kaiser commission on medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

POLICY BRIEF

July 2001

Medicaid "Mandatory" and "Optional" Eligibility and Benefits

Medicaid is the nation's major health and long-term care coverage program for the low-income population. In 1998, 40 million people—more than 1 in 7 Americans—were enrolled in Medicaid at a cost of $169 billion. Jointly financed by the federal and state governments, Medicaid covers three primary groups of low-income Americans: the elderly, the disabled, and children and their parents. The federal financing share ranges from 50% to 80% of Medicaid expenditures and averaged 57% in 1998. Federal Medicaid spending represents about 7% of the total federal budget and, on average, 15% of state general revenues.

Medicaid is administered by the states within federal guidelines; as such, each Medicaid program is different reflecting state choices over who is eligible and what benefits are covered. If a state chooses to participate in Medicaid, federal rules ensure a "mandatory" level of coverage. In other words, certain population groups will be covered for a specified set of benefits. Beyond these federal minimums, states have substantial flexibility to cover additional "optional" population groups or benefits.

All states currently operate Medicaid programs, and over the years many states have broadened the reach of their programs to cover a greater share of their low-income populations than federal rules require. Although the terms "mandatory" and "optional" refer to whether federal law requires states to cover certain populations or services, or allows states to cover additional populations or a broader set of services, many states would consider "optional" population groups and benefits as essential to their programs.

The National Governors Association (NGA) recently put forward a reform agenda that outlines a fundamental restructuring of coverage, benefits, and financing under the Medicaid program based on the way current law divides mandatory and optional eligibility groups and benefits.[1] Under the NGA reform agenda, coverage of mandatory services for mandatory groups would continue at current matching rates. However, current federal

[1] NGA Policy Position HR-32: Health Care Reform Policy: www.nga.org/nga/legislativeupdate/

1450 G Street NW, Suite 250, Washington, DC 20005
Phone: 202-347-5270, Fax: 202-347-5274, Publications: 1-800-656-4533
Website: www.kff.org

minimums would be eliminated or substantially reduced with respect to all other coverage and spending. Specifically, states would be allowed to reduce the scope of coverage and increase cost-sharing requirements beyond current law with respect to optional services for mandatory populations and all services for optional populations. If states were to maintain coverage or provide a benefit similar to that offered in the Children's Health Insurance Program (CHIP), they would receive an enhanced federal matching rate.

This brief describes the current structure of the Medicaid program and provides information on coverage and spending by mandatory and optional groups based on analysis conducted for the Commission by the Urban Institute.[2] This information is intended to provide a context for understanding the NGA approach to reform, as well as other efforts to restructure Medicaid through legislative change or waivers to the federal statute. This analysis, which is based on the latest available Medicaid data (1998), finds that the changes outlined by the NGA would affect about two thirds of current Medicaid spending and would apply to 35 percent of current spending on children, 66 percent of current spending on the disabled, and 83 percent of current spending on the elderly. Among the benefits affected are nursing home care and prescription drugs.

The Medicaid Program Today

Medicaid provided health and long-term care coverage for 40 million Americans in 1998, including 4 million elderly, 7 million disabled individuals, 8.6 million parents, and 21 million children (Figure 1). Children and their parents made up nearly three-fourths of Medicaid beneficiaries, but they accounted for only a quarter of Medicaid spending. The elderly and disabled accounted for the majority (67%) of spending because of their intensive use of acute and long-term care services. Medicaid spending on services for eligible populations totaled $154 billion in 1998. An additional $15 billion was spent on payments to disproportionate share hospitals.

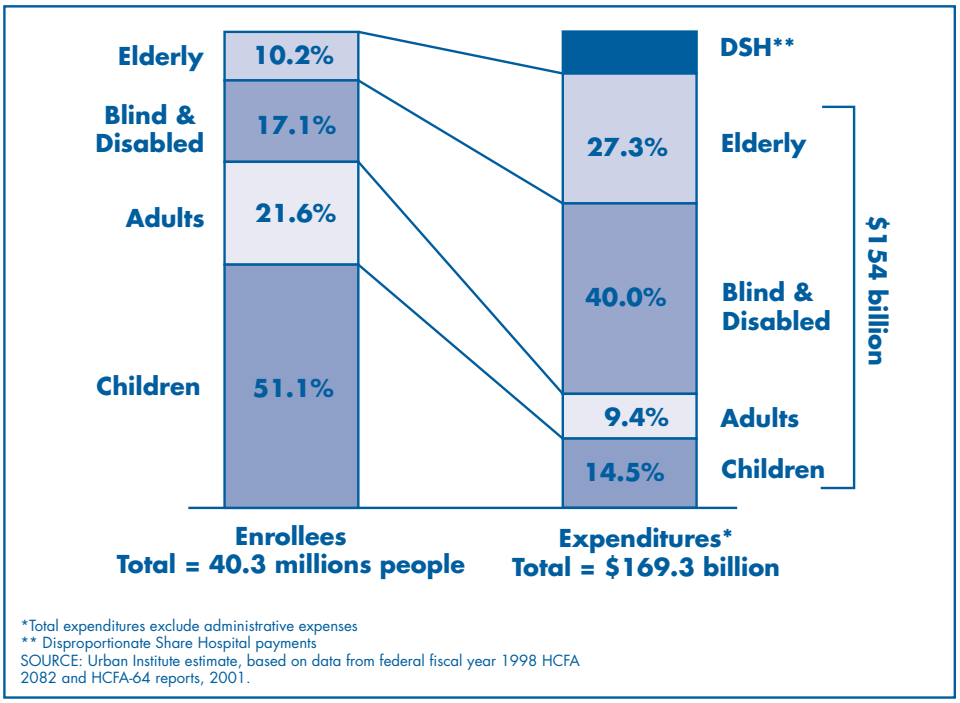
Within federal guidelines and above required minimum eligibility levels for children, pregnant women, and some elderly and disabled, states set their own eligibility criteria and benefit packages, resulting in large variations across states. The proportion of the low-income population (under 200% of poverty; $29,260 for a family of three in 2001) covered by Medicaid ranges from 13% in Nevada to 41% in Vermont (Figure 2). The composition of beneficiary populations and mix of services are unique in each Medicaid program, reflecting individual state priorities on expanding health coverage, as well as eligibility and financing for long-term care services.

