Chapter 1:

Mandatory and Optional Enrollees and Services in Medicaid

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Key Points

- Medicaid is a partnership between the federal government and states. Federal requirements mandate coverage of certain populations and benefits. Within these parameters, states create policy regarding many other program features, including which optional eligibility pathways and services to cover. State decisions reflect the health needs of residents, the cost of paying for care, and other policy goals.
- At the request of the chairmen of MACPAC's congressional committees of jurisdiction, this chapter examines Medicaid enrollment of and spending on mandatory and optional populations and services.
- Consistent with previous studies, our analysis finds that, in fiscal year 2013, seven in ten enrollees were mandatory. The largest share of mandatory enrollees were children living in families with low incomes.
- The share of individuals enrolled under mandatory and optional pathways varies by eligibility group. For example, the vast majority of child enrollees were mandatory, while slightly more than half of adults eligible on a basis other than disability were optional.
- Slightly less than half (47.4 percent) of Medicaid benefit spending was for mandatory populations receiving mandatory services and 21.1 percent was for mandatory populations receiving optional services. The remaining 31.5 percent of spending was for optional populations receiving mandatory or optional services.
- Nationally, the largest share of both mandatory and optional spending was for people eligible on the basis of disability. The majority of spending on their mandatory services was for acute care, reflecting their high health needs. The majority of spending on optional services for these enrollees was for long-term services and supports, which may be provided in lieu of more expensive institutional services.
- The distribution of mandatory and optional enrollment and spending varies by state, reflecting state decisions to adopt optional pathways and services and population characteristics. In Vermont, about 35 percent of enrollees were mandatory, while about 96 percent of enrollees were mandatory in Nevada. The share of Medicaid spending on mandatory populations receiving mandatory services ranged from a high of 74.1 percent in Arizona to a low of 27.1 percent in North Dakota.
- MACPAC's findings are useful in understanding how federal requirements affect state program design and how state choices affect patterns of spending. But mandatory and optional categories are more an artifact of the program's history and do not provide guidance on how to make the program more efficient or set priorities for spending.

CHAPTER 1: Mandatory and Optional Enrollees and Services in Medicaid

Since its enactment in 1965, Medicaid has been structured as a partnership between the federal and state governments. Federal law establishes broad requirements for the program, including mandated coverage of certain populations and benefits, and mechanisms for accountability for the use of federal dollars. Within these federal parameters, states make additional policy decisions regarding many program features, including determining which optional eligibility pathways and services to cover. They also administer the program on a day-to-day basis. Financing is shared, with the federal government matching state spending on allowable expenses based on a formula related to state per capita income. This division of responsibilities reflects that of the Kerr-Mills program, which previously provided federal support to states in funding health services for the indigent (Smith and Moore 2015).

Over time, Medicaid has evolved in terms of the populations and services it covers. Originally focused on financing medical care for individuals receiving cash welfare payments, the program now serves over 70 million low-income individuals, including children and their parents, pregnant women, frail elderly individuals, and people with disabilities (MACPAC 2016a). These changes reflect federal policy decisions to extend coverage to additional populations and to allow states to expand coverage to others in need. Medicaid's list of mandatory and optional benefits has also evolved, reflecting the advancement of medical care, changes in disease patterns, and the longer lifespan of people with disabilities and chronic diseases. Within the federal framework, states vary in the extent to which they have adopted eligibility pathways and optional benefits, reflecting state policy decisions related to the health needs of their residents, and the cost of paying for their care.

At the specific request of the chairmen of MACPAC's congressional committees of jurisdiction, this chapter examines Medicaid enrollment of and spending on mandatory and optional populations and services. The requesters raise concerns about the program's ability to meet the needs of beneficiaries and seek to better understand the optional eligibility groups and optional benefits covered by states and the resources associated with them.

This chapter begins by describing the federal requirements and state options for Medicaid eligibility and benefits. It then describes the congressional request that prompted this analysis. Following a brief overview of the methodology and some of its limitations, we present the detailed results of our analysis.

Briefly, consistent with previous studies, our analysis finds that in fiscal year (FY) 2013:

- Seven in ten (71.1 percent) beneficiaries were mandatory, and 28.9 percent were optional. The largest share of mandatory enrollees were children.
- The share of individuals enrolled under mandatory and optional pathways varies by eligibility group. For example, of 32.2 million child enrollees, 86.0 percent were mandatory. By contrast, slightly more than half (55.2 percent) of adults eligible on a basis other than disability were optional, including 4.6 million beneficiaries who were receiving family planning services only.
- The distribution of mandatory and optional enrollment varies by state, reflecting both state decisions to adopt optional pathways and the demographics of each state. For example, in Vermont, about one-third (34.8 percent) of enrollees were mandatory, while almost all (95.8 percent) enrollees were mandatory in Nevada. Maine had the largest

share of enrollees eligible on the basis of age and West Virginia had the largest share of enrollees eligible on the basis of disability.

- About half (47.4 percent) of Medicaid benefit spending was for mandatory populations receiving mandatory services. Approximately 21 percent of spending was for mandatory populations receiving optional services. The remaining 31.5 percent of spending was for optional populations receiving mandatory or optional services.
- Across states, the share of Medicaid spending on mandatory populations receiving mandatory services ranged from a high of 74.1 percent in Arizona to a low of 27.1 percent in North Dakota.
- Nationally, the largest share of both mandatory spending (34.1 percent) and optional spending (56.8 percent) was for people eligible on the basis of disability.
- Acute services, including inpatient hospital and physician services, accounted for the largest share of mandatory spending (40.8 percent); and long-term services and supports (LTSS) accounted for the largest share of optional spending (52.2 percent).

In the Commission's view, these findings do not provide clear direction for states or the federal government in considering how to make the program more efficient or how to set priorities for spending. Although it is useful to understand how federal requirements affect state program design as well as how states' own choices regarding eligibility and benefits affect patterns of spending, the designation of mandatory and optional categories is more an artifact of the program's history than a clear statement of value. The findings also illustrate the vital role Medicaid plays in providing services to low-income people with complex health needs who use LTSS, services rarely covered by other forms of insurance.

Background

As discussed above, federal statute and regulations mandate the coverage of certain populations and benefits and define the optional populations and services states may cover. States make policy decisions regarding their program's parameters within these federal requirements. Below we describe in detail the mandatory and optional eligibility pathways, and the distinction between mandatory and optional benefits.

Eligibility

Medicaid eligibility is typically defined in terms of both categorical eligibility (the populations covered) and financial eligibility (the income levels or thresholds at which individuals within these populations can be covered). In general, states must cover children and pregnant women up to specified income levels; parents with dependent children with incomes up to the state's 1996 Aid to Families with Dependent Children (AFDC) standards; individuals who are either elderly or disabled and receive Supplemental Security Income (SSI); and certain low-income Medicare enrollees (Table 1-1). In some cases, states have the option to cover individuals in these groups with incomes higher than the federal minimum standard. States can also extend Medicaid to other groups of people, such as those with high medical expenses.[1] (For more detail on the federal eligibility requirements and state options, see MACPAC's fact sheet: *Federal Requirements and State Options: Eligibility*.)

Historical eligibility. At enactment, Medicaid was limited to three groups of low-income individuals: families (including children, parents, and pregnant women), people age 65 and older, and people under age 65 with disabilities. Medicaid eligibility for these groups was automatically linked to eligibility for certain federal cash assistance programs. In addition to covering these three groups of mandatory categorically needy individuals, states

TABLE 1-1. Mandatory and Optional Medicaid Eligibility Groups

Mandatory eligibility groups	Optional eligibility groups
• Poverty-related infants, children, and pregnant women and deemed newborns • Low-income families (with income below the state's 1996 AFDC limit) • Families receiving transitional medical assistance • Children with Title IV-E adoption assistance, foster care, or guardianship care and children aging out of foster care • Elderly and disabled individuals receiving SSI and aged, blind, and disabled individuals in 209(b) states[1] • Certain working individuals with disabilities • Certain low-income Medicare enrollees (e.g., QMBs, SLMBs, QIs)	• Low-income children, pregnant women, and parents above federal minimum standards • Elderly and disabled individuals with incomes above federal minimum standards or who receive long-term services and supports in the community • Medically needy • Adults without dependent children[2] • HCBS and Section 1115 waiver enrollees • Enrollees covered only for specific diseases or services, such as breast and cervical cancer or family planning services

Notes: AFDC is Aid to Families with Dependent Children. SSI is Supplemental Security Income. QMB is Qualified Medicare Beneficiary. SLMB is Specified Low-Income Medicare Beneficiary. QI is Qualifying Individual. HCBS is home- and community-based services. AFDC is the cash assistance program that was replaced by Temporary Assistance to Needy Families (TANF) by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA, P.L. 104-193).

[1] Section 209(b) states can establish more restrictive criteria, both financial (such as income or assets limits) and non-financial (such as the definition of disability) criteria for determining eligibility than the SSI program. However, these criteria may not be more restrictive than those in effect in the state on January 1, 1972.

[2] Although this group is defined by statute as mandatory, the U.S. Supreme Court ruling in *National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566 (2012), effectively made coverage of the group optional for states.

Source: MACPAC, 2017, analysis of the Social Security Act and the *Code of Federal Regulations*.

could also choose to cover optional groups of medically needy individuals—those who fell within one of the population categories eligible for federal cash assistance (aged, blind or disabled, and families with dependent children) but whose higher incomes made them ineligible for such assistance. Individuals in the medically needy groups could have their medical expenses deducted from their income when determining eligibility for Medicaid.

Over the years, the direct link to cash assistance has been eliminated from some, but not all, eligibility pathways. Medicaid eligibility for individuals who receive SSI benefits and for children in Title IV-E foster care remains tied to eligibility for those programs. Eligibility for low-income families and children, however, is now based on the federal poverty level (FPL), a change resulting from the passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA, P.L. 104-193).

Expanding eligibility. Federal policymakers have also expanded eligibility to individuals in certain low-income populations whose incomes are higher than those receiving cash assistance. For example, under the original statute, states were required to cover aged and blind and disabled individuals if

they received cash assistance under the existing state-based welfare system (Paradise et al. 2015). In 1972, with the enactment of the SSI program for individuals age 65 and older and people with disabilities (Social Security Amendments of 1972, P.L. 92-603), states were required to provide Medicaid to these individuals as well, raising the income eligibility threshold to approximately 74 percent FPL in most states.[2]

Additionally, between 1984 and 1990, Congress expanded Medicaid for low-income pregnant women and children, first through optional pathways and then requiring their coverage. In 1986, states were allowed to cover young children through age five and pregnant women with incomes up to 100 percent FPL (Omnibus Reconciliation Act of 1986, P.L. 99-509). In 1988, Congress required states that had not expanded optionally to phase in coverage for these pregnant women and infants (MCCA, Medicare Catastrophic Coverage Act of 1988, P.L. 100-360). In 1989, the income threshold was increased to 133 percent FPL for children under age six and pregnant women, and in 1990, Congress required states to phase in coverage for older children (age 6–18) with family incomes up to 100 percent FPL (OBRA 1989, Omnibus Reconciliation Act of 1989, P.L. 101-239; OBRA 1990, Omnibus Reconciliation Act of 1990, P.L. 101-508). In the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended), Congress made the threshold uniform across age groups, requiring coverage for children of all ages with incomes up to 133 percent FPL.

Federal law also expanded requirements for states to help low-income Medicare enrollees pay their Medicare premiums and cost-sharing obligations. In 1988, the MCCA required states to begin phasing in coverage of Medicare premiums and cost sharing for qualified Medicare beneficiaries (QMBs) with incomes up to 100 percent FPL. This was followed by the requirement to cover Medicare premiums for low-income Medicare beneficiaries with incomes between 101 and 120 percent FPL (referred to as Specified Low-Income Medicare Beneficiaries or SLMBs) under OBRA 1990.

More recently, the ACA expanded Medicaid eligibility to all adults under age 65 who are not pregnant or disabled (including parents and adults without dependent children) with incomes up to 133 percent FPL. To offset the cost to states, the federal government provided full funding for the first three years of the expansion (2014–2016). A subsequent U.S. Supreme Court ruling in June 2012, however, effectively made the expansion optional for states.[3] As of May 2017, 31 states and the District of Columbia have adopted the expansion.

Adding optional pathways. Congress has also established optional eligibility pathways which states can use to expand coverage to other groups, such as people with disabilities, specific health conditions, or particular service needs. For example, states have been given the option to cover people with disabilities who are receiving services in the community who would not otherwise be eligible or who would be eligible for Medicaid if they were in an institution (OBRA 1981, Omnibus Reconciliation Act of 1981, P.L. 97-35; ACA). In 1997, states were given the option of providing coverage to working individuals with disabilities who lost SSI as a result of their earnings (Balanced Budget Act of 1997, P.L. 105-33). Two years later, states were given authority to allow working people with disabilities to buy into Medicaid (Ticket to Work and Work Incentives Improvement Act of 1999, P.L. 106-170).

Additional options exist for serving children with disabilities. For example, the Katie Beckett option allows states to cover children under age 19 who are disabled and living at home (Tax Equity and Fiscal Responsibility Act of 1982, P.L. 97-248). The more recent option established under the Family Opportunity Act allows children with disabilities and family incomes below 300 percent FPL to buy into Medicaid (DRA, Deficit Reduction Act of 2005, P.L. 109-171).

States can also choose to cover individuals needing particular services, such as family planning services and supplies. In limited

situations, they can cover individuals with a particular diagnosis, such as breast or cervical cancer (ACA, Breast and Cervical Cancer Treatment and Prevention Act of 2000, P.L. 106-354).

States have also used Section 1115 waivers to expand coverage. For example, prior to enactment of the ACA, states could apply for a Section 1115 waiver to receive federal Medicaid funds to expand Medicaid eligibility to childless adults under age 65 who were not eligible on the basis of disability and to cover family planning services for individuals not eligible for full Medicaid benefits.

Adoption of optional eligibility pathways among states varies considerably; for a state-by-state breakdown, see Appendix 1A, Tables 1A-1 and 1A-2.

Benefits

States have considerable flexibility in the design of the benefit package for their Medicaid enrollees within federal guidelines. Certain benefits, such as inpatient and outpatient hospital services, physician services, and services at rural health clinics and federally qualified health centers (FQHCs) are mandatory under federal law, but many benefits may be provided at state option (Table 1-2). States also have the flexibility to design the scope of their benefits and how they are administered, including the delivery system and utilization management techniques, such as defining medical necessity. (For more detail on the federal benefit requirements and state options, see MACPAC's factsheet: *Federal Requirements and State Options: Benefits*.)

As the practice of medicine has evolved and the health needs of Medicaid-eligible populations have changed, Congress has added services to the Medicaid statute and provided states with the option to cover these. States have also made changes in their benefit design, for example, adopting or abolishing coverage for particular services, adjusting preferred drug lists, and establishing prior authorization requirements. These changes reflect both the needs of enrollees and state decisions regarding available resources.

Adding new benefits. New benefits have been added for a variety of reasons. For example, hospice care, an optional benefit, did not exist at the time of the program's enactment. Some of the added services, such as those received at FQHCs and freestanding birth centers, or those provided by nurse-midwives, primarily reflect an expansion of the types of providers from whom enrollees can obtain services. Others, such as home- and community-based services (HCBS) and family planning services and supplies, could initially be offered only under a waiver. Targeted case management, primary care case management, and health homes reflect a shift towards more integrated care.

