kaiser commission on medicaid and the uninsured

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Medicaid Enrollment and Expenditures by Federal Core Requirements and State Options

by Brigette Courtot and Emily Lawton, The Urban Institute, and Samantha Artiga, KCMU

EXECUTIVE SUMMARY

Medicaid is the nation's primary health insurance program for low-income and high-need individuals. The program is jointly financed by the federal government and states. To receive federal Medicaid matching funds, states that choose to participate in the program must meet federal requirements, which include covering specified "federal core" enrollee groups and mandatory health benefits. States also may choose to cover additional "state expansion" enrollees and optional benefits with federal matching funds.

The federal core eligibility standards have expanded incrementally over time, mostly for children and pregnant women, as the Medicaid program separated from welfare. Moreover, many states have taken up options to extend coverage to expansion groups, primarily for children and individuals in need of nursing home care. However, eligibility limits vary significantly across groups and states and generally remain low for non-disabled adults. Further, all states cover at least some optional benefits, but the scope of state benefit packages varies widely across states.

Using 2007 data, this analysis examines the proportion of Medicaid enrollment and spending attributable to state expansion enrollees versus federal core enrollees and presents estimates of spending on mandatory versus optional health benefits across all enrollee types.

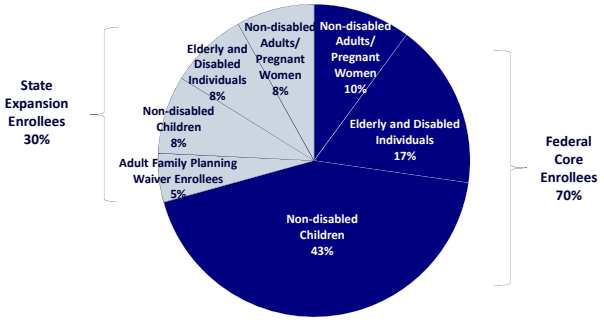
Key Findings

In 2007, 70% of enrollees were federal core enrollees, while three in ten were covered through a state expansion (Figure 1). The large majority (85%) of federal core enrollees were children and elderly and disabled enrollees. State expansion enrollees were more evenly distributed among children, elderly and disabled individuals, and non-disabled adults and pregnant women, and also included about three million non-disabled adults who solely received family planning services.

Four in ten dollars were spent on federally-required services provided to federal core enrollees in 2007 (Figure 2). The remaining 60% of spending was for state expansion enrollees and optional services.

Figure 1

Medicaid Enrollment by Eligibility Pathway and Group, 2007

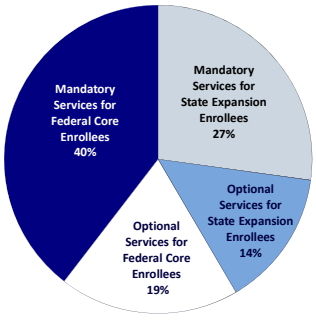


Total Enrollees = 58 million

NOTES: Totals may not sum to 100% due to rounding. Adult family planning waiver enrollees include non-disabled adult (age 21-64) family waiver enrollees, who account for the large majority of family planning waiver enrollees.
SOURCE: Urban Institute estimates based on FFY data from the 2007 MSIS.

Figure 2

Medicaid Expenditures by Eligibility Pathway and Type of Service, 2007



Total = $311 billion

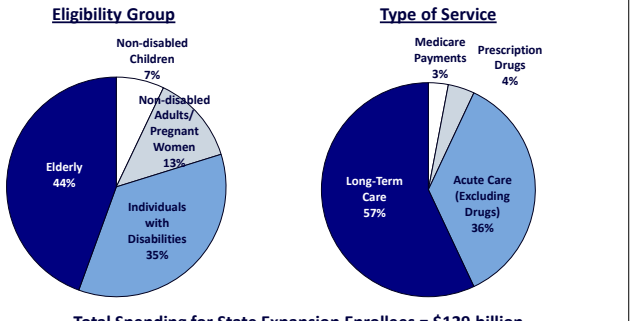
NOTE: Total expenditures do not include disproportionate share hospital (DSH) payments, drug rebates, administrative costs, or accounting adjustments. Shares may not sum to 100% due to rounding.
SOURCE: Urban Institute estimates based on FFY data from the 2007 MSIS and CMS 64.

Spending on mandatory and optional services for state expansion enrollees accounted for 42% of Medicaid spending in 2007. Nearly 80% of this spending was for elderly and disabled individuals, and more than half of spending on state expansion enrollees was for long-term care services (Figure 3).

Spending for optional services provided to both federal core and state expansion enrollees accounted for a third of Medicaid spending in 2007. Nearly half (49%) of this spending was for long-term care services, such as home and community based waiver and personal care services (Figure 4).

Figure 3

Total Medicaid Expenditures for State Expansion Enrollees by Eligibility Group and Service, 2007

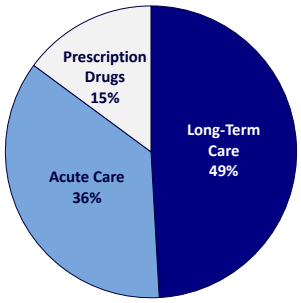


Total Spending for State Expansion Enrollees = $129 billion

NOTE: Total expenditures do not include disproportionate share hospital (DSH) payments, drug rebates, administrative costs, or accounting adjustments. Non-disabled adults/pregnant women category includes individuals enrolled through family planning waivers and other limited benefit programs.
SOURCE: Urban Institute estimates based on FFY data from the 2007 MSIS and CMS 64.

Figure 4

Medicaid Expenditures for Optional Services by Service Type, 2007



Total = $103.4 billion

NOTE: Total expenditures do not include disproportionate share hospital (DSH) payments, drug rebates, administrative costs, or accounting adjustments. Shares may not sum to 100% due to rounding.
SOURCE: Urban Institute estimates based on FFY data from the 2007 MSIS and CMS 64.

Conclusion

In 2007, federal core enrollees, who were primarily low-income children and elderly and disabled individuals, accounted for seven in ten Medicaid enrollees, and mandatory services provided to federal core enrollees accounted for four in ten Medicaid dollars. The remaining three in ten enrollees were covered through state expansions in eligibility. State expansion enrollees included children, elderly and disabled individuals, and non-disabled adults and pregnant women, but the vast majority of spending for state expansion enrollees was for elderly and disabled individuals and their long-term care needs. Further, a third of Medicaid spending was for optional services provided to both federal core and state expansion enrollees, nearly half of which was for optional long-term care services.

It is important to note that these national estimates do not capture the significant variation that exists across states. States vary widely in the extent to which they have expanded eligibility and benefits, and these policy choices directly impact a state's share of enrollment and spending attributable to expansion enrollees as well as the proportion of spending for optional benefits.

The Patient Protection Affordable Care Act (ACA) will significantly expand Medicaid in 2014, creating a new federal minimum eligibility floor of 133% of the federal poverty level, which will significantly increase Medicaid coverage in many states, particularly for non-disabled adults, and change the balance of federal core and state expansion enrollees. The ACA also includes a Maintenance of Eligibility (MOE) provision that requires states to maintain Medicaid and CHIP eligibility and enrollment policies that are no more restrictive than those they had in place at the time the ACA was enacted (March 23, 2010), until 2014 for adults and until 2019 for children. This provision was designed to maintain coverage until the ACA coverage expansions take effect. It has also assured the availability of Medicaid for low-income families amidst the recent recession, helping to prevent greater increases in the uninsured. However, as states continue to face budget pressures, they are looking at a range of program changes to address fiscal concerns, including changes in eligibility and enrollment policies that are not currently allowed under the MOE, as well as changes in benefits and provider payment policies.

INTRODUCTION

Medicaid, the nation's health and long-term care coverage program for low-income Americans, is jointly financed by federal and state governments. States choose to participate in the program and, in exchange, receive federal matching dollars for state spending on Medicaid enrollees. On average, the federal government pays 57% of program costs, but matching rates across states range from 50% to 75% in 2011, with poorer states receiving more federal assistance.[1] As a condition of receiving these federal matching funds, states are required to meet federal core requirements, which include covering certain groups of individuals ("federal core" enrollees) and a specified set of mandatory health benefits. States may also choose to expand coverage to additional groups ("state expansion" enrollees) and to cover optional benefits beyond the federal requirements, for which they may receive federal matching funds.

