EXHIBIT 51. Service Categories Used to Adjust FY 2023 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	• 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

EXHIBIT 51. (continued)

Service category	T-MSIS service types[1]	CMS-64 service types
Non-hospital acute care (continued)	• Sterilizations • 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	• Health home for children with medically complex conditions • Tobacco cessation for pregnant women • 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, 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	Based on the following hierarchy: 1) Program type: • HCBS waiver • HCBS—1915(i) • HCBS—1915(j) • HCBS—1915(k) 2) If program type is missing waiver type: • 1915(c) waiver (values 06–20) • 1115 managed LTSS or other demonstration in Arizona, New Jersey, Rhode Island, and Vermont* 3) If program type and waiver type are missing, HCBS service code: • 1915(c) • 1915(i) • 1915(j) • 1915(k) 1115 waiver in Arizona, New Jersey, Rhode Island, and Vermont* 4) If program type, waiver type, and HCBS service code are missing, benefit type is: • Self-directed personal assistance under 1915(j) Community First Choice 1915(k) 5) If all variables above are missing, 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) * For Arizona, New Jersey, Rhode Island, and Vermont, a claim selected using waiver type or HCBS service code must also have at least one line with a procedure code mapped to a HCBS taxonomy in CMS's Data Quality Atlas methodology brief no. 7061.	• Home health • Personal care • Personal care—1915(j) • HCBS waiver • HCBS—1915(i) • HCBS—1915(j) • HCBS—1915(k) • Certified community behavior health clinic

EXHIBIT 51. (continued)

Service category	T-MSIS service types[1]	CMS-64 service types
LTSS institutional	• Nursing facility • Inpatient hospital and nursing facility services for individuals age 65 and older in an 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 • Intermediate care facility for persons with intellectual disabilities • Intermediate care facility for persons with intellectual disabilities 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).

[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 select 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.

Sources: MACPAC, 2025, analysis of T-MSIS and CMS-64 financial management report net expenditure data. Greener, E., A. Carpenter, and L. Nolan. 2023. *Identifying enrollees who use home and community-based services in the TAF* (TAF DQ brief #7061). Baltimore, MD: CMS and https://www.medicaid.gov/dq-atlas/downloads/supplemental/HCBS-In-TAF-Supplement.xlsx.