kaiser commission on medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

ISSUE PAPER

June 2005

Medicaid: An Overview of Spending on "Mandatory" vs. "Optional" Populations and Services

Medicaid is a federal-state program that provides health and long-term care services to 52 million low-income Americans. Federal Medicaid matching funds for the costs of these services are available to states that elect to participate in the program. As a condition of participation, states must cover certain populations (e.g., elderly poor receiving Supplemental Security Income) and certain services (e.g., hospital care). These are referred to as "mandatory" eligibility groups and "mandatory" services.

Participating states may also receive federal matching funds for the costs of covering other populations (e.g., elderly poor not eligible for SSI) and services (e.g., prescription drugs). These are known as "optional" eligibility groups and "optional" services. The use of the term "optional" is completely unrelated to whether a particular population or service is somehow less worthy or necessary than another. Instead, the term simply reflects whether, under federal Medicaid rules, a state may receive federal matching funds for the costs of covering a specific population group or service. Coverage of these "optional" eligibility groups and "optional" services is not required by federal law.

Medicaid reform discussions have often focused around giving states greater flexibility with respect to coverage of "optional" populations and services. To inform this debate, this issue brief provides an overview of Medicaid's optional beneficiaries and services. It draws on an analysis conducted for the Kaiser Commission on Medicaid and the Uninsured by the Urban Institute based on data collected by the Centers for Medicare and Medicaid Services (CMS). This work demonstrates that although "optional" populations account for only 29 percent of Medicaid enrollment, 60 percent of all Medicaid expenditures for both "mandatory" and "optional" populations are "optional," and the majority of these (86%) pay for services provided to the elderly and disabled. Some of the sickest and poorest Medicaid beneficiaries are considered "optional," and many "optional" benefits provided under Medicaid, such as prescription drugs, often are integral to appropriate care and functioning.

Medicaid Eligibility Groups

States that receive federal Medicaid matching funds must cover certain "mandatory" groups of beneficiaries (Figure 1). In general, Medicaid provides coverage of three basic groups of low-income Americans: children and parents, the elderly, and people

Figure 1

Medicaid Beneficiary Groups

Mandatory Populations

- **Children age 6 and older below 100% FPL ($15,670 a year for a family of 3)**
- **Children under age 6 below 133% FPL ($20,841 a year for a family of 3)**
- **Parents below state's AFDC cutoffs from July 1996 (median = 42% FPL)**
- **Pregnant women ≤133% FPL**
- **Elderly and disabled SSI beneficiaries with income ≤ 74% FPL ($6,768 a year for an individual).**
- **Certain working disabled**
- **Medicare Buy-In groups (QMB, SLMB, QI)**

Optional Populations

- **Low-income children above 100% FPL who are not mandatory by age (see column on left).**
- **Low-Income parents with income above state's 1996 AFDC level.**
- **Pregnant women >133% FPL**
- **Disabled and elderly below 100% FPL ($9,310 a year for an individual), but above SSI level.**
- **Nursing home residents above SSI levels, but below 300% of SSI ($1,692 a month).**
- **Individuals at risk of needing nursing facility or ICF-MR care (under HCBS waiver)**
- **Certain working disabled (>SSI levels)**
- **Medically needy**

with disabilities. The designation of some groups as "mandatory" and others as "optional" is to a large extent an artifact of Medicaid's origins as a health care program for traditional welfare populations. These populations historically eligible for cash-assistance programs are "mandatory" under Medicaid law, while most populations not eligible for cash assistance were made eligible for the program through new laws enacted over the program's 40-year history. As new eligibility pathways were created, most were offered as an option each state could decide whether to adopt.

