Identifying Home and Community-Based Services and the Enrollees Who Use Them in the TAF

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TAF Methodology Brief

Summary

- Home and community-based services (HCBS) provide opportunities for Medicaid enrollees to receive services that help them conduct routine activities of daily living in their own home or community, rather than in institutions or other isolated settings. Each state and HCBS program has its own rules for eligibility and coverage, and serves a variety of enrollees covered by Medicaid, including frail older adults and enrollees of all ages with intellectual or developmental disabilities, physical disabilities, and behavioral health conditions.
- HCBS can involve various funding mechanisms and differing eligible populations and services. As a result, identifying HCBS claims in the Transformed Medicaid Statistical Information System Analytic File (TAF) is not straightforward.
- This brief explains (1) how to identify claims for HCBS categories in the TAF, (2) how to discern between HCBS provided by an HCBS program and HCBS provided as a State Plan benefit, and (3) how to identify enrollment in specific HCBS programs.

Background

Home and community-based services (HCBS) are a type of long-term services and supports (LTSS) provided in an enrollee's home or community rather than in an institutional care setting. LTSS include medical and personal care provided to people with cognitive, mental, or physical disabilities and other conditions, and they help people live in the community safely. These services help people conduct routine activities of daily living, from assistance with shopping to toileting to eating. Without this help, they would need to live in an institutional setting rather than at home or in the community (Medicaid.gov n.d.[a]). In recent decades, Medicaid policy changes have reflected the effort to shift state LTSS systems toward HCBS rather than LTSS provided in institutional settings (Murray et al. 2021). With this shift in focus has come greater interest in analyzing the HCBS provided through Medicaid.

HCBS financed by Medicaid can be funded through program waivers, through the State Plan, or as part of optional Medicaid programs and demonstrations. This variety of options contributes to much of the variability by state. States often choose to provide HCBS through a waiver authority because of the flexibility those authorities provide. Specifically, states can

choose which populations are eligible for services, limit the number served, establish eligibility criteria, and determine which services are offered for each HCBS waiver (Medicaid and CHIP [Children's Health Insurance Program] Payment Access Commission n.d.). State Plan HCBS benefits are provided under a state's Medicaid plan, rather than through a specific HCBS program (42 CFR § 440.182).

The Centers for Medicare & Medicaid Services (CMS) developed an HCBS taxonomy for the Medicaid Analytic eXtract (MAX) data system, the predecessor to the Transformed Medicaid Statistical Information System (T-MSIS) Analytic File (TAF), in an effort to standardize HCBS research. Specifically, the taxonomy was developed to classify services provided under Section 1915(c) waiver programs. However, the HCBS taxonomy can also be used more broadly to make it easier to assess and identify state-level variation in HCBS use (Peebles and Bohl 2014).

This brief provides a methodology, adapted from the MAX HCBS taxonomy, for identifying claims for 13 HCBS categories. The brief also presents a methodology for identifying participants in various HCBS programs. Some HCBS categories could be covered under several different HCBS programs—for example, a state could elect to cover personal care services as (1) an optional State Plan benefit available to all enrollees who need these services, (2) through a specific Section 1915(c) waiver program focusing on a specific population, or (3) as an optional Section 1915(k) program also known as Community First Choice (CFC) programs. Table 1 describes the HCBS categories and example services in each category, and Table 2 provides a list and brief descriptions of Medicaid HCBS programs. The appendix lists the TAF variables that can be used to identify HCBS claims, HCBS provided by particular HCBS programs, and enrollee participation in specific HCBS programs.

Table 1. HCBS categories and examples of services

Service category	Examples of services
Home-based services	• Home health aide • Personal care services • Chore services • Companion care • Domiciliary or rest home visits • Therapeutic services
Case management services	• Case management (can include enrollees with either state plan targeted case management or statewide case management) • Targeted case management • Coordinated care
Nursing services	• Private duty nursing • Skilled nursing
Round-the-clock services	• Group living • Supported housing • Adult foster care • Therapeutic child foster care • Assisted living

Table 1 (*continued*)

Service category	Examples of services
	• Residential care
Supported employment services	• Ongoing support to maintain employment • Supported employment habilitation
Day services	• Specialized childcare • Day habilitation • Adult day care services
Home-delivered meal services	• Home-delivered meals, including preparation
Caregiver support services	• Respite care services • Family training and counseling
Services supporting participant-directed services	• Financial management • Supports brokerage
Participant training	• Home care training • Medication training and support
Nonmedical transportation	Transportation to nonmedical community services and support, such as the following: • Adult day programs • Shopping • Activities for community integration • Nonmedical therapeutic sessions
Community transition services	Nonrecurring expenses that enable Medicaid enrollees who are transitioning from a nursing facility or other institutional setting to the community to establish a basic household but that do not constitute room and board
Technical modifications or equipment	• Home modifications • Utility services • Vehicle modifications • Electronic medication compliance management device • Emergency response system

Source: HCBS taxonomy; LTSS expenditures report; 42 C.F.R. § 440.182.