Medicaid Eligibility

Medicaid provides coverage for three basic groups of low-income Americans: the elderly, the disabled, and parents and children. For each group, the federal government has set basic parameters on mandatory populations that must be covered if a state chooses to participate in Medicaid (all do) (Figure 3). All states must cover pregnant women and children under age 6

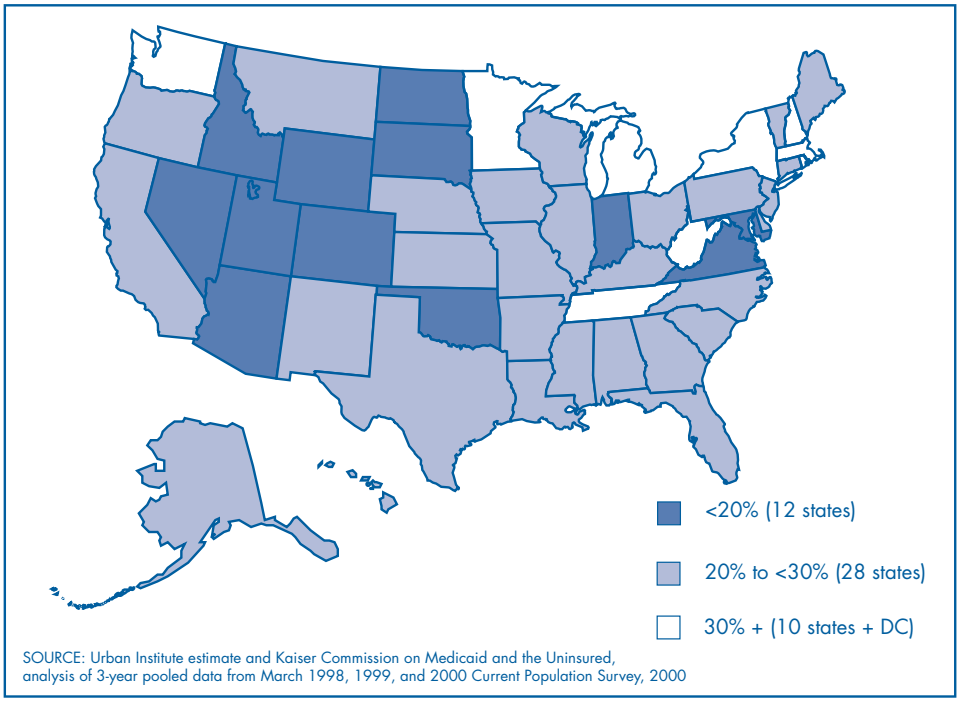
[2] A separate Commission issue paper, "Restructuring Medicaid Financing: Implications of the NGA proposal" (pub. #2257) analyzes the potential fiscal impact of changes described in the NGA proposal.

Figure 1—Medicaid Enrollees and Expenditures by Enrollment Group, 1998



*Total expenditures exclude administrative expenses
** Disproportionate Share Hospital payments
SOURCE: Urban Institute estimate, based on data from federal fiscal year 1998 HCFA 2082 and HCFA-64 reports, 2001.

Figure 2—Percent of the Low-Income Population Covered by Medicaid, 1997–1999



SOURCE: Urban Institute estimate and Kaiser Commission on Medicaid and the Uninsured, analysis of 3-year pooled data from March 1998, 1999, and 2000 Current Population Survey, 2000

Figure 3—Medicaid Beneficiary Groups

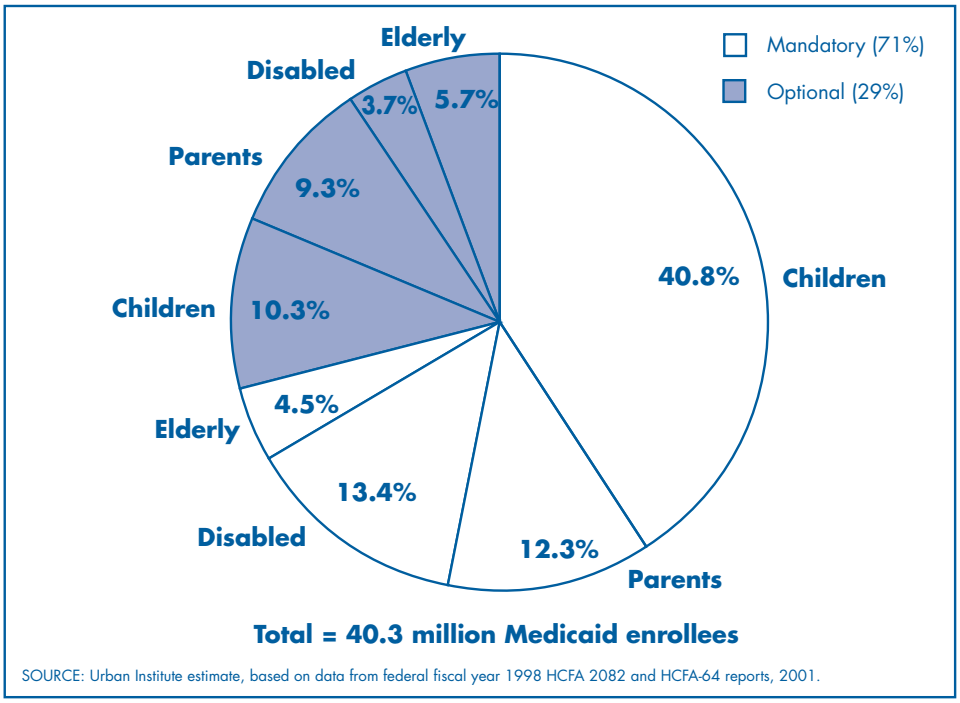
Mandatory Populations	Optional Populations
• Children below federal minimum income levels	• Children above federal minimum income levels
• Adults in families with children (Section 1931 and TMA)	• Adults in families with children (above Section 1931 minimums)
• Pregnant women ≤133% FPL	• Pregnant women >133% FPL
• Disabled SSI beneficiaries	• Disabled (above SSI levels)
• Certain working disabled	• Disabled (under HCBS waiver)
• Elderly SSI beneficiaries	• Certain working disabled (>SSI levels)
• Medicare Buy-In groups (QMB, SLMB, QI-1, QI-2)	• Elderly (>SSI; SSP-only recipients)
	• Elderly nursing home residents (>SSI levels)
	• Medically needy

with family incomes under 133% of poverty ($19,458 for a family of 3 in 2001) and older children (age 6 to 17) with family incomes under 100% of poverty ($14,630 for a family of 3 in 2001). States must also cover parents and 18 year olds whose income and resources are below state AFDC standards as of July 16, 1996 and extend transitional Medicaid assistance (TMA) to low-income working families. In most cases, states are also required to cover elderly and disabled individuals who are eligible for the Supplemental Security Income (SSI) program. In addition, states are required to assist certain low-income Medicare beneficiaries by paying their Medicare Part B premiums and, in some cases, cost-sharing.