Some of the most significant changes to the benefit structure reflect the shift from serving people with disabilities in institutions to serving them in community settings. In 1971, Congress established optional benefits to cover services provided in intermediate care facilities and intermediate care facilities for people with intellectual and developmental disabilities that were previously financed with state-only funds (Paradise et al. 2015). States were given a new waiver authority under Section 1915(c) to provide HCBS to individuals who would otherwise be served in an institution in 1981 (OBRA 1981). In *Olmstead v. L.C.*, 527 S. Ct. 581 (1999), the U.S. Supreme Court ruled that individuals with disabilities have the right to reside in the least restrictive environment possible, leading to an increased focus on providing HCBS (Paradise et al. 2015, HCFA 2000). Section 1915(i), established under the DRA and expanded by the ACA, allows states to offer HCBS as part of the state plan benefit package instead of through a waiver (CMS 2014a). And although coverage of HCBS benefits is optional, states must cover many of these services to meet their legal and strategic goals as they rebalance the delivery of LTSS between institutions and the community. As an example of the change, in FY 1995, less than one-fifth (18 percent) of Medicaid LTSS spending

TABLE 1-2. Mandatory and Optional Medicaid Benefits

Mandatory benefits	Optional benefits
• Inpatient hospital • Outpatient hospital • Rural health clinic • Federally qualified health center (FQHC) • Laboratory and X-ray • Nursing facility services (age 21 and older) • Family planning services and supplies • Tobacco cessation counseling and prescription drugs for pregnant women • Physician services • Nurse-midwife services • Certified pediatric and family nurse practitioner services • Freestanding birth centers • Home health • Medical transportation[1] • Early and periodic screening, diagnostic, and treatment (EPSDT) services	• Prescription drugs • Dental services • Intermediate care facilities for individuals with intellectual disabilities (ICF/ID) • Services in an institution for mental disease (IMD)[2] • Clinic services • Occupational therapy • Physical therapy • Speech, hearing, and language disorder services • Targeted case management • Prosthetic devices • Hospice services • Eyeglasses • Dentures • Other diagnostic, screening, preventive, and rehabilitative services • Respiratory care services • Home- and community-based services (HCBS, § 1915(i)) • Community supported living arrangements • Personal care services • Private duty nursing services • Primary care case management • Health homes for enrollees with chronic conditions • Other licensed practitioner services (e.g., podiatrist, optometrist) • Services for certain diseases (tuberculosis, sickle cell disease) • Chiropractic services • Program for All-Inclusive Care for the Elderly (PACE) services • Services furnished in a religious, non-medical health care institution

Notes: Although the benefit category may be covered, the amount and scope of coverage available can vary by state and plan. Benefit categories are broad and may not include coverage of specific benefits. Some benefits are available only when determined medically necessary. As such, although a benefit may be covered, this does not guarantee that an individual will be able to obtain it.

[1] Although medical transportation is not listed as a required benefit in the statute, states must ensure necessary transportation for beneficiaries to and from Medicaid-covered services (42 CFR 431.53).

[2] Services provided in an institution for mental disease are optional services that states can cover for children under age 21 or adults age 65 and older. Services provided to adults age 21–64 are not eligible for federal matching funds.

Source: MACPAC, 2017, analysis of the Social Security Act and the *Code of Federal Regulations*.

occurred in non-institutional settings; by FY 2014, the percentage had risen to more than half (Eiken et al. 2016).

Scope of coverage. When determining their benefit packages, states consider the health needs of beneficiaries and the cost of services; as a result, some optional services are covered widely, and others less so. For example, all states cover prescription drugs, reflecting the integral role of pharmaceuticals in treating and slowing the progression of disease. Coverage for other services, such as chiropractic services or health homes that coordinate care for enrollees with chronic diseases, are less common (KCMU 2014). For details on state adoption of optional benefits, see Appendix 1A, Tables 1A-3 and 1A-4.

In general, states must offer the same coverage to all enrollees (the comparability rule) and offer the same benefits throughout the state (the statewideness rule), but there are exceptions for states that implement managed care or expand HCBS in certain geographic areas. States also have flexibility in defining how much of a service an enrollee can receive. For adults, states may limit the extent to which a covered benefit is available by defining both medical necessity criteria and the amount, duration, and scope of services. As such, state coverage of a particular benefit does not guarantee that an individual will be able to obtain it. However, under the early and periodic screening, diagnostic, and treatment (EPSDT) requirements for children under age 21, states must provide any necessary service named in the Medicaid statute—including optional services not otherwise covered by the state—without caps or other limits that are unrelated to medical necessity (Box 1-1).[4]

Alternative benefit plans. As an alternative to traditional Medicaid benefits, states were given authority under the DRA to enroll state-specified groups in benchmark and benchmark-equivalent benefit packages. States can offer what are now known as alternative benefit plans (ABPs) to all enrollees and are required to enroll the new adult eligibility group covered through the ACA in ABPs. However, some groups are excluded from mandatory enrollment.[5] As of 2012, 12 states had adopted the use of ABPs in Medicaid. Most of these states used Secretary-approved coverage, typically covering the standard Medicaid benefit package, and in some cases additional services, such as chronic care management, targeted to the population enrolled in the plan (Herz 2012). Similarly, most states expanding coverage to the new adult group offer Secretary-approved benefit packages aligned with their traditional Medicaid benefit package with some modifications. For example, North Dakota's ABP offers traditional state plan benefits except that it does not include adult dental coverage (Lilienfeld 2014).

Congressional Request

The analysis presented in this chapter was requested by the chairmen of MACPAC's committees of jurisdiction in a letter dated January 11, 2017 (Appendix 1B). The letter describes Medicaid as an important safety-net program, providing health coverage and LTSS to the nation's most vulnerable patients. The requesters go on to note that growth in federal Medicaid expenditures is a major concern and as the program extends its reach, both as a result of legislative and demographic changes, they express their concern about Medicaid's ability to meet the needs of these individuals. They comment that beneficiaries already face challenges in accessing high-quality services and that additional strains to the system will further erode access and quality.

Within this context, the requesters see the need to have a better understanding of the optional eligibility groups and optional benefits that states are covering, the resources associated with these, and how state choices may be affecting spending growth. Specifically, the letter requests that MACPAC determine the following for each state:

- the intersection of the coverage of optional eligibility groups and the receipt of optional benefits for those groups to show the extent

BOX 1-1. Mandatory Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Children under Age 21

All children under age 21 enrolled in Medicaid through the categorically needy pathway are entitled to the early and periodic screening, diagnostic, and treatment (EPSDT) benefit. The requirement to cover EPSDT services was introduced in the Social Security Act Amendments of 1967. These amendments were part of a larger package of reforms aimed at improving the availability and quality of children's health care (Rosenbaum et al. 2005). Subsequent legislative changes in the Omnibus Reconciliation Act of 1989 (OBRA 1989, P.L. 101-239) strengthened the standards for identification of children in need of screening, as well as the standards for the screening services themselves. These changes also clarified that vision, dental, and hearing services must be covered, as well as any treatments necessary to correct or ameliorate the conditions discovered during screening. Services identified as medically necessary must be covered whether or not these services are covered under the state plan. Litigation has also played a role in shaping the EPSDT benefit (Perkins 2014).

States are allowed to create some limits on services for children for the purposes of utilization management. For example, even though states may not require prior authorization for screening services, they may require prior authorization for certain treatment services. States may also base coverage decisions on the cost effectiveness of a treatment. Although a state cannot deny a medically necessary service based only on cost, it can consider cost as part of the prior authorization process, for example, approving a less-expensive, but equally effective service. However, when making these decisions, the state must also consider the child's quality of life and must meet the requirement to cover services in the most appropriate integrated setting (CMS 2014b).

States must also inform all Medicaid-eligible families about the EPSDT benefit; they must screen children at reasonable intervals, cover diagnosis and treatment for any health problems found, and report certain data regarding EPSDT participation annually to the Centers for Medicare & Medicaid Services.

to which, for example, optional populations in [a] given state are receiving optional benefits;

- the number of people covered by each state who qualify for Medicaid through an optional eligibility category; and
- the federal and state expenditures for each category of (a) optional populations and (b) optional benefits in each state.

The letter requests that the analysis be completed within six months, or by July 11, 2017. MACPAC issued a response to this letter on January 23, 2017, stating that the analysis would be completed within the time frame requested.[6]

Methodology and Limitations

Building on prior analyses, MACPAC examined enrollment and spending for mandatory and optional individuals and services using Medicaid Statistical Information System (MSIS) and CMS-64 data for FY 2013, the most recent year for which such data are available (Courtot et al. 2012).[7] Because these data sources do not specifically

identify individuals and services as mandatory or optional, MACPAC determined the mandatory and optional status based upon a review of the statutory and regulatory citations in comparison with the MSIS data dictionary definitions.

Note that in our determinations of whether an individual or service is mandatory or optional, we refer only to the federal requirements, and do not attempt to take into account state-specific requirements, such as state-mandated benefits or consent decrees that require coverage of certain benefits. Neither do we account for state variations in the breadth of coverage, such as amount, duration, and scope. To the greatest extent possible, this analysis reflects assumptions and adjustments that MACPAC routinely makes in MACStats and outlined in its technical guide.

Appendix 1C provides additional details on the methodology and limitations.

Classification of enrollees

We retained Medicaid's eligibility categories (i.e., aged, blind or disabled, adult, child), but classified individuals within each category as mandatory or optional based on their maintenance assistance status (MAS) and basis of eligibility (BOE) designations in MSIS. This approach resulted in each individual being assigned to one of the following classifications: mandatory aged, optional aged, mandatory blind or disabled, optional blind or disabled, mandatory adult, optional adult, mandatory child, or optional child.

As discussed in more detail in Appendix 1-C, some of the MSIS-defined MAS/BOE groups contain multiple eligibility pathways that can all be identified as either mandatory or optional, while other groups include both mandatory and optional eligibility pathways. For the MAS/BOE groups with uniform or almost uniform eligibility pathways, all enrollees were categorized as either mandatory or optional; for MAS/BOE groups with mixed eligibility pathways, enrollees were divided between mandatory and optional based on certain assumptions. For example, children were randomly assigned by age to either mandatory or optional status based on the share of children within their state in families with incomes at or below the federal minimum standard and those with family incomes above the federal minimum standard but below the state eligibility threshold for 2013.

Because our analysis is based on data from FY 2013, we are not able to analyze spending or enrollment for the new adult group established by the ACA. As noted above, this group is mandatory under the statute, but was effectively made optional by a 2012 U.S. Supreme Court decision.

Classification of services

Services were classified as mandatory or optional using the MSIS code for the type of service. Spending that was not directly related to Medicaid services (including supplemental payments and payments under Section 1115 waivers for costs not otherwise matchable) was classified separately using CMS-64 data. Almost all services for children, including those received through managed care, were considered mandatory because of the EPSDT requirement; services received by children under HCBS waivers were considered optional.

Classification of managed care expenditures

MSIS includes records of each capitated payment made on behalf of an enrollee to a managed care plan, as well as records of each service received by the enrollee from a provider under contract with a managed care plan (also referred to as encounter data). Because the amount paid by the managed care plan for a specific service is not available from the encounter data in MSIS, we had to make an assumption about the distribution of managed care spending on mandatory and optional services. We assumed that it would mirror the distribution of spending in fee-for-service (FFS) arrangements at the state and eligibility group (e.g., adults) level. For states where the managed care penetration rate for

a particular group exceeded 75 percent, we applied the national distribution of mandatory and optional FFS spending.

For most enrollees, all services received through managed care were assumed to be acute care services. However, in states with a large proportion of LTSS users in managed LTSS (MLTSS), the proportions of FFS spending used to determine the proportion of mandatory and optional managed care spending for the aged and blind or disabled groups included both acute and LTSS spending. Capitation payments also include an amount to cover plans' administrative costs. These costs would be apportioned as mandatory or optional in the same manner as other services received under managed care. Additionally, prescription drug rebates that were collected on managed care utilization were also allocated to managed care expenditures and apportioned as mandatory or optional in the same manner as other services.

Limitations

MACPAC has described the limitations associated with administrative data, including their timeliness and accuracy, in several prior reports (MACPAC 2013, 2011). In addition, as these data were not designed to identify the mandatory or optional status of enrollees and services, we had to make a number of assumptions. Despite these limitations, there is not an alternative source for this analysis. In this study, some constraints regarding this classification, and the approach taken to account for these constraints, are particularly worth noting.

Level of specificity regarding enrollees' eligibility pathways. As discussed above, MACPAC classified individuals as mandatory or optional enrollees using a combination of MAS and BOE designations. Each MAS/BOE combination contains multiple eligibility pathways, some of which are mandatory and some optional. However, there is no way to associate an individual with a specific eligibility pathway under a MAS/BOE combination in MSIS. As a result, this analysis makes several assumptions about the distribution of enrollees within these MAS/BOE groups, and altering these assumptions could lead to different results. A new version of the MSIS, referred to as the transformed MSIS (T-MSIS), will include more granular information on eligibility, including whether the eligibility pathway is mandatory or optional. At this time, however, states are still in the process of transitioning to T-MSIS reporting and such data could not be used for this analysis.

Limited encounter data for managed care enrollees. As discussed above, because the amount paid by the managed care plan for a specific service is not available from the encounter data, assumptions must be made regarding how much spending under managed care was for mandatory and how much was for optional services. As noted above, we assumed that the distribution of managed care spending on mandatory and optional services mirrored the distribution of spending in FFS arrangements at an eligibility group and state level. However, it is possible that due to differences in populations covered and services provided in managed care, the FFS proportions are not an accurate model for the distribution of mandatory and optional spending under managed care. On the other hand, while there may be a shift in the type of service received under a managed care arrangement relative to FFS, for example from inpatient hospital to physician services, that does not necessarily result in a shift in the share of mandatory and optional spending, because both of these services would be considered mandatory. This analysis attempts to account for this variation by applying the FFS distribution by population and by factoring in state-level penetration of managed care, including MLTSS.

Data cannot take into account the substitution of services. Some optional services are provided in lieu of other services. As an example, many home- and community-based services are optional. However, were these services not covered, some individuals would require mandatory services in an institution. This would result in an increase in the share of mandatory spending and could also

increase the level of spending. The analysis also cannot project how service use and spending would change in response to changes in covered benefits.

Given the complexity of the analysis, we requested feedback on our methods from a number of experts. We modified some of our original assumptions based on this input. Even with such changes, the experts we consulted pointed out some of the same limitations identified by the Commission and confirmed that our assumptions were reasonable.

Results

Overall, the findings show that approximately 70 percent of enrollees were mandatory, and almost half of benefit spending was on mandatory services for these enrollees. Less than one-third of enrollees were eligible on an optional basis, and less than one-third of spending was on services to them. This division reflects federal and state policy decisions as well as the characteristics of state populations and health care markets, as discussed in more detail below.

In FY 2013, children comprised the largest population enrolled in Medicaid, illustrating the dominant role that Medicaid plays in providing coverage to the majority of low-income children (MACPAC 2016b). The largest share of spending was for people with disabilities, despite the fact that they made up a smaller share of enrollment. This highlights the unique position of Medicaid as the largest payer nationally of LTSS (MACPAC 2016c).

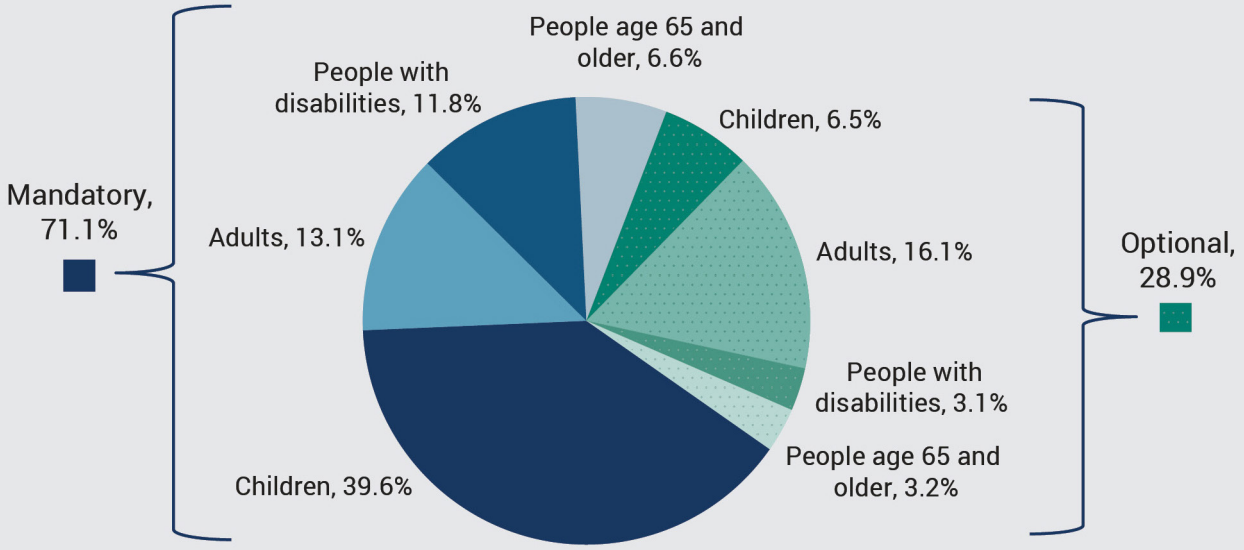
Enrollment of mandatory and optional populations

In 2013, 71.1 percent of Medicaid enrollees were mandatory, and 28.9 percent of enrollees were optional (Figure 1-1). The largest share of mandatory enrollees were children (39.6 percent), followed by adults, including pregnant women and parents (13.1 percent), then people eligible on the basis of disability (11.8 percent), and people over age 65 (6.6 percent). Adults made up the largest share of optional enrollees (16.1 percent), followed by children (6.5 percent). People eligible on the basis of disability (3.1 percent) and people age 65 and older (3.2 percent) made up relatively equal shares of optional enrollees.