Note: These service modalities were derived from the HCBS taxonomy, which was developed for the MAX data system, and from the services categorized in the Medicaid Long-Term Services and Supports Expenditures Report (Murray et al. 2021). These service categories are meant to represent common categories or types of HCBS; they are not meant to be an exhaustive list of HCBS. Different users of the TAF data may have different definitions of which services constitute HCBS.

HCBS = home and community-based services; LTSS = long-term services and supports; MAX = Medicaid Analytic eXtract.

Table 2. Medicaid HCBS programs

HCBS program	Description
1915(c) Home and Community-Based Waivers	Section 1915(c) waivers allow states to adjust program offerings to meet enrollee needs in their home or community rather than in institutional care settings. States can waive certain Medicaid program requirements to provide care for people who might not otherwise be eligible under Medicaid. Separate waivers are required for each eligible population, so states often operate multiple waivers under 1915(c) authority to target services to specific populations who need LTSS.
1915(i) State Plan Home and Community-Based Services	States can offer a variety of services under the 1915(i) State Plan HCBS benefit, while restricting the benefits to enrollees who meet state-defined criteria based on need and who typically receive a combination of acute-care medical services (such as dental services or skilled nursing services) and LTSS (such as respite, case management, supported employment, and environmental modifications) in HCBS settings. Unlike 1915(c), 1915(i) permits states to serve enrollees who do not require an institutional level of care. Although Medicaid does not typically fund institutional care for non-elderly adults with mental health or substance use disorders (behavioral health conditions), enrollees with behavioral health conditions can receive assistance through 1915(i) because the program does not require states to show that HCBS provision reduces Medicaid's institutional care costs. Under 1915(i), adults with behavioral health conditions qualify for HCBS, even though the Institutions for Mental Disease exclusion barred Medicaid from covering their institutional care.
1915(j) Self-Directed Personal Assistance Services Under State Plan	Self-directed personal assistance services are personal care and related services provided under the Medicaid State Plan and/or Section 1915(c) waivers that the state already has in place. Participants set their own provider qualifications, train their personal assistance providers, and determine how much they pay for a service, support, or item. With the state option, 1915(j) enrollees can do the following: • Hire legally liable relatives (such as parents or spouses) • Manage a cash disbursement • Purchase goods, supports, services, or supplies that increase their independence or substitute for human help • Use a discretionary amount of their budget to purchase items not otherwise listed in the budget or reserved for permissible purchases
1915(k) Community First Choice	This State Plan option, established under the Affordable Care Act of 2010 (ACA), allows states to provide HCBS and supports to eligible Medicaid enrollees. 1915(k) CFC gives states another avenue through which they can provide people with personal attendant services to help with activities of daily living.
Section 1115 Demonstrations	Section 1115 demonstrations provide states with a flexible option for administering HCBS programs. Under Section 1115 authority, states can do the following: • Determine target groups and define their own eligibility criteria • Define eligible categories and expand eligibility • Set eligibility requirements for services • Decide what services are covered (subject to CMS approval)
Money Follows the Person (MFP)	The MFP demonstration, which focuses on helping Medicaid enrollees transition from institutional care to HCBS, provides states with enhanced federal matching funds for HCBS and supports state efforts to rebalance their LTSS system so that people have a choice of where they live and receive services.
Program of All-Inclusive Care for the Elderly (PACE)	PACE provides comprehensive medical and social services to certain elderly, frail, community-dwelling enrollees, most of whom are dually eligible for Medicare and Medicaid benefits. In fact, it is the comprehensive service packaged provided by PACE that makes it a good option for dually eligible individuals. This service package enables most enrollees to remain in the community, instead of receiving care in an institution. Day services are a defining feature of the PACE program, wherein people receive daily services without needing institutional care.

