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Medicaid Enrollment and Spending by "Mandatory" and "Optional" Eligibility and Benefit Categories

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June 2005

THE HENRY J. KAISER FAMILY FOUNDATION

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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.

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Introduction

Medicaid is the nation's largest health and long-term care coverage program for low-income Americans. In 2003, state and federal Medicaid expenditures totaled $275.5 billion[1] and covered 40.6 million individuals as of June 2003, and 52.4 million enrollees at some point during the year.[2] Medicaid spending grew on average 10.2% annually between 2000 and 2003, resulting in an increase in program expenditures of about one-third.[3] Much of this growth was due to increases in enrollment. Average spending per enrollee increased as well, but increased more slowly than average costs in the private insurance market. Growth in Medicaid enrollment and spending, in addition to continued growth in health care costs overall, have spurred proposals to either reduce costs or spending growth under the Medicaid program at both the state and federal level. All 50 states and DC took steps to contain Medicaid spending in response to expenditure and enrollment growth during the recent economic downturn as many lost jobs and income while state revenues declined. As deficits continue to grow at the federal level, policy makers in Washington have also sought ways to control Medicaid spending growth.

Such proposals have often divided Medicaid enrollees and spending into categories considered to be mandated under federal statute and those considered to be a state option. This analysis presents new estimates of the proportion of Medicaid beneficiaries and spending that is mandatory and optional to promote an increased understanding of how Medicaid restructuring proposals might affect the various groups and services covered by the program.

Structure of the Medicaid Program Today

Medicaid covers four primary groups of low-income people: the elderly, people with disabilities, children, and pregnant women and parents. Adults under age 65 who are not living with a disability and are not caring for children generally do not qualify for coverage except through special state waivers. Medicaid is jointly financed by federal and state governments. The federal government matches funds allocated by states at rates based on each state's per capita income. The federal financing share was roughly 57% nationally in 2003 and ranged from 50 to 77 percent across the states.

States administer Medicaid within federal guidelines, which mandate coverage for certain groups of individuals. The eligibility of these individuals is considered "mandatory" because federal guidelines require coverage of these groups as a condition of a state's participation in Medicaid and the receipt of federal matching funds. The eligibility of other individuals is considered "optional" because federal guidelines allow, but do not require, states to cover these groups and receive federal matching funds.

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." Some examples of mandatory groups include children in families with incomes below the poverty level ($16,090 for a family of three in 2005), pregnant women with incomes under 133% of poverty ($17,064 in 2005 for a mother with one child), and individuals with disabilities who receive Supplemental Security Income (SSI) (Table 1).

Table 1
Medicaid Beneficiary Groups

Mandatory Populations	Optional Populations
▪ Children age 6 and older below 100% FPL ($15,670 a year for a family of 3)	▪ Low-income children above 100% FPL who are not mandatory by age (see column on left).
▪ Children under age 6 below 133% FPL ($20,841 a year for a family of 3)	▪ Low-Income parents with income above state's 1996 AFDC level.
▪ Parents below state's AFDC cutoffs from July 1996 (median = 42% FPL)	▪ Pregnant women >133% FPL
▪ Pregnant women ≤133% FPL	▪ Disabled and elderly below 100% FPL ($9,310 a year for an individual), but above SSI level.
▪ Elderly and disabled SSI beneficiaries with income ≤ 74% FPL ($6,768 a year for an individual).	▪ Nursing home residents above SSI levels, but below 300% of SSI ($1,692 a month).
▪ Certain working disabled	▪ Individuals at risk of needing nursing facility or ICF-MR care (under HCBS waiver)
▪ Medicare Buy-In groups (QMB, SLMB, QI)	▪ Certain working disabled (>SSI levels)
	▪ Medically needy

Above these federal minimums, states have flexibility to choose to cover other individuals and receive federal matching funds for the cost of their coverage. These groups are referred to as "optional" groups. Some examples of optional groups include individuals who would be eligible for Medicaid if institutionalized, but who receive community-based services instead, low-income pregnant women over 133% of poverty, and low-income parents with incomes above state

eligibility thresholds established in 1996 for Assistance for Families with Dependent Children (AFDC), at the time of welfare reform.

In general, individuals in both mandatory and optional groups are entitled to a set of benefits that are also mandated by federal guidelines (Tables 2 and 3). These benefits include, among other services, inpatient hospital care, physician, lab and x-ray services, and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for children. Although services covered within these benefit categories are intended to be comprehensive, states have the option—and some do—to place restrictions on mandated benefits, such as placing caps on the number of physician visits or hospital days covered.

Table 2
Medicaid Acute Care Benefits

"Mandatory" Items and Services	"Optional" Items and Services*
▪ Physicians services	▪ Prescription drugs
▪ Laboratory and x-ray services	▪ Medical care or remedial care furnished by other licensed practitioners
▪ Inpatient hospital services	▪ Rehabilitation and other therapies
▪ Outpatient hospital services	▪ Clinic services
▪ Early and periodic screening, diagnostic, and treatment (EPSDT) services for individuals under 21	▪ Dental services, dentures
▪ Family planning and supplies	▪ Prosthetic devices, eyeglasses, durable medical equipment
▪ Federally-qualified health center (FQHC) services	▪ Primary care case management
▪ Rural health clinic services	▪ TB-related services
▪ Nurse midwife services	▪ Other specialist medical or remedial care
▪ Certified pediatric and family nurse practitioner services	

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

Table 3
Medicaid Long-Term Care Benefits

"Mandatory" Items and Services	"Optional" Items and Services*
Institutional Services	
▪ Nursing facility (NF) services for individuals 21 or over	▪ 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 health care services (for individuals entitled to nursing facility care)	▪ 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.

When states choose to cover an optional eligibility group, these groups are entitled to the same set of benefits offered to mandatory groups. An exception is individuals covered through the optional state Medically Needy category. Individuals qualifying through this category may have incomes above the state's eligibility thresholds for the categorically needy, but when their significant medical expenditures are taken into account, they fall below such income thresholds. Many individuals with chronic diseases requiring high-cost treatments, such as individuals with cancer, HIV-AIDS, or nursing home patients, qualify for Medicaid through this category. It is noteworthy that such individuals in institutions are required to contribute virtually all of their income (with some protection of income for a spouse in the community) toward their medical bills. Under federal guidelines, states may provide a reduced benefit package relative to the mandated benefits package for the Medically Needy.

In addition to the mandated benefits package, states may provide additional "optional" services. All fifty states do. Except under very limited circumstances, these optional benefits must be offered to all enrollees whether they are mandatory or optional. Optional services include lower cost practitioners other than physicians, and many services that provide care coordination or continuity,

such as targeted case management, primary care case management, and transportation.[4] Prescription drugs, and most home and community-based long-term care services, are also considered optional.

This brief provides new estimates on coverage and spending for mandatory and optional populations to provide a context for assessing the impact of future proposals to reform or to cap overall expenditures for Medicaid. The brief is based on analysis conducted for the Kaiser Commission on Medicaid and the Uninsured by The Urban Institute.

The current analysis uses person-level data from the FY2001 Medicaid Statistical Information System Summary File (MSIS) and CMS-64 reports. This analysis presents estimates on the proportion of Medicaid beneficiaries and spending that was mandatory and optional in 2001, including more detailed information on the proportions optional across different eligibility groups. In addition, this analysis provides estimates separately for adults and children under 21 with disabilities.

These estimates are not entirely comparable to previous estimates already published by the Commission using aggregate 1998 data from state CMS-64 and HCFA 2082 reports.[5] While most approaches to allocating enrollees and spending to mandatory and optional groups were similar, this analysis uses different data sources as well as new methods. For the most part, comparability is limited due to a very different approach we take to allocating spending for children. In addition, further refinements to allocation methods only possible using person-level data were applied. Thus, readers should not attempt to draw conclusions about changes over time based on a comparison of findings.

Methods

This section describes the assumptions made to allocate beneficiaries and expenditures for services into mandatory and optional categories.