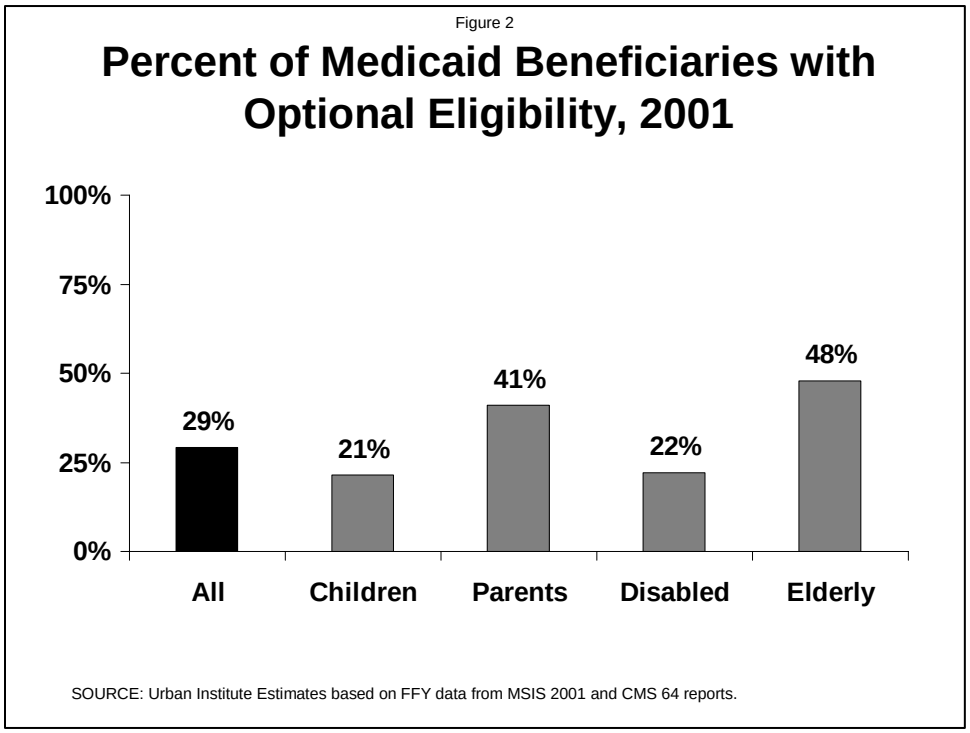
The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, commonly known as "welfare reform," severed the historical link between Medicaid and cash assistance and furthered the evolution of Medicaid into a health insurance and long-term care financing program rather than a welfare program. However, one of the many legacies of this link is the continued designation of populations with incomes below historical cash assistance income eligibility levels as "mandatory," while others are "optional." "Mandatory" populations include pregnant women and children under age 6 with family income below 133 percent of poverty ($21,400 a year for a family of 3 in 2005) and older children with family income below 100 percent of poverty ($16,090 a year for a family of 3 in 2005); most persons with disabilities and elderly people receiving assistance through the Supplemental Security Income (SSI) program ($7,082 a year for an individual in 2005); and parents with income and resources below states' welfare eligibility levels as of July 1996, often below 50% of the federal poverty line.

Beyond these federal minimums, states have substantial flexibility to cover additional "optional" population groups (Figure 1). "Optional" eligibility categories include children and parents above mandatory coverage limits; persons with disabilities and the elderly up to 100 percent of poverty ($9,570 a year for an individual in 2005); persons residing

in nursing facilities with income less than 300 percent of SSI standards ($1,770 a month for an individual in 2005); and individuals who have high recurring health expenses that "spend-down" to a state's medically needy income limit.

Overall, 29 percent of Medicaid beneficiaries qualify on the basis of an "optional" eligibility group. The likelihood of qualifying for Medicaid on the basis of a "mandatory" or "optional" group varies substantially by group (Figure 2). Most children (79%) qualify on the basis of "mandatory" coverage, reflecting Congressional legislative changes that have raised the minimum income eligibility threshold above cash assistance levels. In contrast, nearly half (48%) of the elderly qualify through "optional" eligibility groups, reflecting state decisions to extend coverage to nursing home residents and the medically needy population who have incomes above SSI eligibility levels.

Figure 2



Many individuals who qualify as an "optional" beneficiary are poor and have extensive health and long-term care needs, especially the elderly and persons with disabilities. "Optional" coverage allows states to provide health insurance to children and their parents, low-income working parents who can not obtain health insurance in the workforce, and people with disabilities who are excluded from private coverage due to their disabilities. Without Medicaid, many of these individuals would not have health insurance.