Table 2 (*continued*)

HCBS program	Description
	Although PACE is officially a program under Medicare, PACE services can be provided to Medicaid enrollees as an optional state Medicaid benefit. In that case, the PACE program becomes the sole source of Medicaid and Medicare benefits for PACE participants. People are eligible for PACE if they meet the following criteria: • Are age 55 or older • Live in the service area of a PACE organization • Need a nursing home level of care need • Can live safely in the community
Health Homes Program	The ACA created an optional Medicaid State Plan benefit that provides care coordination for Medicaid enrollees who have chronic conditions. Health Homes Program providers operate under a whole-person philosophy by integrating and coordinating all primary, acute, behavioral health, and LTSS to treat the whole person. Program eligibility can depend on a variety of factors, including the presence of chronic conditions, but many programs focus on enrollees with serious and persistent behavioral health needs. Services provided through the Health Homes Program include the following: • Comprehensive care management • Care coordination • Health promotion • Comprehensive transitional care and follow-up • Patient and family support • Referral to community and social support services
State Plan HCBS[a]	HCBS are provided under the State Plan and are made available to people who are otherwise eligible for coverage under that plan. The State Plan HCBS benefit consists of one or more of the following services: • Case management services • Homemaker services • Home health aide services • Personal care services • Adult day health services • Habilitation services • Respite care services • Subject to the conditions in § 440.180(d)(2) for people with chronic mental illness: – Day treatment or other partial hospitalization services – Psychosocial rehabilitation services – Clinic services (whether or not furnished in a facility) • Other services requested by the agency and approved by CMS

Source: Medicaid.gov (n.d.[b]); 42 CFR § 440.182 (2014); Dorn et al. (2016).

[a] For the U.S. statute on state plans, see https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-440/subpart-A/section-440.169

ACA = Affordable Care Act of 2020; CMS = Centers for Medicare and Medicaid Services; HCBS = home and community-based services; LTSS = long-term services and supports; MFP = Money Follows the Person; PACE = Program of All-Inclusive Care for the Elderly

Methods

This section explains how to use TAF data (1) to identify claims for HCBS, (2) to discern between HCBS provided through a program versus HCBS provided through the State Plan

benefit, and (3) to identify enrollee participation in an HCBS program. Due to the various funding mechanisms, differing eligible populations and services, and variation in state coding practices, identifying HCBS claims in the TAF is not straightforward. The level of state variation across these different dimensions suggests using broad criteria when trying to identify HCBS in the TAF, as that is most likely to work in most states. If users have specific states of interest, a narrower set of criteria might be more appropriate.

Identifying HCBS claims in the TAF

Identifying claims for HCBS in the TAF can be complicated because claims for HCBS are not often labeled as such and there are state-level coding differences (Peebles and Bohl 2014). However, there are several TAF data elements in the other services (OT) claims file that TAF users can use to identify claims for HCBS: procedure code, type of service code, benefit type code, and federally assigned service category (FASC) code. The OT claims file includes claims for services rendered outside of inpatient hospitals and any of the institutional care settings included in the long-term care (LT) file and they exclude claims for prescription drugs. OT claims include both professional and institutional claims for outpatient services, physician services, laboratory and imaging services, home health services, HCBS, and dental services (CMS 2021). The file includes fee-for-service claims, managed care encounter claims, capitation payment records, service tracking claims, and supplemental payment claims for Medicaid and the Children's Health Insurance Program (CHIP)[1]. This section provides an overview of these data elements and discusses considerations for using each to identify HCBS.[2]

Most TAF users will want to take a multi-stage approach to identifying HCBS, relying first on procedure codes, and in some cases, on place of service codes, which are supplied by providers on their billing records. The OT claims also include other indicators populated by states during T-MSIS production. TAF users should consider applying a hierarchical approach to ensure that claims are not flagged as multiple HCBS categories (Table 3).

Table 3. Step-by-step process for identifying HCBS claims

Step	Description	Information source
1a.	Identify claims for HCBS using state-specific procedure codes	Providers populate procedure codes directly on claims
2b.	On remaining claims, use national procedure codes to identify HCBS claims, applying restrictions for type of service codes and benefit type codes	Providers populate procedure codes directly on claims
3.	On remaining claims, use type of service codes to identify HCBS claims	The state T-MSIS production system applies type of service codes to claims

[1] TAF users should restrict the OT file to fee-for-service (FFS) or managed care (MC) encounters claims using the claim type code (CLM_TYPE_CD), exclude denied claim lines using the claim line status code (CLL_STUS_CD), and exclude claims that were partially covered by Medicare (crossover claims) using the crossover claim indicator (XOVR_IND).