The federal core minimum eligibility standards have expanded incrementally over time, mostly for children and pregnant women, as the Medicaid program separated from welfare. Moreover, many states have utilized the flexibility to extend eligibility to expansion groups, primarily for children and individuals in need of nursing home care. However, eligibility limits vary significantly across groups and states and generally remain low for non-disabled parents and other adults. Further, all states cover at least some optional benefits, but there is variation across states in the scope of their benefit packages.

Using 2007 data, this analysis examines the proportion of Medicaid enrollment and spending attributable to state expansion enrollees versus federal core enrollees. It also presents estimates of spending on mandatory versus optional health benefits across all enrollee types.

BACKGROUND

Federal Core and State Expansion Enrollees

Medicaid was originally enacted to enable states, at their option, to furnish medical assistance, as well as rehabilitative and other services, to certain individuals. To receive federal Medicaid matching funds, states must meet certain conditions. One condition is that states must cover core groups of low-income individuals. At the time Medicaid was enacted, these core groups included families with dependent children and aged, blind, and disabled individuals receiving cash assistance. Minimum eligibility levels for Medicaid expanded incrementally over time—mostly for children and pregnant women—as the program separated from welfare. However, prior to the passage of the ACA, adults under age 65, who were not living with a disability and were not caring for dependent children, generally were not able to qualify for coverage except through waivers.[2]

[1] Through June 2011, states received federal matching funds at an enhanced rate due to a temporary increase under the American Recovery and Reinvestment Act. Kaiser Commission on Medicaid and the Uninsured, "Key Questions about Medicaid and its Role in State/Federal Budgets and Health Reform," January 2011.

[2] Effective April 2010, the ACA provides states with a new option to receive federal funds to cover low-income non-disabled adults without dependent children with incomes up to 133% FPL. Under the ACA, Medicaid eligibility will expand to a national minimum of 133% FPL with an across the board 5% disregard of income, making the effective minimum income level 138% FPL ($15,028 for an individual and $25,571 for a family of 3 in 2011) across all groups in 2014.

Today, federal core enrollees include children and pregnant women up to federally specified minimum income levels, parents of dependent children with incomes below a state's 1996 welfare eligibility level, elderly and disabled individuals receiving Supplemental Security Income (SSI) and certain other working disabled individuals and Medicare beneficiaries (Table 1). Above these federal minimums, states can choose to expand coverage to other individuals and receive federal matching funds.

Table 1:
Medicaid Eligibility Groups, 2011

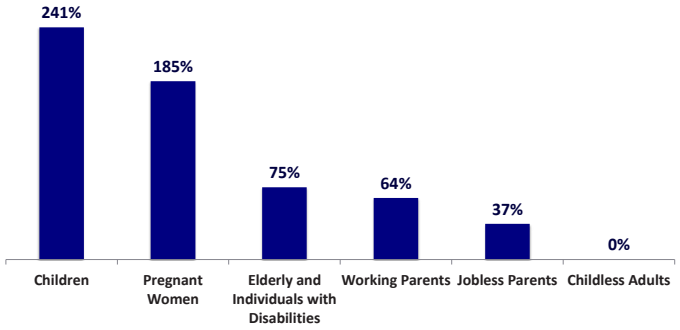
Federal Core Enrollees	State Expansion Enrollees
• Pre-school children ≤133% FPL ($24,645 per year for a family of three) • School-age children ≤100% FPL ($18,530 per year for a family of three) • Pregnant women ≤133% FPL • Parents <state's AFDC limit as of July 1996 (median = 64% FPL or $11,859 for a family of three) • Elderly and disabled individuals receiving SSI (<75% FPL $8,168 per year for an individual) • Certain working disabled • Medicare buy-in groups (QMB, SLB, QI)	• Low-income children above federal core minimum income thresholds • Low-income parents >1996 AFDC limits • Pregnant women >133% FPL • Adults <133% FPL* • Disabled and elderly individuals above SSI level, but <100% FPL ($10,890 for an individual) • Nursing home residents above SSI level, but below 300% of SSI ($2,022 per month) • Individuals at risk of needing nursing facility or ICF-MR care (HCBS waiver enrollees) • Certain working disabled above SSI levels • Section 1115 waiver enrollees (including family planning waiver enrollees) • Medically needy

* Effective April 2010, the ACA provides states with a new option to receive federal funds to cover low-income, non-disabled adults without dependent children with incomes up to 133% FPL.

To date, all states have expanded coverage for children well above the federal minimum levels through Medicaid and CHIP, and many have expanded Medicaid eligibility for other groups (Figure 5). Still, eligibility levels vary considerably across groups and states, and, overall, eligibility levels for non-disabled, non-elderly adults remain low (Appendix A: Tables 1 and 2). The Medicaid eligibility limit for parents remains below poverty in 33 states and the national median is 64% FPL ($11,859 for a family of three in 2011).[3] Further, in most states, other non-disabled adults are ineligible for coverage at any income.

Figure 5

Median Medicaid/CHIP Eligibility Thresholds as a Percent of the Federal Poverty Level, 2011



Note: Income eligibility for most elderly and individuals with disabilities is based on the income threshold of Supplemental Security Income (SSI). SOURCE: Kaiser/Georgetown Medicaid Eligibility and Enrollment Survey, 2011 and Medicaid and CHIP Payment and Access Commission Report, March 2011.

[3] Heberlein, M., et al., "Holding Steady, Looking Ahead: Annual Findings of a 50-State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost Sharing Practices in Medicaid and CHIP, 2010-2011," Kaiser Commission on Medicaid and the Uninsured, January 2011.

For elderly and disabled individuals, less than half of states (23, including DC) have increased eligibility above the SSI assistance level (75% FPL or $8,168 for an individual in 2011).[4] However, 32 states (including DC) offer medically needy coverage, enabling individuals with high medical bills to spend down to a state-set eligibility standard, and 44 states (including DC) allow people in need of nursing home care to qualify with incomes up to 300% of the SSI level.[5] Many states also allow working individuals with disabilities and children with disabilities with family incomes above eligibility limits to buy-in to Medicaid.

Mandatory and Optional Benefits

A second key condition of participation in the Medicaid program is that states provide federal core and state expansion enrollees with a set of "mandatory" benefits (Table 2). For children, these benefits include Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, which consist of screening, vision, dental, and hearing services and any medically necessary care.

Table 2:
Medicaid Benefits, 2011

Mandatory Benefits	Optional Benefits
• Physician services • Laboratory and x-ray services • Inpatient hospital services • Outpatient hospital services • Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for individuals <age 21 • Family planning services • Rural and federally-qualified health center (FQHC) services • Nurse midwife services • Nursing facility services for individuals ≥age 21 • Home health care services for individuals entitled to nursing facility care • Smoking cessation services for pregnant women* • Free-standing birth center services *	• Prescription drugs • Clinic services • Dental services, dentures • Physical therapy and rehab services • Prosthetic devices, eyeglasses • Primary care case management • Intermediate care facilities for the mentally retarded (ICF/MR) services • Inpatient psychiatric care for individuals <age 21 • Home health care and other services provided under home and community-based waivers • Personal care services • Hospice services • 'Health home' services for individuals with chronic conditions* • Home and community-based attendant services and supports*

* Benefit classification established by the Patient Protection and Affordable Care Act (ACA) on March 23, 2010.

In addition to the mandated benefits package, states may provide additional "optional" services. All states cover at least some optional benefits (including prescription drugs for adults) but there is variation across states in the scope of benefit packages (Appendix A: Table 3). Under most circumstances, when a state chooses to provide an optional benefit, it must cover that benefit for all enrollees in both federal core and state expansion groups. For both mandatory and optional benefits, states have the latitude to determine the amount, duration, and scope of covered benefits. For example, they may impose reasonable limits on the number of physician visits or hospital days covered.

[4] Medicaid and CHIP Payment and Access Commission, "Report to the Congress on Medicaid and CHIP," March 2011.
[5] Ibid.

Medicaid Eligibility Under Health Reform and Current State Activity

The federal health reform law, the Patient Protection and Affordable Care Act (ACA), will expand Medicaid to nearly all individuals under age 65 with incomes up to 133% of the federal poverty level (FPL) in 2014 ($24,645 for a family of three in 2011).[6] This eligibility increase will significantly expand Medicaid coverage in many states, particularly for non-disabled adults whose eligibility limits have remained low in most states to date. The ACA also includes a Maintenance of Eligibility (MOE) provision that requires states to maintain Medicaid and CHIP eligibility and enrollment policies that are no more restrictive than those they had in place at the time the ACA was enacted (March 23, 2010), until 2014 for adults and until 2019 for children. This provision was designed to maintain coverage levels until the ACA coverage expansions take effect in 2014. It has also ensured the availability of Medicaid for low-income families amidst the recent recession, helping to prevent greater increases in the uninsured.