The opportunity to obtain help from Medicaid after "spending down" income and resources due to health care expenses is particularly important to elderly individuals in nursing facilities and children and adults with disabilities who live in the community and incur high prescription drug, medical equipment, or other health care expenses.

Examples of "Optional" Beneficiaries

- An elderly nursing facility resident whose annual income ($7,184) is just above SSI standards (74% of poverty) but below 100% of poverty ($9,570 in 2005).
- A parent of two children who works full-time at a minimum wage level in a service sector job that does not provide health insurance coverage.
- A pregnant woman who has a part-time job, which does not offer health insurance, and earns more than $12,728/year (133% of poverty in 2005).
- A 68 year-old widow with multiple conditions, such as fibrosis of the lungs, rheumatoid arthritis, and high blood pressure, whose income ($8,400) is too high to qualify for SSI (74% of poverty or $7,082 in 2005) but qualifies for Medicaid home and community-based services, allowing her to remain in the community.
- A 7 year-old boy with autism living with his parents whose income is 110% of poverty ($17,699 in 2005) and qualifies through a home and community-based service waiver.
- A woman with disabilities who earns less than $23,925/year (250% of poverty in 2005), whose employer does not over coverage and needs Medicaid's coverage of physician services, personal care services, and prescription drugs.
- An 85-year old with Alzheimer's disease with a monthly income of $1,472 (less than 300% of SSI) qualifies for nursing facility care. She is allowed to keep $30 a month for personal needs, and the remainder of her income goes to the nursing facility to cover her medical and support needs.
- A 50 year-old man who has multiple sclerosis with recurring drug and physician costs that average $750/month "spends down" to Medicaid medically needy eligibility levels (median is 55% of poverty).

Medicaid Benefits

When extending coverage to a Medicaid beneficiary, states must provide physician services, hospital care, nursing facility care, and a range of other "mandatory" services, but they also can provide an array of "optional" services (Figures 3 & 4). Services offered at state option include prescription drugs and a broad range of disability-related services, such as, case management, rehabilitative services, personal care services, and home and community-based services. Many of these "optional" benefits provide important benefits for both Medicaid "mandatory" and "optional" beneficiaries and are particularly important for persons with disabilities and the elderly. These services

Figure 3

Medicaid Acute Care Benefits

"Mandatory" Items and Services

- Physicians services
- Laboratory and x-ray services
- Inpatient hospital services
- Outpatient hospital services
- Early and periodic screening, diagnostic, and treatment (EPSDT) services for individuals under 21
- Family planning and supplies
- Federally-qualified health center (FQHC) services
- Rural health clinic services
- Nurse midwife services
- Certified pediatric and family nurse practitioner services

"Optional" Items and Services*

- Prescription drugs
- Medical care or remedial care furnished by other licensed practitioners
- Rehabilitation and other therapies
- Clinic services
- Dental services, dentures
- Prosthetic devices, eyeglasses, durable medical equipment
- Primary care case management
- TB-related services
- Other specialist medical or remedial care

*These benefits are treated as mandatory for children under 21 through EPSDT in this analysis.

Figure 4

Medicaid Long-Term Care Benefits

"Mandatory" Items and Services

Institutional Services

- Nursing facility (NF) services for individuals 21 or over

Home & Community-Based Services

- Home health care services (for individuals entitled to nursing facility care)

"Optional" Items and Services*

Institutional Services

- Intermediate care facility services for the mentally retarded (ICF/MR)
- Inpatient/nursing facility services for individuals 65 and over in an institution for mental diseases (IMD)
- Inpatient psychiatric hospital services for individuals under age 21

Home & Community-Based Services

- Home- and community-based waiver services
- Other home health care
- Targeted case management
- Respiratory care services for ventilator-dependent individuals
- Personal care services
- Hospice services
- Services furnished under a PACE program

*These benefits are treated as mandatory for children under 21 through EPSDT in this analysis, with the exception of Home and Community-based waiver services.

enable many persons with disabilities to remain in the community or recover from a serious illness or accident. Many of the "optional" services, such as case management, prosthetics, physical therapy, and hospice care are components of medically-appropriate care.