[2] Table 9 includes a list of TAF data elements and values that can be used to identify specific services in OT claims.

Table 3 (*continued*)

Step	Description	Information source
4.	On remaining claims, use benefit type codes to identify HCBS claims	The state T-MSIS production system applies benefit type codes to claims
5.	Identify claims using FASC code	The FASC code is created during the CMS TAF production process

Note: Federally assigned service category codes are available in the TAF OT claims file starting in 2020.

Procedure codes

Identifying claims for HCBS using procedure codes allows TAF users to take an approach that focuses on service utilization. The most reliable way to identify claims for specific services is to use procedure codes, include codes from the Healthcare Common Procedure Coding System (HCPCS), ICD-10 Procedure Coding System (ICD-10-PCS), or Current Procedural Terminology (CPT) code that describes a specific good or service delivered by a provider to an enrollee. Procedure codes are added to billing records by providers rendering services.

Procedure code modifiers provide additional details on a service that might not be available in the procedure code description. For example, modifiers can indicate whether a claim is for services such as occupational, speech, or physical therapy. Modifiers can also provide additional context; some state programs use modifiers to track specific services furnished through certain HCBS programs or waivers. Using procedure code modifiers coupled with place of service and type of service codes can help improve claim identification for specific services. The HCBS taxonomy code list developed for the MAX data contains a variety of procedure codes, including national HCPCS procedure codes, CPT procedure codes, and state-specific procedure codes. The code list also includes procedure code modifiers, place of service codes, and type of service codes that can be used to identify HCBS.

Place of service codes

TAF users may need additional context to determine whether a service identified by a procedure code is HCBS, such as where the service took place. In particular, case management, nursing, and therapeutic services such as physical or occupational therapy are not always considered HCBS, unless they are furnished in someone's home or a community setting. Table 4 provides examples of place of service code restrictions that TAF users might apply to HCBS claims, and the supplemental Excel file provides recommendations for procedure codes that require place of service code restrictions.[3]

[3] More information about this issue can be found in the TAF *DQ Atlas* topic-specific displays for Place of Service at https://www.medicaid.gov/dq-atlas/.

Table 4. HCBS place of service code restrictions

Place of service code	Place of service name	Place of service description
03	School	A facility whose primary purpose is education
04	Homeless shelter	A facility or location whose primary purpose is to provide temporary housing to individuals who are experiencing homelessness (for example, emergency shelters and individual or family shelters)
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence
13	Assisted living facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24/7, with the capacity to deliver or arrange for services, including some health care and other services
14	Group home	A residence with shared living areas where clients receive supervision and other services such as social or behavioral services; custodial services; and minimal services (for example, medication administration)
16	Temporary lodging	A short-term accommodation, such as a hotel, campground, hostel, cruise ship, or resort, where the patient receives care that is not identified by any other place of service code
55	Residential substance abuse treatment facility	A facility that provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care; services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board

Source: CMS.gov "Place of Service Code Set" (n.d.)

Note: For rehabilitative services, TAF users will want to restrict claims to those rendered in a non-school-based setting (that is, claims with a place of service code that is not "school"). If using the American Rescue Plan Act's definition of an eligible location for HCBS rehabilitative services and private duty nursing claims, TAF users will want to restrict claims to those rendered in a non-institutional setting (that is, exclude claims in which place of service = 55 - Residential substance abuse treatment facility).

Type of service codes

State Medicaid agencies are responsible for populating the type of service code on claim line records, which is an additional field specific to T-MSIS. States use the type of service code to classify individual services appearing on a claim into standard categories that map to benefit and provider definitions in the Code of Federal Regulations (CFR). Although most states submit valid type of service codes on nearly all claims, states differ in how they interpret and apply these code values, making it challenging to use type of service codes for comparisons across states.[4] Because of this state variation, TAF users should be very cautious when using the type of service data element to systematically identify a specific service across different states without including information from other fields, such as procedure codes. Table 5 shows examples of type of service codes that TAF users could use to identify HCBS claims.

[4] More information about this issue can be found in the TAF *DQ Atlas* topic-specific displays for Type of Service - OT at https://www.medicaid.gov/dq-atlas/.