Beyond these mandatory groups, states can choose to cover any or all of the optional groups established under the law and receive federal matching payments. For example, states can extend Medicaid to families with income above federal minimums; nursing home residents whose income exceeds SSI limits; families, disabled and elderly individuals with high medical expenses; and low-income individuals with disabilities who need home and community-based care or exceed the SSI income limits. States have considerable flexibility to set income and asset criteria for these optional groups. However, not all individuals are eligible for Medicaid under either a mandatory or optional eligibility group. For example, childless adults cannot generally qualify for Medicaid, unless disabled or pregnant.

Most (71%) Medicaid beneficiaries qualify for coverage on the basis of a mandatory eligibility group (Figure 4). This reflects federal efforts to broaden coverage of low-income children and pregnant women and to assure Medicaid coverage of populations eligible for cash assistance through the SSI or welfare programs. However, nearly 12 million additional beneficiaries,

Figure 4—Mandatory and Optional Medicaid Eligibility Groups, 1998



SOURCE: Urban Institute estimate, based on data from federal fiscal year 1998 HCFA 2082 and HCFA-64 reports, 2001.

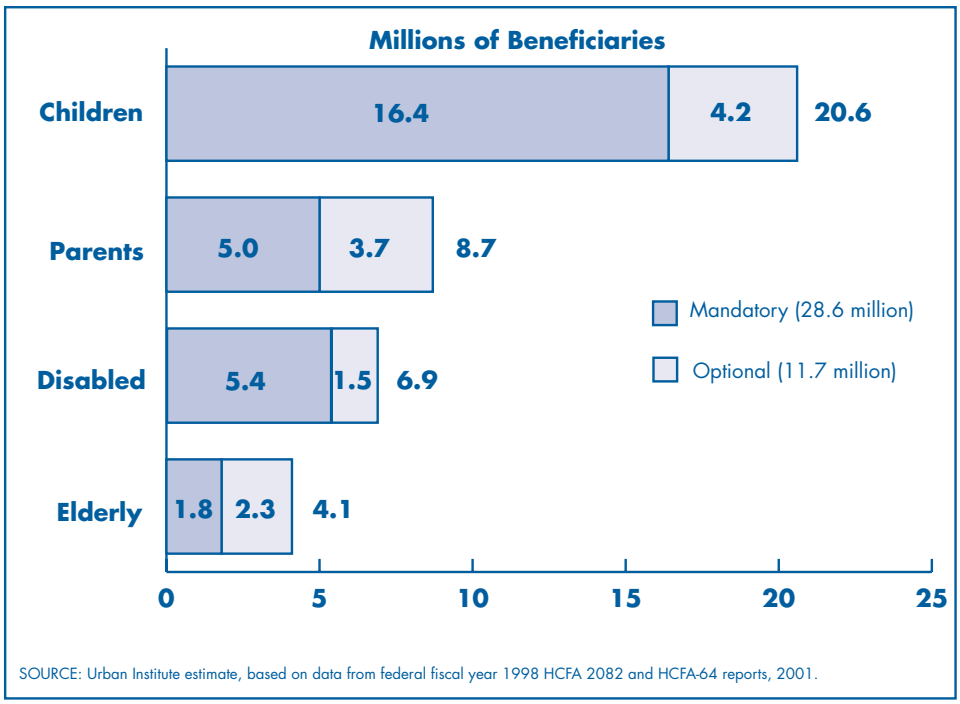
including 4.2 million children, 3.7 million parents, 1.5 million disabled, and 2.3 million elderly, qualify for Medicaid through an optional eligibility group covered by the state (Figure 5).

The likelihood of qualifying for Medicaid on the basis of a mandatory or optional group varies substantially by group (Figure 6). Most children (80%) 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, over half (56%) 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.

Medicaid Benefits

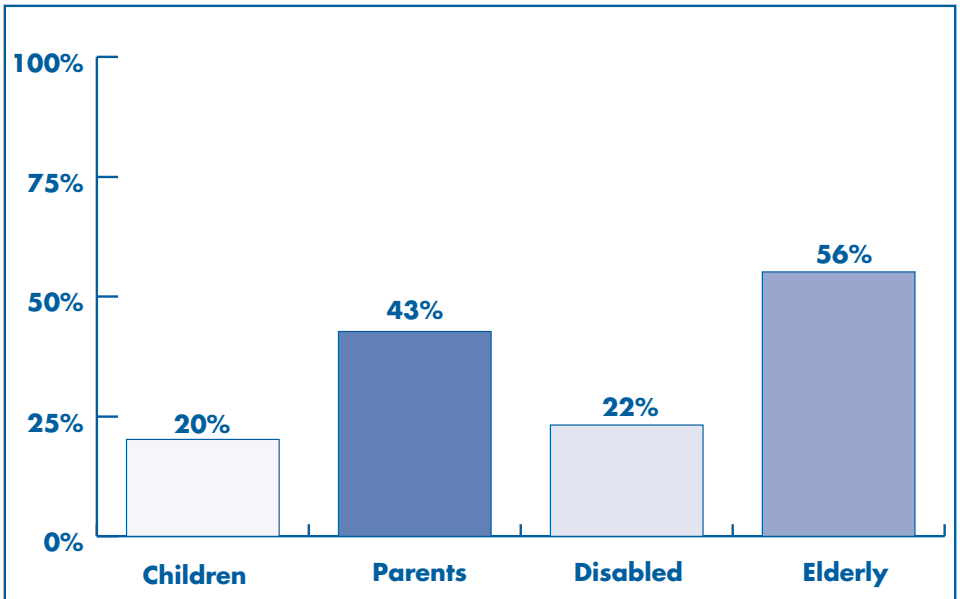
The structure of the Medicaid benefit package has been designed to meet the diverse needs of its beneficiaries. For example, pregnant women require prenatal and maternity care, while children require immunizations, lead screening, well-child care and primary care services. Children with disabilities may also need specialty care, home-based care, medical equipment and, in some cases, institutional care. Working individuals with disabilities may need personal attendants, prescription drugs, and other supportive services to remain independent. Frail elderly individuals may require home health care or nursing home care. Medicaid covers a broad range of services to meet all these needs. Many of the services included in the Medicaid program, particularly costly long-term institutional care, are generally not covered by private insurers or Medicare.

Figure 5—Medicaid Enrollment by Eligibility Group, 1998



SOURCE: Urban Institute estimate, based on data from federal fiscal year 1998 HCFA 2082 and HCFA-64 reports, 2001.