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;[6] and 5) Section 1115 waiver. We group MAS categories into four Basis of Eligibility (BOE) categories: 1) aged; 2) people with disabilities; 3) parents and pregnant women; and 4) children. The people with disabilities category includes both adults and children. 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 available at the state level to determine Medicaid eligibility. Within

some MAS/BOE eligibility groups in the MSIS, some eligibles are mandatory and others optional. With no data on narrower eligibility groups used by states, determining the proportion of these eligibles that have mandatory status requires a set of assumptions. For instance, the cash aged group includes individuals who receive SSI (a mandatory group), as well as some individuals who only receive state supplementation to SSI (an optional 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. The most critical limitation is related to expenditures under managed care plans. States report total expenditures for capitated managed care plans, but do not collect or report how funds are dispersed by managed care plans across services. These expenditures would include a mix of both mandatory and optional services.[7]

In sum, any analysis of the implications of Medicaid restructuring based on mandatory and optional coverage is subject to the limitations presented by the available federal data. Other researchers have explored the methodological challenges related to conducting such an analysis, but have not published any estimates on this topic.[8] To the extent possible given the available data, we have applied the Medicaid statute to allocate enrollees and spending into optional and mandatory categories.

Allocation of Enrollees and Spending to Mandatory and Optional Groups

For purposes of this analysis, all cash/1931 categories are treated as mandatory enrollees. Many poverty-related children and adults are eligible under mandatory categories, but some are optional. Based on results from the TRIM3 simulation model of the Current Population Survey using state eligibility guidelines, 75% of children and 82% of adults in poverty-related categories are estimated to be mandatory. Individual enrollees in MSIS are allocated based on random assignment. Thirteen states used the OBRA '86 option to expand coverage to aged and individuals with disabilities with incomes above SSI standards (generally 100% of poverty) and these individuals are reportedly in poverty-related categories. These individuals are coded optional. In the remaining states, most poverty-related beneficiaries are dual eligibles (including partial duals) and are assigned mandatory status. We assign as optional all medically needy and Section 1115 demonstration expansion categories, and all children identified as SCHIP enrollees in every month. Aged and disabled in "other" MAS/BOE categories are assigned optional status. Adult and child "other" enrollees eligible through home and community-based waiver programs (HCBS) are optional, so any with HCBS spending are treated as optional enrollees in our analysis, while the remainder are treated as mandatory, including all foster children.

We assign as mandatory acute care expenditures all physician services, outpatient services, lab and x-ray services, midwife and abortion services. Some

services are allocated differently depending on the eligibility group and age based on application of the Medicaid statute.[9] We expect that a portion of managed care spending for adults would include optional acute services, such as prescription drugs, and allocate 20% of managed care spending to optional services. We assume that all managed care expenditures were spent on acute care.[10] We assign as optional acute care expenditures dental services, other licensed practitioner services, clinic services, prescription drugs for the aged and adults age 21 and over, primary care case management, nurse practitioner services for adults and aged over age 45, transportation, rehabilitation services for aged and adults age 21 and over, other therapies, and sterilization for the aged.

In terms of long-term care spending, nursing facility payments 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 remainder of these services are allocated as optional. Included as optional long-term care expenditures are nursing facility services for people over age 65 in mental institutions, intermediate care facility services for the mentally retarded (ICF-MR), payments attributable to HCBS, personal care services, targeted case management, private duty nursing, and hospice. 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.

Expenditures for HCBS are reported separately in the MSIS and on the CMS-64, but are not designated by an MSIS service category. A residual service category, referred to as "other" services, includes prosthetic devices, eyeglasses, and some HCBS spending, and may include both mandatory and optional services. We back out HCBS dollars from the "other" service category and other categories, primarily personal care services and home health, to prevent double-counting and attribute optional HCBS expenditures using a state-by-state protocol (see Appendix B). The remaining dollars in the "other" category are treated as 50% optional and 50% mandatory for adults and 100% mandatory for children, and 100% of these services for all groups are designated as acute care.

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 age 21 and under, 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 spending under HCBS, home health, personal care, targeted case management, private duty nursing, and hospice.

Treatment of Services for Children

Services for children, both disabled and non-disabled, are treated differently in our analysis than services for adults and aged. The difference in treatment is based on mandatory Early and Periodic Screening, Diagnosis, 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.[11] 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 may only be denied if the treatment is deemed experimental, non-medical, or does not meet the state definition of medical necessity.

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 all services for children as mandatory, including managed care, institutional and community-based long-term care services.[12] 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).[13] It should also be noted that services provided to foster children, who often have high health care needs, are counted in the general "children" category, not in the people with disabilities category.

Alignment to CMS-64 Expenditure Totals

Total expenditures reported in MSIS for known beneficiaries fall short of the total aggregate Medicaid expenditures reported by states on the CMS-64 forms.[14] We inflate expenditures in the MSIS up to CMS-64 reported totals by service category. Some expenditure lines in CMS-64 do not have comparable service categories in MSIS, or are not reported separately in MSIS. We group some services in MSIS to better align totals to comparable groups in CMS-64. MSIS does not account for prescription drug "offsets," or rebates that are reported on the CMS-64. To account for these savings, we inflate prescription service expenditures in the MSIS up to prescription drug expenditures reported on the CMS-64 minus offsets.

Study Limitations

This national analysis on mandatory and optional eligibility and benefits using MSIS data has important limitations. First, these data are not designed to record the status of individuals or payments based on mandatory or optional designation. Thus, any research on the structure of Medicaid that requires designation of beneficiaries or expenditures based on "mandatory" and "optional" status and that uses national Medicaid expenditure data must rely on a set of assumptions, as outlined above.

Second, the nature of this analysis limits the ability to project national estimates on mandatory and optional enrollment and expenditures using more current Medicaid program data. Estimates in this analysis are based on the distribution of beneficiaries and services across specific eligibility and service categories reported in the MSIS 2001. Any projections to future years produced from these estimates would have to assume equal growth for all enrollment categories, and all services by enrollment category. Comparative analyses using the same methods on MSIS 2000 data found results to be stable between 2000-2001. Nonetheless, generation of projected estimates to future years that do not utilize information on growth rates in expenditures and enrollment by beneficiary group are not advised.

Study Results

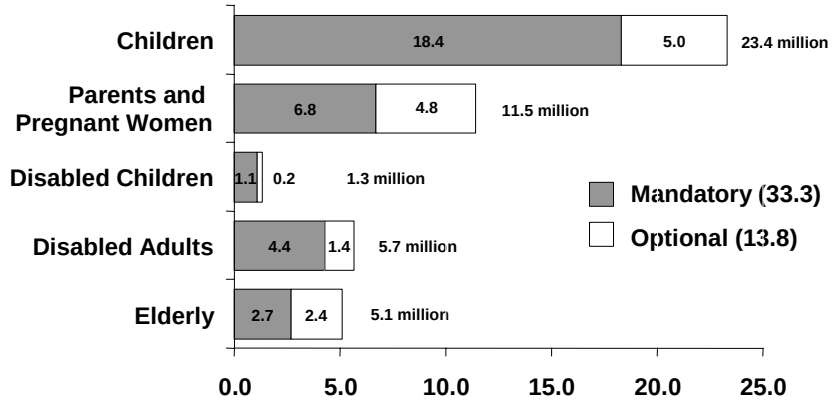
Mandatory and Optional Medicaid Beneficiary Groups

Estimates are provided separately for the elderly, adults with disabilities, children with disabilities, parents and pregnant women, and (non-disabled) children. Individuals with disabilities are defined as the categorically disabled, or those who qualify for Medicaid through a disability. Parents include others who are caring for children, and some non-disabled adults without children who qualify only through Section 1115 state waiver programs.

Of the 47.1 million Medicaid beneficiaries estimated to be enrolled in 2001, most (33.3 million) qualified for coverage on the basis of a mandatory eligibility group (Figure 1). A total of 13.8 million beneficiaries qualified for coverage on the basis

Figure 1

Medicaid Enrollment by Eligibility Group, 2001
(in millions)



NOTE: Because of rounding, numbers may not exactly sum to totals.