Table 5. HCBS type of service codes

HCBS category	Type of service code and description
Home health services	016: Home health services – Nursing services 017: Home health services – Home health aide services 018: Home health services - Medical supplies, equipment, and appliances suitable for use in the home 019: Home health services - Physical therapy provided by a home health agency or by a facility licensed by the State to provide medical rehabilitation services 020: Home health services - Occupational therapy provided by a home health agency or by a facility licensed by the State to provide medical rehabilitation services 021: Home health services - Speech pathology and audiology services provided by a home health agency or by a facility licensed by the State to provide medical rehabilitation services 064: HCBS - Home health aide services 079: HCBS-65-plus - Home health aide services
Case management services	053: Targeted case management services
Nursing services	022: Private duty nursing services
Round-the-clock services	051: Personal care services
Non-medical transportation	056: Transportation Services

Source: RESDAC.org “Type of Service Code” (n.d.)

Notes: The supplemental Excel file contains procedure codes adapted from the MAX HCBS taxonomy and includes suggested restrictions for type of service codes.

Benefit type codes

Benefit type codes correspond to the service reported on the claim or encounter record. States add these codes, which are not required for payment, to claims during their T-MSIS production process. Because states add the codes through this secondary process, the codes are not considered as reliable as procedure codes and other data the provider populates on a bill.

TAF users should exercise caution when using benefit type codes because the data quality of the codes has not been explored in depth. TAF users interested in assessing services that map to specific benefit types in the Medicaid and CHIP Program Data System (MACPro) should verify the information in the benefit type code with a secondary field, such as procedure code or FASC code.

Form CMS-64 category of service codes

TAF users interested in mapping specific claims to Medicaid expenditures reported on the CMS-64 may wish to use the Form CMS-64 Category of Service for the Paid Claim (XIX_SRVC_CTGRY_CD) data element as a means of identifying claims for HCBS in the TAF.[5] However, TAF users should exercise caution when using this field because the data quality has not been explored in depth. The Title XIX service category code is not populated in encounter claims because managed care encounters are not reported on the CMS-64 form. TAF users wishing to use this field should ensure that (1) they are examining fee-for-service claims, (2) the field is well-populated for the states they want to examine, and (3) the information in XIX_SRVC_CTGRY_CD is consistent with what is reported in the type of service code.

Federally assigned service category codes
FASC codes are a new variable added to the TAF after 2020. Developed to help overcome the limitations of type of service codes, FASC codes are derived from data elements that providers code directly on their bills, rather than information that states add to the records before submitting to T-MSIS. TAF users interested in HCBS more generally, as opposed to exploring specific HCBS categories, might find this data element helpful. But TAF users interested in specific HCBS categories might find this data element to be too broad and should consider incorporating procedure codes to identify specific HCBS services (Hula et al. 2021).

How to discern between HCBS provided through a program versus HCBS provided through the State Plan benefit

Unlike the data elements that provide information on HCBS waivers and programs, there is no single TAF data element indicating whether HCBS was provided under a State Plan or an HCBS program. Claims for HCBS provided under a State Plan are those considered HCBS coverable by the State Plan based on claim characteristics and are not otherwise flagged as being paid for by another HCBS waiver or program.

To identify Medicaid enrollees who used HCBS furnished through the State Plan benefit, including personal care assistance, home health, rehabilitative services, case management, and private duty nursing, TAF users should do the following:

1. Use procedure codes to identify claims for HCBS
2. Restrict to the universe of claims that were not flagged as program-based HCBS claims based on their program type code, waiver type code, HCBS service code, and/or benefit type code values
3. Use type of service code to categorize claims into the remaining five categories of state plan benefit services: home health services, non-school-based rehabilitative services, case management services, personal care assistance, and private duty nursing services

[5] The XIX_SRVC_CTGRY_CD is a code indicating the category of service for the paid claim; the category is the line item from the CMS-64 form that states use to report their expenditures and request federal financial participation.

4. If the type of service code is missing, TAF users should use the benefit type code to supplement the identification strategy

How to identify participation in an HCBS program

Some TAF users may wish to analyze HCBS use among enrollees in specific HCBS programs. Similar to identifying claims for HCBS, there is no one TAF data element that captures HCBS program enrollment. To find enrollees covered under an HCBS program listed in Table 6, TAF users should use program-specific data elements in the Demographic and Eligibility (DE) and OT files to identify enrollees with at least one month of program enrollment in or one claim covered under the program. For a complete list of data elements that can be used to identify enrollee HCBS program participation, see Tables 7 and 8.