Enrollment by population. The number of enrollees eligible under mandatory and optional pathways varied by eligibility group (Figure 1-2). As discussed above, to be eligible for Medicaid through a mandatory pathway, an individual must be eligible on a categorical basis and have income (and in some cases, assets) below an established threshold.

- Overall, 32.2 million (46.1 percent) enrollees were children, the vast majority (86.0 percent) of whom were mandatory.[8] These mandatory children live in families with low incomes—up to 133 percent FPL for young children (through age five) and up to 100 percent FPL for older children (age 6–18).[9]
- Adults eligible on a basis other than disability, including pregnant women and parents, together numbering 20.4 million, represented about 30 percent of enrollees overall. Approximately 55 percent of adult enrollees were optional. In addition, a large share (40.9 percent or 4.6 million) of these optional adult beneficiaries were receiving family planning services only (Box 1-2).
- Fifteen percent (10.4 million) of enrollees were people eligible on the basis of disability. Almost 80 percent of these enrollees were mandatory, including those who receive SSI payments based on their low incomes (approximately 74 percent of FPL), as well as some who are working. Optional enrollees in this eligibility category include those who have slightly higher incomes (less than or equal to 100 percent FPL for non-working individuals,

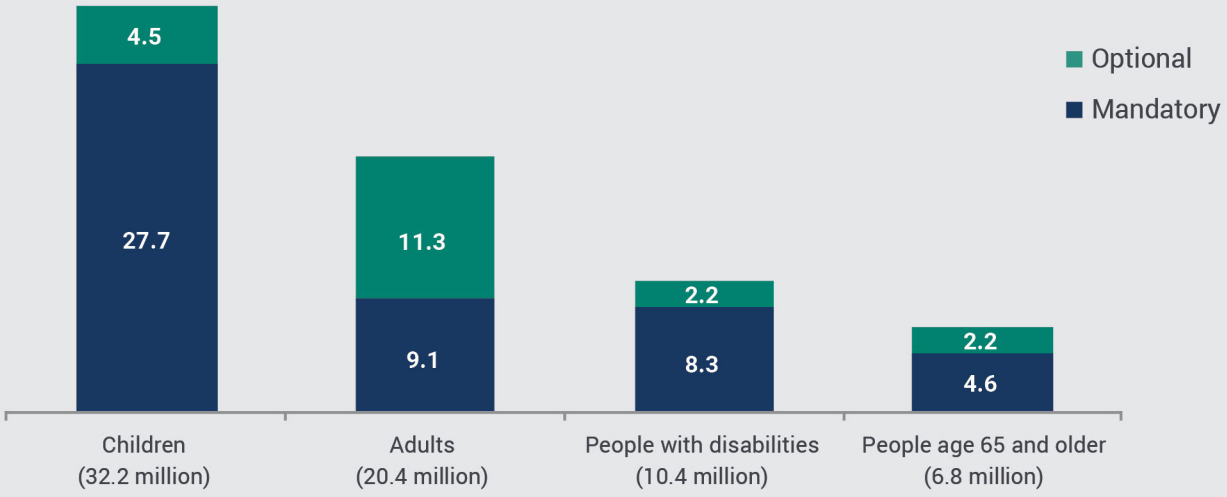
FIGURE 1-1. Share of Mandatory and Optional Medicaid Enrollees by Eligibility Group, FY 2013



Notes: FY is fiscal year. Excludes approximately 3,000 children who could not be classified as mandatory or optional due to missing information. Excludes Idaho, Louisiana, and Rhode Island due to data reliability concerns regarding the completeness of monthly claims and enrollment data.

Source: MACPAC, 2017, analysis of Medicaid Statistical Information System (MSIS) data as of December 2015.

FIGURE 1-2. Number of Mandatory and Optional Medicaid Enrollees by Eligibility Group, FY 2013 (millions)



Notes: FY is fiscal year. Excludes approximately 3,000 children who could not be classified as mandatory or optional due to missing information. Excludes Idaho, Louisiana, and Rhode Island due to data reliability concerns regarding the completeness of monthly claims and enrollment data.

Source: MACPAC, 2017, analysis of Medicaid Statistical Information System (MSIS) data as of December 2015.

BOX 1-2. Medicaid Eligibility for Adults

Prior to passage of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended), the only adults under age 65 eligible to receive Medicaid benefits, aside from those eligible on the basis of disability, were low-income pregnant women and parents. Specifically, states are required to cover pregnant women with incomes up to 133 percent of the federal poverty level (FPL). Parents and caretaker relatives with dependent children are also eligible for Medicaid, although often at much lower income thresholds, which typically are tied to historical eligibility standards for cash assistance.

As a result, non-disabled adults without dependent children were generally excluded from Medicaid unless the state covered them under a Section 1115 waiver. A number of states also used Section 1115 waivers to cover family planning services and supplies for adults who would not otherwise qualify for Medicaid.

The ACA expanded Medicaid eligibility to all adults under age 65 (including parents and adults without dependent children) with incomes up to 133 percent FPL. However, the U.S. Supreme Court ruling in *National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566 (2012), effectively made the expansion optional for states. As of May 2017, 31 states and the District of Columbia have chosen to adopt the adult expansion. However, because the data presented here are from fiscal year 2013, they do not reflect changes in enrollment composition as a result of implementation of the ACA.

perhaps more for those who have jobs) and those receiving HCBS.

- Approximately 10 percent (6.8 million) of enrollees were people age 65 and older. Almost seven in ten (67.5 percent) were eligible under a mandatory pathway. Similar to people eligible on the basis of disability, individuals age 65 and older are mandatory if they qualify for SSI. Optional enrollees in this group include those with incomes less than or equal to 100 percent FPL and individuals receiving HCBS, who would not otherwise be eligible.

There were approximately 10.7 million people dually eligible for Medicaid and Medicare in FY 2013, distributed across the eligibility groups of people eligible on the basis of disability and those age 65 and older (not shown in Figure 1-2).[10] Of these, approximately 70 percent were mandatory. Included in this 70 percent are 2.9 million so-called partial duals—dually eligible beneficiaries who receive assistance with Medicare premiums and cost sharing through the Medicare Savings Programs (MSPs) but who are not eligible for full Medicaid benefits. The balance of mandatory beneficiaries comprised 4.6 million dually eligible beneficiaries eligible for full Medicaid benefits through a mandatory pathway, who may or may not receive assistance through the MSPs.

It is important to note that because FY 2013 is the most recent year for which complete data are available, these figures do not reflect changes in enrollment composition as a result of the ACA Medicaid expansion to the new adult group. Post-ACA implementation data from MSIS are not yet available, but data from CMS-64 reports show that in FY 2015, there were 11.8 million enrollees in the new adult group and spending for this group totaled $75 billion (MACPAC 2017).[11] As noted previously, this population is mandatory under the

statute; however, a 2012 U.S. Supreme Court ruling effectively made their coverage optional.

Considerable enrollment in the new adult group since the ACA was implemented has likely added to the number of optional enrollees in states adopting the expansion. On the other hand, the ACA also resulted in increased enrollment among already eligible mandatory and optional populations (often referred to as the woodwork or welcome mat effect). The available data cannot provide information on how the distribution of mandatory and optional enrollment may have shifted as a result of these increases. Furthermore, we do not have details on the utilization of services by enrollees in the new adult group to analyze the composition of mandatory and optional services.

Enrollment by state. The distribution of mandatory and optional enrollment varies by state, reflecting both state decisions to adopt optional pathways and the demographics and income of each state. (State-by-state enrollment data are presented in Appendix 1A, Table 1A-5.) For example, in Vermont, 34.8 percent of enrollees were mandatory, compared to 95.8 percent in Nevada. The share of enrollees in each eligibility group also differed—Maine had the largest share (16.9 percent) of enrollees eligible on the basis of age and West Virginia had the largest share (28.3 percent) of enrollees eligible on the basis of disability.

Spending on mandatory and optional populations and services

In FY 2013, federal and state Medicaid spending totaled $401 billion.[12] Nationally, almost half (47.4 percent, $190.1 billion) of this spending was for mandatory populations receiving mandatory services (Table 1-3). Approximately 21 percent of spending ($84.6 billion) was for optional services for mandatory populations. The remaining 31.5 percent of spending was for optional populations, and was about evenly split between spending on mandatory and optional services.

Spending by population. Spending on enrollees eligible on the basis of disability comprised the largest share of spending overall (42.4 percent, $170.2 billion). This was followed by spending on those age 65 and older (23.1 percent), children (19.0 percent), and adults (15.5 percent). Spending for mandatory and optional enrollees and services varied by eligibility group, although people eligible on the basis of disability also accounted for the largest share of mandatory spending (34.1 percent, $86.6 billion) and optional spending (56.8 percent, $83.5 billion) (Figure 1-3).

TABLE 1-3. Medicaid Spending on Mandatory and Optional Populations and Services, FY 2013 (billions)

Mandatory enrollment and mandatory services		Mandatory enrollment and optional services		Optional enrollment and mandatory services		Optional enrollment and optional services	
Dollars	Percent	Dollars	Percent	Dollars	Percent	Dollars	Percent
$190.1	47.4%	$84.6	21.1%	$64.2	16.0%	$62.3	15.5%

Notes: FY is fiscal year. Medicare premiums are not reported in the Medicaid Statistical Information System (MSIS). The Medicare premium amounts reported in CMS-64 reports are distributed proportionately across dually eligible beneficiaries identified in the MSIS for each state. As such, Medicare premiums are included in the total spending and are considered to be mandatory. In FY 2013, spending on Medicare premiums totaled $13.4 billion. Medicare coinsurance and deductibles are reported under individual service types throughout the MSIS and are therefore included in mandatory and optional spending when examined by service type. Excludes $2.3 million in spending associated with the approximately 3,000 children who could not be classified as mandatory or optional. Excludes Idaho, Louisiana, and Rhode Island due to data reliability concerns regarding the completeness of monthly claims and enrollment data.

Source: MACPAC, 2017, analysis of MSIS data as of December 2015 and analysis of CMS-64 Financial Management Report net expenditure data from the Centers for Medicare & Medicaid Services as of June 2016.

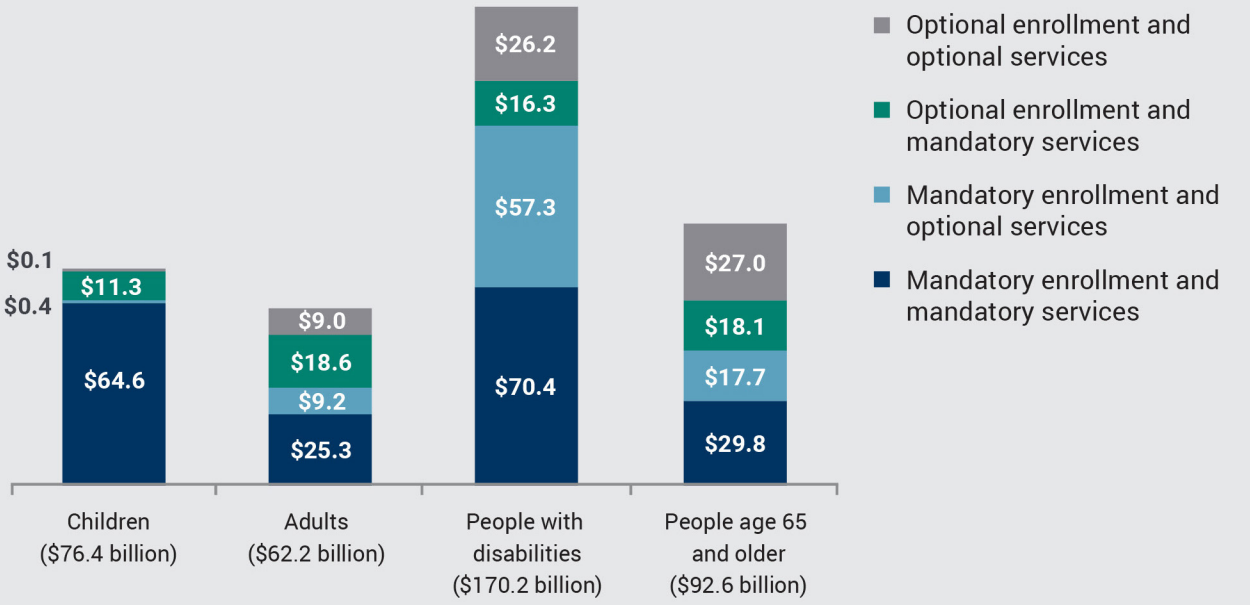
- Almost all spending on children (99.3 percent), regardless of mandatory or optional enrollment status, was mandatory because of the requirement to cover EPSDT services. Approximately $530 million was spent on optional services for children, primarily on services provided through HCBS waivers, most of this on mandatory enrollees.
- Just over half (55.6 percent) of all spending on adults was for those enrolled through a mandatory eligibility pathway. Spending for adults was more likely to be for mandatory services than for optional services, regardless of enrollment status. Specifically, for those enrolled on a mandatory basis, 73.4 percent of spending was for mandatory services; for those enrolled on an optional basis, 67.3 percent of spending was for mandatory services. This is likely the case because adults may be more likely to use mandatory services. For example, pregnant women are likely to use inpatient hospital and physician services, both mandatory services.
- The majority (75.0 percent) of spending for people eligible on the basis of disability was for those enrolled on a mandatory basis. For these individuals, spending on mandatory (55.1 percent) and optional (44.9 percent) services was more evenly divided. Spending for optional beneficiaries eligible on the basis of disability, however, was more likely to be on optional services (61.6 percent) than mandatory services (38.4 percent). The use of optional services, such as HCBS, physical therapy, or community supported living arrangements, may be more common among individuals with disabilities enrolled through optional pathways, which likely explains why the distribution skews toward optional services.
- Approximately half (51.4 percent) of spending for people age 65 and older was for those enrolled under a mandatory eligibility pathway. Spending on services for mandatory enrollees age 65 and older was higher for mandatory services (62.7 percent) than for optional services (37.3 percent). The opposite was true for optional enrollees—optional spending made up the majority (59.9 percent) of spending. This may reflect the higher use of nursing facility care (a mandatory service) for mandatory enrollees age 65 and older, as well as the shift to provide HCBS to optional individuals who would otherwise be ineligible for coverage.[13]

Overall, $143.3 billion was spent on dually eligible individuals in FY 2013 and just over half (53.7 percent) was spent on those whose eligibility was mandatory.[14] As noted above, these individuals were distributed across the eligibility groups of people eligible on the basis of disability and those age 65 and older.

Spending by service. In terms of mandatory and optional spending by type of service, the majority (40.8 percent) of mandatory spending was for acute services, including inpatient hospital and physician services; over one-third (37.0 percent) of mandatory spending was for managed care; and 16.9 percent was for mandatory LTSS. The majority (52.2 percent) of optional spending was for LTSS. Spending on optional managed care represented 27.2 percent of optional spending, followed by spending on optional acute services (20.6 percent). Included in acute spending, spending on FFS prescription drugs accounted for just 2.0 percent of overall spending. For adults, people eligible on the basis of disability, and people age 65 and older, where drug spending is optional, FFS spending on prescription drugs accounted for about 3.4 percent of optional spending.[15]

Overall, people eligible on the basis of disability and people age 65 and older accounted for almost all (98.0 percent) spending on LTSS. However, much of this spending was optional—about half of LTSS spending for people age 65 and older was mandatory, and just 21.0 percent of LTSS for people eligible on the basis of disability was mandatory. As discussed above, this use of optional HCBS

FIGURE 1-3. Medicaid Spending on Mandatory and Optional Populations and Services by Eligibility Group, FY 2013 (billions)



Notes: FY is fiscal year. Medicare premiums are not reported in the Medicaid Statistical Information System (MSIS). The Medicare premium amounts reported in CMS-64 reports are distributed proportionately across dually eligible beneficiaries identified in the MSIS for each state. As such, Medicare premiums are included in the total spending and are considered to be mandatory. Medicare coinsurance and deductibles are reported under individual service types throughout the MSIS and are therefore included in mandatory and optional spending when examined by service type. Excludes $2.3 million in spending associated with the approximately 3,000 children who could not be classified as mandatory or optional. Includes federal and state spending. Excludes Idaho, Louisiana, and Rhode Island due to data reliability concerns regarding the completeness of monthly claims and enrollment data.