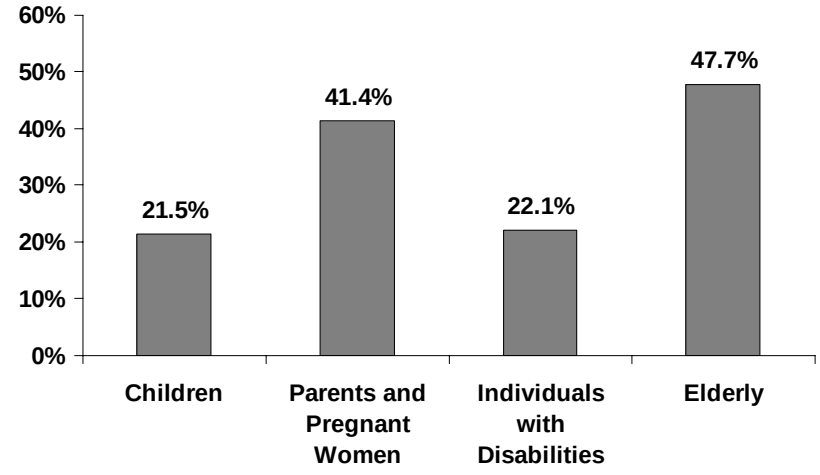
SOURCE: Urban Institute Estimates based on FFY data from MSIS 2001 and CMS 64 reports.

of an optional eligibility group, including 2.4 million elderly, 1.4 million adults with disabilities, 0.2 million children with disabilities, 4.8 million parents, and 5.0 million children.

Overall, 29.3% of beneficiaries are estimated to be enrolled through state options. The likelihood of qualifying for Medicaid on the basis of a mandatory or optional group varies substantially by eligibility category (Figure 2). More than one in five children (21.5%) qualify through optional eligibility categories. Children qualifying through optional categories include medically needy children, and children with family incomes above federally mandated eligibility thresholds. One example of an optional child enrollee would be a seven-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 waiver program.

Figure 2

Percent of Medicaid Beneficiaries with Optional Eligibility, 2001



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

In contrast, 41.4% of non-disabled adults qualify through optional categories. Many of these adults are pregnant women. For instance, a typical example would be a pregnant woman who has a part-time job, which does not offer health insurance, and earns more than $12,728 a year (133% of poverty in 2005). Without Medicaid, she might not have access to prenatal and maternity care. Another typical example would be a parent of two children who works full-time at minimum wage earning $10,712 a year (67% of poverty in 2005) in a service sector job that does not provide health insurance coverage. Also included are adults without children covered under large state waiver programs in New York, Tennessee, Massachusetts, and other states.

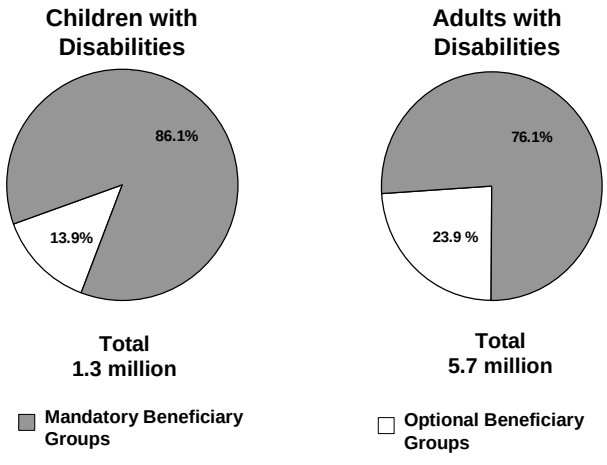
Just under half (47.7%) of the elderly qualify through optional eligibility categories, including medically needy aged with incomes above SSI eligibility levels living in nursing homes or the community. One example of an optional elderly enrollee would be a 68-year old widow with multiple conditions, such as fibrosis of the lungs, rheumatoid arthritis, and high blood pressure, whose income of $700 a month is too high to qualify for SSI (74% of poverty), but qualifies for Medicaid home and community-based services. These services, as well as the Medicaid prescription drug coverage, allow her to remain in the community.

Among all people with disabilities, 77.9% qualify through mandatory eligibility categories. The remaining 22.1% include many medically needy with disabilities or those who qualify only through home and community-based waiver programs. An example would be a 50-year old man who has multiple sclerosis with recurring drug and physician costs that average $750 a month, an amount which offsets his income to such an extent as to qualify him for Medicaid based on his state's optional medically needy eligibility levels (the median is 55% of poverty). Another example of an optional disabled enrollee would be an employed woman with disabilities who earns less than $23,925 a year (250% of poverty in 2005), whose employer does not offer coverage, but who needs Medicaid's coverage of physician services, personal care services, durable medical equipment, and prescription drugs to continue working and living in the community.

Adults and children living with disabilities demonstrate somewhat different patterns of enrollment based on eligibility. As a result, a greater proportion of children with disabilities (86.1%) than adults with disabilities (76.1%) qualify through mandatory categories (Figure 3).

Figure 3

Percent of Disabled Beneficiaries with Optional Eligibility, 2001



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

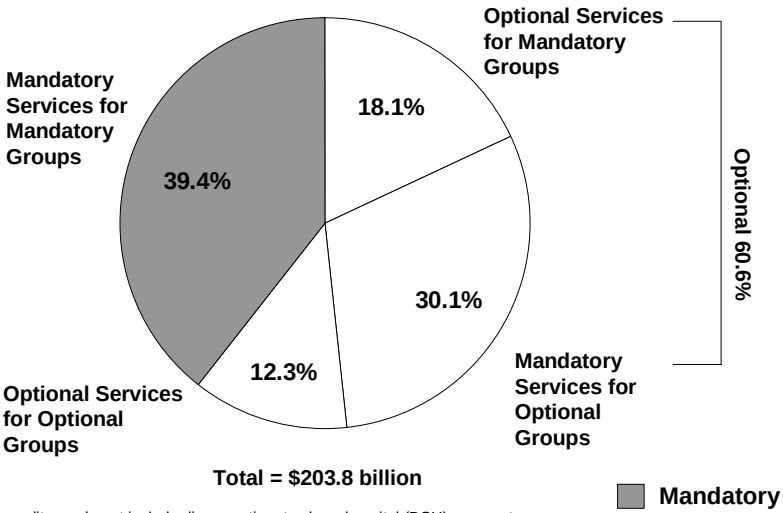
SOURCE: Urban Institute Estimates based on FFY data from MSIS 2001 and CMS 64 reports.

Mandatory and Optional Medicaid Spending

In 2001, Medicaid spent $203.8 billion on acute and long-term care services for low-income families, individuals with disabilities, and the elderly (Figure 4). This includes $5.0 billion of mandatory payments to Medicare for individuals dually eligible for Medicaid and Medicare, in the form of premiums, copayments, and coinsurance. Of the $203.8 billion in Medicaid expenditures, 39.4% was mandatory, or spending on mandatory benefits for mandatory eligibility groups. The remaining 60.6% was considered optional spending: 18.1% of spending was on optional benefits for mandatory groups, 30.1% was for mandatory benefits for optional groups, and 12.3% was for optional benefits for optional groups.

Figure 4

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.

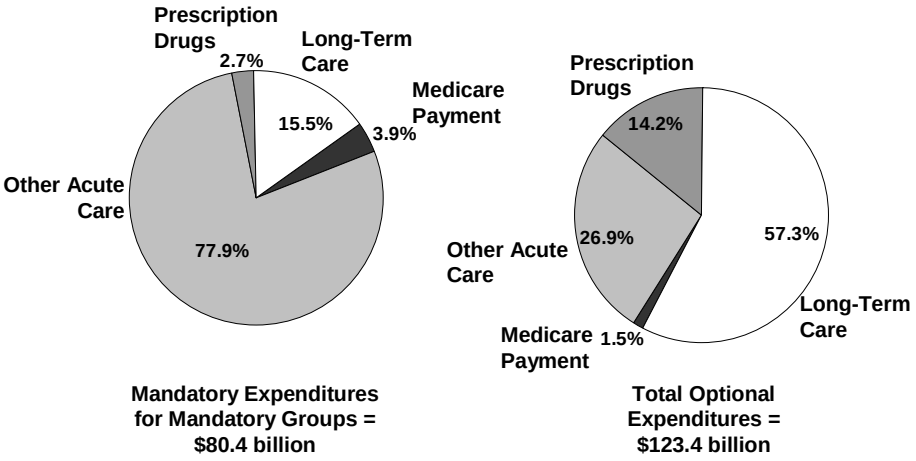
SOURCE: Urban Institute Estimates based on FFY data from MSIS 2001 and CMS 64 reports.