Figure 6—Percent of Medicaid Beneficiaries with Optional Eligibility, 1998



SOURCE: Urban Institute estimate, based on data from federal fiscal year 1998 HCFA 2082 and HCFA-64 reports, 2001.

Medicaid services fall into two broad groups: mandatory and optional. States electing to participate in Medicaid must cover a mandatory set of benefits (Figure 7). Federally required

Figure 7—Medicaid Statutory Benefits Categories

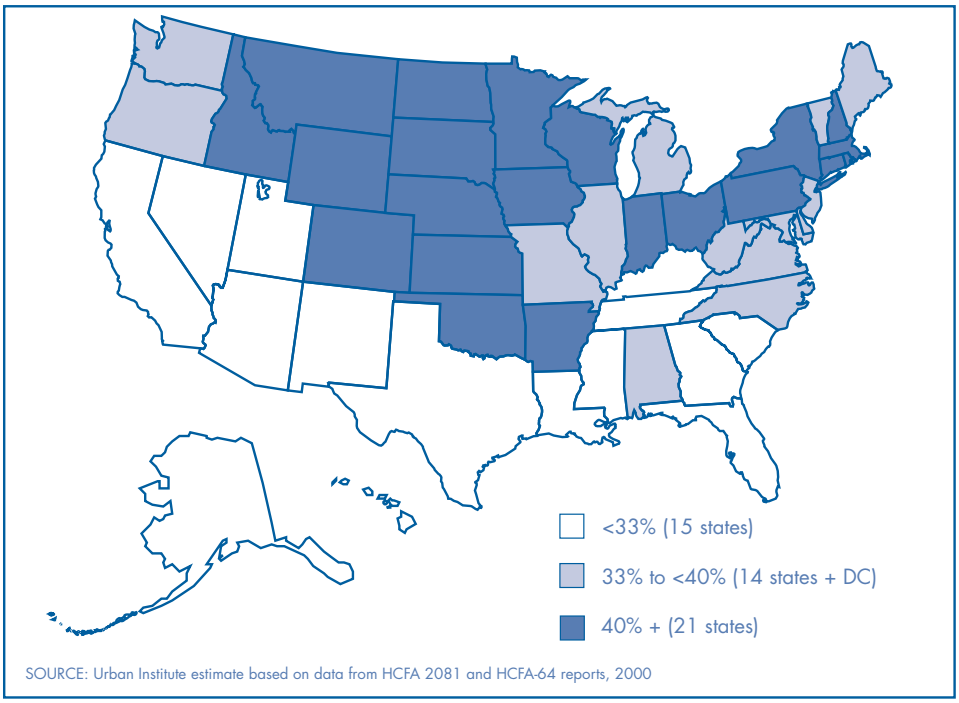
"Mandatory" Items and Services	**"Optional" Items and Services**
Acute care	
• Physicians' services	• Prescribed drugs
• Laboratory and x-ray services	• Medical care or remedial care furnished by licensed practitioners under state law
• Inpatient hospital services	• Diagnostic, screening, preventive, and rehabilitative services
• Outpatient hospital services	• Clinic services
• Early and periodic screening, diagnostic, and treatment (EPSDT) services for individuals under 21	• Dental services, Dentures
• Family planning services and supplies	• Physical therapy and related services
• Federally-qualified health center (FQHC) services	• Prosthetic devices, Eyeglasses
• Rural health clinic (RHC) services	• TB-related services
• Nurse midwife services	• Primary care case management services
• Certified nurse practitioner services	• Other specified medical and remedial care
Long-term care	
Institutional Services	
• Nursing facility (NF) services for individuals 21 or over	• Intermediate care facility for individuals with mental retardation (ICF/MR) services
	• Inpatient and nursing facility services for individuals 65 or 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 NF care)	• Home health care services
	• Case management services
	• Respiratory care services for ventilator-dependent individuals
	• Personal care services
	• Private duty nursing services
	• Hospice care
	• Services furnished under a PACE program
	• Home- and community-based (HCBS) services (under budget neutrality waiver)

services include inpatient and outpatient hospital; physician, midwife, and certified nurse practitioner; laboratory and x-ray; Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for children; and family planning. Nursing facility services for individuals age 21 or older and home health care services for individuals entitled to nursing facility care are also mandatory.

All other services are allowable for federal matching at state option, including prescription drugs, dental services, physical therapy, intermediate care facilities for the mentally retarded (ICF/MR) services, personal care services, and home and community based services. States receive the same matching rate for optional and mandatory services. States can choose to cover as many optional benefits as they want (or to cover none), but if they cover an optional benefit, it generally must be covered for all covered population groups and in all areas of the state. Partly as a result of the flexibility accorded states with respect to services, each state's Medicaid benefits package and spending differs in the type and scope of covered services. For example, in North Dakota, over 60 percent of Medicaid spending was for long-term care compared to 24% in Nevada (Figure 8). Likewise, per capita spending also varies considerably across states. For example, Medicaid spending on children averaged $1,225 in 1998, but ranged from $794 in Mississippi to $2,542 in New Hampshire (Figure 9).

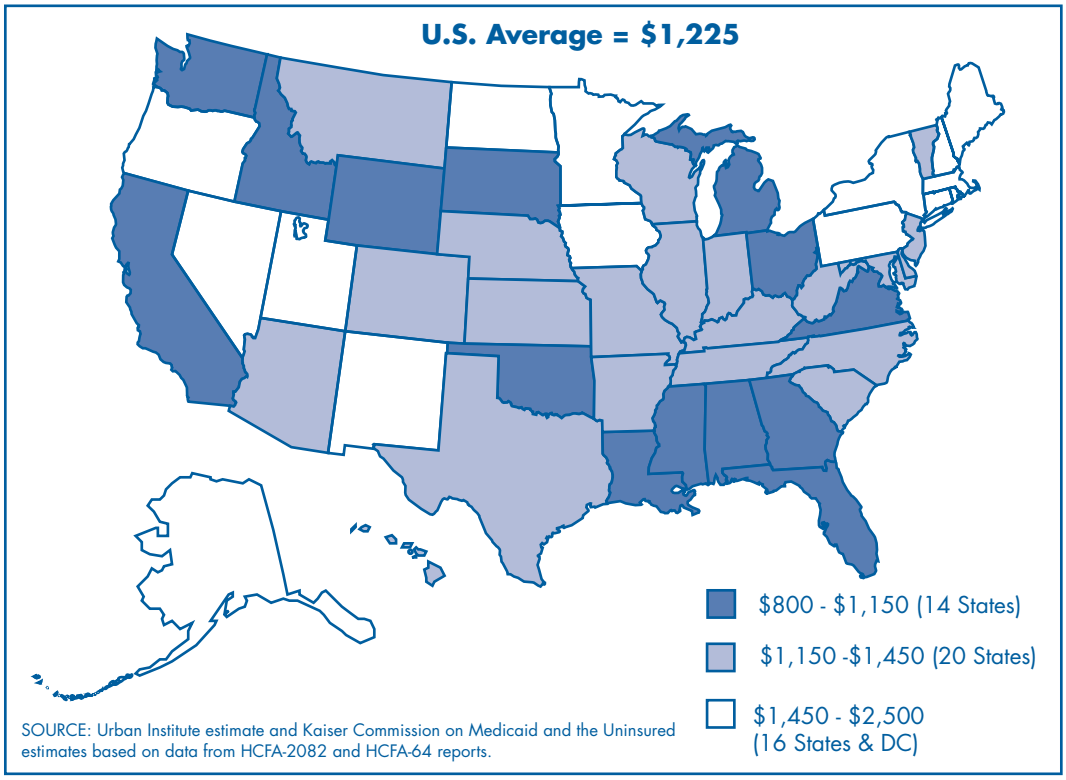
States can impose reasonable limits on most mandatory and optional services. For example, within federal guidelines, states can limit the number or amount of prescription drugs beneficiaries may receive. Federal law also allows states to impose "nominal" cost-sharing on services, but exempts children, pregnant women (for pregnancy-related services), and