Source: MACPAC, 2017, analysis of MSIS data as of December 2015 and analysis of CMS-64 Financial Management Report net expenditure data from the Centers for Medicare & Medicaid Services as of June 2016.

may be in lieu of services received in institutions. People eligible on the basis of disability also accounted for the largest share (44.4 percent) of spending on acute care and the largest share (33.7 percent) of spending on managed care payments. This is likely because they have higher needs and higher service use, and not because they are enrolled in managed care in greater numbers.

Spending by service type varied across the enrollee populations, but did not vary based on mandatory or optional status (Table 1-4). As noted above, the vast majority of services for children are mandatory because of requirements to cover EPSDT services, including 100 percent of non-waiver acute care services and managed care capitation payments. For both mandatory and optional populations of children, spending on mandatory services was about evenly split between acute services and managed care, with little spent on mandatory LTSS. All of the optional spending for children was for services provided through HCBS waivers.[16] As with children, spending on mandatory services for adults was about evenly split between acute services and managed care, regardless of mandatory or optional enrollment status.

On the other hand, the majority of spending on mandatory services for people eligible on the basis of disability was for acute services and the majority of spending on optional services was for LTSS, regardless of enrollment status. For those age 65 and older, the majority of both mandatory and optional spending was for LTSS—most likely for nursing facilities and HCBS.

Spending by state. Across states, the share of spending on mandatory populations receiving mandatory services ranged from a high of 74.1 percent in Arizona to a low of 27.1 percent in North Dakota. Spending on optional services for mandatory enrollees ranged from 5.4 percent in Arizona to 39.0 percent in Tennessee. Spending on optional enrollees had similar ranges; New Hampshire had the largest share (31.1 percent) of spending on mandatory services for optional enrollees and North Dakota had the largest share (48.2 percent) of spending on optional services for optional enrollees. (State-by-state spending data are presented in Appendix 1A, Table 1A-6.) Similar to the variation seen in enrollment, these differences in spending reflect state choices and the demographic and health status characteristics of state residents. They also reflect differences in provider payment policies as well as geographic differences in the cost of medical care.

Overall, the results from this study mirror those of an earlier analysis by the Kaiser Commission on Medicaid and the Uninsured (KCMU) and the Urban Institute, which found that in 2007, 70 percent of

TABLE 1-4. Medicaid Spending on Mandatory and Optional Services by Enrollment Status and Eligibility Group, FY 2013

Enrollment status	Mandatory services					Optional services			
	Total	Managed care	Acute services	LTSS	Medicare premiums	Total	Managed care	Acute services	LTSS
Mandatory	**$190.1**	**38.9%**	**42.3%**	**13.8%**	**5.0%**	**$84.6**	**30.9%**	**20.3%**	**48.8%**
Children	**64.6**	54.6	43.7	1.7	0.0	**0.4**	0.4	–	99.6
Adults	**25.3**	45.5	53.7	0.3	0.5	**9.2**	68.6	30.4	1.0
People with disabilities	**70.4**	33.0	48.6	13.2	5.3	**57.3**	26.2	20.0	53.8
People age 65 and older	**29.8**	13.5	14.8	52.9	18.8	**17.7**	27.4	16.6	56.0
Optional	**$64.2**	**31.5%**	**36.3%**	**26.0%**	**6.2%**	**$62.3**	**22.2%**	**21.0%**	**56.8%**
Children	**11.3**	46.7	49.7	3.5	0.0	**0.1**	1.0	–	99.0
Adults	**18.6**	50.6	48.5	0.5	0.4	**9.0**	63.6	35.6	0.9
People with disabilities	**16.3**	23.9	46.0	20.8	9.3	**26.2**	12.2	24.1	63.7
People age 65 and older	**18.1**	9.3	6.6	70.9	13.2	**27.0**	18.2	13.2	68.6

Notes: FY is fiscal year. LTSS is long-term services and supports. Medicare premiums are not reported in the Medicaid Statistical Information System (MSIS). The Medicare premium amounts reported in CMS-64 reports are distributed proportionately across dually eligible beneficiaries identified in the MSIS for each state. As such, Medicare premiums are included in the total spending and are considered to be mandatory, but not in the distribution by service type. Medicare coinsurance and deductibles are reported under individual service types throughout the MSIS and are therefore included in mandatory and optional spending when examined by service type. Excludes $2.3 million in spending associated with the approximately 3,000 children who could not be classified as mandatory or optional. Includes federal and state spending. Excludes Idaho, Louisiana, and Rhode Island due to data reliability concerns regarding the completeness of monthly claims and enrollment data.

Dash (–) indicates zero; 0.0 percent indicates a value less than 0.05 percent that rounds to zero.

Source: MACPAC, 2017, analysis of MSIS data as of December 2015 and analysis of CMS-64 Financial Management Report net expenditure data from the Centers for Medicare & Medicaid Services as of June 2016.

enrollees were mandatory (Courtot et al. 2012). That study found that 40 percent of spending was for mandatory services for these mandatory enrollees, somewhat lower than our finding of 47 percent.[17]

Discussion

These findings show that almost half of total federal and state Medicaid spending is on mandatory services for mandatory enrollees. Mandatory coverage requirements, whether defined in terms of enrollee populations or services, reflect a set of decisions made by Congress over time regarding the core features of the program that must be implemented by every state. These include providing services to ensure the healthy growth and development of low-income children, to ensure that low-income pregnant women receive adequate prenatal care, and to improve access to care.

A significant amount (about one-third) of spending is on optional enrollees; that spending is about evenly split between mandatory and optional services. Like many other aspects of the Medicaid program, states vary considerably in the optional populations and the optional benefits they cover and the amount of spending attributable to each. These variations reflect both deliberate state choices when considering the health needs of their residents and the cost of paying for their care. For example, states consider the budgetary impact when expanding coverage to an optional population, including the costs of providing benefits and the number of people who may be eligible. In addition, they consider other policy goals, such as reducing the number of uninsured residents or the desire to ensure access to particular services, such as family planning. Similar to eligibility decisions, state adoption of optional services reflects multiple considerations, including the needs of the populations, the appropriate services to meet these needs, and the costs—both for the optional service and for the service it may be replacing. For example, as discussed above, providing HCBS, an optional benefit, may be less costly than providing mandatory services in an institution. State decisions to adopt certain benefits also vary over time; for example, states change Medicaid coverage of adult dental benefits on a regular basis, cutting these benefits when budgets are tight and expanding them when more funds are available (MACPAC 2015). By contrast, states are less likely to cut optional eligibility pathways once they have been introduced (MACPAC 2016d). Variations across states also reflect demographic and economic factors beyond Medicaid, such as the age of state residents, the underlying cost of medical care, and the health care infrastructure in the state. A deeper analysis of these state choices and their relationship to spending is beyond the scope of this analysis.

Although this analysis gives a sense of the scope and scale of how federal requirements affect states and how states exercise flexibility, it does not provide a clear picture of what should be considered fundamental and what might be considered useful but not necessary. With respect to benefits, for example, some of the optional services exist to encourage use of a more efficient setting or approach to meeting the needs of some beneficiaries, as in the HCBS example discussed previously. Other optional services, such as prescription drugs, are now integral to the practice of medical care and are needed to avoid other costs associated with conditions that can be treated pharmaceutically. In addition, some services are substitutes for each other; for example, coverage of behavioral therapy for someone with mental illness or a substance use disorder (which would be an optional service) may reduce the need for hospitalization (which would be a mandatory service).

In short, the statutory structure of mandatory and optional benefits and eligibility is not particularly useful in drawing conclusions about who is most in need and the necessity of certain kinds of care.

In thinking about Medicaid's role and the future direction of the program, it is also important

to consider the consequences of eliminating optional benefits and pathways. Medicaid plays a singular role in the U.S. health system in several key respects, including coverage of LTSS for frail elderly, adults with physical and intellectual disabilities, people with severe mental illness and addictions, and children with special health care needs. Many of these individuals do not have access to other sources of coverage. For others, coverage from an employer or in the individual or exchange market does not pay for the services, such as LTSS, they most need. If eligibility pathways or optional benefits for these vulnerable populations are eliminated, the costs of addressing their needs will be shifted elsewhere, either within the program or, more likely, to other agencies of state government.

From the Commission's perspective this analysis is most valuable for understanding the types of services that are being used by different populations. Other work the Commission is undertaking—examining delivery system reform, rebalancing long-term services and supports, and monitoring access—can help to inform discussions on the extent to which those services are being provided in a manner that is efficient, ensures access, and promotes appropriate health and functional outcomes.

Endnotes

[1] Prior to the ACA, states typically expanded eligibility by using less restrictive approaches to counting income and assets. However, with the introduction of a consistent income counting methodology for many populations—modified adjusted gross income (MAGI)—states are no longer able to do this.

[2] Section 209(b) states can establish more restrictive criteria than the SSI program—both financial (such as income or assets limits) and non-financial (such as the definition of disability)—to determine eligibility. However, these criteria may not be more restrictive than those in effect in the state on January 1, 1972.

[3] *National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566 (2012).

[4] Although EPSDT services are considered optional for medically needy children, if a state's medically needy coverage for any group includes services provided in institutions for mental diseases (IMD) or intermediate care facilities for individuals with intellectual disabilities (ICF/ID), then the state must include certain other services outlined in the statute, including EPSDT services (§1902(a)(10)(C)(iv) of the Act). If the EPSDT benefit is elected for the medically needy population, it must be made available to all Medicaid eligible individuals under age 21.

[5] Groups that are exempt from mandatory enrollment in ABPs include certain parents, pregnant women, individuals dually enrolled in Medicaid and Medicare, those who qualify for Medicaid on the basis of blindness or disability, enrollees receiving hospice care, those who are medically frail or have special medical needs, and children enrolled through child-welfare involved pathways (§1937(b) of the Social Security Act).

[6] MACPAC's January 23, 2017 response is available at https://www.macpac.gov/publication/macpac-response-to-request-for-report-on-medicaid-optional-eligibility-groups-and-benefits/.

[7] The Kaiser Commission on Medicaid and the Uninsured and the Urban Institute have undertaken similar analyses, with the most recent published in 2012. That analysis used 2007 MSIS data and CMS-64 reports to estimate the proportion of enrollment and spending attributable to mandatory (referred to as federal core) and optional (referred to as state expansion) enrollees. They assigned beneficiaries to either mandatory or optional status for the four major eligibility groups: the elderly, individuals with disabilities, non-disabled adults and pregnant women, and non-disabled children. Using MSIS service codes, they also allocated spending as either mandatory or optional.

[8] In FY 2013, there were approximately 3.1 million enrollees in Medicaid programs funded by the State Children's Health Insurance Programs (CHIP). Spending for CHIP-funded Medicaid enrollees totaled $4.1 billion. Almost all of these enrollees were optional and almost all of the spending was for mandatory services.

[9] Prior to the ACA, the mandatory eligibility levels for children in Medicaid differed by age; states were required to cover infants and children through age 5 in Medicaid in families with incomes less than or equal to 133 percent FPL and children age 6–18 in families with incomes less than or equal to 100 percent FPL. The ACA aligned minimum Medicaid eligibility for children at 133 percent FPL, requiring some states to shift older children (age 6–18) from separate CHIP programs into Medicaid in 2014.

[10] Almost all (98.4 percent) of dually eligible beneficiaries were people eligible on the basis of age (6.3 million) or on the basis of a disability (4.3 million).

[11] The 11.8 million enrollees in the new adult group represent average monthly enrollment or full-year equivalent.

[12] This analysis excludes $15.5 billion in disproportionate share hospital (DSH) payments (which would be considered mandatory spending) and $10.8 billion and certain non-DSH supplemental payments made under Section 1115 waiver expenditure authority (which would be considered optional spending). Section 1115 wavier authority payments include those made under uncompensated care pools, delivery system reform incentive payments, designated state health programs, and other non-DSH supplemental payments.

[13] States have the option to cover individuals who are not otherwise eligible for Medicaid (under Section 1915(i)) or who would be eligible for Medicaid if they were institutionalized (under Sections 1915(c) and (d) waivers) who are receiving services under HCBS waivers (§§ 1902(a)(10)(ii)(VI) and 1902(a)(10)(ii)(XXII) of the Social Security Act, 42 CFR 435.217, 42 CFR 435.219).

[14] Of the spending on dually eligible beneficiaries, $13.4 billion was spent on Medicare premiums, which are considered mandatory spending.

[15] This number does not include spending for prescription drugs that occurred under managed care. MACPAC estimates that about 59 percent of net prescription drug spending (i.e., after rebates) was under managed care (MACPAC 2016e). The figure does, however, include drug rebates that states receive.

[16] The vast majority of this spending (99.4 percent) was for HCBS waiver services. The remainder of optional spending (0.6 percent) was for managed care payments which had an HCBS waiver flag. Using the available data, we cannot determine what share of the capitation payment went toward HCBS services.

[17] Although the overall findings of the two studies align, there are some shifts in spending at the state level, with the majority of states showing a shift from spending on mandatory services for mandatory populations in 2007 to spending on optional populations in 2013. Because the data reported from the earlier work do not include enrollment figures or more detailed spending information, it is not possible to determine whether the shift is due to methodological differences or to changes in state policy. However, between 2007 and 2013, there was a considerable increase in the use of HCBS waivers and rebalancing the use of institutional and home- and community-based services (Eiken et al. 2016). This may explain some of the shift from mandatory to optional spending.