A total of $80.4 billion was spent on mandatory services for mandatory groups in 2001 (Figure 5). The vast majority of mandatory spending, 78 percent or $62.6 billion, was attributable to acute care services other than prescription drugs. Over 90% of these expenditures were attributable to "major" acute care services, defined as inpatient, outpatient hospital, physician, lab/x-ray, clinic, and managed care services. Long-term care accounted for 16% of all mandatory spending, of which just over half (54%) was for nursing facility care. Payments to Medicare for premiums and coinsurance for mandatory dual eligible individuals accounted for nearly 4% of mandatory spending.

A total of $123.4 billion was spent on optional services for mandatory groups combined with all spending for optional groups in 2001 (Figure 5). Nearly sixty percent of all of this optional spending (57.3%) was attributable to long-term care. Payments to Medicare for premiums and coinsurance for optional dual eligible

Figure 5

Medicaid Expenditures by Service, 2001



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

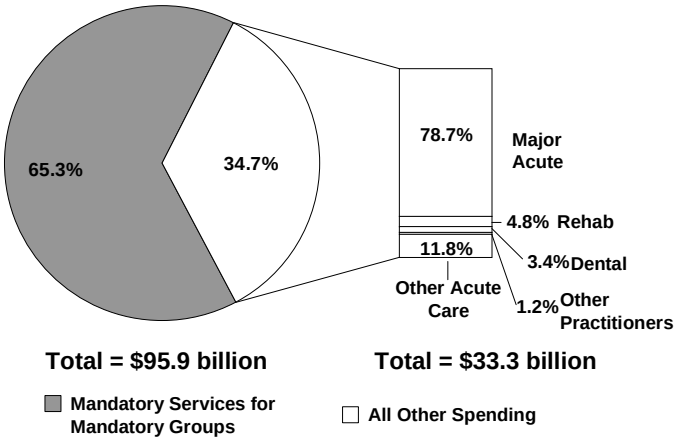
SOURCE: Urban Institute Estimates based on FFY data from MSIS 2001 and CMS 64 reports.

individuals accounted for 1.5% of optional spending. Spending on acute care services other than prescription drugs accounted for 26.9% of optional spending. Optional spending on prescription drugs for adults and elderly accounted for 14.2% of all optional spending (Figure 5). Prescription drug coverage can play a central role in the care, for example, of a forty-year old male with mental illness, who takes four prescription drugs a day to manage his bipolar disorder, or a 51 year-old woman who must take twice daily doses of medications that include ten different prescriptions to help manage her HIV disease.

Figure 6 presents more detail on acute care spending. As shown here, more than two-thirds (65.3%) of all acute care spending is for mandatory services provided to mandatory groups. Of the remaining one-third, the vast majority (78.7%) was for "major" acute care services, as defined in the figure's note. Less than 10% of this acute care spending was attributable to rehabilitation ($1.6 billion), non-physician practitioners ($389 million), or dental care ($1.1 billion). Most of the remaining spending was attributable to transportation ($924 million), and other services, a residual category that includes spending on prosthetics, eyeglasses and other unspecified services ($2.9 billion). Many acute care services falling outside the "major acute" category are critically important for groups such as adults with spinal cord injury who require primary case management to assist with physician monitoring of skin and bladder conditions, which can be life threatening in this population. Rehabilitation and occupational therapies can play an important role for adults with developmental disability, who with such services may live more independently in their communities.

Figure 6

Medicaid Expenditures for Acute Care, 2001



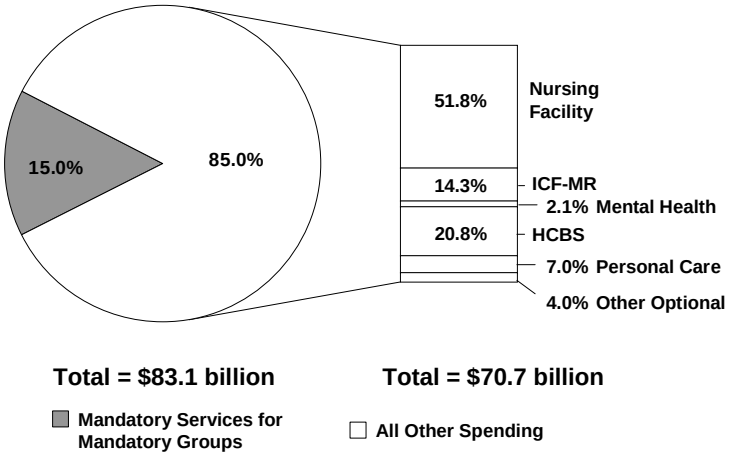
"Major Acute" includes inpatient, physician, laboratory/x-ray, outpatient, clinic, and all managed care and prepaid services.
"Other Practitioners" includes midwives, nurse practitioners, and other licensed practitioners.
"Other Acute Care" includes transportation, other therapies, sterilization, abortion, and unspecified services.

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

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

Figure 7

Medicaid Expenditures for Long Term Care, 2001



"Other Optional" includes home health, targeted case management, hospice and private duty nursing.
"Mental Health" includes inpatient psychiatric services for individuals under 21 and mental health services for individuals over 65.

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

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

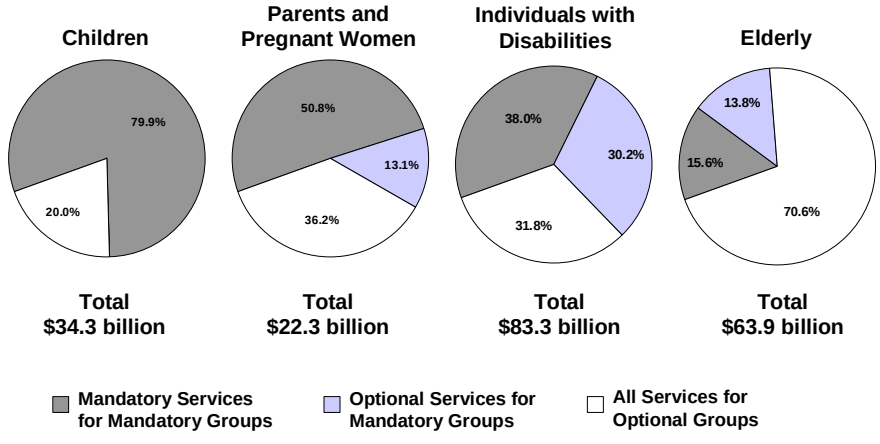
The vast majority of Medicaid spending on long-term care is on optional services or enrollees (Figure 7). About two-thirds (68.2%) of this optional spending was for institutional-based long-term care. Most of this spending was for nursing facility care ($36.6 billion), with the remainder spent on ICF-MR facilities and other institutional care for individuals with mental disease. The remaining one third (31.8%) of optional spending on long-term care was attributable to community-based long-term care, primarily waiver programs ($14.7 billion), and personal care services ($4.9 billion).

Other optional community-based services include other home health, hospice, private duty nursing, and targeted case management, but accounted for about 4% of all optional long-term care spending. Optional long-term care services can play a central role in the provision of care for a 25-year old man with cerebral palsy who relies on a personal care assistant who helps him bathe, dress, eat, and live a life more fully integrated with his community.

The proportion of services considered mandatory varies considerably across groups (Figure 8 and Table 4). Most of the $34.3 billion spent on children (80%) were mandatory services spent on mandatory eligibility groups. These services are primarily acute care services, and cover preventive services and treatment covered under EPSDT program and prescription drugs. Further analysis of the distribution of acute care services for children showed that 36.5% of this spending for all children was attributable to managed care plans, limiting analysis of the types of acute care services used by children in Medicaid. About 3.3% of mandatory spending for children was attributable to community-based long-term care. Only 20% of spending on children was optional, based on our assumption that virtually all services for children are mandatory as an extension of EPSDT,

Figure 8

Distribution of 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. Because of rounding, numbers may not exactly sum to totals.