However, as states continue to face budget pressures—collectively reporting a combined budget shortfall of $194 billion for FY 2010—they are looking at a range of program changes to address fiscal concerns, including changes in eligibility and enrollment policies that are not currently allowed under the MOE provision, as well as changes in benefits and provider payment policies.[7] Moreover, pending federal legislation would repeal the MOE provision.[8]

Under the MOE provision, as a condition of receiving federal Medicaid matching funds, a state may not reduce or eliminate eligibility for state expansion enrollees to which the state had extended eligibility as of March 23, 2010. (There is an exception that allows states that cover non-disabled and non-pregnant adults with incomes above 133% FPL to reduce eligibility if they are facing a documented budget deficit, as well as certain other exceptions for waiver coverage.) In addition, a state may not implement more restrictive enrollment and renewal requirements or policies than they had in place at the time the ACA was enacted for both federal core and state expansion enrollees.

The MOE provision does not affect a state's eligibility requirements for federal core enrollees—coverage for this group has been and continues to be a requirement for states to participate in Medicaid. Moreover, the MOE provision does not affect coverage of optional benefits; states currently determine coverage of these benefits for federal core and state expansion enrollees. States also have the discretion to impose limits on the amount, duration, and scope of both mandatory and optional services.

[6] The ACA expands Medicaid eligibility to 133% of the FPL and allows an across the board income disregard of 5%, which raises the effective income eligibility threshold to 138% of the FPL.

[7] "GOP Governors ask feds to ease health care mandates," Republican Governors Association, January 7, 2011, http://www.rga.org/homepage/gop-governors-ask-feds-to-ease-healthcare-mandates/.

[8] Senate Bill 868/HR 1683, the "State Flexibility Act" introduced May 3, 2011 in the 112th Congress (2011 - 2012).

METHODS

This analysis uses person-level data from the FY2007 Medicaid Statistical Information System Summary File (MSIS) and CMS-64 reports to estimate the proportion of Medicaid enrollment and spending attributed to federal core requirements and state expansions in 2007 at a national level. (Appendix B: Table 1 shows state-by-state estimates of expenditures by federal core requirements and state expansions.) In assigning beneficiaries to federal core and state expansion categories, and when allocating service spending as either mandatory or optional, the analysis uses Medicaid rules in effect in 2007, prior to changes made by the ACA. (See Appendix C for a more detailed explanation of methodology.)

Using MSIS eligibility codes, it makes a series of assumptions, informed by federal Medicaid statute and regulations, to assign beneficiaries either federal core or state expansion status. It examines the eligibility status of four distinct populations: (1) the elderly (65 years old or older); (2) people with disabilities (64 years old or younger); (3) non-disabled adults and pregnant women (21-64 years old); and (4) non-disabled children (20 years old or younger). Among the non-disabled adults and pregnant women population, we distinguished between enrollees who were eligible solely for family planning services (adult family planning waiver enrollees) and those eligible for more comprehensive benefits.

In addition, this analysis uses MSIS service expenditure codes to allocate acute care, prescription drug, and long-term care spending as either mandatory or optional. Since managed care expenditures include a mix of both mandatory and optional services, the analysis estimates a proportion of this spending as mandatory or optional for each enrollee population. Reflecting EPSDT rules, almost all services for children are treated as mandatory, including managed care.

This analysis has important limitations. First, it relies on a set of assumptions since MSIS data are not designed to record eligibility based on federal core or state expansion status, or to designate spending as either mandatory or optional. Second, it cannot be used to project national estimates using more current Medicaid program data. Estimates in this analysis are based on the distribution of beneficiaries and services reported in the MSIS 2007, and any projections produced from these estimates would have to assume equal growth for all enrollment groups and for all services by enrollment group. These assumptions would be unsound in view of both the growth in Medicaid due to the economic recession that began at the end of 2007 and the unprecedented expansion of Medicaid beginning in 2014.

Finally, these estimates are not comparable to previous estimates published by the Commission using MSIS 2001 data and CMS-64 reports. While approaches to allocating enrollees and spending to mandatory and optional groups were similar, this analysis has been refined to use several new methods to allocate enrollees into federal core and state expansion groups. As such, readers should not attempt to draw conclusions about changes over time based on a comparison of findings.

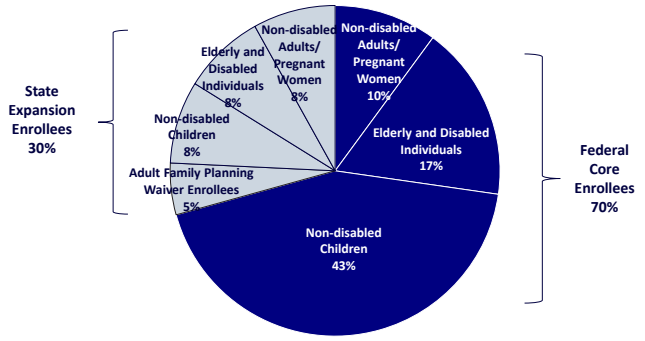
FINDINGS

Federal Core and State Expansion Enrollees

Seven in ten (70%) of the 58 million Medicaid enrollees in 2007 were eligible under federal core requirements, and the remaining 30% were eligible through a state expansion (Figure 6). Reflecting their relatively higher minimum eligibility levels, the large majority of federal core enrollees (85%) were children (24.8 million) and elderly and disabled enrollees (9.8 million), with 5.9 million non-disabled adults and pregnant women making up the remaining 15% of federal core enrollees. State expansion enrollees were more evenly distributed among children (4.7 million), elderly and disabled individuals (4.9 million), and non-disabled adults and pregnant women (4.9 million), and included about 3 million non-disabled adults who solely received family planning services (see Text Box 1).

Figure 6

Medicaid Enrollment by Eligibility Pathway and Group, 2007



Total Enrollees = 58 million

NOTES: Totals may not sum to 100% due to rounding. Adult family planning waiver enrollees include non-disabled adult (age 21-64) family waiver enrollees, who account for the large majority of family planning waiver enrollees.
SOURCE: Urban Institute estimates based on FFY data from the 2007 MSIS.

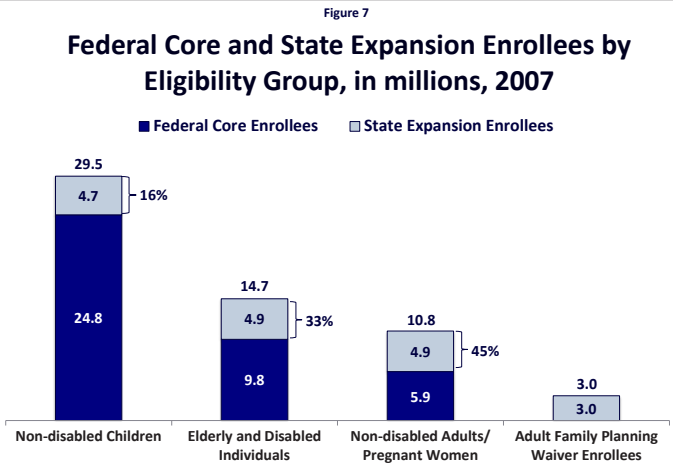
Text Box 1:

Examples of State Expansion Enrollees

- An elderly nursing facility resident whose annual incomes is just above SSI standards (75% of poverty or $8,168 for an individual in 2011) but below 100% of poverty ($10,890 for an individual in 2011).
- A parent of two children who works full-time at a minimum wage level in a service sector job.
- A pregnant woman who has a part-time job and earns more than $19,569 per year (133% of poverty for a pregnant individual in 2011).
- A 68-year-old widow with multiple conditions, such as fibrosis of the lungs, rheumatoid arthritis, and high blood pressure, whose income is too high to qualify for SSI ($8,168 for an individual in 2011) but qualifies for Medicaid home and community-based services, allowing her to remain in the community.
- An 85-year-old woman with Alzheimer's disease and a monthly income of $1,500 (less than 300% of SSI) who qualifies for nursing facility care. She is allowed to keep $30 a month for personal needs, but the remainder of her income goes to the nursing facility to help cover her medical and support needs.
- A 7-year-old boy with autism living with his parents whose family income is 110% of poverty ($20,383 for a family of three in 2011).
- A 35-year-old single woman who earns $20,147 per year (185% FPL for an individual in 2011) and qualifies solely for family planning services through Medicaid.