Examples of "Optional" Services

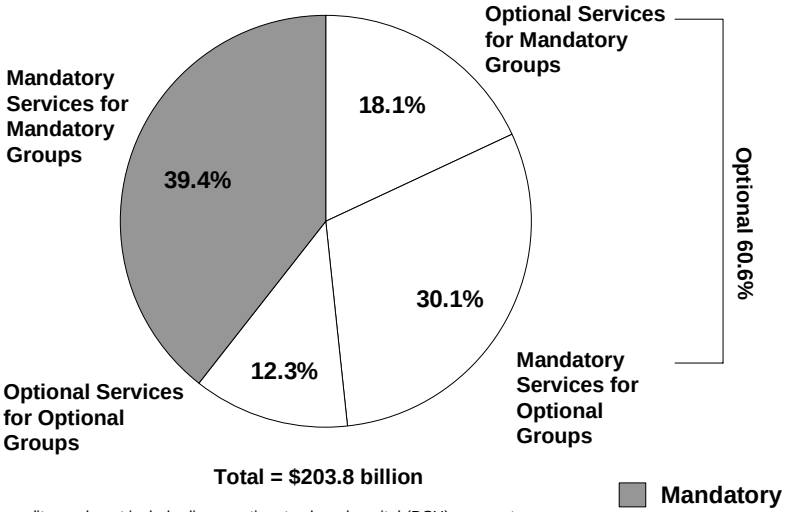
- A 22 year-old male with autism relies on the speech and occupational therapy and home based therapeutic services to learn basic life skills, such as how to dress, how to make his bed, and how to interact with other people.
- A 40 year-old woman with mental illness takes 4 prescription drugs a day to manage her bipolar disorder.
- A 32 year-old male with cerebral palsy relies on a personal care assistant who helps him bath, dress, eat, and essentially "have a normal life."
- A 51 year-old woman relies on Medicaid's prescription drug coverage for her twice daily dose of medications that include 10 different prescriptions to help manage her HIV disease.

Medicaid Spending on Optional Groups and Services

If a state decides to extend Medicaid coverage to an "optional" population, it must generally offer the same benefits package that it makes available to its "mandatory" populations. In every state, this benefits package includes both "mandatory" and "optional" services. Thus, the optional populations that a state includes in its Medicaid program will generally have coverage for both "mandatory" and "optional" services. As shown in Figure 5, sixty percent of total Medicaid spending is "optional." "Optional" populations account for about 42 percent of all Medicaid spending; of this spending, 70

Figure 5

Medicaid Expenditures by Eligibility Group and Type of Service, 2001



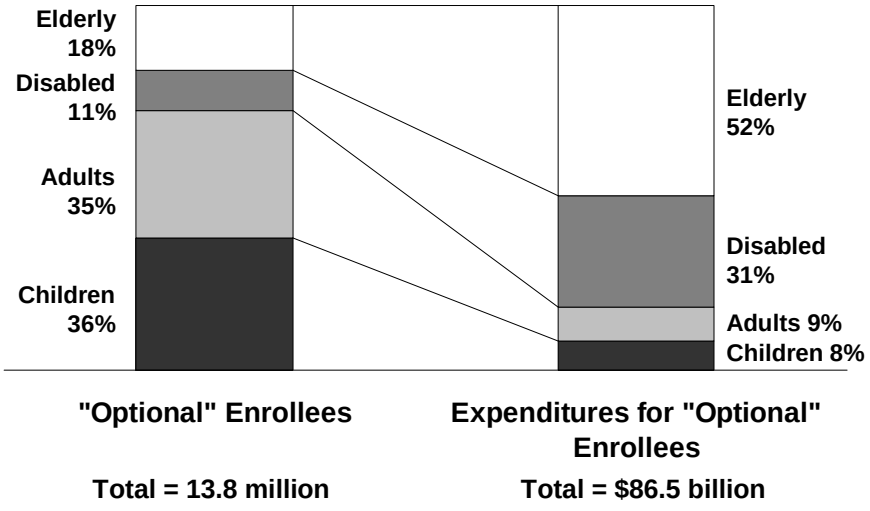
NOTE: Total expenditures do not include disproportionate share hospital (DSH) payments, administrative costs, or accounting adjustments.