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

Table 4

Distribution of Medicaid Expenditures (in millions) by Basis of Eligibility and Type of Service, 2001

Basis of Eligibility	Total		Type of Service: Mandatory Services for Mandatory Groups		Optional Services for Mandatory Groups		All Services for Optional Groups	
	#	Col %	#	Col %	#	Col %	#	Col %
Elderly	**$63,886.6**	31%	$9,961.5	12%	$8,798.6	24%	$45,126.6	52%
Row %	100%		16%		14%		71%	
Individuals with Disabilities	**$83,319.7**	41%	$31,677.9	39%	$25,182.9	68%	$26,458.9	31%
Row %	100%		38%		30%		32%	
Parents and Pregnant Women	**$22,290.5**	11%	$11,321.0	14%	$2,911.0	8%	$8,058.4	9%
Row %	100%		51%		13%		36%	
Children	**$34,269.2**	17%	$27,391.2	34%	$29.3	0%	$6,848.6	8%
Row %	100%		80%		0%		20%	
Total	**$203,766.0**	**100%**	**$80,351.6**	**100%**	**$36,921.9**	**100%**	**$86,492.5**	**100%**
Row %	100%		39%		18%		42%	

Source: Urban Institute estimates based on MSIS 2001 data inflated to CMS-64 2001 total expenditures by service.
Notes: Does not include disproportionate share hospital payments, administrative costs, or accounting adjustments.

with the exception of spending on HCBS. But virtually all of the $6.9 billion of optional spending was for optional enrollees. Spending for optional children reflects state expansions to children at income levels that exceed the federal minimum standards and provide a comprehensive package of services. Of all optional spending on non-disabled children, 8.6% was for long-term care services, mostly community-based long-term care.

Further analysis indicates that slightly less than half of long-term care services for non-disabled children are attributable to children receiving foster care or adoption assistance services. Out of $2.9 billion spent on long-term care for non-disabled children, almost $1.3 billion was spent on these foster children. These foster children account for less than 4% of all non-disabled child enrollees, but account for 12.2% of all expenditures on non-disabled children.

Just over half of $22.3 billion spent on parents and pregnant women (50.8%) were mandatory services spent on mandatory eligibility groups (Figure 8), including low-income parents who qualify for Temporary Assistance for Needy Families, and pregnant women with income below 133% of poverty. 36.2% of spending on parents and pregnant women was for optional groups, and 13.1% was for optional spending for mandatory groups. Optional spending for parents above federal minimum standards includes prenatal and maternity care for pregnant women. Optional spending also reflects efforts to reach lower income working parents, and additional adults with no children eligible for Medicaid only through Section 1115 waivers. Virtually all of the optional spending on parents was for acute care and prescription drugs, with only 4.5% attributable to long-term care.

The majority of spending for both the elderly and individuals with disabilities, who together accounted for 72% of all Medicaid spending in 2001, was optional (Figure 8). Only 15.6% of the $63.9 billion spent on the elderly was mandatory. Most spending (70.6%) on the elderly was for optional groups, and 13.8% was

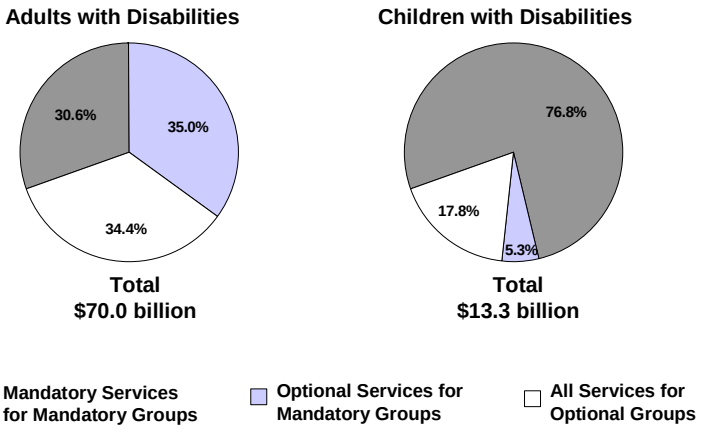
for optional services for mandatory groups. The primary driver for this spending was nursing home care. In 2001, Medicaid spent $37.6 billion on institutional long-term care for the elderly, $33.2 billion of which was spent on optional groups, primarily the medically needy whose significant medical expenditures offset their income to such an extent that they qualify for Medicaid in states that offer this optional eligibility category. Medicaid is the major public source of financial assistance for nursing facility care, and most of this assistance is provided at state option.

Of the $83.3 billion spent on people with disabilities, only one-third (38.0%) was mandatory (Figure 8), and represents primarily spending on SSI recipients for acute care services, as well as most spending for children with disabilities. Just under one third of spending (30.2%) was to cover optional services for mandatory groups. These services were primarily spending for community-based long-term care services ($9.4 billion) and prescription drugs ($6.8 billion). The remaining third of spending ($26.5 billion) was for services for optional groups, including the working disabled. However $10.8 billion covered services provided in institutional settings, including nursing facilities and facilities serving individuals with mental disease or mentally retardation.

The distribution of mandatory and optional spending differs between adults and children with disabilities (Figure 9). Of the $13.3 billion spent on children with disabilities, 76.8% of spending was mandatory spending for mandatory groups, while 30.6% of the $70.0 billion spent on adults with disabilities was for mandatory services for mandatory groups. Less than one-fifth (17.8%) of spending for children with disabilities was spent on optional groups, compared to

Figure 9

Medicaid Expenditures by Eligibility Category and Type of Service, 2001



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

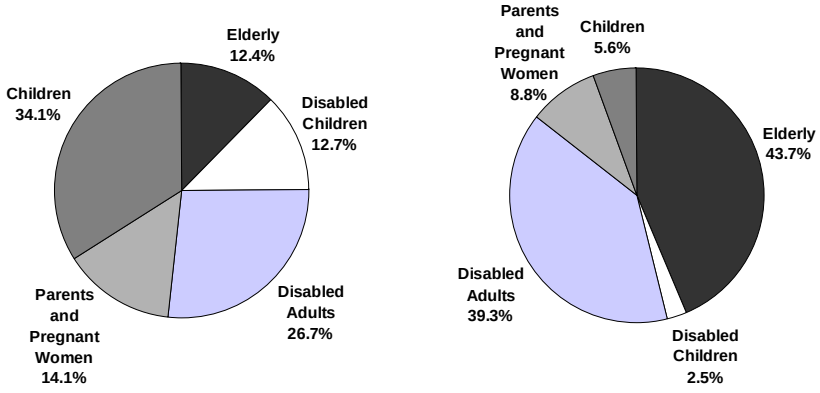
SOURCE: Urban Institute Estimates based on FFY data from MSIS 2001 and CMS 64 reports.

over one third (34.4%) of spending for adults with disabilities. These differences in optional and mandatory spending are based in part on different patterns of service use, and are largely related to the treatment of most services for children with disabilities as mandatory under EPSDT. Adults with disabilities spent more on long-term care, particularly institutional care, relative to children with disabilities. Of all spending on adults with disabilities, 23.1% was spent on institutional care and another 19.5% for community-based long-term care, compared to the 14.1% of expenditures on children with disabilities spent for institutional care, and 19.5% spent on community-based long-term care.

Notably, Medicare is the primary payor of services for most of the elderly and individuals of disabilities, many of whom are dually eligible for Medicare and Medicaid. Most acute care services are covered by Medicare, and so are not attributable to the elderly and disabled under total Medicaid expenditures. However, Medicare fails to cover most long-term care services, and states have used options to expand coverage under Medicaid to pay for the costs of these services for the poor. This shared burden for the dually eligible results in a higher proportion of services paid for by Medicaid for the elderly and disabled being attributable to long-term care than would be the case if all spending for the dually eligible were countable under a single program. Since the elderly and disabled incur higher per enrollee costs, they account for a larger portion of all spending, about 72% in 2001. However, because Medicare pays for most acute care services for the elderly and disabled, about half (48%) of all mandatory spending, which was primarily spending on acute care, was attributable to non-disabled children and parents (Figure 10). In contrast, 86% of optional spending, primarily spending on long-term care, was attributable to the elderly and disabled. The lack of long-term care coverage by Medicare, particularly

Figure 10

Medicaid Expenditures by Eligibility Group, 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.

nursing facility care, results in many near-poor elderly spending down their income and depleting their assets to qualify for Medicaid when nursing facility care is finally needed. Any changes to the Medicare program—such as the addition of the prescription drug benefit through Part D in 2006—will in turn have consequences for total Medicaid spending.