The proportion of state expansion enrollees varied substantially by eligibility group (Figure 7). About 16% of non-disabled children were enrolled via state expansion, compared to a third of elderly and disabled individuals (33%), and more than four in ten non-disabled adults and pregnant women (45%). All 3 million non-disabled adult family planning waiver enrollees were covered via a state expansion.

Figure 7

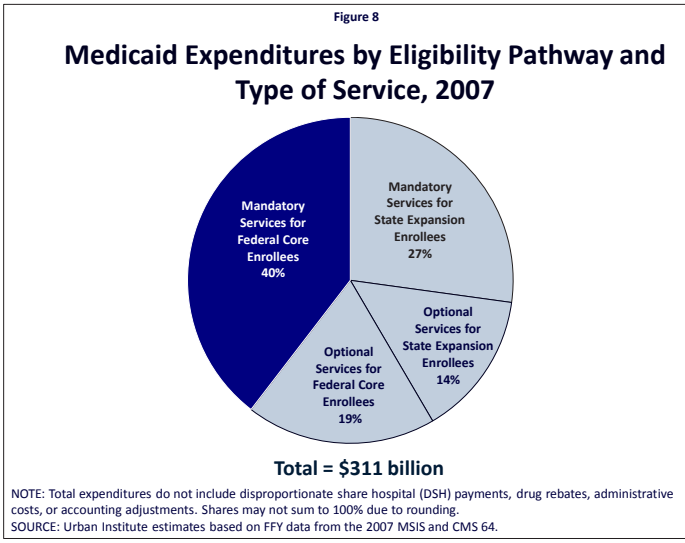


NOTE: Adult family planning waiver enrollees include non-disabled adult (age 21-64) family waiver enrollees, who account for the large majority of family planning waiver enrollees.
SOURCE: Urban Institute estimates based on FFY data from the 2007 MSIS.

Expenditures

Four in ten dollars went to the base federal requirements of mandatory services provided to federal core enrollees in 2007 (Figure 8). The remaining 60% of spending was for state expansion enrollees and optional services.

Figure 8



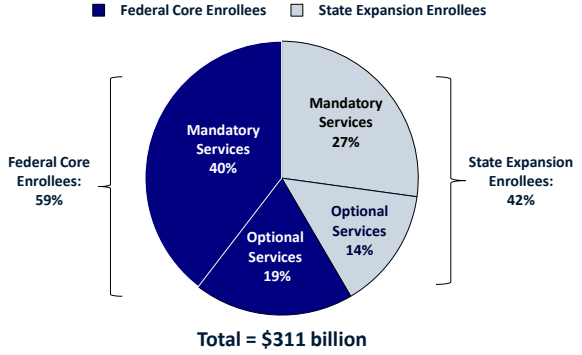
NOTE: Total expenditures do not include disproportionate share hospital (DSH) payments, drug rebates, administrative costs, or accounting adjustments. Shares may not sum to 100% due to rounding.
SOURCE: Urban Institute estimates based on FFY data from the 2007 MSIS and CMS 64.

Expenditures for State Expansion Enrollees

Spending for state expansion enrollees accounted for 42% of total Medicaid expenditures in 2007 (Figure 9). Overall, two-thirds of the spending for state expansion enrollees was for mandatory services.

Figure 9

Medicaid Expenditures by Eligibility Pathway and Type of Service, 2007

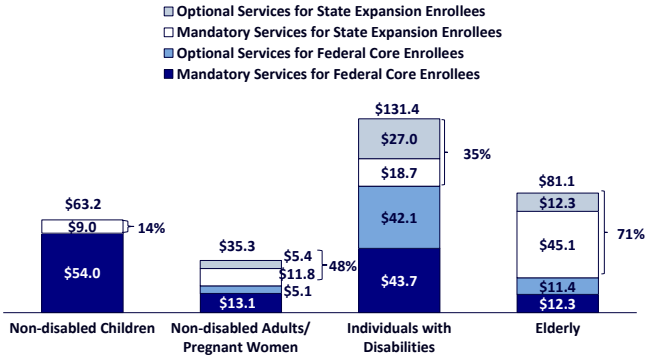


NOTE: Total expenditures do not include disproportionate share hospital (DSH) payments, drug rebates, administrative costs, or accounting adjustments. Shares may not sum to 100% due to rounding.
SOURCE: Urban Institute estimates based on FFY data from the 2007 MSIS and CMS 64.

The proportion of spending attributable to state expansion enrollees ranged from 14% of spending for children to over 70% of spending for elderly individuals (Figure 10). The majority of spending on state expansion enrollees was for mandatory services across all groups, except individuals with disabilities—most spending for this population was on optional services. Spending for non-disabled adults and pregnant women includes $1.9 billion (about 5% of total spending for the group) for services provided to the three million state expansion enrollees within this group who are solely receiving family planning waiver services.

Figure 10

Medicaid Expenditures by Eligibility Group and Types of Service, in billions, 2007

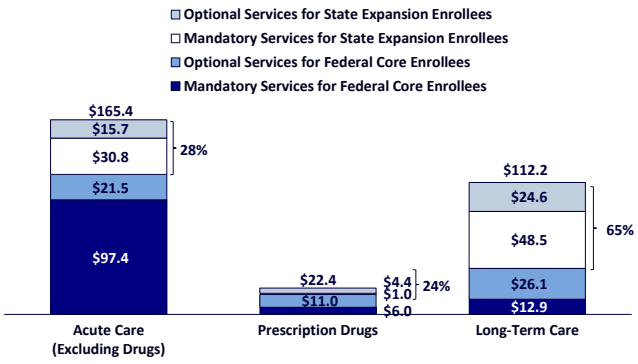


NOTE: Total expenditures do not include disproportionate share hospital (DSH) payments, drug rebates, administrative costs, or accounting adjustments.
SOURCE: Urban Institute estimates based on FFY data from the 2007 MSIS and CMS 64.

Spending for state expansion enrollees varied considerably by type of service. Roughly two-thirds of spending on long-term care services was attributable to state expansion enrollees, and the majority of that spending was on mandatory services (Figure 11). In contrast, less than a third of acute care spending and less than a quarter of prescription drug spending were for state expansion enrollees.

Figure 11

Mandatory and Optional Expenditures by Type of Service, in billions, 2007

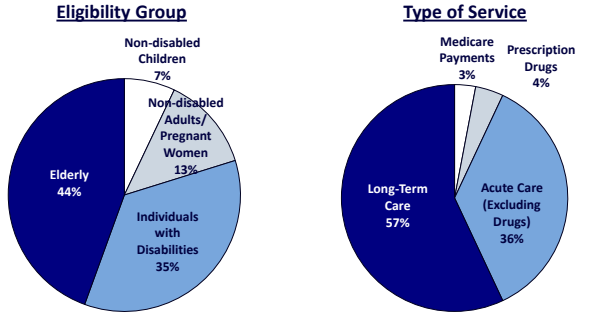


NOTE: Total expenditures do not include disproportionate share hospital (DSH) payments, drug rebates, administrative costs, or accounting adjustments.
SOURCE: Urban Institute estimates based on FFY data from the 2007 MSIS and CMS 64.

Overall, spending on elderly and disabled individuals accounted for nearly 80% of all state expansion enrollee expenditures (Figure 12). Further, spending on long-term care services comprised more than half of all spending on state expansion enrollees.

Figure 12

Total Medicaid Expenditures for State Expansion Enrollees by Eligibility Group and Service, 2007



Total Spending for State Expansion Enrollees = $129 billion

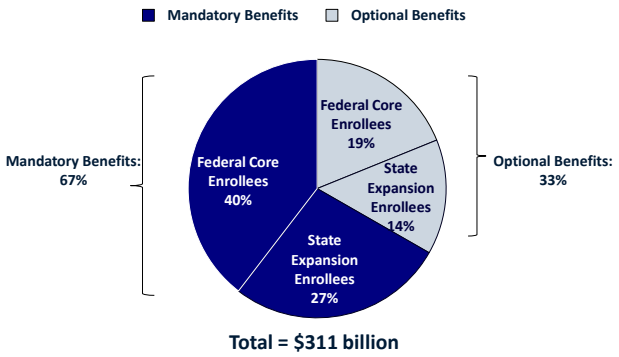
NOTE: Total expenditures do not include disproportionate share hospital (DSH) payments, drug rebates, administrative costs, or accounting adjustments. Non-disabled adults/pregnant women category includes individuals enrolled through family planning waivers and other limited benefit programs.
SOURCE: Urban Institute estimates based on FFY data from the 2007 MSIS and CMS 64.