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APPENDIX 1A: State Summary Tables

TABLE 1A-1. State Adoption of Optional Medicaid Eligibility Pathways: Coverage for Children, Adults, and Qualified Immigrants

State	Children					Adults	Qualified immigrants		
	Chafee option (Independent foster care adolescents up to age 21)	Former foster care youth up to age 26, from other states	Ribicoff children up to age 21[1]	Katie Beckett children (or children with comparable coverage)	Family Opportunity Act buy-in	New adult group	Coverage of all qualified immigrants after 5 years of residency[2]	CHIPRA/ICHIA option (qualified children)[3]	CHIPRA/ICHIA option (qualified pregnant women)[3]
Alabama	–	–	–	–	–	–	–	–	–
Alaska	–	–	Y	Y	–	Y	Y	–	–
Arizona	Y	–	–	–	–	Y	Y	–	–
Arkansas	–	–	–	Y	–	Y	Y	–	–
California	Y	Y	–	–	–	Y	Y	Y	Y
Colorado	Y	–	–	–	Y	Y	Y	Y	Y
Connecticut	Y	–	Y	Y	–	Y	Y	Y	Y
Delaware	–	–	–	Y	–	Y	Y	Y	Y
District of Columbia	–	–	Y	Y	–	Y	Y	Y	Y
Florida	Y	–	–	–	–	–	Y	Y	–
Georgia	Y	Y	–	Y	–	–	Y	–	–
Hawaii	–	–	–	–	–	Y	Y	Y	Y
Idaho	–	–	–	Y	–	–	Y	–	–
Illinois	–	–	–	–	–	Y	Y	Y	–
Indiana	Y	–	–	–	–	Y	Y	–	–
Iowa	Y	–	Y	–	Y	Y	Y	Y	–
Kansas	Y	–	–	–	–	–	Y	–	–
Kentucky	–	Y	–	–	–	Y	Y	Y	–

TABLE 1A-1. (continued)

State	Children					Adults	Qualified immigrants		
	Chafee option (Independent foster care adolescents up to age 21)	Former foster care youth up to age 26, from other states	Ribicoff children up to age 21[1]	Katie Beckett children (or children with comparable coverage)	Family Opportunity Act buy-in	New adult group	Coverage of all qualified immigrants after 5 years of residency[2]	CHIPRA/ICHIA option (qualified children)[3]	CHIPRA/ICHIA option (qualified pregnant women)[3]
Louisiana	Y	Y	–	–	Y	Y	Y	–	–
Maine	–	–	Y	Y	–	–	Y	Y	Y
Maryland	Y	–	Y	–	–	Y	Y	Y	Y
Massachusetts	Y	Y	–	Y	–	Y	Y	Y	Y
Michigan	Y	Y	–	Y	–	Y	Y	–	–
Minnesota	–	–	Y	Y	–	Y	Y	Y	Y
Mississippi	Y	–	–	Y	–	–	–	–	–
Missouri	Y	–	–	–	–	–	Y	–	–
Montana	–	Y	–	–	–	Y	Y	Y	–
Nebraska	–	–	–	Y	–	–	Y	Y	Y
Nevada	Y	–	–	Y	–	Y	Y	–	–
New Hampshire	–	–	–	Y	–	Y	Y	–	–
New Jersey	Y	–	Y	–	–	Y	Y	Y	Y
New Mexico	Y	Y	–	–	–	Y	Y	Y	Y
New York	–	Y	–	–	–	Y	Y	Y	Y
North Carolina	Y	–	Y	–	–	–	Y	Y	Y
North Dakota	–	–	Y	–	Y	Y	–	–	–
Ohio	Y	–	Y	–	–	Y	Y	Y	Y
Oklahoma	Y	–	–	Y	–	–	Y	–	–
Oregon	Y	–	–	–	–	Y	Y	Y	–
Pennsylvania	–	Y	Y	–	–	Y	Y	Y	Y

TABLE 1A-1. (continued)

State	Children					Adults	Qualified immigrants		
	Chafee option (Independent foster care adolescents up to age 21)	Former foster care youth up to age 26, from other states	Ribicoff children up to age 21[1]	Katie Beckett children (or children with comparable coverage)	Family Opportunity Act buy-in	New adult group	Coverage of all qualified immigrants after 5 years of residency[2]	CHIPRA/ICHIA option (qualified children)[3]	CHIPRA/ICHIA option (qualified pregnant women)[3]
Rhode Island	Y	–	–	Y	–	Y	Y	Y	–
South Carolina	Y	–	–	Y	–	–	Y	–	–
South Dakota	Y	Y	–	Y	–	–	Y	–	–
Tennessee	–	–	Y	–	–	–	Y	–	–
Texas	Y	–	–	–	Y	–	–	Y	–
Utah	Y	Y	–	–	–	–	Y	Y	–
Vermont	–	–	Y	Y	–	Y	Y	Y	Y
Virginia	–	Y	–	–	–	–	–	Y	Y
Washington	Y	–	–	–	–	Y	Y	Y	Y
West Virginia	–	–	–	Y	–	Y	Y	Y	Y
Wisconsin	Y	Y	–	Y	–	–	Y	Y	Y
Wyoming	Y	–	–	–	–	–	–	–	Y
States adopting optional pathway	**30**	**14**	**14**	**22**	**5**	**32**	**45**	**31**	**23**

Notes: CHIPRA is the Children's Health Insurance Program Reauthorization Act. ICHIA is the Legal Immigrant Children's Health Improvement Act. For more detail on the federal eligibility requirements and state options, see MACPAC's March 2017 fact sheet, *Federal Requirements and State Options: Eligibility*, at https://www.macpac.gov/wp-content/uploads/2017/03/Federal-Requirements-and-State-Options-Eligibility.pdf.

– Dash indicates that state has not adopted this optional eligibility pathway.

[1] Under the Ribicoff option, states may cover all children or a state-defined reasonable classification of children under age 21 up to the state's 1996 Aid to Families with Dependent Children (AFDC) levels. Poverty-related pathways may have superseded this eligibility pathway.

[2] The count of states listed as adopting coverage of all qualified immigrants after five years of residency shows coverage as of December 2015. Any state that covers some, but not all, qualified immigrants after five years is listed as not adopting this pathway.

TABLE 1A-1. (continued)

[3] States were given the option to cover lawfully residing immigrant children and pregnant women without imposing a five-year waiting period under Section 214 of the CHIP Reauthorization Act of 2009 (CHIPRA, P.L. 111-3). The provision became known by an acronym, ICHIA, based on the name of the original legislation proposed in 2007.

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TABLE 1A-2. State Adoption of Optional Medicaid Eligibility Pathways: Coverage for Elderly, Disabled, Medically Needy, and Specific Diseases or Services

State	Elderly and disabled						Medically needy				Specific diseases or services[1]			
	Special income group	Buy-in for working disabled	State supplemental payments	§ 1915(i) HCBS state plan option	PACE	Expanded MSP income and asset levels	Medically needy children	Medically needy adults	Medically needy elderly	Medically needy disabled	Tuberculosis treatment services	Breast or cervical cancer treatment services	Family planning services and supplies	
													State plan	Waiver
Alabama	Y	–	Y	–	Y	Y	–	–	–	–	–	Y	–	Y
Alaska	Y	Y	Y	–	–	–	–	–	–	–	–	Y	–	–
Arizona	Y	Y	–	–	–	Y	–	–	–	–	–	Y	–	–
Arkansas	Y	Y	–	–	Y	–	Y	Y	Y	Y	–	Y	–	–
California	–	Y	Y	Y	Y	–	Y	Y	Y	Y	Y	Y	Y	–
Colorado	Y	Y	Y	Y	Y	–	–	–	–	–	–	Y	–	–
Connecticut	Y	Y	Y	Y	–	Y	Y	Y	Y	Y	Y	Y	Y	–
Delaware	Y	Y	Y	Y	Y	Y	–	–	–	–	–	Y	–	–
District of Columbia	Y	Y	Y	Y	–	Y	Y	Y	Y	Y	–	Y	–	–
Florida	Y	–	Y	–	Y	–	Y	Y	Y	Y	–	Y	–	Y
Georgia	Y	Y	Y	–	–	–	Y	Y	Y	Y	–	Y	–	Y
Hawaii	–	–	Y	–	–	–	Y	Y	Y	Y	–	Y	–	–
Idaho	Y	Y	Y	Y	–	–	–	–	–	–	–	Y	–	–
Illinois	–	Y	Y	–	–	–	Y	Y	Y	Y	–	Y	–	–
Indiana	Y	Y	Y	Y	Y	Y	–	–	–	–	–	Y	Y	–
Iowa	Y	Y	Y	Y	Y	–	Y	Y	Y	Y	–	Y	–	Y
Kansas	Y	Y	Y	–	Y	–	Y	Y	Y	Y	–	Y	–	–
Kentucky	Y	Y	Y	–	–	–	Y	Y	Y	Y	–	Y	–	–
Louisiana	Y	Y	Y	Y	Y	–	Y	Y	Y	Y	–	Y	Y	–
Maine	Y	Y	Y	–	–	Y	Y	Y	Y	Y	–	Y	Y	–
Maryland	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	–	Y	–	Y

TABLE 1A-2. (continued)

State	Elderly and disabled						Medically needy				Specific diseases or services[1]			
	Special income group	Buy-in for working disabled	State supplemental payments	§ 1915(i) HCBS state plan option	PACE	Expanded MSP income and asset levels	Medically needy children	Medically needy adults	Medically needy elderly	Medically needy disabled	Tuberculosis treatment services	Breast or cervical cancer treatment services	Family planning services and supplies	
													State plan	Waiver
Massachusetts	Y	Y	Y	–	Y	–	Y	Y	Y	Y	–	Y	–	–
Michigan	Y	Y	Y	Y	Y	–	Y	Y	Y	Y	–	Y	–	–
Minnesota	Y	Y	Y	–	–	Y	Y	Y	Y	Y	–	Y	Y	–
Mississippi	Y	Y	–	Y	–	Y	–	–	–	–	–	Y	–	Y
Missouri	Y	–	Y	–	–	–	–	–	–	–	–	Y	–[1]	–
Montana	Y	Y	Y	Y	–	–	Y	Y	Y	Y	–	Y	–	Y
Nebraska	–	Y	Y	–	Y	–	Y	Y	Y	Y	–	Y	–	–
Nevada	Y	Y	Y	Y	–	–	–	–	–	–	–	Y	–	–
New Hampshire	Y	Y	Y	–	–	–	Y	Y	Y	Y	–	Y	Y	–
New Jersey	Y	Y	Y	–	Y	–	Y	Y	Y	Y	–	Y	–	–
New Mexico	Y	Y	Y	–	Y	–	–	–	–	–	–	Y	Y	–
New York	–	Y	Y	–	Y	Y	Y	Y	Y	Y	–	Y	Y	–
North Carolina	–	Y	Y	–	Y	–	Y	Y	Y	Y	–	Y	Y	–
North Dakota	–	Y	–	–	Y	–	Y	Y	Y	Y	–	Y	–	–
Ohio	Y	Y	Y	–	Y	–	–	–	–	–	–	Y	–	–
Oklahoma	Y	–	Y	–	Y	–	–	–	–	–	–	Y	Y	–
Oregon	Y	Y	–	Y	Y	Y	–	–	–	–	–	Y	–	Y
Pennsylvania	Y	Y	Y	–	Y	–	Y	Y	Y	Y	–	Y	Y	–
Rhode Island	Y	Y	Y	–	Y	–	Y	Y	Y	Y	Y	Y	–	Y
South Carolina	Y	–	Y	–	Y	–	–	–	–	–	Y	Y	Y	–
South Dakota	Y	Y	Y	–	–	–	–	–	–	–	–	Y	–	–
Tennessee	Y	–	–	–	Y	–	Y	–	–	–	–	Y	–	–

TABLE 1A-2. (continued)

State	Elderly and disabled						Medically needy				Specific diseases or services[1]			
	Special income group	Buy-in for working disabled	State supplemental payments	§ 1915(i) HCBS state plan option	PACE	Expanded MSP income and asset levels	Medically needy children	Medically needy adults	Medically needy elderly	Medically needy disabled	Tuberculosis treatment services	Breast or cervical cancer treatment services	Family planning services and supplies	
													State plan	Waiver
Texas	Y	Y	Y	Y	Y	–	–	–	–	–	Y	Y	–[1]	–
Utah	Y	Y	Y	–	–	–	Y	Y	Y	Y	–	Y	–	–
Vermont	Y	Y	Y	–	–	Y	Y	Y	Y	Y	–	Y	–[1]	–
Virginia	Y	Y	Y	–	Y	–	Y	Y	Y	Y	–	Y	Y	–
Washington	Y	Y	Y	–	Y	–	Y	Y	Y	Y	–	Y	–	Y
West Virginia	Y	Y	–	–	–	–	Y	Y	Y	Y	–	Y	–	–
Wisconsin	Y	Y	Y	Y	Y	–	Y	Y	Y	Y	Y	Y	Y	–
Wyoming	Y	Y	Y	–	Y	–	–	–	–	–	–	Y	–	Y
States adopting optional pathway	**44**	**44**	**44**	**17**	**31**	**13**	**33**	**32**	**32**	**32**	**6**	**51**	**15**	**11**

Notes: HCBS is home- and community-based services. MSP is Medicare Savings Program. PACE is Program of All-Inclusive Care for the Elderly. For more detail on the federal eligibility requirements and state options, see MACPAC's March 2017 fact sheet, *Federal Requirements and State Options: Eligibility*, at https://www.macpac.gov/wp-content/uploads/2017/03/Federal-Requirements-and-State-Options-Eligibility.pdf.

– Dash indicates that state has not adopted this optional eligibility pathway.

[1] Missouri, Texas, and Vermont have state-funded family planning programs. In Missouri and Texas, women age 18 and older with incomes under 185 percent of the federal poverty level are eligible. In Missouri, women losing Medicaid postpartum are also eligible for the family planning program. In Vermont, anyone with income below 200 percent of the federal poverty level is eligible. (Guttmacher Institute 2017)

Sources: Brooks, T., K. Wagnerman, S. Artiga, et al. 2017. *Medicaid and CHIP eligibility, enrollment, renewal and cost-sharing policies as of January 2017: Findings from a 50-state survey.* Washington, DC: Kaiser Commission on Medicaid and the Uninsured. http://kff.org/report-section/medicaid-and-chip-eligibility-enrollment-renewal-and-cost-sharing-policies-as-of-january-2017-tables/; California Department of Health Care Services (CDHCS). 2017. Medi-Cal. Sacramento, CA: CDHCS. http://www.dhcs.ca.gov/services/medi-cal/Pages/default.aspx. https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/Downloads/MAX_IB12_CHIPData.pdf. Centers for Disease Control and Prevention (CDC). 2016. National Breast and Cervical Cancer Early Detection Program (NBCCEDP). Atlanta, GA: CDC. https://www.cdc.gov/cancer/nbccedp/about.htm. Connecticut Department of Public Health. 2013. Tuberculosis Medicaid program. http://www.ct.gov/dph/cwp/view.asp?a=3136&Q=492600&PM=1; Guttmacher Institute. 2017. *Medicaid family planning eligibility expansions.* Washington, DC: Guttmacher Institute. https://www.guttmacher.org/state-policy/explore/medicaid-family-planning-eligibility-expansions; Center for Health Law and Policy Innovation (CHLPI), Harvard Law School. 2015. *The Medicaid tuberculosis option: an opportunity for policy reform.* Jamaica Plain, MA: CHLPI. http://www.chlpi.org/wp-content/uploads/2014/01/Issue-Brief-June-2015-The-Medicaid-Tuberculosis-Option.pdf; Kaiser Commission on Medicaid and the Uninsured (KCMU). 2016. Medicaid Benefits: Program of All-Inclusive Care for the Elderly (PACE). Washington, DC: KCMU. http://kff.org/medicaid/state-indicator/program-of-all-inclusive-care-for-the-elderly-2/?currentTimeframe=0; Kaiser Commission

TABLE 1A-2. (continued)

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TABLE 1A-3. State Adoption of Optional Medicaid Benefits: Acute Services

State	Chiropractic services	Dental services	Eyeglasses	Health homes for enrollees with chronic conditions	Occupational therapy services	Optometry services	Other diagnostic, screening, preventive, and rehabilitative services	Physical therapy services	Prescribed drugs	Prosthetic devices	Speech, hearing, and language disorder services	Targeted case management services
Alabama	–	–	Mandatory	Yes	–	Mandatory	–	–	Mandatory	Mandatory	–	Mandatory
Alaska	–	Mandatory	Mandatory	–	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory
Arizona	–	Both	Both	–	Both	Both	Both	Both	Both	Both	Both	Both
Arkansas	Both	Both	Both	–	–	Both	–	–	Both	Both	–	Both
California	Both	Both	Both	–	Both	Both	Both	Both	Both	Both	Both	Both
Colorado	–	Mandatory	Mandatory	–	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory
Connecticut	–	Both	Both	Yes	–	Both	Both	–	Both	Both	–	Both
Delaware	–	–	–	–	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	–
District of Columbia	–	Both	Both	Yes	–	Both	Both	Both	Both	Both	–	Mandatory
Florida	Both	Both	Both	–	Both	Both	Both	Both	Both	Both	Both	Both
Georgia	–	Both	Both	–	–	Both	Both	–	Both	Both	–	Both
Hawaii	–	Both	Both	–	Both	Both	Both	Both	Both	Both	Both	Both
Idaho	Mandatory	Mandatory	Mandatory	–	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory
Illinois	–	Both	Both	–	Both	Both	Both	Both	Both	Both	Both	Both
Indiana	Mandatory	Mandatory	Mandatory	–	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	–
Iowa	Both	Both	Both	Yes	Both	Both	Both	Both	Both	Both	Both	Both
Kansas	–	Both	Both	–	Both	Both	–	Both	Both	Both	Both	Both
Kentucky[1]	Other	Other	–	–	–	Other	Other	–	Other	Other	–	Other
Louisiana	–	Mandatory	–	–	–	Both	Both	–	Both	Both	–	Both
Maine	Both	Both	Both	Yes	Both	Both	Both	Both	Both	Both	Both	Both
Maryland	–	Both	–	Yes	–	Both	Both	Both	Both	Both	–	Both
Massachusetts	Both	Both	Both	–	Both	Both	Both	Both	Both	Both	Both	Both

TABLE 1A-3. (continued)