SOURCE: Urban Institute Estimates based on FFY data from MSIS 2001 and CMS 64 reports.

percent is for "mandatory" services and 30 percent is for "optional" services. Spending is not evenly distributed among the "optional" populations. As shown in Figure 6, the elderly and disabled represent 29 percent of the "optional" populations but account for 83 percent of Medicaid spending on these populations. Conversely, children and their parents account for 71 percent of the "optional" populations but only 17 percent of Medicaid spending on these populations.

Figure 6

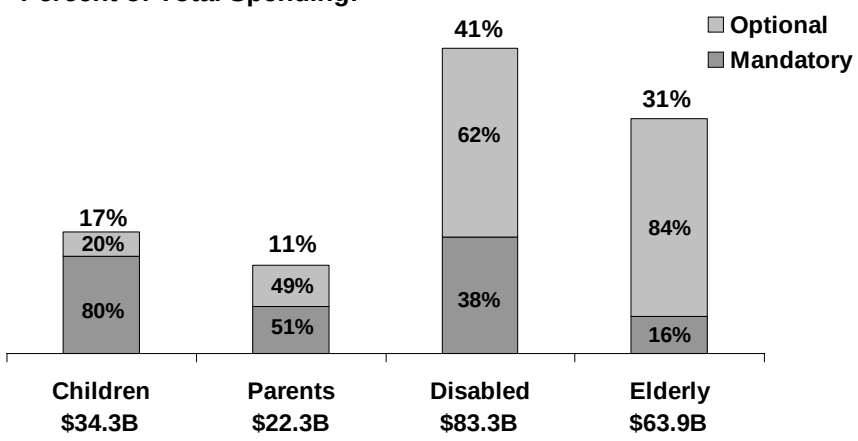
Medicaid Optional Enrollees and Their Expenditures, by Group, 2001



Although three fifths of total Medicaid spending is "optional," the share of spending that is "mandatory" or "optional" varies substantially across beneficiary groups (Figure 7).

Figure 7

Medicaid Expenditures by Eligibility Category and Type of Service



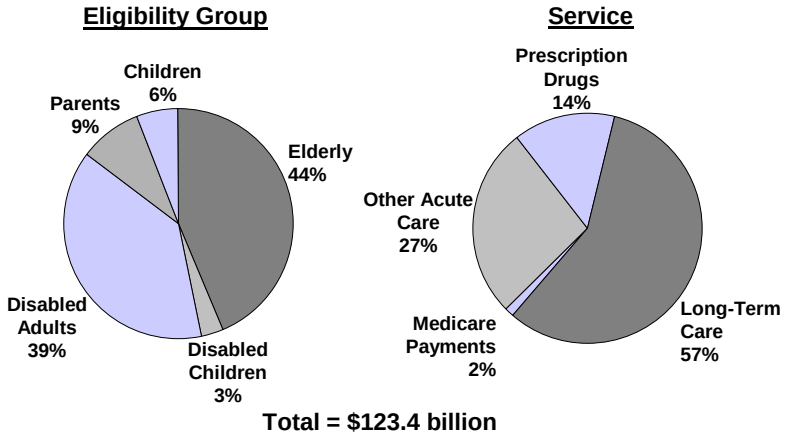
NOTE: Optional services for mandatory groups are counted as "optional" spending.

SOURCE: Urban Institute Estimates based on FFY data from MSIS 2001 and CMS 64 reports.