Expenditures for Mandatory and Optional Services

The majority of Medicaid expenditures in 2007 were for mandatory services provided to both federal core and state expansion enrollees. Spending for mandatory services accounted for two-thirds (67%) of the total $311 billion Medicaid spent on acute care, Medicare premiums, prescription drugs, and long-term care services (Figure 13)**.** The remaining third (33%) of spending was for optional services provided by states to both federal core and state expansion enrollees.

Figure 13

Medicaid Expenditures by Eligibility Pathway and Type of Service, 2007



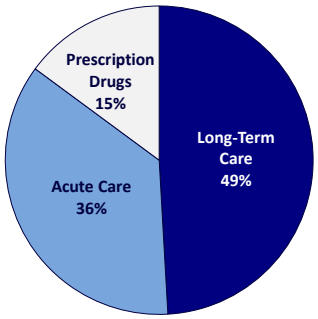
Total = $311 billion

NOTE: Total expenditures do not include disproportionate share hospital (DSH) payments, drug rebates, administrative costs, or accounting adjustments. Shares may not sum to 100% due to rounding.
SOURCE: Urban Institute estimates based on FFY data from the 2007 MSIS and CMS 64.

Roughly half (49%) of the total $103.4 billion spent on optional services for both federal core and state expansion enrollees was attributable to long-term care services (Figure 14). Spending on prescription drugs accounted for 15% of all optional spending, and spending on other acute care accounted for 36%.

Figure 14

Medicaid Expenditures for Optional Services by Service Type, 2007



Total = $103.4 billion

NOTE: Total expenditures do not include disproportionate share hospital (DSH) payments, drug rebates, administrative costs, or accounting adjustments. Shares may not sum to 100% due to rounding.
SOURCE: Urban Institute estimates based on FFY data from the 2007 MSIS and CMS 64.

CONCLUSION

In 2007, federal core enrollees, who were primarily low-income children and elderly and disabled individuals, accounted for seven in ten Medicaid enrollees, and mandatory services provided to federal core enrollees accounted for four in ten Medicaid dollars. The remaining three in ten enrollees were covered through state expansions in eligibility. State expansion enrollees included children, elderly and disabled individuals, and non-disabled adults and pregnant women, but the vast majority of spending for state expansion enrollees was for elderly and disabled individuals and their long-term care needs. Further, a third of Medicaid spending was for optional services provided to both federal core and state expansion enrollees, nearly half of which was for optional long-term care services.

It is important to note that while these national estimates provide measures of Medicaid enrollment and spending attributable to state expansions in eligibility and benefits, they do not capture the significant variation that exists among states. As noted, states vary widely in the extent to which they have expanded eligibility beyond federal core minimum levels and in the scope of their Medicaid benefit packages. These state policy decisions have a significant impact on a state's share of expansion enrollees, spending on these enrollees, and the proportion of Medicaid spending on optional services. States with more expansive eligibility policies have larger shares of state expansion enrollees and spend more on these enrollees (as a share of total spending). Similarly, states with broader benefit packages spend a greater share of total spending on optional services.

The Patient Protection Affordable Care Act (ACA) will significantly expand Medicaid in 2014, creating a new federal minimum eligibility floor of 133% FPL, which will significantly increase Medicaid coverage in many states, particularly for non-disabled adults, and change the balance of federal core and state expansion enrollees. The ACA also includes a Maintenance of Eligibility (MOE) provision that requires states to maintain Medicaid and CHIP eligibility and enrollment policies that are no more restrictive than those they had in place at the time the ACA was enacted (March 23, 2010), until 2014 for adults and until 2019 for children. This provision was designed to maintain coverage until the ACA coverage expansions take effect. It also has assured the availability of Medicaid for low-income families amidst the recent recession, helping to prevent greater increases in the uninsured. However, as states continue to face budget pressures, they are looking at a range of program changes to address fiscal concerns, including changes in eligibility and enrollment policies that are not currently allowed under the MOE, as well as changes in benefits and provider payment policies.

The authors thank John Holahan of the Urban Institute for providing guidance and review during the analysis and writing of this report. They also acknowledge the programming assistance of Vicki Chen of the Urban Institute.

Appendix A: Table 1

Medicaid Income Eligibility Limits for Pregnant Women and Children as a Percent of the Federal Poverty Level (FPL) , January 2011

	Pregnant Women	Children		
		Ages 0-1	Ages 1-5	Ages 6-19
FEDERAL MINIMUM	**133**	**133**	**100**	**100**
Alabama	133	133	133	100
Alaska	175	150	150	150
Arizona	150	140	133	100
Arkansas	162	133	133	100
California	200	200	133	100
Colorado	133	133	133	100
Connecticut	250	185	185	185
Delaware	200	185	133	100
District of Columbia	300	185	133	100
Florida	185	185	133	100
Georgia[1]	200	200	133	100
Hawaii[2]	185	185	133	100
Idaho	133	133	133	100
Illinois[1]	200	133	133	100
Indiana	200	200	133	100
Iowa	300	133	133	100
Kansas	150	150	133	100
Kentucky	185	185	133	100
Louisiana	200	133	133	100
Maine[1]	200	133	133	125
Maryland	250	185	133	100
Massachusetts	200	185	133	114
Michigan[3]	185	185	150	150
Minnesota[4]	275	275	275	275
Mississippi	185	185	133	100
Missouri	185	185	133	100
Montana	150	133	133	100
Nebraska	185	150	133	100
Nevada	133	133	133	100
New Hampshire	185	185	185	185
New Jersey[1]	185	200	133	100
New Mexico	235	185	185	185
New York	200	200	133	100
North Carolina	185	185	133	100
North Dakota	133	133	133	100
Ohio	200	150	150	150
Oklahoma	185	133	133	100
Oregon	185	133	133	100
Pennsylvania	185	185	133	100
Rhode Island[5]	185	185	133	100
South Carolina	185	150	150	150
South Dakota	133	133	133	100
Tennessee	185	185	133	100
Texas	185	185	133	100
Utah	133	133	133	100
Vermont[6]	200	225	225	225
Virginia	133	133	133	100
Washington	185	200	200	200
West Virginia	150	150	133	100
Wisconsin	300	300	185	100
Wyoming	133	133	133	100

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2011.

Table only reflects Medicaid-funded coverage; states extend coverage for children to higher incomes through the Children's Health Insurance Program.

The income eligibility levels noted may refer to gross or net income depending on the state. To be eligible in the infant category, a child has not yet reached his or her first birthday; to be eligible in the 1-5 category, the child is age one or older, but has not yet reached his or her sixth birthday; and to be eligible in the 6-19 category, the child is age six or older, but has not yet reached his or her 19th birthday.

1. Infants born to mothers enrolled in Medicaid in Georgia, Illinois, Maine, and New Jersey are covered up to 200% FPL in Medicaid. In Georgia, Maine, and New Jersey, infants born to non-Medicaid covered mothers are covered to 185% FPL, and in Illinois to 133% FPL.
2. In Hawaii, pregnant women whose income exceeds 185% of the FPL can enroll in Quest-ACE by paying premiums. Coverage goes up to 200% of the FPL, but provides limited benefits.
3. In Michigan, coverage for children ages 16 to 18 between 100% and 150% FPL is funded through the Children's Health Insurance Program.
4. In Minnesota, Medicaid coverage for infants covers children up to age 2; income eligibility for children ages 2-19 is up to 150% FPL under Medicaid and up to 275% FPL under a Section 1115 Medicaid waiver.
5. In Rhode Island, income eligibility for children ages 1 to 7 is up to 133% FPL and for children ages 8 through their 19th it is up to 100% FPL.
6. In Vermont, underinsured children are covered in Medicaid up to 300% FPL.