Table 6. TAF files containing HCBS program enrollment information

HCBS program	Identifiable in OT claims	Identifiable in the DE file
Section 1915(c) waiver programs	Yes	Yes
Section 1915(i) State Plan Home and Community-Based Services	Yes	Yes
Section 1915(j) self-directed personal assistance service (PAS) option	Yes	Yes
Section 1915(k) Community First Choice (CFC) option	Yes	Yes
Health Homes Program	No	Yes
Money Follows the Person (MFP) demonstration	Yes	Yes
Program of All-Inclusive Care for the Elderly (PACE)	No	Yes

Note: The authors of the LTSS expenditures report found that for most programs, using the OT file (reflecting service utilization) provided more realistic user counts based on data missingness and available benchmarking sources, such as the fiscal year 2020 Medicaid LTSS Annual Expenditures Report and the 2018–2019 Medicaid Section 1915(c) Waiver Programs Annual Expenditures and Beneficiaries Report, compared with the first approach of using the DE file (reflecting program enrollment) (Murray et al. 2021). The authors did not identify any claims for Health Homes Programs and PACE in the OT file. Records of capitated payments to PACE programs are available in the TAF OT file, however as these are capitated payments, specific service use information is not available.

Identifying OT claims paid for by specific HCBS programs

TAF users who want to study the services used in a specific HCBS program or identify HCBS claims paid for by specific HCBS programs may use the (1) program type, (2) waiver type, (3) HCBS service type, and (4) benefit type code data elements found in claim header and line records. The information in each of these data elements comes directly from the state's T-MSIS production process and remains unchanged throughout the TAF production process. This means that service providers do not report this type of information on their bills. Program-specific valid values for program type code, waiver type code, and HCBS service code can be found in Table 8.

Because what a state reports in these three data elements can conflict, TAF users should employ a hierarchical approach to identifying OT claims paid for by specific HCBS programs, only looking at the next variable in the hierarchy if the previous one is missing. In testing different approaches, Murray et al. (2021) started with the program type code found on the

[header/line] record, followed by the wavier type and HCBS service codes. The benefit type code was last in their hierarchy.

Table 7. Hierarchy for identifying claims paid for by specific HCBS programs in the OT claims file

Step	Variable location	Logic description	Variable description
1. Apply PGM_TYPE_CD	OT header	Use program type code to categorize claims by Medicaid program type	Code indicating special Medicaid program under which the service was provided.
2. Apply WVR_TYPE_CD	OT header	If program type code is missing, use the waiver type code	Code for specifying waiver type under which the eligible beneficiary is covered during the month and receiving services/under which claim is submitted.
3. Apply HCBS_SRVC_CD	OT line	If both the program type code and the waiver type code are missing, use the HCBS service code	Codes indicating that the service represents a long-term care home and community-based service or support for a beneficiary with chronic medical and/or mental conditions. The codes are to help clearly delineate between acute care and long-term care provided in the home and community setting (for example, 1915l, 1915(i), 1915(j), and 1915(k) services).
4. Apply BNFT_TYPE_CD	OT line	If the program type code, waiver type code, and HCBS service code are all missing, use the benefit type code	The benefit category corresponding to the service reported on the claim or encounter record. Note: The code definitions in the valid value list originate from the MACPro's benefit type list.

Source: Murray et al. (2021).

HCBS = home and community-based services; MACPro = Medicaid and CHIP Program Data System; OT = other services

Identifying enrollees in specific HCBS programs in the annual DE file

TAF users might wish to use the DE file to verify enrollment in specific HCBS programs for enrollees with HCBS claims records or they could start by identifying enrollees in HCBS programs and then look for their HCBS claims. The annual DE file includes demographic data elements and eligibility characteristics for all Medicaid and CHIP enrollees who were enrolled for at least one day during a calendar year. These data elements are derived from the monthly Beneficiary Summary file, which contains demographic, eligibility, and enrollment information for all Medicaid- or CHIP- eligible beneficiaries enrolled for at least one day during a given month.