State	Chiropractic services	Dental services	Eyeglasses	Health homes for enrollees with chronic conditions	Occupational therapy services	Optometry services	Other diagnostic, screening, preventive, and rehabilitative services	Physical therapy services	Prescribed drugs	Prosthetic devices	Speech, hearing, and language disorder services	Targeted case management services
Michigan	Both	Both	Both	Yes	–	Both	Both	–	Both	Both	Both	Both
Minnesota[1]	Other	Other	Other	Yes	Other	Other	Other	Other	Other	Other	Other	Other
Mississippi	Mandatory	Mandatory	Mandatory	–	–	Mandatory	Mandatory	–	Mandatory	–	–	Mandatory
Missouri	–	Mandatory	Mandatory	Yes	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory
Montana[1]	–	Other	Other	–	Other	Other	Other	Other	Other	Other	Other	Other
Nebraska	Both	Both	Both	–	Both	Both	Both	Both	Both	Both	Both	Both
Nevada	–	Mandatory	Mandatory	–	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory
New Hampshire	–	Both	Both	–	Both	Both	Both	Both	Both	Both	Both	Both
New Jersey	Both	Both	Both	Yes	–	Both	Both	–	Both	Both	–	Both
New Mexico	–	Mandatory	Mandatory	Yes	Mandatory	Mandatory	–	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory
New York	–	Both	Both	Yes	Both	Both	Both	Both	Both	Both	Both	Both
North Carolina	Both	Both	–	Yes	–	Both	Both	–	Both	Both	–	Both
North Dakota	Both	Both	Both	–	Both	Both	Both	Both	Both	Both	Both	Both
Ohio	Mandatory	Mandatory	Mandatory	Yes	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory
Oklahoma	–	Mandatory	–	Yes	–	Mandatory	Mandatory	–	Mandatory	Mandatory	–	Mandatory
Oregon[1]	Other	Other	Other	–	Other	Other	Other	Other	Other	Other	Other	Other
Pennsylvania	Both	Both	Both	–	–	Both	Both	–	Both	Mandatory	–	Both
Rhode Island[1]	–	Other	Other	Yes	–	Other	Other	–	Other	Other	–	Other
South Carolina	Mandatory	–	Mandatory	–	–	Mandatory	Mandatory	–	Mandatory	Mandatory	–	Mandatory
South Dakota	Mandatory	Mandatory	Mandatory	Yes	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory
Tennessee[1]	–	–	Other	–	Other	Other	Other	Other	Other	Other	Other	Other
Texas	Both	Both	Both	–	Both	Both	Both	Both	Both	Both	Both	Both

TABLE 1A-3. (continued)

State	Chiropractic services	Dental services	Eyeglasses	Health homes for enrollees with chronic conditions	Occupational therapy services	Optometry services	Other diagnostic, screening, preventive, and rehabilitative services	Physical therapy services	Prescribed drugs	Prosthetic devices	Speech, hearing, and language disorder services	Targeted case management services
Utah[1]	Other	Other	Other	–	Other	Other	Other	Other	Other	Other	Other	Other
Vermont[1]	Other	Other	–	Yes	Other	Other	Other	Other	Other	Other	Other	Other
Virginia	–	Both	–	–	–	Both	Both	–	Both	Both	Both	Both
Washington	–	Both	–	Yes	Mandatory	Both	Both	Mandatory	Both	Both	Mandatory	Both
West Virginia[1]	Other	Other	Other	Yes	Other	Other	Other	Other	Other	Other	Other	Other
Wisconsin	Both	Both	Both	–	Both	Both	–	Both	Both	Both	Both	Both
Wyoming	–	Mandatory	Mandatory	–	Mandatory	Mandatory	–	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory
States adopting optional benefit	**26**	**47**	**42**	**20**	**34**	**51**	**45**	**36**	**51**	**50**	**38**	**49**

Notes: Mandatory indicates that the state provides a benefit to mandatory populations. Other indicates that the state offers different benefit packages to different populations. Both indicates that the state provides the benefit to both mandatory and optional populations. A dash (–) indicates that the state does not provide the benefit at all. Although the benefit category may be covered, the amount or scope of coverage available can vary by state and plan. Benefit categories are broad and may not include coverage of specific benefits. For example, dental services might include emergency dental services only, or might cover preventative or restorative services. Some benefits are only available when determined medically necessary. For more detail on the federal benefit requirements and state options, see MACPAC's March 2017 fact sheet, *Federal Requirements and State Options: Benefits*, at https://www.macpac.gov/wp-content/uploads/2017/03/Federal-Requirements-and-State-Options-Benefits.pdf.

[1] Kentucky, Minnesota, Montana, Oregon, Rhode Island, Tennessee, Utah, Vermont, and West Virginia offer different benefit packages to different populations. For additional details on how these tiered benefit packages are structured, please see the Medicaid benefits database (KCMU 2014).

Source: Kaiser Commission on Medicaid and the Uninsured (KCMU). 2014. Medicaid benefits database. Washington, DC: KCMU, http://kff.org/data-collection/medicaid-benefits/.

TABLE 1A-4. State Adoption of Optional Medicaid Benefits: Long-Term Services and Supports

State	Home- and community-based services	Hospice services	Inpatient hospital and nursing facility services for individuals age 65 and older in IMDs	Inpatient psychiatric services for individuals under 21	ICF services for individuals with intellectual disabilities	Personal care services	Private duty nursing services	PACE services	Services furnished in a religious non-medical health care institution
Alabama	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	–	–	Mandatory	–
Alaska	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	–	–	–
Arizona	Both	Both	Both	Both	Both	Both	Both	–	Both
Arkansas	Both	Both	–	Both	Mandatory	Mandatory	Both	Mandatory	–
California	Both	Both	Both	Both	Both	Both	–	Both	Both
Colorado	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	–	Mandatory	Mandatory	–
Connecticut	Both	–	Both	Both	Both	–	–	–	–
Delaware	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	–	Mandatory	Mandatory	–
District of Columbia	Both	–	Both	Both	Both	Both	Both	–	–
Florida	Both	Both	Mandatory	Both	Mandatory	–	–	Both	Both
Georgia	Both	Both	–	Mandatory	Mandatory	–	–	–	–
Hawaii	Both	–	–	Both	Both	–	–	–	–
Idaho	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	–	–	–
Illinois	Both	Both	Both	Both	Both	–	–	–	–
Indiana	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	–	Mandatory	–	Mandatory
Iowa	Both	Both	Mandatory	Mandatory	Mandatory	–	–	Both	–
Kansas	Both	Both	Both	Both	Both	–	–	Both	–
Kentucky[1]	Other	Other	Other	Other	Other	–	–	–	–
Louisiana	Both	Both	Both	Both	Both	Both	–	Mandatory	–
Maine	Both	Both	Both	Both	Both	Both	Both	–	–
Maryland	Both	Both	Both	Both	Both	Both	–	Both	–
Massachusetts	Both	–	Both	Both	Both	Both	Both	Both	–
Michigan	Both	Both	Both	Both	–	Both	–	Both	–

TABLE 1A-4. (continued)

State	Home- and community-based services	Hospice services	Inpatient hospital and nursing facility services for individuals age 65 and older in IMDs	Inpatient psychiatric services for individuals under 21	ICF services for individuals with intellectual disabilities	Personal care services	Private duty nursing services	PACE services	Services furnished in a religious non-medical health care institution
Minnesota[1]	Other	Other	Other	Other	Other	Other	Other	–	–
Mississippi	Mandatory	Mandatory	–	Mandatory	Mandatory	–	–	–	–
Missouri	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	–	Mandatory	–
Montana[1]	Other	Other	Other	Other	Other	Other	–	–	–
Nebraska	Both	Both	Both	Both	Both	Both	Both	–	–
Nevada	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	–	–
New Hampshire	Both	–	Both	Both	–	Both	Both	–	–
New Jersey	Both	–	Mandatory	Mandatory	Mandatory	Both	–	Mandatory	Mandatory
New Mexico	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	–	Mandatory	–
New York	Both	–	Both	Both	Both	Both	Both	Both	–
North Carolina	Both	Both	Both	Both	Both	Both	Both	Both	–
North Dakota	Both	Both	Both	Both	Both	Both	Both	Both	–
Ohio	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	–	Mandatory	Mandatory	Mandatory
Oklahoma	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	–	Mandatory	–
Oregon[1]	Other	Other	Other	Other	–	Other	Other	Other	–
Pennsylvania	Both	–	Both	Both	Both	–	–	Both	–
Rhode Island[1]	Other	–	Other	Other	Other	Other	Other	Other	–
South Carolina	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	–	–	Mandatory	–
South Dakota	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	–	–	–
Tennessee[1]	Other	Other	Other	Other	Other	–	Other	Other	Other
Texas	Both	Both	Both	Both	Both	Both	–	Both	Mandatory
Utah[1]	Other	Other	Other	Other	Other	Other	Other	–	–

TABLE 1A-4. (continued)

State	Home- and community-based services	Hospice services	Inpatient hospital and nursing facility services for individuals age 65 and older in IMDs	Inpatient psychiatric services for individuals under 21	ICF services for individuals with intellectual disabilities	Personal care services	Private duty nursing services	PACE services	Services furnished in a religious non-medical health care institution
Vermont[1]	Other	Other	Other	Other	Other	–	Other	Other	–
Virginia	Both	–	Mandatory	Mandatory	Mandatory	–	–	Both	–
Washington	Both	Both	Both	Both	Both	Mandatory	Both	Mandatory	–
West Virginia[1]	Other	Other	–	Other	Other	Other	–	–	–
Wisconsin	Both	Both	Both	Both	Both	Both	Both	Both	Both
Wyoming	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory	–	–	Mandatory	–
States adopting optional benefit	**51**	**41**	**46**	**51**	**48**	**31**	**23**	**31**	**11**

Notes: IMD is institutions for mental diseases. ICF is intermediate care facility. PACE is Program of All-Inclusive Care for the Elderly. Mandatory indicates that the state provides a benefit to mandatory populations. Other indicates that the state offers different benefit packages to different populations. Both indicates that the state provides the benefit to both mandatory and optional populations. A dash (–) indicates that the state does not provide the benefit at all. Although the benefit category may be covered, the amount or scope of coverage available can vary by state and plan. Benefit categories are broad and may not include coverage of specific benefits. For example, dental services might include emergency dental services only, or might cover preventative or restorative services. Some benefits are only available when determined medically necessary. For more detail on the federal benefit requirements and state options, see MACPAC's March 2017 fact sheet, *Federal Requirements and State Options: Benefits*, at https://www.macpac.gov/wp-content/uploads/2017/03/Federal-Requirements-and-State-Options-Benefits.pdf.

[1] Kentucky, Minnesota, Montana, Oregon, Rhode Island, Tennessee, Utah, Vermont, and West Virginia offer different benefit packages to different populations. For additional details on how these tiered benefit packages are structured, please see the Medicaid benefits database (KCMU 2014).

Source: Kaiser Commission on Medicaid and the Uninsured (KCMU). 2014. Medicaid benefits database. Washington, DC: KCMU, http://kff.org/data-collection/medicaid-benefits/.

TABLE 1A-5. Mandatory and Optional Enrollment in Medicaid, by State, FY 2013

State	Mandatory		Optional	
	Number	Percent	Number	Percent
Alabama	1,019,798	84.1%	192,495	15.9%
Alaska	113,056	83.2	22,830	16.8
Arizona	1,445,777	86.0	235,376	14.0
Arkansas	477,003	68.5	219,133	31.5
California	7,318,779	62.3	4,423,210	37.7
Colorado	790,061	88.2	106,144	11.8
Connecticut	604,811	70.5	253,675	29.5
Delaware	190,897	73.4	69,279	26.6
District of Columbia	129,978	52.9	115,688	47.1
Florida	3,676,953	85.3	636,059	14.7
Georgia	1,807,203	89.8	205,789	10.2
Hawaii[1]	149,787	49.9	150,666	50.1
Illinois	1,795,397	59.1	1,243,138	40.9
Indiana[2]	941,641	75.3	308,354	24.7
Iowa	409,508	64.6	224,706	35.4
Kansas	401,699	90.8	40,602	9.2
Kentucky	778,025	83.9	148,856	16.1
Maine	244,914	66.1	125,640	33.9
Maryland	722,580	63.4	416,249	36.6
Massachusetts	781,810	51.2	744,998	48.8
Michigan	1,530,384	66.8	760,726	33.2
Minnesota	627,013	54.3	527,176	45.7
Mississippi	713,301	90.8	72,665	9.2
Missouri	820,278	73.1	301,554	26.9
Montana	118,335	83.1	24,095	16.9
Nebraska	147,525	56.2	114,841	43.8
Nevada	403,760	95.8	17,878	4.2
New Hampshire	79,909	48.2	85,989	51.8
New Jersey[3]	929,966	78.1	260,255	21.9
New Mexico	419,078	63.5	240,579	36.5
New York	3,193,283	53.2	2,805,766	46.8

TABLE 1A-5. (continued)

State	Mandatory		Optional	
	Number	Percent	Number	Percent
North Carolina	1,583,722	79.2%	416,686	20.8%
North Dakota	67,924	77.9	19,236	22.1
Ohio	1,737,605	65.7	907,124	34.3
Oklahoma	595,404	62.6	355,649	37.4
Oregon	628,675	82.7	131,538	17.3
Pennsylvania	1,897,481	73.9	669,718	26.1
South Carolina	716,642	65.7	374,657	34.3
South Dakota	110,994	82.8	23,014	17.2
Tennessee	1,418,642	91.1	138,081	8.9
Texas	4,781,021	91.2	459,073	8.8
Utah	310,049	79.7	78,844	20.3
Vermont	71,761	34.8	134,470	65.2
Virginia	854,551	75.3	280,986	24.7
Washington	904,851	63.7	516,021	36.3
West Virginia	378,570	86.5	58,834	13.5
Wisconsin	758,412	60.5	495,382	39.5
Wyoming	81,271	91.1	7,982	8.9

Notes: Idaho, Louisiana, and Rhode Island were excluded due to data reliability concerns regarding the completeness of monthly claims and enrollment data. Excludes approximately 3,000 children who could not be classified as mandatory or optional due to missing information.

[1] Hawaii reports adult coverage under its Section 1115 waiver and does not report enrollment under the adult Medicaid Assistance Status/Basis of Eligibility category.

[2] Indiana uses restricted benefits flag 5 to identify pregnant women who receive only pregnancy-related services and non-citizens eligible only for emergency services.

[3] In 2013, New Jersey covered some optional parents in Medicaid using Title XXI funding. As such, these parents are excluded from expenditures reported here.

Source: MACPAC, 2017, analysis of Medicaid Statistical Information System data as of December 2015.

TABLE 1A-6. Share of Medicaid Spending on Mandatory and Optional Populations and Services, by State, FY 2013

State	Mandatory enrollment and mandatory services	Mandatory enrollment and optional services	Optional enrollment and mandatory services	Optional enrollment and optional services
Alabama	67.3%	15.2%	15.3%	2.2%
Alaska	50.9	34.2	12.3	2.5
Arizona	74.1	5.4	18.2	2.3
Arkansas	55.5	19.6	18.7	6.2
California	47.8	24.3	9.7	18.3
Colorado	65.3	23.3	8.6	2.8
Connecticut	39.9	21.0	23.4	15.7
Delaware	38.6	31.1	15.6	14.7
District of Columbia	34.1	26.5	15.8	23.5
Florida	60.5	15.6	16.8	7.2
Georgia	65.0	16.9	13.8	4.2
Hawaii	29.3	21.4	27.8	21.5
Illinois	37.9	7.0	18.5	36.6
Indiana	51.2	17.8	23.3	7.7
Iowa	43.7	22.3	19.6	14.4
Kansas	54.3	23.0	13.2	9.5
Kentucky	58.7	21.9	13.5	5.9
Maine	42.9	18.0	25.7	13.4
Maryland	43.1	24.2	13.1	19.6
Massachusetts	31.4	21.7	23.5	23.4
Michigan	46.2	20.4	21.6	11.8
Minnesota	30.5	29.4	20.9	19.1
Mississippi	66.2	14.2	15.2	4.4
Missouri	47.5	25.7	18.6	8.2
Montana	52.9	15.8	16.5	14.8
Nebraska	27.5	19.4	13.9	39.2
Nevada	71.5	16.2	8.3	4.0
New Hampshire	29.8	16.2	31.1	22.9
New Jersey[1]	46.6	22.3	15.7	15.3

TABLE 1A-6. (continued)

State	Mandatory enrollment and mandatory services	Mandatory enrollment and optional services	Optional enrollment and mandatory services	Optional enrollment and optional services
New Mexico	50.8%	20.0%	25.1%	4.1%
New York	32.4	21.4	14.3	31.9
North Carolina	53.8	14.4	18.1	13.7
North Dakota	27.1	19.8	4.8	48.2
Ohio	48.3	24.3	18.7	8.7
Oklahoma	52.7	13.4	26.3	7.7
Oregon	43.4	29.6	14.4	12.5
Pennsylvania	48.0	19.6	22.3	10.0
South Carolina	50.3	21.0	21.5	7.2
South Dakota	53.3	25.2	16.0	5.5
Tennessee	43.7	39.0	4.8	12.5
Texas	66.5	21.1	8.2	4.1
Utah	53.1	18.0	12.4	16.6
Virginia	44.9	28.1	15.9	11.1
Washington	45.1	25.6	19.4	9.8
West Virginia	47.5	23.2	12.7	16.6
Wisconsin	34.3	23.2	23.4	19.2
Wyoming	49.9	20.4	16.1	13.7

Notes: Idaho, Louisiana, Rhode Island, and Vermont were excluded due to data reliability concerns regarding the completeness of monthly claims and enrollment data. Includes federal and state spending. Medicare premiums are not reported in the Medicaid Statistical Information System (MSIS). The Medicare premium amounts reported in CMS-64 reports are distributed proportionately across dually eligible beneficiaries identified in the MSIS for each state. As such, Medicare premiums are included in the total spending and are considered to be mandatory. Medicare coinsurance and deductibles are reported under individual service types throughout the MSIS and are therefore included in mandatory and optional spending when examined by service type. Excludes $2.3 million in spending associated with the approximately 3,000 children who could not be classified as mandatory or optional.