Appendix A: Table 2
Medicaid Income Eligibility Limits for Parents as a Percent of the Federal Poverty Level (FPL), January 2011
(Limits for Working Parents are Calculated Based on a Family of Three)

	Federal	Jobless		Working	
	Minimum	1931 Eligibility	1115 Waiver	1931 Eligibility	1115 Waiver
Alabama	11%	11%		24%	
Alaska	54%	77%		81%	
Arizona	23%	100%		106%	
Arkansas	13%	13%		17%	200%
California	40%	100%	200%	106%	200%
Colorado	28%	100%		106%	
Connecticut	57%	185%		191%	
Delaware	22%	75%	100%	120%	106%
District of Columbia	28%	200%		207%	
Florida	20%	20%		59%	
Georgia	28%	28%		50%	
Hawaii	41%	100%	200%	100%	200%
Idaho	21%	21%		39%	185%
Illinois	25%	185%		191%	
Indiana	19%	19%	200%	36%	200%
Iowa	28%	28%	200%	83%	250%
Kansas	26%	26%		32%	
Kentucky	34%	36%		62%	
Louisiana	11%	11%		25%	
Maine	36%	200%		200%	
Maryland	24%	116%		116%	
Massachusetts	37%	133%	300%	133%	300%
Michigan	32%	37%		64%	
Minnesota	35%	100%	275%	121%	275%
Mississippi	24%	24%		44%	
Missouri	19%	19%		37%	
Montana	28%	32%		56%	
Nebraska	24%	47%		58%	
Nevada	23%	25%		88%	200%
New Hampshire	36%	39%		49%	
New Jersey[1]	28%	29%	200% ***(closed)***	133%	200% ***(closed)***
New Mexico	25%	29%	200% ***(closed)***	67%	408% ***(closed)***
New York	46%	69%	150%	75%	150%
North Carolina	36%	36%		49%	
North Dakota	28%	34%		59%	
Ohio	22%	90%		90%	
Oklahoma	20%	37%	200%	53%	200%
Oregon	30%	32%	201%	40%	201%
Pennsylvania	26%	26%		46%	
Rhode Island	36%	110%	175%	116%	181%
South Carolina	13%	50%		93%	
South Dakota	33%	52%		52%	
Tennessee	38%	70%		127%	
Texas	12%	12%		26%	
Utah	37%	38%	150% ***(closed)***	44%	150%
Vermont[2]	43%	77%	300%	83%	300%
Virginia	23%	25%		31%	
Washington	36%	37%		74%	
West Virginia	17%	17%		33%	
Wisconsin	34%	200%		200%	
Wyoming	24%	39%		52%	

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured, and Georgetown University Center for Children and Families 2011; Federal minimum levels from CCF calculations based House Ways and Means Committee, "1996 Green Book: Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means" (November 4, 1996); Federal Register, Vol 61(3): 8286-8288 (March 4, 1996); and Federal Register, 75(148): 45628-45629 (August 3, 2010).

The table takes earning disregards, when applicable, into account when determining income thresholds for working parents. Computations are based on a family of three with one earner.

"Closed" indicates that the state was not enrolling new adults eligible for coverage into a program at any point between January 1, 2010 and January 1, 2011.

Waiver programs often provide more limited benefits than regular Medicaid. Further, some waiver programs are limited to parents who meet certain employment requirements, such as working for a small employer.

1. In New Jersey, parents up to 200% FPL are covered under the FamilyCare waiver program. Waiver enrollment closed in 2010 for parents who do not qualify for Medicaid using an enhanced income disregard.

2. In Vermont, 1931 coverage is available up to 77% FPL in urban areas and 73% FPL in rural areas.

Appendix A: Table 3
Coverage of Selected Medicaid Benefits for Adults in New York, Florida, and Texas, October 2008

		New York		Florida		Texas	
Income Eligibility Limits for Adults (% of the Federal Poverty Level)							
Parents		150%		59%		26%	
Childless Adults		100%		0%		0%	
Aged, blind, and disabled		85%		75%		75%	
Benefit	**M/O**	**Covered?**	**Limitations**	**Covered?**	**Limitations**	**Covered?**	**Limitations**
Institutional and Clinic Services							
Inpatient Hospital Services	M	Yes		Yes	45 days/year	Yes	$200,000/year, LOS limited to 30 days in a 90 day period
Outpatient Hospital Services	M	Yes	10 outpatient visits/year in combination with other specified providers	Yes	$1,500/year for non-emergency services (excluding surgery)	Yes	
FQHC	M	Yes	10 clinic visits/year in combination with other specified providers	Yes	1 encounter/day except mental health services limited to 26 encounters/year	Yes	
Practitioner Services							
Physician Services	M	Yes	10 visits/year in combination with other specified providers	Yes	1 non-emergency visit/day, 1 routine physical exam/year, 10 prenatal visits/pregnancy, 2 postpartum visits/pregnancy	Yes	
Prescription Drugs	O	Yes	40 prescriptions/year	Yes	Step therapy required for some drugs not on PDL	Yes	3 prescriptions/month
Dental Services	O	Yes	3 visits/year (limit applicable to dental clinics, but not dental offices)	Yes	Limited to services to alleviate pain or infection or preparatory or related to dentures	Yes	Adult coverage for other than ICM/MR residents limited to trauma or cancer-related care
Optometrist Services	O	Yes	1 refractive exam/ 2 years, visual aids covered when visual acuity criteria met	Yes	eye exams limited to determining presence of disease or reported vision problems	Yes	1 refractive exam/2 years
Podiatrist Services	O	No		Yes	Visit frequency limitations based on site of service, routine foot care covered only for specified systemic conditions	Yes	
Psychologist Services	O	Yes		No		Yes	30 visits/year
Physical Therapy and Other Services							
Occupational Therapy Services	O	Yes		No		No	
Physical Therapy Services	O	Yes		No		Yes	180 days of treatment/year for acute or exacerbation of chronic condition
Services for Speech, Hearing, and Language Disorders	O	Yes		Yes	Liited to services for provision of augmentative and assistive communication systems	No	
Products and Devices							
Eyeglasses	O	Yes	1 pair eyeglasses/2 years	Yes	Eyeglasses, contact lenses, and prosthetic eyes for specified medical conditions, 2 pair of eyeglasses/year eyeglasses/year	Yes	1 pair of eyeglasses/2 years if minimum diopter correction criteria met
Dentures	O	Yes		Yes	1 full upper and/or lower partial or full denture/lifetime	Yes	Adult coverage limited to ICM/MR residents
Hearing Aids	O	Yes		Yes	1 evaluation/3 years, 1 hearing aid/ear/3 years	Yes	45 degree hearing loss in better ear required, 1 hearing aid/6 years, repairs not covered
Medical Equipment and Supplies	O	Yes		Yes	Limitations vary by item	Yes	
Prosthetic and Orthotic Devices	O	Yes		Yes		Yes	Adult coverage limited to NF and ICF/MR residents
Long-Term Services and Supports							
Nursing Facility Services	M	Yes		Yes	8 hospital leave days/hospitalization, 16 thereapeutic leave days/year	Yes	3 consecutie thereapuetic leave days
Home Health Services	M	Yes	40 visits/year and must be in lieu of hospitalization	Yes	4 nursing or home health aide visits/day up to 60/lifetime, therapies not covered, only specified med equipment and supplies covered	Yes	
Personal Care Services	O	Yes	Services provided at 2 levels, must be supervised by RN	No		Yes	Functional limitation criteria must be met, care limited to 50 hours/week

Source: Kaiser Family Foundation Medicaid Benefits Database (http://medicaidbenefits.kff.org)
Coverage is for adults enrolled on a fee-for-service basis; adults enrolled through medically needy pathways may be subject to additional coverage limitations.
M/O denotes whether a service is mandatory or optional.

Appendix B: Table 1
Medicaid Expenditures by Eligibility Pathway and Type of Service, 2007