For example, only 20 percent of spending on children is "optional," while 84 percent of spending on the elderly is "optional." Overall, the majority of "optional" spending is on persons with disabilities and elderly individuals needing nursing facility care. "Optional" spending is driven in large part by coverage of long-term care services for the elderly and persons with disabilities for nursing facility care, ICF/MR services, and home and community-based services. As a result of state decisions to cover these services, over half (57%) of total "optional" spending is for long-term care services (Figure 8).

Figure 8

Medicaid Optional Spending by Eligibility Group and Service, 2001



Total = $123.4 billion

NOTE: Total expenditures do not include disproportionate share hospital (DSH) payments, administrative costs, or accounting adjustments.

SOURCE: Urban Institute Estimates based on FFY data from MSIS 2001 and CMS 64 reports

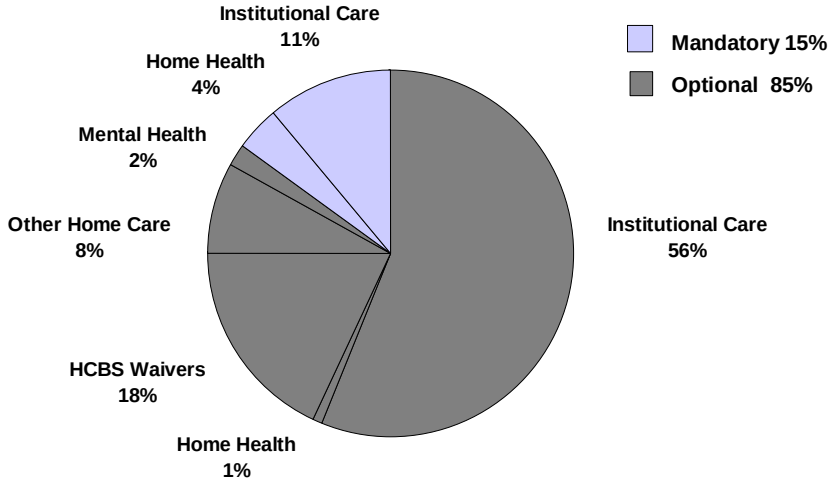
Coverage of prescription drugs is "optional" for all eligibility groups other than children (prescription drug coverage is required

under EPSDT). However, all states have chosen to include prescription drugs in their Medicaid benefits. Spending for prescription drugs comprised only 14 percent of all "optional" spending, with the majority of prescription drug spending (54%) for persons with disabilities.

Eighty-five percent of Medicaid spending on long-term care is "optional" (Figure 9). Two thirds of all "optional" long-term care spending is for institutional care. While 32 percent of "optional" spending is for home and community-based waiver services and other home care, only 4 percent of total long-term care spending is for "mandatory" home health services.

Figure 9

Medicaid Spending on Long-Term Care, by Optional and Mandatory Services



Total = $83.1 billion

SOURCE: Urban Institute Estimates based on FFY data from MSIS 2001 and CMS 64 reports

Conclusion

Although federal Medicaid law distinguishes between certain classes of eligible individuals and benefits as "mandatory" or "optional," these distinctions may not reflect the practical alternatives states face within today's policy environment. While fewer than 30% of Medicaid enrollees fall into "optional" categories, spending that occurs because of state's choices to cover "optional" services or "optional" populations makes up the majority (60.6%) of all Medicaid spending. Furthermore, the health delivery system in the past forty years has evolved toward greater continuity of care, care coordination, and away from institutionalized care, placing a greater relevance on a set of services currently considered "optional." Thus, the legal distinction of services by "mandatory" and "optional" classes imposed by federal statute may not provide a useful roadmap for distinguishing populations and services that are central to Medicaid's role.

This brief publication draws on Sommers, Ghosh, and Rousseau, *Medicaid Enrollment and Spending by "Mandatory" and "Optional" Eligibility and Benefit Categories* (publication #7332), prepared by the Urban Institute for the Kaiser Commission on Medicaid and the Uninsured, June 2005.

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

Additional copies of this report (#7331) are available
on the Kaiser Family Foundation's website at www.kff.org.

THE HENRY J. KAISER FAMILY FOUNDATION

The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.