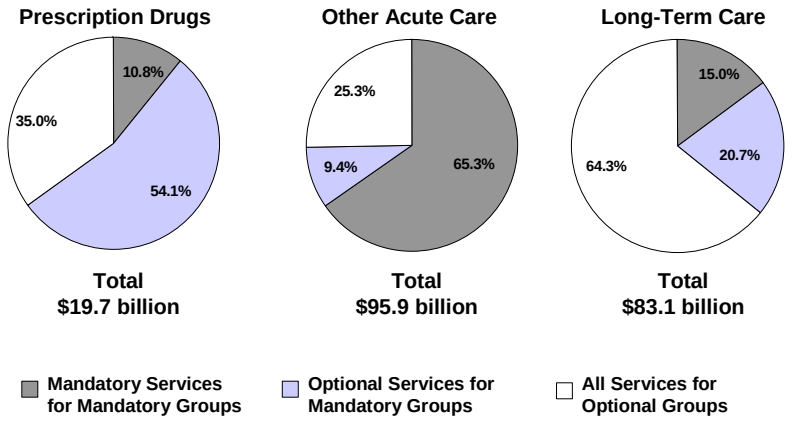
Spending by Service

The amount of Medicaid spending that was mandatory or optional varies considerably by service (Figure 11). Most spending for prescription drugs was covered through state options, with 35.0% spent on optional groups, and 54.1% spent on optional drug coverage for adults covered by mandatory eligibility. In contrast, spending on acute care other than prescription drugs was driven primarily by mandatory spending on mandatory groups (65.3%), and consists predominantly of inpatient, hospital outpatient, and physician services. Spending on long-term care was driven primarily by services for optional groups (64.3%), the majority of which is nursing facility care, a mandatory service for optional groups. About one-fifth (20.7%) of long-term care spending was for optional services for mandatory groups, primarily home and community-based waiver programs (HCBS). Only 15.0% of long-term care spending was attributable to mandatory services for mandatory groups, and includes $2.0 billion on inpatient psychiatric care and institutional spending for children with mental disease or mental retardation.

Discussion and Policy Implications

Figure 11

Mandatory and Optional Medicaid Expenditures by 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.

Optional eligibility and benefit categories are important components of the Medicaid program. The flexibility afforded by these options provides important tools to improve the reach of the program and the services covered beyond mandatory requirements. Overall, 29.3% of Medicaid enrollees were enrolled through optional eligibility categories. More than two thirds (71.0%) of optional enrollees were pregnant women and low-income working parents and their children who would most likely be uninsured if not enrolled in Medicaid. People with disabilities and the elderly accounted for over a quarter (29.0%) of optional enrollees. These individuals rely on Medicaid predominately for assistance with long-term care.

Three fifths of all Medicaid spending is optional, including services for optional populations and optional services for mandatory populations. Of this optional spending, the majority (57.3%) goes toward long-term care services, particularly institutional-based services, including nursing facilities, ICF-MR facilities and institutions for persons with mental disease. Community-based long-term care is also largely provided as an optional service assisting people with disabilities who are working and the elderly who need institutional care but who have chosen to live in the community instead. Prescription drug coverage accounts for 14.2% of optional spending, but is a critical component of medical care.

These findings have several policy implications. First, although most optional beneficiaries are low-income pregnant women and families, they are relatively low-cost because they rely on the program primarily for health insurance coverage. The gaps in employer-sponsored coverage are widely acknowledged and growing for this group. In the absence of Medicaid, these populations would likely be uninsured. Spending on services for these pregnant women and families comprises only 14.0% of optional spending. Eliminating or reducing coverage for this group would save states little money and could threaten the ability of local clinics and other providers who depend on Medicaid as a source of revenue to continue to serve the uninsured.

Second, the vast majority (85.5%) of optional spending is devoted toward services for the elderly and people with disabilities. These populations have significant health and long-term care needs that result in high average costs. States have historically covered them through Medicaid to obtain federal matching funds. Reducing optional services for these groups is unlikely to diminish the need for care, but would shift these costs to providers, individuals, or to state-only and local funding sources.

Third, optional services have provided an important vehicle for Medicaid to provide long-term care services in the community. Most optional community-based long-term care spending was attributable to state waiver programs. Home and community-based long-term care services play an important role in promoting the independence of the elderly and people with disabilities.

Expenditures for home and personal care services have been growing steadily over the past decade, reflecting interest in expanding community-based initiatives at both the state and federal level. Such independence has been supported as federal priorities through the 2004 Money Follows the Individual Rebalancing Initiative and the 1999 Supreme Court ruling in Olmstead v. L.C., which found that the medically unjustifiable institutionalization of people with disabilities who desire to live in the community violates Title II of the Americans with Disabilities Act (ADA). Such violation of the ADA requires states to remedy these discriminatory practices through reasonable modifications to their public programs and services.

Fourth, most optional acute care spending was for core services, such as inpatient, physician, and managed care services. Many states have already applied strategies for cost containment on these services through reimbursement limits. Remaining optional spending related to other acute care, including rehabilitation and other therapies, transportation, and dental care, accounts for only a small portion (5.7%) of optional spending. Reducing these services is likely to yield little in savings.

Finally, prescription drug coverage is an optional spending component that has been targeted by both states and the federal government for cost savings. In 2001, about $17.6 billion was spent on prescription drugs through state option. Roughly $15.8 billion of optional drug spending was attributable to the elderly and people with disabilities, many of whom will soon receive their drug coverage through the new Medicare Part D benefit. Nevertheless, drug spending will no doubt continue to be scrutinized by states seeking strategies for containing Medicaid costs. Restructuring drug pricing and payments under Medicaid, either directly or through federal and state rebates, has been one approach to reducing prescription drug costs that has been proposed by some at the federal level.

In summary, while the Medicaid statute 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 Medicaid restructuring.

Endnotes

[1] Including state and federal administrative costs and accounting adjustments, based on Urban Institute estimates of edited CMS-64 2003 reports.

[2] Based on estimates from the Congressional Budget Office and Office of Management and Budget.

[3] Holahan John and Arunabh Ghosh, "Understanding The Recent Growth In Medicaid Spending, 2000-2003," Health Affairs Web Exclusive, 26 January 2005, available at <http://content.healthaffairs.org/cgi/content/full/hlthaff.w5.52/DC1>.

[4] Transportation services are not formally a statutory benefit category. However, states are required to ensure necessary transportation for beneficiaries to and from providers. In addition, as part of the EPSDT benefit, states are required to offer to eligible children and their families "necessary assistance with transportation" to and from providers. For more on this issue see Schneider et al., *The Medicaid Resource Book*, The Kaiser Commission on Medicaid and the Uninsured, July 2002, pp. 56-57.

[5] Kaiser Commission on Medicaid and the Uninsured, "Medicaid 'Mandatory' and 'Optional' Eligibility and Benefits." Pub. No. 2256. July 2001. See also John Holahan, "Restructuring Medicaid Financing: Implications of the NGA Proposal." Kaiser Commission on Medicaid and the Uninsured, Pub. No. 2257. June 2001.

[6] 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.

[7] About 15% of all expenditures on benefits to enrollees in 2001 were to managed care plans. This proportion ranged from 0% to 82% depending on the state and ranged from 37% of expenditures for children and 4% for the elderly. These estimates are based on FY 2001 MSIS data inflated to CMS-64 expenditure totals, but exclude payments to Medicare.

[8] We reviewed preliminary analysis and statute interpretation conducted by the Congressional Research Service and Mathematica Policy Research Group, Inc., and would like to acknowledge their advisement in preliminary stages of our work.

[9] 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.

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

[11] 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).

[12] 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).

[13] 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.

[14] In part this is due to about $22 billion dollars in 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.