The data elements in the annual DE file are useful for identifying enrollment in all HCBS programs and enable TAF users the to track enrollment in those programs on a monthly basis. The annual DE file is especially useful for finding enrollees in programs where it may be more challenging to identify enrollees through utilization, such as PACE, Health Homes Program,

and the 1915(j) state plan option. Table 8 describes annual DE data elements that TAF users can use to identify enrollees in HCBS programs.

Table 8. Annual DE data elements for identifying HCBS program enrollment

HCBS program	TAF data element(s)	TAF RIF data element(s)	Notes
Section 1915(c) Home and Community-Based Services waiver programs	_1915C_WVR_TYPE _1915C_WVR_MOS	WVR_1915C_TYPE_CD WVR_1915C_MOS	This data element contains a code indicating the type of 1915(c) waiver under which an enrollee received coverage. When combined with the 1915(c) Waiver Months data element, TAF users can track monthly enrollment in 1915(c).
1915(i) State Plan Home and Community-Based Services	_1915I_SPO_FLAG_01 - _1915I_SPO_FLAG_12	SPO_1915I_IND_01 - SPO_1915I_IND_12	These monthly flags indicate whether the beneficiary received coverage through the 1915(i) State Plan Option in the month.
Section 1915(j) self-directed personal assistance service (PAS) option	_1915J_SPO_FLAG_01 - _1915J_SPO_FLAG_12	SPO_1915J_IND_01 - SPO_1915J_IND_12	These monthly flags indicate whether the beneficiary received coverage through the 1915(j) State Plan Option in a specified month.
Section 1915(k) Community First Choice (CFC) option	CMNTY_1ST_CHS_SPO_FLAG_01 - CMNTY_1ST_CHS_SPO_FLAG_12	CFC_SPO_IND_01 - CFC_SPO_IND_12	These monthly flags indicate whether the beneficiary received coverage through the CFC State Plan Option in the month
Health Homes Program	HH_PGM_PRTCPNT_FLAG_01 – HH_PGM_PRTCPNT_FLAG_12	HLTH_HOME_PGM_IND_01 – HLTH_HOME_PGM_IND_12	These monthly flags indicate whether the enrollee participated in the Health Homes Program in the month.
Money Follows the Person (MFP) demonstration	MFP_PRTCPNT_FLAG_01 – MFP_PRTCPNT_FLAG_12	MFP_IND_01 – MFP_IND_12	These monthly flags indicate wither the enrollee participated in the MFP program in the month.
Program of All-Inclusive Care for the Elderly (PACE)	MC_PLAN_TYPE_CD1_01 – MC_PLAN_TYPE_CD16-12	MC_PLAN_TYPE_CD_01_01 – MC_PLAN_TYPE_CD_16_12	These flags indicate the MC plan identification number under which the eligible enrollee is enrolled in the month,

Source: Murray et al. (2021).

CFC = Community First Choice; HCBS = home and community-based services; RIF = Research Identifiable Files; MFP = Money Follows the Person; MC = managed care

Table 9. TAF data elements used to identify Medicaid enrollees who use HCBS

TAF data element	TAF RIF data element	Description	File	Data element value used for analysis
ELGBLTY_GRP_CD_01 – ELGBLTY_GRP_CD_12	ELGBLTY_GRP_CD_01 – ELGBLTY_GRP_CD_12	This code identifies the eligibility group applicable to the individual based on the state's eligibility determination process in the month.	DE	• Codes 1-60 or 69-75 See TAF DE data dictionary for a description of each code
TOS_CD	TOS_CD	This code categorizes the service provided.	OT	• Home health (016–021, 064, 079) • Rehabilitative services (043) • Case management services (053, 062, 077) • Private duty nursing services (022)
BNFT_TYPE_CD	BNFT_TYPE_CD	This code identifies the benefit category for the service of the claim.	OT	• PACE (105) • Health Homes (055) • Home health (015–017, 022, 068, 076) • Rehabilitative services (036) • Case management services (042) • Private duty nursing services (023, 069)
PGM_TYPE_CD	PGM_TYPE_CD	This code indicates the special Medicaid program under which the service was provided.	OT	• Section 1915(c) waiver program (07) • 1915(i) – state plan HCBS (13) • 1915(j) – PAS (16) • 1915(k) – CFC (11) • MFP demonstration (08)
WVR_TYPE_CD	WVR_TYPE_CD	This code specifies the waiver type under which the claim was submitted.	OT	Section 1915(c) waiver program (06–20, 33)
HCBS_SRVC_CD	HCBS_SRVC_CD	This code indicates that the service was HCBS for an enrollee with chronic medical or mental conditions.	OT	• Section 1915(c) waiver program (4) • 1915(i) – state plan HCBS (1) • 1915(j) – PAS (2) • 1915(k) – CFC (3)
PRCDR_CD	LINE_PRCDR_CD	This code indicates the CPT or HCPCS code for the service or good rendered by the provider.	OT	For a complete list of procedure codes, see the supplemental Excel workbook.