Figure 8—Percent of Medicaid Spending on Long-Term Care by State, 1998



SOURCE: Urban Institute estimate based on data from HCFA 2081 and HCFA-64 reports, 2000

Figure 9—Annual Medicaid Spending per Child Enrollee, 1998



individuals receiving hospice care. In addition, some services, such as emergency services and family planning services and supplies, are exempt from cost-sharing. States are also not required to provide the full benefit package to individuals who qualify through the medically needy program and spend-down to Medicaid eligibility levels or to low-income Medicare beneficiaries who qualify for assistance with Medicare premiums and cost-sharing.

States can also apply to HHS for a waiver to support program changes that otherwise would not meet federal rules, including modifying the delivery system, expanding health coverage, limiting the benefits package, or increasing cost-sharing levels. These waiver requests are subject to public review, HHS approval, and budget neutrality requirements. Budget neutrality means that total federal Medicaid expenditures under a Section 1115 waiver can be no greater than they would have been in the absence of the demonstration for comparable services for the same beneficiaries. Eighteen states have implemented statewide Section 1115 waivers.

Interaction between Eligibility and Benefits

Under current law, every individual who is eligible for Medicaid, whether under a mandatory or optional population group, is generally guaranteed a minimum set of benefits. Mandatory beneficiaries are entitled to coverage for mandatory services and the optional services covered by the state. For example, when a state decides to cover prescription drugs (all do), this benefit is covered for poor children, as well as the elderly and disabled.

Likewise, beneficiaries covered through optional eligibility groups, are entitled to the same mandatory benefits, as well as the optional benefits that a state chooses to offer. This means that a five year-old living in a family with income at 150% of poverty, covered through an optional group, is entitled to the same benefits as a five year-old child in a family with income at 133% of poverty.

The exception is medically needy individuals who qualify for Medicaid because they have incurred medical expenses that reduce their incomes below Medicaid thresholds. If a state chooses to cover the medically needy, the benefit package may be more limited.

The NGA Approach

The NGA reform agenda outlines an approach that would fundamentally restructure Medicaid into three broad categories of coverage based on the "mandatory" and "optional" eligibility and benefits defined in the federal Medicaid statute (Figure 10). Under the NGA proposal, mandatory services would be maintained for mandatory population groups as under current law (Category I). All other federal rules on eligibility and benefits would be eliminated or substantially altered, including optional benefits provided for mandatory eligibility groups, as well as all mandatory and optional benefits for optional eligibility groups. States could decide to cover fewer people or fewer benefits. They could decide to eliminate whole categories of optional coverage, or to impose additional limits on benefits or eligibility than exist under the law today.

Figure 10—The NGA Proposal

Category	Cost-Sharing Permitted	Matching Rate	State Must Cover
Category 1 Mandatory services for mandatory groups	No	Current matching rate	Yes
Category 2 Optional services for mandatory groups; CHIP-level benefit package for optional groups	Yes	Enhanced matching rate (30% or higher)	No
Category 3 Any services; any groups	Yes	Current matching rate	No

SOURCE: National Governors Association Policy Position HR-32; Health Care Reform Policy; www.nga.org/nga/legislativeupdate/

States would receive an enhanced match (30% higher) for optional services for mandatory populations and for optional populations if they provided a benefit resembling that offered under CHIP, or the "actuarial equivalent" (Category II). The governors view the enhanced match as an incentive to states to expand coverage and a mechanism for increasing the amount of federal financing for a substantial share of current Medicaid spending.

Finally, the NGA proposes that states be permitted to cover any optional services or population groups and receive the current federal matching rate, without any federal rules (Category III). The absence of federal guidelines means that states could provide radically different benefit packages to currently eligible beneficiaries or provide more limited, targeted benefits to specific population groups. This level of open-ended federal financing to states is unprecedented and could result in a major shifting of financing responsibility for a wide range of services from the states to the federal government. It also potentially places a substantial amount of current coverage and benefits at risk.

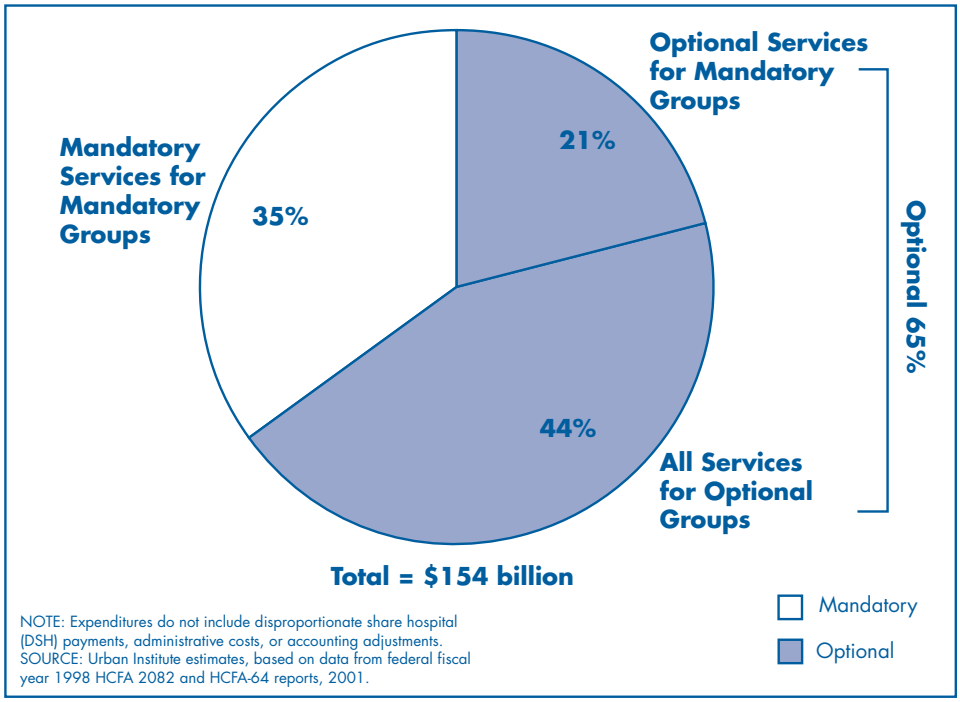
How would the NGA Approach Affect Current Medicaid Spending