Appendix A: Detailed Tables

Table 1
Medicaid Enrollment by Basis of Eligibility

Table 2
Medicaid Enrollment by Basis of Eligibility for Adults and Children with Disabilities

Table 3
Total Medicaid Expenditures by Basis of Eligibility for Mandatory Enrollees

Table 4
Total Medicaid Expenditures by Basis of Eligibility for Optional Enrollees

Table 5
Total Medicaid Expenditures by Basis of Eligibility for Mandatory Enrollees with Disabilities

Table 6
Total Medicaid Expenditures by Basis of Eligibility for Optional Enrollees with Disabilities

Appendix Table 1

Medicaid Enrollment by Basis of Eligibility, 2001

	Total Enrollees	Basis of Eligibility		Percent Distribution (row)		
		Mandatory	Optional	Mandatory	Optional	Total
Total	**47,060,370**	**33,269,125**	**13,791,245**	**70.7%**	**29.3%**	**100.0%**
Elderly	**5,132,498**	**2,684,673**	**2,447,825**	**52.3%**	**47.7%**	**100.0%**
People with Disabilities	**7,009,520**	**5,460,330**	**1,549,190**	**77.9%**	**22.1%**	**100.0%**
Adults	**11,537,923**	**6,761,043**	**4,776,880**	**58.6%**	**41.4%**	**100.0%**
Children	**23,380,429**	**18,363,079**	**5,017,350**	**78.5%**	**21.5%**	**100.0%**

Source: Urban Institute estimates based on MSIS 2001.

Appendix Table 2

Medicaid Enrollment by Basis of Eligibility, Adults and Children with Disabilities, 2001

	Total Enrollees	Basis of Eligibility		Percent Distribution (row)		
		Mandatory	Optional	Mandatory	Optional	Total
Adults with Disabilities	**5,731,995**	**4,359,995**	**1,372,000**	**76.1%**	**23.9%**	**100.0%**
Children with Disabilities	**1,277,525**	**1,100,335**	**177,190**	**86.1%**	**13.9%**	**100.0%**

Source: Urban Institute estimates based on MSIS 2001.

Appendix Table 3

Total Medicaid Expenditures (in millions) by Basis of Eligibility for Mandatory Enrollees

MANDATORY ENROLLEES	Total Spending for Mandatory Groups	Mandatory Spending						Optional Spending				
		Total Mandatory Spending	Payments to Medicare	Acute Care		Long Term Care		Total Optional Spending	Acute Care		Long Term Care	
				Drugs	Other Acute	Institutional	Community		Drugs	Other Acute	Institutional	Community
Elderly	**$18,760**	**$9,961**	**$1,583**	**$0**	**$3,957**	**$3,950**	**$471**	**$8,799**	**$3,013**	**$1,506**	**$399**	**$3,880**
Disabled	**$56,861**	**$31,678**	**$1,572**	**$755**	**$23,680**	**$3,878**	**$1,793**	**$25,183**	**$6,837**	**$5,514**	**$3,434**	**$9,398**
Adults	**$14,232**	**$11,321**		**$42**	**$11,240**	**$14**	**$25**	**$2,911**	**$819**	**$2,007**	**$25**	**$61**
Children	**$27,421**	**$27,391**		**$1,333**	**$23,752**	**$1,414**	**$892**	**$29**	**$0**	**$0**	**$0**	**$29**
Total	**$117,274**	**$80,352**	**$3,155**	**$2,130**	**$62,630**	**$9,256**	**$3,181**	**$36,922**	**$10,669**	**$9,026**	**$3,858**	**$13,368**

Source: Urban Institute estimates based on MSIS 2001 data inflated to CMS-64 2001 total expenditures by service.

Notes: Does not include disproportionate share hospital payments, administrative costs, or accounting adjustments.

Drug spending in MSIS is inflated to CMS-64 totals minus reported offsets.

Institutional long term care includes mental health services for individuals over 65, inpatient psychiatric services for individuals under 21, nursing facility and intermediate care facility services for the mentally retarded (ICF-MR).

Community long term care includes home and community-based waiver programs, home health, hospice, targeted case management, all personal care services, and private duty nursing.

Mandatory services are those that states are required to offer to participate in Medicaid. They include inpatient, physician, lab/x-ray, outpatient, EPSDT, FQHCs, rural health clinics, home health not attributable to waiver programs, and nursing facility. Prescription drugs and all prepaid services for children are classified as a mandatory service based on the assumption that all acute care would be covered as an extension of EPSDT requirements.

Optional services are additional services that states are not required to offer, but may do so and receive federal reimbursement. They include prescription drugs, other clinic, ICF-MR, mental health services, home and community-based waiver programs, personal care services, dental, rehabilitation and other therapies for adults. 20 percent of prepaid services for adults, disabled, and elderly are allotted to optional services, assuming that some of these services are attributable to optional outpatient services.

Appendix Table 4

Total Medicaid Expenditures (in millions) by Basis of Eligibility for Optional Enrollees

OPTIONAL ENROLLEES	Total Spending for Optional Groups	Mandatory Spending						Optional Spending				
		Total Mandatory Spending	Payments to Medicare	Acute Care		Long Term Care		Total Optional Spending	Acute Care		Long Term Care	
				Drugs	Other Acute	Institutional	Community		Drugs	Other Acute	Institutional	Community
Elderly	**$45,127**	**$36,674**	**$1,445**	**$0**	**$2,741**	**$32,068**	**$420**	**$8,452**	**$3,238**	**$1,056**	**$1,144**	**$3,013**
Disabled	**$26,459**	**$11,957**	**$447**	**$107**	**$5,827**	**$4,907**	**$670**	**$14,502**	**$2,614**	**$1,607**	**$5,869**	**$4,412**
Adults	**$8,058**	**$5,951**		**$17**	**$5,881**	**$26**	**$26**	**$2,108**	**$583**	**$1,166**	**$18**	**$340**
Children	**$6,849**	**$6,761**		**$344**	**$5,946**	**$335**	**$137**	**$88**	**$0**	**$0**	**$0**	**$88**
Total	**$86,492**	**$61,343**	**$1,892**	**$468**	**$20,395**	**$37,337**	**$1,252**	**$25,149**	**$6,436**	**$3,830**	**$7,031**	**$7,853**

Source: Urban Institute estimates based on MSIS 2001 data inflated to CMS-64 2001 total expenditures by service.
Notes: Does not include disproportionate share hospital payments, administrative costs, or accounting adjustments.
Drug spending in MSIS is inflated to CMS-64 totals minus reported offsets.
Institutional long term care includes mental health services for individuals over 65, inpatient psychiatric services for individuals under 21, nursing facility and intermediate care facility services for the mentally retarded (ICF-MR).
Community long term care includes home and community-based waiver programs, home health, hospice, targeted case management, all personal care services, and private duty nursing.

Mandatory services are those that states are required to offer to participate in Medicaid. They include inpatient, physician, lab/x-ray, outpatient, EPSDT, FQHCs, rural health clinics, home health not attributable to waiver programs, and nursing facility. Prescription drugs and all prepaid services for children are classified as a mandatory service based on the assumption that all acute care would be covered as an extension of EPSDT requirements.

Optional services are additional services that states are not required to offer, but may do so and receive federal reimbursement. They include prescription drugs, other clinic, ICF-MR, mental health services, home and community-based waiver programs, personal care services, dental, rehabilitation and other therapies for adults. 20 percent of prepaid services for adults, disabled, and elderly are allotted to optional services, assuming that some of these services are attributable to optional outpatient services.

Appendix Table 5

Total Medicaid Expenditures (in millions) by Basis of Eligibility for Mandatory Enrollees with Disabilities

		Mandatory Spending						Optional Spending				
				Acute Care		Long Term Care			Acute Care		Long Term Care	
MANDATORY ENROLLEES	Total Spending for Mandatory Groups	Total Mandatory Spending	Payments to Medicare	Drugs	Other Acute	Institutional	Community	Total Optional Spending	Drugs	Other Acute	Institutional	Community
Children with Disabilities	**$10,967**	**$10,256**	**$317**	**$755**	**$6,648**	**$1,424**	**$1,111**	**$710**	**$0**	**$0**	**$0**	**$710**
Adults with Disabilities	**$45,894**	**$21,421**	**$1,255**	**$0**	**$17,032**	**$2,453**	**$681**	**$24,473**	**$6,837**	**$5,514**	**$3,434**	**$8,688**
Total	**$56,861**	**$31,678**	**$1,572**	**$755**	**$23,680**	**$3,878**	**$1,793**	**$25,183**	**$6,837**	**$5,514**	**$3,434**	**$9,398**

Source: Urban Institute estimates based on MSIS 2001 data inflated to CMS-64 2001 total expenditures by service.
Notes: Does not include disproportionate share hospital payments, administrative costs, or accounting adjustments.
Drug spending in MSIS is inflated to CMS-64 totals minus reported offsets.