Table 9 (*continued*)

TAF data element	TAF RIF data element	Description	File	Data element value used for analysis
SRVC_PLC_CD	POS_CD	This code indicates where the services took place.	OT	• School (03) • Prison/correctional facility (9) • Inpatient hospital (21) • Skilled nursing facility (31) • Nursing facility (32) • Custodial care facility (33) • Inpatient psychiatric facility (51) • ICF/IIDs (54) • Residential substance abuse treatment facility (55) • Psychiatric residential treatment center (56) • Comprehensive inpatient rehabilitation facility (61)
_1915C_WVR_TYPE	WVR_1915C_TYPE_CD	This code indicates the type of section 1915(c) waiver program under which the enrollee received coverage; most recent in the calendar year.	DE	Section 1915(c) waiver program (1)
_1915C_WVR_MOS	WVR_1915C_MOS	Number of months the beneficiary was enrolled in a section 1915(c) waiver in the calendar year	DE	0-12
_1915I_SPO_FLAG_01 - _1915I_SPO_FLAG_12 _1915J_SPO_FLAG_01 - _1915J_SPO_FLAG_12 CMNTY_1ST_CHS_ SPO_FLAG_01 - CMNTY_1ST_CHS_ SPO_FLAG_12	SPO_1915I_IND_01 - SPO_1915I_IND_12 SPO_1915J_IND_01 - SPO_1915J_IND_12 CFC_SPO_IND_01 - CFC_SPO_IND_12	These monthly flags indicate whether the enrollee received coverage through the 1915(i), 1915(j), or 1915(k) state plan options in the month.	DE	• 1915(i) – state plan HCBS (1 for any month) • 1915(j) – PAS (1 for any month) • 1915(k) – CFC (1 for any month)
HH_PGM_PRTCPNT_FLAG_01 – HH_PGM_PRTCPNT_FLAG_12	HLTH_HOME_PGM_IND_01 – HLTH_HOME_PGM_IND_12	These monthly flags indicate whether the enrollee participated in the Health Homes program in the month.	DE	Health Homes (1 for any month)
MFP_PRTCPNT_FLAG_01 – MFP_PRTCPNT_FLAG_12	MFP_IND_01 – MFP_IND_12	These monthly flags indicate wither the enrollee participated in the MFP program in the month.	DE	MFP demonstration (1 for any month)
MC_PLAN_TYPE_CD1_01 – MC_PLAN_TYPE_CD16-12	MC_PLAN_TYPE_CD_01_01 – MC_PLAN_TYPE_CD_16_12	These flags indicate the managed care plan identification number under which the eligible enrollee is enrolled in the month,	DE	PACE (17 for any month)

Table 9 (*continued*)

Source: The variable names and valid values in this report come from the codebooks for interim TAF data we used for the analysis. TAF Research Identifiable Files (RIF) codebooks are publicly available on ResDAC's TAF file data documentation webpage at https://www.resdac.org/cms-data/files/taf-de/data-documentation, https://resdac.org/cms-data/files/taf-lt/data-documentation and https://resdac.org/cms-data/files/taf-ot/data-documentation. During the transformation into TAF RIF, some interim TAF data elements are suppressed, changed, or renamed.

CFC = Community First Choice CHIP = Children's Health Insurance Program; CPT = Current Procedural Terminology; DE = Demographic and Eligibility; FFS = fee-for-service; HCBS = home and community-based services; HCPCS = Healthcare Common Procedure Coding System; ICF/IID = Intermediate Care Facility for Individuals with Intellectual Disabilities; LT = Long-Term Care; MFP = Money Follows the Person; OT = Other Services; PACE = Program of All-Inclusive Care for the Elderly; PAS = personal assistance services; ResDAC = Research Data Assistance Center; RIF = Research Identifiable Files; TAF = T-MSIS Analytic File; T-MSIS = Transformed Medicaid Statistical Information System

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