	Total Medicaid Service Expenditures and Medicare Payments (in billions)	Share of Total Spending for:	
		Mandatory Services for Federal Core Enrollees	Optional Services for Federal Core Enrollees and Mandatory and Optional Services for State Expansion Enrollees
United States	**$311.0**	**39.6%**	**60.4%**
Alabama	$3.8	48.4%	51.6%
Alaska	$1.0	43.0%	57.0%
Arizona	$6.5	76.9%	23.1%
Arkansas	$3.1	40.6%	59.4%
California	$35.1	40.5%	59.5%
Colorado	$2.8	51.1%	48.9%
Connecticut	$4.1	22.1%	77.9%
Delaware	$1.0	40.2%	59.8%
District of Columbia	$1.3	39.1%	60.9%
Florida	$13.7	47.0%	53.0%
Georgia	$6.8	58.1%	41.9%
Hawaii	$1.1	29.2%	70.8%
Idaho	$1.1	44.2%	55.8%
Illinois	$12.8	37.6%	62.4%
Indiana	$4.9	38.5%	61.5%
Iowa	$2.6	30.6%	69.4%
Kansas	$2.1	39.2%	60.8%
Kentucky	$4.5	48.9%	51.1%
Louisiana	$4.6	39.8%	60.2%
Maine	$2.0	30.8%	69.2%
Maryland	$5.4	34.3%	65.7%
Massachusetts	$10.8	32.2%	67.8%
Michigan	$9.0	40.2%	59.8%
Minnesota	$6.2	26.1%	73.9%
Mississippi	$3.2	48.0%	52.0%
Missouri	$6.0	36.9%	63.1%
Montana	$0.7	40.7%	59.3%
Nebraska	$1.5	32.6%	67.4%
Nevada	$1.2	51.6%	48.4%
New Hampshire	$1.0	22.3%	77.7%
New Jersey	$7.7	35.4%	64.6%
New Mexico	$2.6	41.9%	58.1%
New York	$42.9	28.5%	71.5%
North Carolina	$9.7	45.2%	54.8%
North Dakota	$0.5	23.5%	76.5%
Ohio	$12.2	25.3%	74.7%
Oklahoma	$3.4	37.5%	62.5%
Oregon	$2.9	39.7%	60.3%
Pennsylvania	$15.4	39.0%	61.0%
Rhode Island	$1.7	37.2%	62.8%
South Carolina	$3.8	44.4%	55.6%
South Dakota	$0.6	42.7%	57.3%
Tennessee	$7.2	53.7%	46.3%
Texas	$19.8	57.1%	42.9%
Utah	$1.4	45.9%	54.1%
Vermont	$0.9	18.9%	81.1%
Virginia	$4.9	37.7%	62.3%
Washington	$5.6	37.6%	62.4%
West Virginia	$2.2	41.6%	58.4%
Wisconsin	$5.0	26.0%	74.0%
Wyoming	$0.4	39.1%	60.9%

Note: Total expenditures do not include disproportionate share hospital (DSH) payments, drug rebates, administrative costs, or accounting adjustments.
Source: Urban Institute estimates based on FFY state-reported data from MSIS 2007 and CMS-64 2007. See methods for more information on the analysis and its limitations.

APPENDIX C: DETAILED METHODOLOGY

MSIS File Structure

In the MSIS Summary File, eligibility for Medicaid is reported in five broad categories based on Maintenance Assistance Status (MAS): 1) individuals receiving cash assistance or eligible under Section 1931 of the Act (cash/1931); 2) medically needy; 3) poverty related categories; 4) "other" eligibles;[a] and 5) Section 1115 waiver. We further group beneficiaries into four Basis of Eligibility (BOE) categories: 1) elderly (65 years old or older); 2) people with disabilities (64 years old or younger); 3) non-disabled adults (21-64 years old); and 4) non-disabled children (20 years old or younger). The MAS and BOE groups combine to form 20 MAS/BOE eligibility groups.

Each of the 20 MAS/BOE eligibility groups is comprised of multiple eligibility pathways used to determine Medicaid eligibility at the state level. Some MAS/BOE eligibility groups in the MSIS include a mix of "federal core" and "state expansion" eligibles. With no data on narrower eligibility groups used by states, determining the proportion of those eligible with federal core status requires a set of assumptions. For instance, the cash aged group includes individuals who receive SSI (a federal core group), as well as some individuals who only receive state supplementation to SSI (a state expansion group).

Medicaid expenditures as submitted by states under federal guidelines face the same limitations. Expenditures are submitted under broad service groups, some of which include both mandatory and optional services. There are no standard reporting categories for many optional services, such as podiatry and optometry, so how such services are classified in MSIS is unknown and varies by state. The most important limitation is related to expenditures under managed care plans. States report total expenditures for capitated managed care plans, but do not report how funds are dispersed by managed care plans across services. These expenditures would include a mix of both mandatory and optional services.

Assignment of Enrollees to Federal Core or State Expansion Groups

Our counts of the number of beneficiaries in the FY2007 MSIS include all beneficiaries with known age and MAS/BOE eligibility codes who had at least one month of Medicaid enrollment for the year, with the exception of beneficiaries whose most recent eligibility status was through a breast and cervical cancer program (these enrollees were excluded). Our counts include beneficiaries who are institutionalized and those entitled to only limited Medicaid benefits, including those reported by states through family planning programs, emergency services for undocumented aliens, and partial dual eligibles only eligible for Medicare premium assistance.

For purposes of this analysis, we treat all medically needy and Section 1115 waiver demonstration groups as state expansion enrollees. We treat all aged and disabled cash/1931 enrollees and all non-disabled adult cash/1931 enrollees as federal core enrollees. Children in the cash/1931, poverty-related, and "other" eligible categories were assigned federal core status by state and MAS category by applying state-level shares of child Medicaid enrollees with federal core status, calculated from analysis of Current Population Survey data using 2007 state eligibility rules for Medicaid.[b] We determined the proportion of Medicaid enrollees ages 0-19 with incomes in the federal core or state expansion range. The federal core range extends up to the federally-mandated minimum eligibility level (133% FPL for infants and pre-school age children and 100% FPL for school-age children) and the state expansion range

extends from the federal minimum to the maximum eligibility level set by the state. Federal core and state expansion ranges varied by state and by age group. In Utah, for example, all children in Medicaid are considered federal core because the state does not extend eligibility beyond the federally-mandated minimum level. In California, infants with incomes between 134%-200% FPL are in the state expansion range, but all preschool and school-age children are federal core since the state has not expanded Medicaid eligibility for those populations. Since children enrolled only in the Children's Health Insurance Program (CHIP) are not included in this study, federal core and state expansion ranges do not include eligibility levels for CHIP. We established federal core/state expansion proportions for each state and used random assignment to identify individual MSIS non-disabled child enrollees within the cash/1931, poverty-related, and other eligible categories to match these state-level proportions. The resulting national federal core shares by MAS group ranged from 88.1% among poverty-related non-disabled child enrollees to 91.7% among cash/1931 non-disabled child enrollees.

The MSIS data dictionary includes an eligibility crosswalk that lists the multiple eligibility subgroups that comprise each of the 20 MAS/BOE eligibility groups. We designated each subgroup as federal core or state expansion, per a review of the statutory authority for each, and determined that roughly half of the subgroups comprising poverty-related and 'other' eligible non-disabled adult enrollees are federal core. Accordingly, 50% of individuals in those eligibility groups are allocated federal core (based on random assignment). As an example, the chart below demonstrates the subgroup designations for the 'Other Eligible' Non-disabled Adult MAS/BOE category.

Subgroups Comprising the 'Other Eligible' Non-disabled Adults Category	**Federal Core/ State Expansion Designation**
Families receiving up to 12 months of extended Medicaid benefits (if eligible on or after 4/1/90)	Federal Core
Qualified pregnant women whose pregnancies have been medically verified and who meet the State's AFDC income and resource requirements	Federal Core
Adults who are ineligible for AFDC-related Medicaid because of requirements that do not apply under Title XIX	Federal Core
Adults who would be eligible for Medicaid under Section 1931 of the Act (low income families with children) except for the 7/1/72 (PL 92-325) OASDI increase; and were entitled to OASDI and received cash assistance in 8/72.	Federal Core
Women who were eligible while pregnant, and are eligible for family planning and pregnancy related services until the end of the month in which the 60th day occurs after pregnancy.	Federal Core
Adult aliens who are not lawful, permanent residents or who do not have PRUCOL status, but who are otherwise qualified, and who require emergency care	Federal Core
Adults who meet the income and resource requirements for AFDC, SSI, or an optional State Supplement.	State Expansion
Adults who would be eligible for AFDC, SSI, or an optional State Supplement if not in a medical institution.	State Expansion
Adults who have become ineligible who are enrolled in a qualified HMO or "1930 (m)(2)(G) entity" that has a risk contract.	State Expansion
Adults who solely because of coverage under a home and community based waiver, are not in a medical institution, but who would be eligible if they were.	State Expansion
Adults who elect to receive hospice care, and who would be eligible if in a medical institution.	State Expansion
Adults who would be eligible for AFDC if work-related child care costs were paid from earnings rather than received as a State service.	State Expansion
Pregnant women who have been granted presumptive eligibility.	State Expansion
Adults who would be eligible for AFDC if the State used the broadest allowable AFDC criteria.	State Expansion

Spending for randomly assigned individuals is allotted as either federal core or state expansion based on each individual's status as well as the status of the spending category. This means that our estimation of the proportion of spending that is optional within the non-disabled child cash/1931 and both the non-disabled child and non-disabled adult poverty-related and 'other eligible' groups is subject to variation based on this random assignment.

Poverty-related elderly and disabled groups also comprise a mix of federal core and state expansion enrollees, including many beneficiaries who are dually eligible for Medicaid and Medicare. Enrollees who are identified as partial dual eligibles in the MSIS are assigned federal core status, and all remaining enrollees in the elderly and disabled poverty-related group are coded as state expansion enrollees. Elderly and disabled beneficiaries in the "other" eligible group are coded as state expansion enrollees.