To assess how the NGA proposal could affect current beneficiaries and spending under Medicaid, the Urban Institute analyzed Medicaid spending in the 1998. This analysis highlights mandatory and optional eligibility and benefits to promote an increased understanding of how today's Medicaid program operates, and what portion of coverage and benefits could be affected by the NGA approach. This study does not examine the implications of the proposed enhanced match.

In 1998, Medicaid spent $154 billion on acute and long-term care services for low-income families, the disabled and the elderly (Tables 1–3). Spending on mandatory services for mandatory populations comprised 35% of total Medicaid spending (Figure 11). This $54 billion in Medicaid spending corresponds to Category I of the NGA proposal whereby the current federal rules and matching rate would be maintained. The remaining $100 billion in Medicaid spending (65%) was for optional groups and benefits, including optional services for mandatory groups (21%) and mandatory and optional services for optional population groups (44%). Under the NGA approach, this spending could be covered under Category II, with reduced federal rules and an enhanced match, or Category III with no federal rules at the current matching rate, depending on what the state decided.

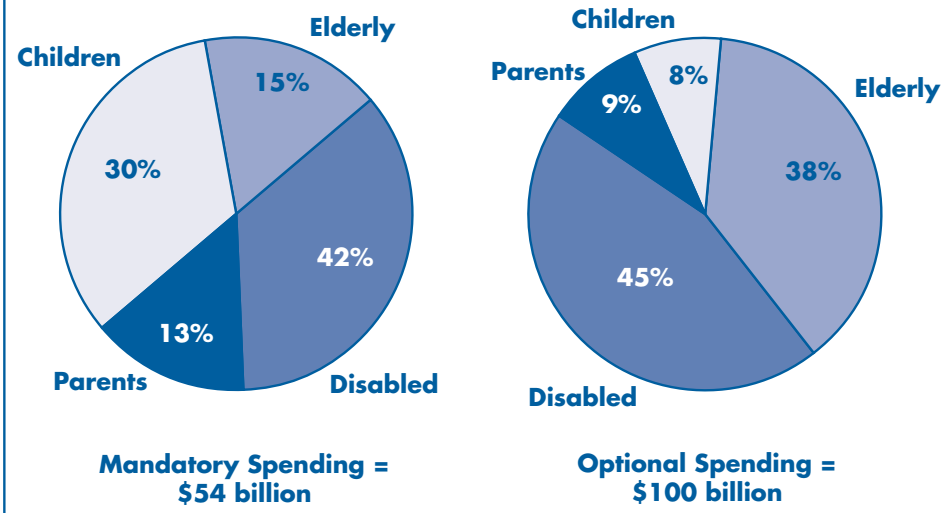
Of the $100 billion in Medicaid spending at state option, the vast majority (83%) went toward coverage of services for elderly and disabled beneficiaries, reflecting state decisions to provide optional coverage to population groups who have extensive health and long-term care needs (Figure 12). The elderly and disabled rely on Medicaid for nursing home care, ICF/MR services, and home and community-based services. As a result of state decisions to cover these services, long-term care comprised the largest share (58%) of optional spending (Figure 13). Prescription drugs (10%) and other acute care (32%) accounted for the remaining optional spending. Low-income children and parents account for a much smaller share (17%) of Medicaid optional spending. Although many states have chosen to provide Medicaid coverage for low-income families beyond federal minimums, the cost of this coverage is relatively inexpensive compared to the cost of long-term care services covered under Medicaid.

Figure 11—Medicaid Expenditures by Eligibility Group and Type of Service, 1998



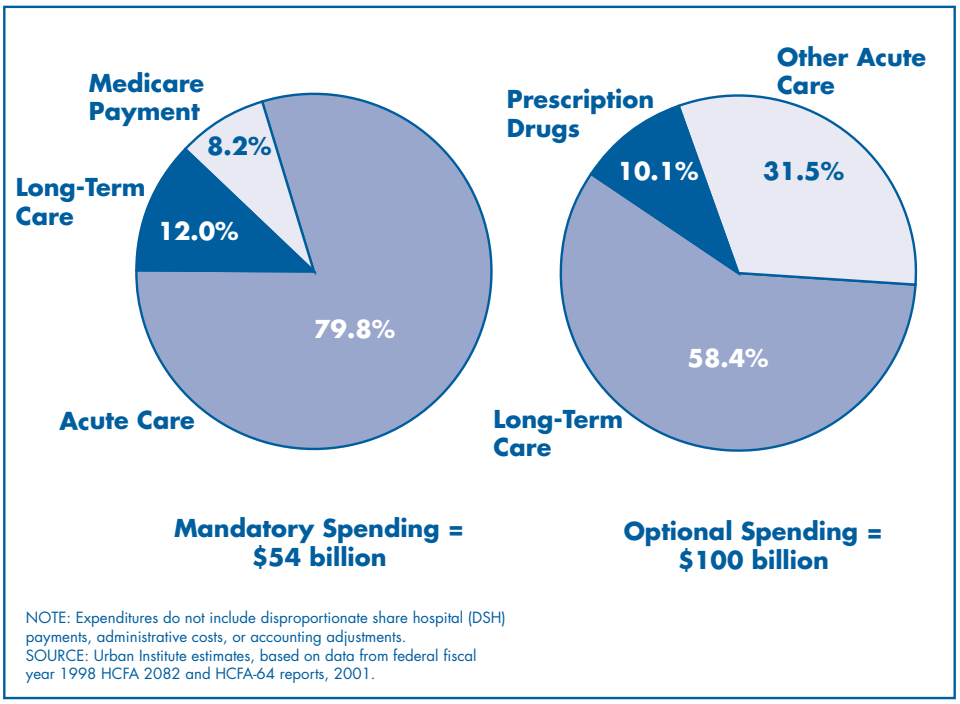
NOTE: Expenditures do not include disproportionate share hospital (DSH) payments, administrative costs, or accounting adjustments.
SOURCE: Urban Institute estimates, based on data from federal fiscal year 1998 HCFA 2082 and HCFA-64 reports, 2001.