[1] In 2013, New Jersey covered some optional parents in Medicaid using Title XXI funding. As such, these parents are excluded from expenditures reported here.

Source: MACPAC, 2017, analysis of Medicaid Statistical Information System data as of December 2015 and analysis of CMS-64 Financial Management Report net expenditure data from the Centers for Medicare & Medicaid Services as of June 2016.

APPENDIX 1B: Congressional Request for a Study on Mandatory and Optional Populations and Services in Medicaid

Congress of the United States
Washington, DC 20515

January 11, 2017

Commissioners
The Medicaid and CHIP Payment and Access Commission
1800 M Street N.W.
Suite 650
Washington, DC 20036

Dear Commissioners:

Today Medicaid is an important safety net program that provides health coverage and long-term care services for some of our nation's most vulnerable patients. As legislative expansions and demographic developments require the Medicaid program to do more and more, we are concerned that the Medicaid safety net faces increased strain in the years to come, which could cause further access and health care quality problems for beneficiaries.

Medicaid is the world's largest health insurance program–covering more than 77 million Americans in 2016 and the Congressional Budget Office (CBO) estimates Medicaid will provide health care or long-term care for up to 98 million Americans in 2017. [1] The program already consumes more general revenue from the federal government than Medicare and a recent tally estimates that the size of the population covered by Medicaid is greater than the entire population of the 29 least populous States, *combined.*[2] In fact, if Medicaid enrollment were its own country, Medicaid would be the 21st most populous country in the world – larger than France, Italy, or the United Kingdom.

The growth of the Medicaid program continues a longstanding trend within the program. Medicaid program expenditures and enrollment are both about three times larger than they were under President Clinton in 1997.[3] CBO warns that the federal share of Medicaid outlays is expected to roughly double over the coming decade, increasing from $371 billion in 2015 to more than $624 billion in 2026. That means that by 2026, total federal and state expenditures on Medicaid will cost about $1 trillion *each year.*[4]

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[1] https://www.cbo.gov/sites/default/files/recurringdata/51301-2016-03-medicaid.pdf
[2] https://energycommerce.house.gov/news-center/blog-posts/ec-shares-handy-medicaid-overview-tool
[3] https://www.macpac.gov/wp-content/uploads/2015/01/Figure-1.-Medicaid-Enrollment-and-Spending-FY-1966-FY-2013.pdf
[4] Federal Medicaid spending has grown by more than 2,500 percent since 1980.

Troublingly, there is already a growing range of literature showing that many Medicaid beneficiaries are indeed facing challenges related to access and quality. With Medicaid expenditures growing, many States face difficult choices about which benefits and populations are served. Due to these budget pressures, some States have been forced to make changes which result in more children and individuals with intellectual and developmental disabilities being placed on waiting lists—thus ultimately delaying or even denying care to some of the most vulnerable patients served by Medicaid.[5]

In this environment, we believe it is important to better understand the optional eligibility groups and optional benefits States are covering. Clearly, some optional benefits – such as prescription drug coverage – are important for virtually all beneficiaries. Yet other benefits may be more necessary as a covered benefit for a subset of beneficiaries. However, this information is not easily discernable in one source for each state. Instead, this information exists across multiple, disaggregated sources that make meaningful review a challenge. The information currently available from the Centers for Medicare & Medicaid Services is limited to a list of mandatory and optional eligibility groups, as well as mandatory and optional benefits.[6]

Congress in particular needs to have the most comprehensive and current information available, especially given that CBO warns that federal spending for mandatory programs and net interest will exceed total federal revenues by the 2027 – 2036 period. Without action, the unrestrained spending on Medicaid, which increases for each benefit and individual covered, could crowd out funding for other critical State and federal priorities like education, criminal justice enforcement, and transportation.[7]

To better inform Congressional oversight, we request MACPAC immediately initiate work to report on optional eligibility groups covered and optional benefits in each State Medicaid program for the most recent year data is available. Specifically, we request that MACPAC's work specify the following for each State:

- The intersection of the coverage of optional eligibility groups and the receipt of optional benefits for those groups to show the extent to which, for example, optional populations in given State are receiving optional benefits.
- The number of people covered by each State who qualify for Medicaid through an optional eligibility category.
- The Federal and State expenditures for each category of (a) optional populations; and, (b) optional benefits in each State.

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[5] http://kff.org/health-reform/state-indicator/waiting-lists-for-hcbs-waivers/
[6] Benefits: https://www.medicaid.gov/medicaid/benefits/list-of-benefits/index.html
Eligibility groups: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/List-of-Eligibility-Groups.pdf
[7] Source: Extended baseline projections in CBO's *July 2016 Long-Term Budget Outlook.*

Such comprehensive data would not only be helpful in informing Congressional efforts to best ensure that the Medicaid program continues to provide health care coverage and long-term care services for some of our nation's most vulnerable patients, but it would also assist researchers and other Medicaid stakeholders. This is a significant undertaking, but an appropriate and valuable use of MACPAC resources, which we believe can be completed within a six-month time frame.

Thank you for your timely consideration of our request. We respectfully request your reply to our request outlining your intended actions and timeframes, by January 25, 2017. Please contact Josh Trent of the Committee on Energy and Commerce Majority staff at 202-225-2927, or Kim Brandt of the Senate Finance Majority staff at 202-224-4515 with any questions.

Sincerely,

Orrin G. Hatch
Chairman
Committee on Finance
U.S. Senate

Greg Walden
Chairman
Committee on Energy and Commerce
U.S. House of Representatives

Tim Murphy
Chairman
Subcommittee on Oversight
and Investigations
U.S. House of Representatives

Michael C. Burgess, M.D.
Chairman
Subcommittee on Health
U.S. House of Representatives

APPENDIX 1C: Methodology

Building on a prior analysis using 2007 data that was conducted by the Kaiser Commission on Medicaid and the Uninsured and the Urban Institute, MACPAC conducted an analysis examining Medicaid enrollment and spending on mandatory and optional enrollees and services using the Medicaid Statistical Information System (MSIS) and the CMS-64 data for fiscal year (FY) 2013 (Courtot et al. 2012).

These data sources do not specifically identify individuals and services as mandatory or optional; therefore MACPAC determined the mandatory and optional status based upon a review of the statutory and regulatory citations in comparison with the MSIS data dictionary definitions (CMS 2014). MACPAC's determinations refer only to the federal requirements and do not attempt to take into account state-specific requirements, such as state-mandated benefits or consent decrees that require coverage of certain benefits. Neither do they account for state variation in the breadth of coverage, such as amount, duration, and scope.

To the greatest extent possible, this analysis reflects assumptions outlined in the technical guide to MACStats (MACPAC 2016a).

Classification of Enrollees

We retained Medicaid's eligibility categories (i.e., aged, blind or disabled, adult, or child), but classified individuals within each category as mandatory or optional based on the combination of their maintenance assistance status (MAS) and basis of eligibility (BOE) designation in MSIS (using the last best month of enrollment for eligibility determination). This approach resulted in each individual being assigned to one of the following classifications: mandatory aged, optional aged, mandatory blind or disabled, optional blind or disabled, mandatory adult, optional adult, mandatory child, or optional child (Table 1C-1). We excluded people covered under separate State Children's Health Insurance Programs (MAS-0, BOE-0) because the analysis is focused on Medicaid enrollees and services. Data for approximately 3,000 children were missing, so these children could not be classified as either mandatory or optional. Spending for these children was included in the overall distribution of spending, but excluded when spending was examined by population.

Upon review of the statutory and regulatory citations included in the MAS/BOE definitions, MACPAC found that some MAS/BOE groups contain multiple eligibility pathways that can all be identified as either mandatory or optional (for example, the medically needy—aged group (MAS-2, BOE-1) in which all pathways are optional), while some MAS/BOE groups include both mandatory and optional eligibility pathways (for example, the other eligibles—aged group (MAS-4, BOE-1)). For the MAS/BOE groups with uniform or almost uniform eligibility pathways, all enrollees were categorized as either mandatory or optional; for MAS/BOE groups with mixed eligibility pathways, enrollees were divided between mandatory and optional, as discussed in more detail below.

Classification of adult, aged, and blind or disabled enrollees

Individuals receiving cash assistance (MAS-1) were considered mandatory. The BOEs for all individuals in this category are mandatory except for adults age 65 and older and individuals who are blind or disabled who receive state supplemental payments (SSP) but do not also receive supplemental security income (SSI). From a preliminary search of SSPs, it appears that states are only providing payments to individuals also receiving SSI, so this may not be a widely used pathway.

Individuals in the medically needy category (MAS-2) were considered optional. All BOEs in this category are optional except for newborns born to medically needy pregnant women.

TABLE 1C-1. Maintenance Assistance Status (MAS) and Basis of Eligibility (BOE) Group Classifications

Eligibility category or group description	MSIS MAS/BOE group designations	Mandatory or optional classification
Individuals receiving only family planning services	All MAS/BOE groups and restricted-benefits flag 6	All assigned optional
Individuals entitled only to emergency Medicaid services due to immigration status	All MAS/BOE groups and restricted-benefits flag 2	All assigned mandatory
Partial dually eligible beneficiaries	All MAS/BOE groups and dual-eligible flags 1, 3, 5, or 6	All assigned mandatory
Individuals receiving cash assistance or eligible under § 1931—aged, blind or disabled, adults	MAS 1, BOE 1; MAS 1, BOE 2; MAS 1, BOE 5; MAS 1, BOE 7	All assigned mandatory
Medically needy—aged, blind or disabled, children, adults	MAS 2, BOE 1; MAS 2, BOE 2; MAS 2, BOE 4; MAS 2, BOE 5	All assigned optional
Section 1115 demonstration Medicaid expansion—aged, blind or disabled, children, adults	MAS 5, BOE 1; MAS 5, BOE 2; MAS 5, BOE 4; MAS 5, BOE 5	All assigned optional
Poverty related eligibility—aged, blind or disabled	MAS 3, BOE 1; MAS 3, BOE 2	All assigned optional
Poverty related eligibility—adults	MAS 3/5	Randomly assigned: 50 percent mandatory, 50 percent optional
Other eligibility—aged, blind or disabled, adults	MAS 4, BOE 1; MAS 4, BOE 2; MAS 4, BOE 5	Randomly assigned: 50 percent mandatory, 50 percent optional
Individuals receiving treatment for breast or cervical cancer	MAS 3, BOE A	All assigned optional
Children—cash assistance or § 1931, poverty related, other	MAS 1, BOE 4; MAS 1, BOE 6; MAS 3, BOE 4; MAS 4, BOE 4	Randomly assigned based on ACS-reported state share of children in families above or below federal and state income thresholds
Foster care children	MAS 4, BOE 8	Randomly assigned: 75 percent mandatory, 25 percent optional

Notes: MSIS is Medicaid Statistical Information System. ACS is the American Community Survey. MAS is maintenance assistance status. BOE is basis of eligibility. Table shows the MSIS-defined Medicaid eligibility groups, the MAS and BOE designations of individuals that fall within these groups, and MACPAC's assignment of beneficiaries into mandatory or optional coverage status.

Source: MACPAC, 2017, analysis of MSIS data dictionary, the Social Security Act, and the *Code of Federal Regulations*.

Individuals eligible under a Section 1115 waiver (MAS-5) were considered optional.

Individuals receiving breast or cervical cancer treatment (MAS-3, BOE-A) were considered optional.

Dually eligible beneficiaries (also known as partial duals) who receive assistance with Medicare premiums and cost-sharing through the Medicare Savings Programs (MSPs), were considered mandatory; other dually eligible individuals were considered mandatory or optional according to their MAS/BOE designation.

Other adult, aged, and blind or disabled enrollees (MAS-3 and MAS-4) were randomly assigned mandatory or optional status so that half of the enrollees in these groups were considered mandatory and half were considered optional. This is based on a review of statutory and regulatory eligibility pathways described in the MSIS data dictionary, which indicated that half of the categories in these MAS/BOE groups are mandatory and half are optional. Enrollment data within these groups are not available. Overall, 17.2 percent of adult, aged, and blind or disabled enrollees were randomly assigned. Two additional assumptions were made:

- The MAS-3, BOE-5 group includes both mandatory and optional eligibility pathways for pregnant women.[1] This MAS/BOE group also includes other adults eligible through the use of Section 1902(r)(2) disregards who would be considered optional and another optional adult pathway (funded under Title XXI) that is no longer available to states. Because it would be difficult to identify pregnant women and the eligibility threshold for defining the mandatory and optional status of the other adults, all enrollees in this MAS/BOE were randomly assigned.
- Because there is not an assigned MAS/BOE group for adults under age 65 newly eligible for Medicaid under the ACA's Medicaid expansion, we assumed that states would report these newly enrolled adults in MAS-3, BOE-5 or MAS-4, BOE-5. This new adult group is mandatory under the statute, but the U.S. Supreme Court ruling in *National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566 (2012), effectively made it an optional eligibility group. Seven states implemented early expansions to the new adult group in 2013. Additionally, some states were covering these adults under Section 1115 waivers. Because there is no way to identify these adults separately as optional, they were treated the same as all other adults in these two MAS/BOE groups.

The following populations that receive only limited benefits were categorized as follows:

- Individuals receiving only family planning services (restricted flag 6) were optional.
- Individuals receiving only emergency Medicaid services due to their immigration status (restricted flag 2) were mandatory.

Classification of children

Given the mixture of mandatory and optional eligibility pathways for children in the MAS/BOE groups, their mandatory and optional status was determined on a state-by-state basis based on the state distribution of family income relative to state eligibility thresholds. Specifically, mandatory and optional status under income-related pathways was determined based on the distribution of children's family income relative to the federal poverty level (FPL) and state eligibility thresholds using data from the 2013 American Community Survey (ACS). Children were randomly assigned by age to either mandatory or optional status, respectively, based on the share of children within the state in families with incomes at or below the federal minimum (100 percent or 133 percent FPL) and those with family incomes above the federal minimum, but below the state eligibility threshold for 2013. Although some income-related MAS/BOE groups include only mandatory children (e.g.,

MAS-1, BOE-4 and MAS-1, BOE-6), we took the same state-by-state approach to define all children enrolled in income-related MAS/BOE groups.

Children eligible for Medicaid on the basis of foster care assistance were randomly assigned so that 75 percent of enrollees were considered mandatory and 25 percent were optional. Prior research suggests that between 40 percent and 50 percent of children in foster care are receiving Title IV-E assistance (i.e., they are mandatory), and 75 percent of children eligible for Medicaid on the basis of adoption-related assistance are receiving Title IV-E benefits. Children in foster care account for about 25 percent of Title IV-E assistance (MACPAC 2015).

Classification of Services

MACPAC classified services as mandatory or optional using the MSIS type-of-service code.