Allocation of Spending as Mandatory or Optional

For beneficiaries older than 20, we assign as mandatory acute care expenditures all inpatient services, physician services, nurse practitioner services (for those up to age 45), outpatient services, lab and x-ray services, sterilization for the non-elderly, nurse-midwife services, and abortion services. Some services are allocated differently depending on the eligibility group and age based on application of the Medicaid statute.[c] For this population older than 20, we assign the following as optional acute care expenditures: all dental services, other licensed practitioner services, clinic services, prescription drugs, primary care case management, targeted case management, private duty nursing, hospice, nurse practitioner services (for adults over age 45 and the elderly), transportation, religious non-medical services, rehabilitation services, other therapies, sterilization for the elderly, and expenditures in a residual "other" service category which includes (but is not limited to) prosthetic devices and eyeglasses.

We expect that managed care spending for the aged and adults older than 20 would include a mix of optional and mandatory services. To estimate the portion of managed care spending that is mandatory, we analyzed MSIS 2007 data on the mandatory/optional mix of fee-for-service spending by groups for which the mandatory and optional classification of services differs. Specifically, for Medicaid beneficiaries with zero managed care (HMO or PHP) spending, we designated fee-for-service spending on acute care as either mandatory or optional. We analyzed the fee-for-service data by groups for which mandatory/optional service designations differ (e.g. inpatient hospital services are optional for medically needy enrollees with the exception of pregnancy-related inpatient care) and apply the resulting proportion to the respective group's managed care spending. We allocate managed care spending for each group based on these estimates, so that 73.4% of managed care spending is designated as mandatory for non-disabled adults, 48.5% is mandatory for adults with disabilities, and 34.7% is mandatory for aged enrollees (all managed care services for children are designated mandatory per the explanation below). We assume that all managed care expenditures were spent on acute care.[d]

In terms of long-term care spending, nursing facility services for adults age 21 and over and home health services for adults age 21 and over not attributable to home and community-based waiver programs are allocated as mandatory services, while the remaining long-term care services are allocated as optional for beneficiaries 21 or older. Included as optional long-term care expenditures for this population are mental health facility services for people age 65 or older, intermediate care facility services for the mentally retarded (ICF-MR), payments attributable to HCBS, and personal care services. All long-term care services for children, including home health and inpatient psychiatric care, are treated as mandatory, with the exception of HCBS spending as outlined below.

Treatment of Services for Children

Services for children, both disabled and non-disabled are treated differently in our analysis than services for adults and the aged. The difference in treatment is based on mandatory Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for children under age 21. EPSDT provides screening for all medical, dental, and mental health problems on a periodic basis, as well as referrals for further treatment as needed.[e] Over the years, the law has established that the guarantee of treatment under EPSDT extends to all types of acute and long-term care services as long as the service could be covered by Medicaid (under Section 1905(a)) and the service is necessary to correct or ameliorate defects and physical and mental illnesses and condition discovered by the screening services.

In sum, while many services are listed as optional services by states and applied as such for all enrollees, we assume that benefits for children are uniquely protected under EPSDT case law more broadly than for adults and the elderly. Under this assumption, we treat almost all services for children as mandatory, including managed care.[f] We make the sole exception to treat services provided through state home and community-based waiver programs as optional, because such waiver programs are not listed under Section 1905(a).[g] It should also be noted that services provided to foster children, who often have high health care needs, are counted in the "non-disabled children" category, not in the people with disabilities category.

Designation of Home and Community-based Waiver Program Spending

Expenditures for HCBS are reported separately in the MSIS but are not designated by service category. To capture HCBS spending from service categories, beneficiaries' spending must be backed out of service spending categories that could include HCBS spending (such as personal care and home health care services) so that double-counting of HCBS spending across services does not occur. To extract HCBS payments from service categories, each beneficiary's HCBS program spending as reported on the MSIS must be subtracted from the given beneficiary's MSIS spending in HCBS-related service categories (such as personal care, home health care, targeted case management, rehabilitation, transportation, private duty nursing, other practitioner, occupational/speech/physical therapy, and other unspecified services) so that HCBS spending is not double-counted across the resulting service categories. The new beneficiary-level HCBS service spending variable is the result of aggregating a given beneficiary's spending subtracted from these related services based on his or her aggregate HCBS program spending on the MSIS.

This method allows us to allocate all payments to three groups: institutional long-term care, community-based long-term care, and acute care. Institutional long-term care includes nursing facility services, inpatient psychiatric facility services for adults younger than 21, mental health facility services in institutions for mental disease for adults age 65 and older, and intermediate care facility services for people in institutions for the mentally retarded (ICF-MR). Community-based long-term care includes HCBS, home health, and personal care services.

Alignment to CMS-64 Expenditure Totals

Total service expenditures reported in the MSIS for known beneficiaries fall short of the total aggregate Medicaid service expenditures reported by states on the CMS-64 forms.[h] We inflate expenditures in the MSIS up to CMS-64 reported totals through separate benchmarks to acute care (excluding prescription drugs), long-term care, and prescription drug expenditure totals by state. This adjustment preceded the

exclusion of beneficiaries with missing age and/or MAS group from the base MSIS Medicaid population for the purposes of this study. Total Medicaid expenditures reported in this study also include payments to Medicare for dual eligibles (a Medicaid expenditure that is reported on the CMS-64 but not the MSIS).

Payments to Medicare

Premium payments to Medicare by Medicaid for enrollees dually eligible for both programs are not reported in MSIS. We allocate payments to Medicare from the CMS-64 forms to the aged and disabled eligibility categories by state based on Urban Institute estimates of the state-specific shares of dual eligibles that are aged and disabled, respectively. At the national level, approximately 62 percent of dual eligibles were elderly. Within the aged and disabled eligibility categories, we allocate payments based on the percentage of enrollees who were classified as federal core. This was approximately 60% of aged duals and 65% of disabled duals.

Notes to Detailed Methodology

a. Groups classified as "other" include aliens or permanent residents who qualify to receive only emergency care under Medicaid, some individuals with disabilities who meet more restrictive requirements than SSI, foster children, and children of families receiving up to 12 months of extended transitional Medicaid assistance (TMA), among others.

b. As part of requirements associated with the phased-in expansions to children and pregnant women that occurred in the late 1980s, some states are required to cover pregnant women and infants up to age 1 to a higher federal minimum eligibility level than the 133% FPL limit that otherwise applies. However, no information was available from CMS to determine which states are subject to this requirement, or their respective eligibility levels for the affected populations. In the absence of this information, we treat all states as if their minimum required eligibility level for pregnant women and infants is 133% FPL.

c. Inpatient hospital services for all eligibility categories are allocated mandatory status, except for medically needy eligibility groups. By Medicaid statute, only pregnancy-related inpatient care is mandatory for the medically needy, so for this group, we treat inpatient hospital services for women age 15-45 as mandatory, and the remainder as optional. In addition, some services are only mandatory if related to family planning or provided by family practice nurse practitioners. Thus, nurse practitioner services for adults age 21-45, and sterilization services except for the aged are allocated as mandatory.

d. This assumption may not hold in some states that have developed capitated programs for some long-term care services, particularly under HCBS waivers.

e. The Omnibus Budget Reconciliation Act of 1989 strengthened the program by mandating the coverage of any treatment considered medically necessary as the result of an EPSDT screening. Guarantee of treatment extends to include services listed as optional by state preference, or not covered by a state Medicaid package of benefits if the service is listed in Section 1905(a).

f. Specifically, the following list of services considered optional for other individuals are treated as mandatory for children under age 21 in this analysis: prescription drugs, dental, other clinic, nurse practitioner, other licensed practitioner, primary care case management, rehabilitation, other therapies, transportation, private duty nursing, home health, personal care, targeted case management, hospice, inpatient psychiatric, and intermediate care facility services for the mentally retarded (ICF-MR).

g. Many services provided under waiver programs are also listed under 1905(a) and could be protected, while others are not (e.g. respite care, day care) so our approach is a conservative one.

h. In part this is due to expenditures reported in the MSIS that cannot be attributed to beneficiaries with known eligibility. CMS-64 reports also include payments to providers in excess of actual costs of medical services for Medicaid beneficiaries, which are not reported in MSIS.

1330 G Street NW, Washington, DC 20005
Phone: (202) 347-5270, *Fax:* (202) 347-5274
Website: www.kff.org/KCMU

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