Figure 12—Medicaid Spending by Eligibility Group, 1998



NOTE: Expenditures do not include disproportionate share hospital (DSH) payments, administrative costs, or accounting adjustments.
SOURCE: Urban Institute estimates, based on data from federal fiscal year 1998 HCFA 2082 and HCFA-64 reports, 2001.

Figure 13—Medicaid Spending by Service, 1998



NOTE: Expenditures do not include disproportionate share hospital (DSH) payments, administrative costs, or accounting adjustments.
SOURCE: Urban Institute estimates, based on data from federal fiscal year 1998 HCFA 2082 and HCFA-64 reports, 2001.

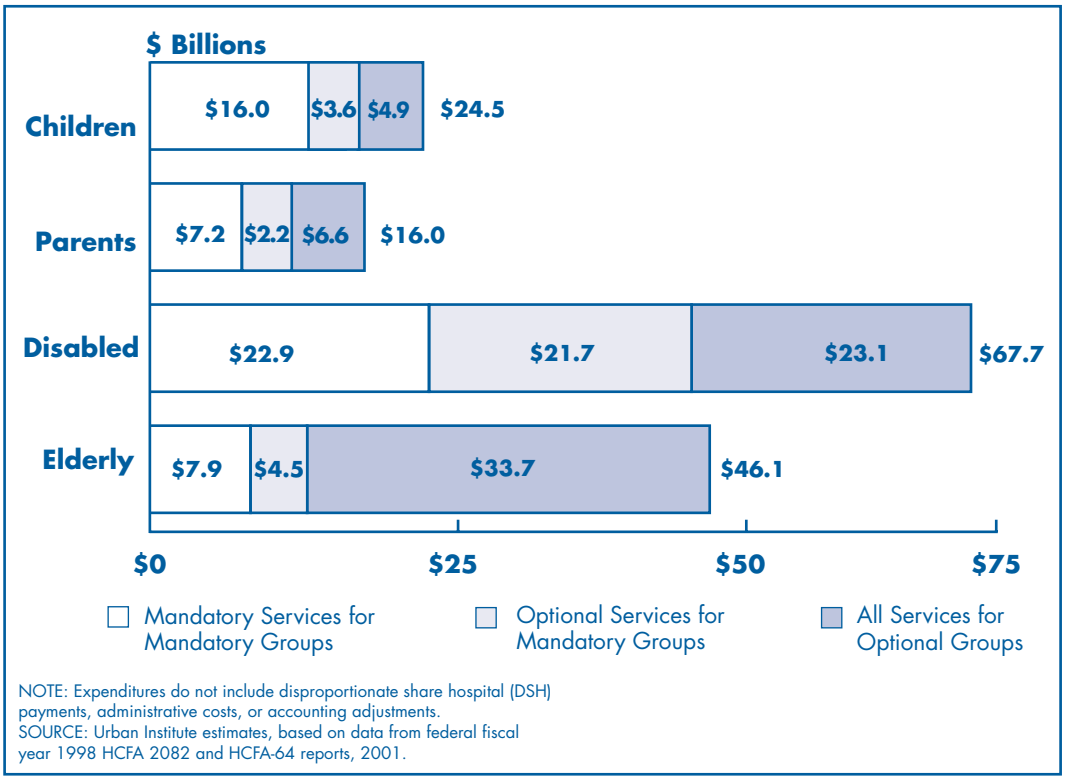
Spending by Beneficiary Group

The share of spending that is mandatory or optional varies substantially across beneficiary groups (Figures 14–15). Of the $24.5 billion that Medicaid spent on children, 65% was for mandatory services for mandatory groups (primarily poor children covered by the federal minimum eligibility levels). Mandatory spending for children includes virtually all services. The Medicaid benefit package for children is broad, including EPSDT services, so that preventive services and treatment for medical problems are covered. Optional spending for children reflects state efforts to expand Medicaid coverage to children at income levels that exceed the federal minimum standards and provide coverage for the full Medicaid package of services.

Medicaid coverage for parents comprises the smallest share of overall spending by beneficiary group. Of the $16 billion in spending on parents, nearly half (45%) was to cover mandatory services for mandatory groups, including pregnant women with income below 133% of poverty and some low-income parents. Mandatory spending includes primarily acute care services and pregnancy-related care. Additional optional spending for parents stems from state efforts to expand Medicaid's reach to cover a broader group of low-income working parents, as well as additional adults through Section 1115 waivers who do not meet Medicaid's eligibility criteria.

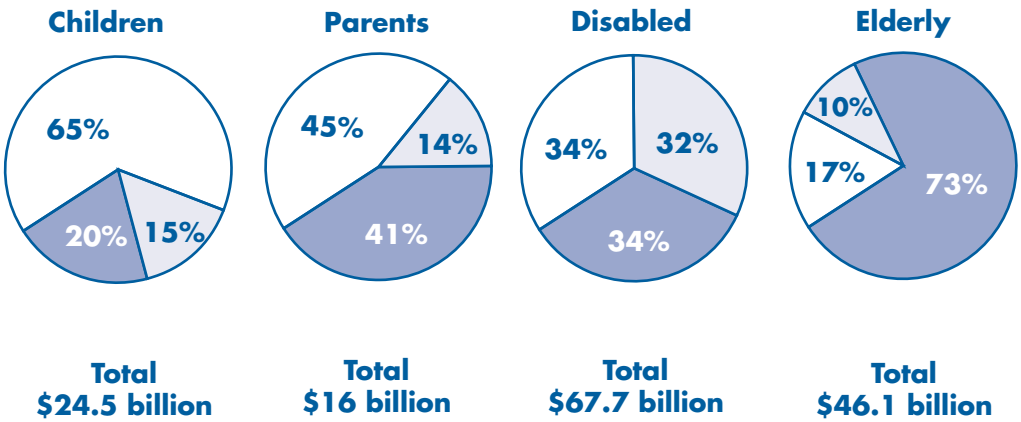
Of the $68 billion that states spent on services for the disabled, two thirds was optional. One third (34%) was for mandatory services for mandatory coverage groups, primarily the SSI population. An additional third of spending was for optional services for mandatory groups, including services such as prescription drugs, physical therapy, prosthetics, case management,

Figure 14—Medicaid Expenditures by Eligibility Category and Type of Service, 1998



NOTE: Expenditures do not include disproportionate share hospital (DSH) payments, administrative costs, or accounting adjustments.
SOURCE: Urban Institute estimates, based on data from federal fiscal year 1998 HCFA 2082 and HCFA-64 reports, 2001.

