EXHIBIT 49. MACPAC Assignment of T-MSIS Eligibility Groups

MACPAC group	T-MSIS eligibility code	Age
Child	06, 07, 08, 28, 29, 30, 31, 54, 55	Any age
	01, 02, 03, 04, 14, 27, 32, 33, 35, 36, 56, 69, 70, 71, 76	Age under 19 years
New adult group[1]	72, 73, 74, 75	Any age
Other adult[2]	05, 09, 34, 53	Any age
	01, 02, 03, 04, 27, 33, 35, 36, 56, 70	Age 19 and older
	32, 69, 71, 76	Age 19–64
Disabled	11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 59, 60	Age under 65 years (age 19–64 for code 14)
Aged	11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 32, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 59, 60, 69, 71, 76	Age 65 and older

Notes: T-MSIS is Transformed Medicaid Statistical Information System. Excludes individuals enrolled in CHIP-financed Medicaid coverage (e.g., Medicaid-expansion CHIP) when the CHIP code indicates separate or Medicaid-expansion CHIP (values of 2 or 3) or the T-MSIS eligibility code is 61–68.

[1] Includes both newly eligible and not newly eligible adults who are eligible under Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (the Act). Newly eligible adults include those who were not eligible for Medicaid under the rules that a state had in place on December 1, 2009. Not newly eligible adults include those who would have previously been eligible for Medicaid under the rules that a state had in place on December 1, 2009; this includes states that had already expanded to adults with incomes greater than 100 percent of the federal poverty level as of March 23, 2010, and receive the expansion state transitional matching rate.

[2] Includes adults under age 65 who qualify through a pathway other than disability or Section 1902(a)(10)(A)(i)(VIII) of the Act (e.g., parents and caretakers, pregnancy).

Source: MACPAC, 2025, analysis of T-MSIS data.

We used additional variables to categorize managed care and non-institutional LTSS claims. We assigned any claim classified as a capitation payment (claim type 2) as managed care regardless of the type of service assigned to the claim.

Beginning in 2025, we implemented a new method for classifying a claim as non-institutional LTSS (Exhibit 51). Building on recent MACPAC work to compare different approaches to identify home- and community-based services (HCBS) and to calculate HCBS spending and utilization, we adapted the methodology developed for CMS's LTSS Expenditures and Users Reports and KFF State Health Facts (MACPAC 2025, 2024; Stepanczuk et al. 2024; Chidambaram and Burns 2023). To identify HCBS claims, we started with the approach used in the TAF-based LTSS Expenditure and User Reports to determine whether a claim was paid for by an HCBS authority (i.e., Sections 1915(c), 1915(i), 1915(j), and 1915(k) of the Act) (Stepanczuk et al. 2024). We relied on the claim's program type, waiver type, HCBS service type, or benefit type. Because what a state reports in these four data elements can conflict, we employed a hierarchical approach tested and validated by the LTSS Expenditure and User Reports, which prioritize the program type code found on the claim, followed by the waiver type code, HCBS service code, and benefit type code. For four states without Section 1915(c) waivers—Arizona, New Jersey, Rhode Island, and Vermont—we adapted the KFF State Health Facts methodology to identify claims under their Section 1115 demonstrations (Chidambaram and Burns 2023). Furthermore, we used HCBS taxonomy to isolate these Section 1115 demonstration claims to HCBS (Rooney et al. 2023). For more information on the various methodological approaches to identifying HCBS users and expenditures, please see MACPAC's publication on *Methodological Approaches for Analyzing Use and Spending in Medicaid Long-Term Services and Supports: A Comparative Review* (MACPAC 2024).