Institutional long term care includes mental health services for individuals over 65, inpatient psychiatric services for individuals under 21, nursing facility and intermediate care facility services for the mentally retarded (ICF-MR).
Community long term care includes home and community-based waiver programs, home health, hospice, targeted case management, all personal care services, and private duty nursing.

Mandatory services are those that states are required to offer to participate in Medicaid. They include inpatient, physician, lab/x-ray, outpatient, EPSDT, FQHCs, rural health clinics, home health not attributable to waiver programs, and nursing facility. Prescription drugs and all prepaid services for children are classified as a mandatory service based on the assumption that all acute care would be covered as an extension of EPSDT requirements.

Optional services are additional services that states are not required to offer, but may do so and receive federal reimbursement. They include prescription drugs, other clinic, ICF-MR, mental health services, home and community-based waiver programs, personal care services, dental, rehabilitation and other therapies for adults. 20 percent of prepaid services for adults, disabled, and elderly are allotted to optional services, assuming that some of these services are attributable to optional outpatient services.

Appendix Table 6

Total Medicaid Expenditures (in millions) by Basis of Eligibility for Optional Enrollees with Disabilities

		Mandatory Spending						Optional Spending				
				Acute Care		Long Term Care			Acute Care		Long Term Care	
OPTIONAL ENROLLEES	**Total Spending for Optional Groups**	**Total Mandatory Spending**	**Payments to Medicare**	Drugs	Other Acute	Institutional	Community	**Total Optional Spending**	Drugs	Other Acute	Institutional	Community
Children with Disabilities	**$2,380**	**$1,986**	**$51**	**$107**	**$976**	**$459**	**$394**	**$393**	**$0**	**$0**	**$0**	**$393**
Adults with Disabilities	**$24,079**	**$9,971**	**$396**	**$0**	**$4,851**	**$4,449**	**$276**	**$14,108**	**$2,614**	**$1,607**	**$5,869**	**$4,019**
Total	**$26,459**	**$11,957**	**$447**	**$107**	**$5,827**	**$4,907**	**$670**	**$14,502**	**$2,614**	**$1,607**	**$5,869**	**$4,412**

Source: Urban Institute estimates based on MSIS 2001 data inflated to CMS-64 2001 total expenditures by service.
Notes: Does not include disproportionate share hospital payments, administrative costs, or accounting adjustments.
Drug spending in MSIS is inflated to CMS-64 totals minus reported offsets.

Institutional long term care includes mental health services for individuals over 65, inpatient psychiatric services for individuals under 21, nursing facility and intermediate care facility services for the mentally retarded (ICF-MR).
Community long term care includes home and community-based waiver programs, home health, hospice, targeted case management, all personal care services, and private duty nursing.

Mandatory services are those that states are required to offer to participate in Medicaid. They include inpatient, physician, lab/x-ray, outpatient, EPSDT, FQHCs, rural health clinics, home health not attributable to waiver programs, and nursing facility. Prescription drugs and all prepaid services for children are classified as a mandatory service based on the assumption that all acute care would be covered as an extension of EPSDT requirements.

Optional services are additional services that states are not required to offer, but may do so and receive federal reimbursement. They include prescription drugs, other clinic, ICF-MR, mental health services, home and community-based waiver programs, personal care services, dental, rehabilitation and other therapies for adults. 20 percent of prepaid services for adults, disabled, and elderly are allotted to optional services, assuming that some of these services are attributable to optional outpatient services.

Appendix B: Notes on Methods

Beneficiary Totals

Our counts of the number of beneficiaries in the FY2001 MSIS include all beneficiaries with known MAS/BOE eligibility codes. This includes beneficiaries that 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 premium assistance.

Allocation of Spending to Mandatory and Optional Enrollees

The proportion of poverty-related enrollees that should be assigned mandatory status in the parent and child eligibility categories is estimated based on the TRIM3 eligibility simulation of the Current Population Survey using state eligibility rules for Medicaid. The identification of individual enrollees within the poverty-related groups in MSIS to match this proportion, with the exception of SCHIP enrollees, is based on random assignment. Spending for these randomly assigned individuals is then allotted to mandatory or optional spending 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 poverty-related groups is subject to variation based on this random assignment. We estimate that 39.7% of all spending is mandatory spending for mandatory groups. If all spending for poverty-related adults and children were allocated to this mandatory group, the estimate would rise by 1.9 percentage points to 41.6%. Thus, random assignment of individuals within the poverty-related group does not have a significant impact on our spending distribution.

Designation of Home and Community-based Waiver Program Spending

To develop a method to extract the HCBS payments from service categories, we pulled 500 records per state from the MSIS 2001 files to examine where HCBS was typically placed in each state. Exact dollar amounts reported under a service category and equivalent to an individual's HCBS total were used to identify the set of services under which a state tends to report HCBS. Based on this analysis, a hierarchy for each state was developed to select services from which to back out HCBS totals. HCBS payments were commonly reported under other services and personal care services, and less commonly under home health.

Alignment to CMS-64 Expenditure Totals

We group some services in MSIS to better align totals to comparable groups in CMS-64 reports. Spending for frail elderly, community supported living, and emergency services for undocumented aliens, are not identifiable in MSIS but are reported in CMS-64. We group MSIS service categories for targeted case management, hospice, and personal care with the same CMS-64 categories, as well as frail elderly and community supported living, in order to assign an inflation factor to MSIS expenditures and align totals for community-based long-term care with the CMS-64. Expenditures for federally qualified health clinics (FQHC) and rural health clinics (RHC) are not identified by service category in MSIS, but are reported separately in CMS-64. Because FQHC and RHC are mandatory programs, we group them with outpatient care on the CMS-64 (a mandatory service), then align with the MSIS category of outpatient care. We align health clinic expenditures separately from other outpatient care, since this service is optional when FQHC and RHC are removed. EPSDT also is reported separately on the CMS-64, but is comprised of many different types of services in the MSIS. Since EPSDT is a mandatory service, we group this spending with physician and lab/radiology totals in the CMS-64, then align MSIS spending totals for these categories. This method allows us to capture EPSDT as mandatory spending, while deflating other optional service categories that might include EPSDT to totals on the CMS-64 that exclude EPSDT. EPSDT totals reported on the CMS-64 are small, and are assumed to represent only a portion of screening and diagnosis performed through EPSDT by primary care providers. Spending for emergency services for undocumented aliens is reported separately on CMS-64 forms, but is not a separate service category in MSIS. Since these services are mandatory, and are likely a combination of outpatient care and inpatient hospital, we group this spending with physician services on the CMS-64 for alignment purposes.

Payments to Medicare

Payments to Medicare by Medicaid for enrollees dually eligible are not reported in MSIS. We apply payments to Medicare from the CMS-64 forms to the aged and disabled eligibility categories, assigning 60 percent of Medicare payment totals to the aged and 40 percent to the disabled, based on Urban Institute estimates that about two-thirds of the dually eligible are elderly. Within these eligibility categories, we apply payments based on the percentage of enrollment within the group classified as mandatory.

Projection of National Estimates to Future Years

Analysis of Medicaid growth trends by Holahan and Ghosh (2005) provide evidence that the assumption of equal growth for all enrollment categories and all services by enrollment category over the period 2000-2003 cannot be met. Specific enrollment categories face different growth trends during the period 2000-2003, and the same service group grows at very different rates across eligibility groups. The proportion of enrollment deemed to fall under mandatory coverage groups is based on a specific distribution in eligibility. Similarly, the proportion of expenditures deemed mandatory is based on the distribution of individuals across eligibility categories as well as the distribution of expenditures within these categories. Thus, projections based on this analysis to more current Medicaid data could substantially misreport the proportion of enrollment and expenditures that are mandatory. The problem would be especially severe when projecting mandatory status within service categories by eligibility group.

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