Classification of services for children (under age 21)

Almost all services for children under age 21, including those received through managed care, were considered mandatory because of the requirement to provide early and periodic screening, diagnostic, and treatment (EPSDT) benefits. Three additional assumptions are made:

- Anyone under age 21 in the adult, disabled, or aged BOE groups was considered a child, and all of their services were considered mandatory because of the EPSDT requirement. This assumption mainly affects the classification of services provided to children enrolled through the disabled BOE.
- Although EPSDT services are considered optional for medically needy children, if a state's medically needy coverage for any group includes services provided by institutions for mental diseases (IMD) or intermediate care facilities for individuals with intellectual disabilities (ICF/ID), then the state must include certain other services outlined in the statute, including EPSDT services (§1902(a)(10)(C)(iv) of the Act). If the EPSDT benefit is elected for the medically needy population, it must be made available to all Medicaid eligible individuals under age 21. It was beyond the scope of this work to determine which states provide EPSDT to children in their medically needy programs, and thus all services provided to medically needy children were considered mandatory.
- Long-term services and supports (LTSS) provided to children, including services provided in inpatient psychiatric and ICF/ID facilities and personal care services, were considered mandatory under the same assumption that all medically necessary services would be covered under the EPSDT requirement. However, services received under a home- and community-based services (HCBS) waiver (based on MSIS program-type flag 6 or 7) were categorized as optional.

Classification of services for adult, aged, and blind or disabled enrollees (age 21 and older)

Acute services for adult, disabled, and aged enrollees (age 21 and older) were classified as mandatory or optional based upon the statutory and regulatory requirements for all adult enrollees except the medically needy (Table 1C-2). States can offer a more limited benefit package to medically needy individuals, but if a state covers institutional services (IMD or ICF/ID services) for any medically needy individual, it must also cover ambulatory services for that individual. States must provide prenatal care and delivery for medically needy pregnant women. Because of this, only inpatient services provided to women age 15–45 were considered mandatory for medically needy enrollees.

LTSS services for adult, disabled, and aged enrollees were classified as mandatory or optional based upon the statutory and regulatory requirements (Table 1C-2). All services received under an HCBS waiver (based on MSIS program-type flag 6 or 7) were categorized as optional regardless of their type-of-service code.

In most circumstances, spending under managed care was assumed to be for acute services. The state-specific proportion of mandatory and optional spending for each BOE group for non-LTSS services in fee-for-service plans was applied to the group's managed care spending (Table 1C-3). There were two exceptions to this approach:

- Seven states (Arizona, Delaware, Florida, Hawaii, New Mexico, Tennessee, and Wisconsin) had a large proportion of LTSS users in managed LTSS (MLTSS) as determined by MACPAC analysis of the Centers for Medicare & Medicaid Services (CMS) 2013 managed care enrollment report (CMS 2015). For these states and for the aged and blind or disabled groups, the proportion of mandatory and optional FFS spending was calculated using both acute and LTSS spending. In most states, the state-specific FFS distribution of acute and LTSS spending was applied, but national-level FFS distributions of acute and LTSS spending were applied to Hawaii's disabled and aged groups and Tennessee's disabled group, based on the large proportion of enrollees in managed care as discussed below.
- For states with more than 75 percent of adult, disabled, or aged enrollees in managed care, the national-level distribution of spending between mandatory and optional FFS acute care services was applied. The 75 percent threshold was determined based on MACPAC analysis of managed care enrollment at the BOE level, so the national-level distribution was not applied to all groups in these states (MACPAC 2016b). The national share was applied in 15 states for adults, in 3 states for the disabled, and in 1 state for the aged (note that this includes the national proportions applied above for high MLTSS states).

All services for adult, aged, and disabled enrollees receiving limited benefits (individuals receiving only family planning services and individuals receiving only emergency Medicaid services due to their immigration status, as defined above using the restricted benefits flag) were considered mandatory because they are only entitled to certain services as a result of their limited eligibility.

TABLE 1C-2. MSIS FFS Type-of-Service Values and Mandatory versus Optional Breakdown by Basis of Eligibility (BOE)

Type of service	Children (under age 21)	Adults age 21 and older, excluding medically needy and limited benefits			Medically needy adults, disabled, aged	Limited benefit adult, disabled, aged[1]
		Adults eligible on a basis other than disability	Adults eligible on the basis of disability (disabled)	Adults age 65 and older (aged)		
HCBS waiver services (program type 6 or 7)[2]	Optional	Optional	Optional	Optional	Optional	Mandatory
01—Inpatient hospital	Mandatory	Mandatory	Mandatory	Mandatory	Mandatory for women age 15–64; optional for all others	Mandatory
02—Mental health services for the aged	Mandatory	Optional	Optional	Optional	Optional	Mandatory
04—Inpatient psychiatric facility for individuals under age 21[3]	Mandatory	Optional	Optional	Optional	Optional	Mandatory
05—ICF/ID	Mandatory	Optional	Optional	Optional	Optional	Mandatory
07—Nursing facility	Mandatory	Mandatory	Mandatory	Mandatory	Optional	Mandatory
08—Physician	Mandatory	Mandatory	Mandatory	Mandatory	Optional	Mandatory
09—Dental	Mandatory	Optional	Optional	Optional	Optional	Mandatory
10—Other practitioners	Mandatory	Optional	Optional	Optional	Optional	Mandatory
11—Outpatient hospital	Mandatory	Mandatory	Mandatory	Mandatory	Optional	Mandatory
12—Clinic	Mandatory	Optional	Optional	Optional	Optional	Mandatory
13—Home health	Mandatory	Mandatory	Mandatory	Mandatory	Optional	Mandatory
15—Lab and X-ray	Mandatory	Mandatory	Mandatory	Mandatory	Optional	Mandatory
16—Prescribed drugs	Mandatory	Optional	Optional	Optional	Optional	Mandatory

TABLE 1C-2. (continued)

Type of service	Children (under age 21)	Adults age 21 and older, excluding medically needy and limited benefits			Medically needy adults, disabled, aged	Limited benefit adult, disabled, aged[1]
		Adults eligible on a basis other than disability	Adults eligible on the basis of disability (disabled)	Adults age 65 and older (aged)		
19—Other services	Mandatory	Optional	Optional	Optional	Optional	Mandatory
24—Sterilizations	Mandatory	Mandatory for under age 65, optional for age 65 and older	Mandatory for under age 65, optional for age 65 and older	Mandatory for under age 65, optional for age 65 and older	Optional	Mandatory
25—Abortions[4]	Mandatory	Mandatory for under age 65, optional for age 65 and older	Mandatory for under age 65, optional for age 65 and older	Mandatory for under age 65, optional for age 65 and older	Optional	Mandatory
26—Transportation	Mandatory	Mandatory	Mandatory	Mandatory	Optional	Mandatory
30—Personal care	Mandatory	Optional	Optional	Optional	Optional	Mandatory
31—Targeted case management	Mandatory	Optional	Optional	Optional	Optional	Mandatory
33—Rehabilitation	Mandatory	Optional	Optional	Optional	Optional	Mandatory
34—PT, OT, ST, hearing	Mandatory	Optional	Optional	Optional	Optional	Mandatory
35—Hospice	Mandatory	Optional	Optional	Optional	Optional	Mandatory
36—Nurse-midwife	Mandatory	Mandatory	Mandatory	Mandatory	Optional	Mandatory
37—Nurse practitioner	Mandatory	Mandatory	Mandatory	Mandatory	Optional	Mandatory
38—Private duty nursing	Mandatory	Optional	Optional	Optional	Optional	Mandatory
39—Religious non-medical	Mandatory	Optional	Optional	Optional	Optional	Mandatory

TABLE 1C-2. (continued)

Notes: MSIS is Medicaid Statistical Information System. FFS is fee for service. HCBS is home- and community-based services. ICF/ID is intermediate care facilities for individuals with intellectual disabilities. PT is physical therapy. OT is occupational therapy. ST is speech therapy. Mandatory indicates that the services were classified as mandatory for the specified eligibility group. Optional indicates that the services were classified as optional for the specified eligibility group.

[1] Includes individuals receiving only family planning services and individuals receiving only emergency Medicaid services due to their immigration status. Although these individuals are entitled to a more limited benefit package, all services they receive are considered mandatory. However, we do not expect them to receive services under every type of service.

[2] These HCBS would be provided under a waiver.

[3] We do not expect individuals over the age of 21 to receive these services.

[4] Federal funds for abortions are available only in cases of life endangerment, rape, or incest, and states must cover abortions that meet these federal exceptions.

Source: MACPAC, 2017, analysis of MSIS data dictionary, the Social Security Act, and the *Code of Federal Regulations*.

TABLE 1C-3. MSIS Managed Care Type-of-Service Values and Mandatory versus Optional Breakdown by Basis of Eligibility

Type of managed care payment	Children (under age 21)	Adults age 21 and older, excluding medically needy and limited benefits			Medically needy adults, disabled, aged	Limited benefit adult, disabled, aged[1]
		Adults eligible on a basis other than disability	Adults eligible on the basis of disability (disabled)	Adults age 65 and older (aged)		
20—Capitated HMO	Mandatory	Mandatory and optional based on FFS distribution; based on state-specific managed care and MLTSS penetration	Mandatory and optional based on FFS distribution; based on state-specific managed care and MLTSS penetration	Mandatory and optional based on FFS distribution; based on state-specific managed care and MLTSS penetration	Optional	Mandatory
21—Capitated PHP	Mandatory	Mandatory and optional based on FFS distribution; based on state-specific managed care and MLTSS penetration	Mandatory and optional based on FFS distribution; based on state-specific managed care and MLTSS penetration	Mandatory and optional based on FFS distribution; based on state-specific managed care and MLTSS penetration	Optional	Mandatory
22—PCCM	Mandatory	Mandatory and optional based on FFS distribution; based on state-specific managed care and MLTSS penetration	Mandatory and optional based on FFS distribution; based on state-specific managed care and MLTSS penetration	Mandatory and optional based on FFS distribution; based on state-specific managed care and MLTSS penetration	Optional	Mandatory

Notes: MSIS is Medicaid Statistical Information System. HMO is health maintenance organization. FFS is fee for service. MLTSS is managed long-term services and supports. PHP is prepaid health plan. PCCM is primary care case management. Mandatory indicates that the services were classified as mandatory for the specified eligibility group. Optional indicates that the services were classified as optional for the specified eligibility group.

[1] Includes individuals receiving only family planning services and individuals receiving only emergency Medicaid services due to their immigration status. Although these individuals are entitled to a more limited benefit package, all services they receive are considered mandatory. We do not expect them to receive services under every type of service.

Source: MACPAC, 2017, analysis of MSIS data dictionary, the Social Security Act, and the *Code of Federal Regulations*.

Data Sources and Limitations

Spending adjustments

Form CMS-64 provides a more complete accounting of spending and is preferable to MSIS spending reports alone when examining state or federal spending totals. However, it cannot be used for analysis of benefit spending by eligibility group and other enrollee characteristics. The MSIS data allow for such comparisons, but some spending information, such as supplemental payments and drug rebates, is missing from MSIS.

Consistent with the methodology used in MACStats, and to help account for the limitations in both data sources, we used the MSIS data to provide the detailed information related to eligibility and service use and then adjusted the spending data to match total benefit spending reported by states in the CMS-64 (MACPAC 2016a). We excluded disproportionate share hospital (DSH) and certain other costs not otherwise matchable (CNOMs), including supplemental, incentive, and uncompensated care pool payments made under Section 1115 waiver authority. We excluded these supplemental payments because not all of the payments are specific to Medicaid services and enrollees, and they may be used more broadly, such as to offset the costs of uninsured individuals. We excluded $15.5 billion in DSH payments (which would be considered mandatory spending) and $10.8 billion in supplemental payments made under Section 1115 waiver authority (which would be considered optional spending).

We did not exclude waiver spending on CNOMs for eligibility expansions. We included waiver spending for several reasons, one being that many of the populations and services covered under these waivers can be covered under a state plan. These waiver costs include expansions to adults without dependent children, which required waivers in 2013 but became a state plan option in 2014. CNOMs also include family planning services and supplies to individuals not otherwise eligible for Medicaid that, until passage of the ACA, also required a waiver. They also include services similar to those provided in Section 1915(c) home- and community-based service waivers and other comparable services that can be covered without a waiver. Furthermore, all of these populations are presumed to be reported by the states in the MAS/BOE groups related to Section 1115 waiver coverage.

Limitations

In the past, MACPAC pointed out some of the limitations with administrative data, including their timeliness and accuracy (MACPAC 2013, 2011). For this study, in particular, the administrative data have the following constraints.

Level of specificity regarding enrollees' eligibility pathways. As discussed above, MACPAC classified individuals as mandatory or optional based on a combination of MAS and BOE designation. Each MAS/BOE combination contains multiple eligibility pathways, some of which are mandatory and some optional. However, there is no way to associate an individual with a specific eligibility pathway under a MAS/BOE combination in MSIS. As a result, we make a number of assumptions about the distribution of enrollees within these MAS/BOE groups.

It is important to note that using different assumptions might lead to different results. For example, for a number of MAS/BOE groups with mixed mandatory and optional eligibility pathways, we randomly assign half of the individuals mandatory status and half optional status, because approximately half of the pathways are mandatory and half are optional. However, it is not known whether enrollment through these pathways is evenly split. For example, other eligibles—adults (MAS-4, BOE-5) contains multiple mandatory pathways that likely have many people enrolled (such as parents eligible for Transitional Medical Assistance and postpartum women), and fewer optional enrollees. Because we had no data on the distribution of enrollees under each specific

eligibility pathway on which to base an alternative assumption, a conservative 50-50 split was applied.

It is also not clear whether reporting is consistent across states, as the pathways may overlap in MAS/BOE groups. For example, based on the statutory and regulatory citations, states can report certain optional enrollees age 65 and older in either MAS-1, BOE-1 or MAS-4, BOE-1. Under MACPAC's methodology for this analysis, individuals reported in the first group would be assigned mandatory status, but individuals in the second group would be randomly assigned an eligibility status.

A new version of the MSIS, referred to as the transformed MSIS (T-MSIS), will include more granular information on eligibility, including whether the eligibility pathway is mandatory or optional. At this time, however, states are still in the process of transitioning to T-MSIS reporting and such data could not be used for this analysis.

Limited spending data for managed care enrollees. For managed care, MSIS includes 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 generally do not include payment amounts and may be referred to as an encounter claims). All states collect encounter data from their Medicaid managed care plans, but some do not report them in MSIS.

Because the amount paid by the managed care plan for a specific service is not available from the MSIS encounter data, assumptions must be made about how much spending under managed care was for mandatory services and how much was for optional services. We assumed that the distribution of managed care spending on mandatory and optional services mirrors the distribution of spending in FFS arrangements at an eligibility group and state level. However, the differences between managed care and FFS in populations covered and services provided might mean that the FFS proportions do not provide an accurate model for the distribution of mandatory and optional spending under managed care. On the other hand, a shift in the type of service received under a managed care arrangement (for example from inpatient hospital to physician services) does not necessarily result in a shift in the share of mandatory versus optional spending, because both of these services would be considered mandatory. It was not within the scope of this project to attempt to adjust for differences in populations or services between FFS and managed care.

Additionally, states may carve out particular benefits from managed care and provide them through FFS arrangements. In these circumstances, an individual's carved out services would be classified as mandatory or optional based on the type-of-service code in the same manner as all other FFS spending. Capitation payments also include administrative costs, which account for approximately 11 percent of the payment (Palmer and Pettit 2014). As part of our CMS-64 adjustments, we also assign prescription drug rebates collected on managed care utilization to the managed care spending category. Both of these would be apportioned as mandatory or optional in the same manner as any services received under managed care.

Data cannot take into account services provided in lieu of other services. Some optional services are provided in lieu of other services. For example, many home- and community-based services would be considered optional. However, were these services not covered, some individuals would require mandatory services in an institution. This would result in an increase in the share of mandatory spending and could also increase the level of spending.

This analysis also cannot project how spending would change in response to changes in service availability. For example, if one type of optional service were to be discontinued, would that lead to an increase in the use of other available services? This type of inquiry would require an actuarial

analysis; this may be something the Commission will explore in the future.

Endnotes

[1] However, in the final rules issued after the enactment of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) the Centers for Medicare & Medicaid Services (CMS) grouped these pathways together under one mandatory category (42 CFR 435.116).

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