal care • Residential care • HCBS waiver • Payments to individuals for personal assistance services under 1915(j) Or program type: • HCBS waiver • Balancing incentive payment • HCBS—1915(i) • HCBS—1915(j) • HCBS—1915(k) Or Title XIX service code is one of the LTSS non-institutional CMS-64 service types	• Home health • Personal care • Personal care—1915(j) • HCBS waiver • HCBS—1915(i) • HCBS—1915(j) • HCBS—1915(k) • Certified community behavior health clinic
LTSS institutional	• Nursing facility • Inpatient hospital and nursing facility services for individuals age 65 and older in institution for mental disease (IMD) • Intermediate care facility • Inpatient psychiatric or skilled nursing facility for individuals under age 21 • Inpatient and residential substance abuse treatment • EHR payments to LTSS institutional provider • Inpatient psychiatric services for beneficiaries ages 22 to 64 who receive services in an IMD	• Nursing facility • Nursing facility supplemental payments • ICF/ID • ICF/ID supplemental payments • Mental health facility for individuals under age 21 or age 65 and older, non-DSH
Medicare[3,4]		• Medicare Part A and Part B premiums • Medicare coinsurance and deductibles for QMBs

Notes: FY is fiscal year. T-MSIS is Transformed Medicaid Statistical Information System. DSH is disproportionate share hospital. GME is graduate medical education. EPSDT is early and periodic screening, diagnostic, and treatment. USPSTF is U.S. Preventive Services Task Force. ACIP is Advisory Committee on Immunization Practices. MAT is medication-assisted treatment. OUD is opioid use disorder. ACA is the Patient Protection and Affordable Care Act (P.L. 111-148, as amended). HMO is health maintenance organization. HIO is health insuring organization. PACE is Program of All-Inclusive Care for the Elderly. PHP is prepaid health plan. MCO is managed care organization. PCCM is primary care case management. PAHP is prepaid ambulatory health plan (a type of PHP). PIHP is prepaid inpatient health plan (a type of PHP). HCBS is home- and community-based services. LTSS is long-term services and supports. ICF/ID is intermediate care facility for persons with intellectual disabilities. QMB is qualified Medicare beneficiary. Service categories and types reflect fee-for-service spending unless noted otherwise. Service types with identical names in T-MSIS and CMS-64 data may still be reported differently in the two sources due to differences in the instructions given to states; amounts for those that appear only in the CMS-64 (e.g., drug rebates) are distributed across Medicaid enrollees with T-MSIS spending in the relevant service categories (e.g., drugs).

EXHIBIT 51. (continued)

[1] Claims in T-MSIS include variables for claim type (e.g., fee for service, capitated payment), type of service (such as inpatient hospital, physician, personal care), program type (including HCBS waiver), and Title XIX service category code (corresponds to CMS-64 category). When classifying T-MSIS claims into service categories, we generally relied on type of service, with a few exceptions. We classified all claims with a claim type indicating a capitated payment as managed care regardless of the type of service associated with the claim. For non-institutional LTSS, we also included any claim with a program type indicating HCBS or a Title XIX service category code that matched the CMS-64 service types we selected for this category.

[2] Emergency services for non-qualified aliens are reported under individual service types throughout T-MSIS but primarily as inpatient and outpatient hospital. As a result, we include this CMS-64 amount in the hospital category.

[3] Medicare premiums are not reported in T-MSIS. We distribute CMS-64 amounts proportionately across dually eligible enrollees identified in the T-MSIS for each state.

[4] Medicare coinsurance and deductibles are reported under individual service types throughout T-MSIS. We distribute CMS-64 amounts for QMBs across CMS-64 spending in the hospital, non-hospital acute, and LTSS institutional categories before calculating state-level adjustment factors based on the distribution of Medicare cost sharing for hospital, Part B, and skilled nursing facility services among QMBs using 2020 Medicare data. See MedPAC and MACPAC, 2024, Table 5: Fee-for-service Medicare Part A and Part B cost sharing incurred by dual-eligible and non-dual Medicare beneficiaries (dollars in billions), CY 2021, in Data book: Beneficiaries dually eligible for Medicare and Medicaid, Washington, DC: MedPAC and MACPAC, https://www.macpac.gov/wp-content/uploads/2024/01/Jan24_MedPAC_MACPAC_DualsDataBook-508.pdf.

Source: MACPAC, 2024, analysis of T-MSIS and CMS-64 financial management report net expenditure data.

Understanding Managed Care Enrollment and Spending Data

There are four main sources of data on Medicaid managed care available from CMS.

Medicaid Managed Care Enrollment and Program Characteristics Report

The Medicaid Managed Care Enrollment and Program Characteristics Report provides state-reported aggregate enrollment statistics and other basic information for each managed care plan within a state. This report is the source of information on Medicaid managed care most commonly cited by CMS as well as by outside analysts and researchers.

T-MSIS

T-MSIS provides person-level and claims-level information for all Medicaid enrollees. For managed care, T-MSIS claims include records of each capitated payment made on behalf of an enrollee to a managed care plan (generally referred to as capitated claims) as well as records of each service received by the enrollee from a provider under contract with a managed care plan (which may be referred to as encounter or so-called dummy claims). All states collect encounter data from their Medicaid managed care plans, and CMS is working with states so these data are reported into T-MSIS. Managed care enrollees may also have FFS claims in the T-MSIS if they used services beyond those covered by a managed care plan's contract with the state.

CMS-64

The CMS-64 financial management report provides aggregate spending information for Medicaid grouped into major benefit categories, including managed care. The spending amounts reported by states on the CMS-64 are used to calculate their federal matching dollars.

SEDS

The SEDS provides aggregate statistics on CHIP enrollment and child Medicaid enrollment that include the number of individuals covered under FFS and managed care systems. The SEDS is currently the primary source of information on managed care participation among separate CHIP enrollees across states. However, states can submit information on separate CHIP into T-MSIS, so T-MSIS may become another source of information on separate CHIP in the future.