Figure 15—Distribution of Medicaid Spending by Eligibility Group and Type of Service, 1998



NOTE: Expenditures do not include disproportionate share hospital (DSH) payments, administrative costs, or accounting adjustments.
SOURCE: Urban Institute estimates, based on data from federal fiscal year 1998 HCFA 2082 and HCFA-64 reports, 2001.

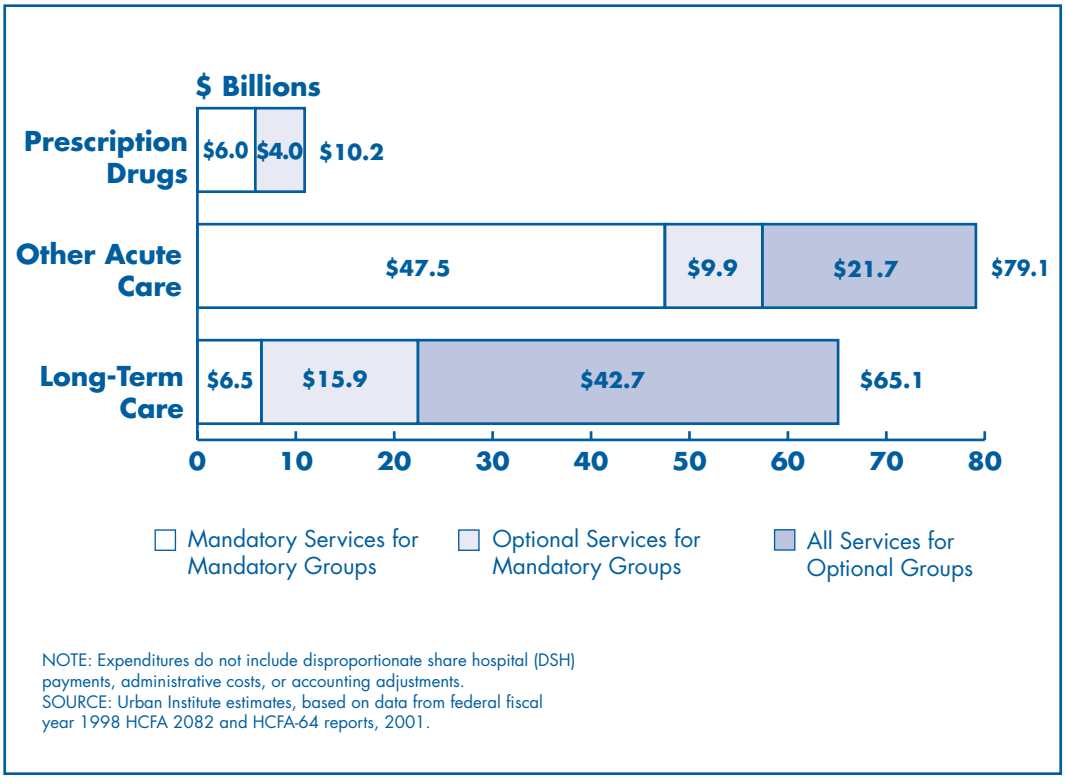
and home and community-based services. The remaining third of spending was for services for optional groups, including the working disabled, as well as those who qualify for home and community-based services under waiver programs.

Medicaid spent $46 billion on the elderly, with most (83%) of this spending at state option. The major factor driving this spending stems from state decisions to cover nursing home residents. Medicaid remains virtually the only source of financial assistance for nursing home care. Thus, optional spending comprises a much larger share of Medicaid spending on the elderly and disabled compared to children and parents (Appendix Figures A1–4). Optional spending is driven in large part by coverage of long-term care services for the elderly and disabled.

Spending by Service

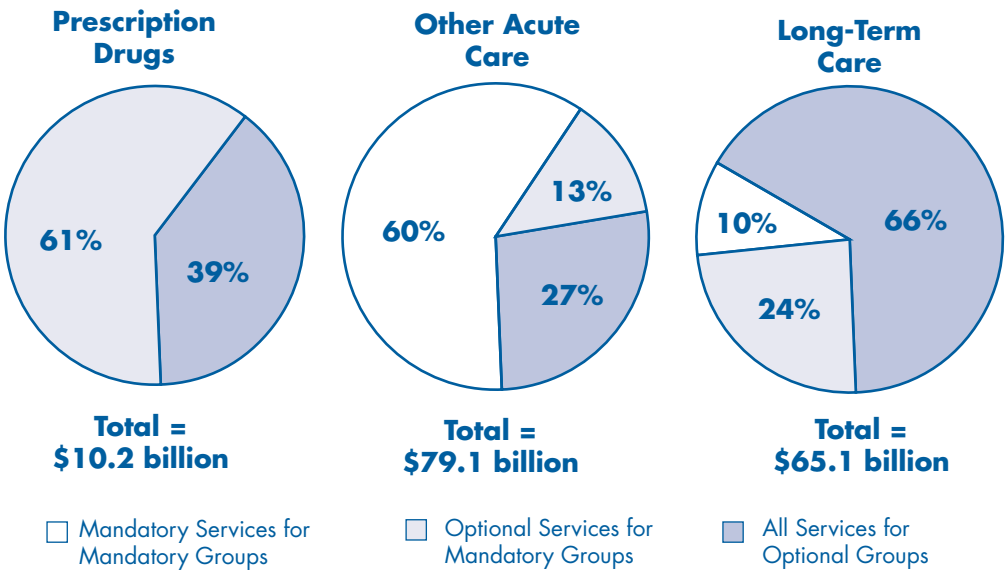
The amount of Medicaid spending that is mandatory or optional varies by service (Figures 16–17). Spending on acute care is driven primarily by mandatory services, including physician and hospital care. In contrast, long-term care spending is driven predominately by optional spending. Of the $65 billion Medicaid spent on long-term care services, only 10% was for mandatory services for mandatory populations. Most Medicaid spending on long-term care is for optional eligibility groups (66%), primarily nursing facility services for the elderly, while 24% of spending is for optional long-term care services for mandatory beneficiary groups, primarily for ICF/MR and home and community-based waiver services for the disabled. Half of all optional long-term care spending, $30 billion, is for nursing facility care covered at state option (Figure 18). An additional $10 billion is spent on optional ICF/MR services and $15.5 billion is spent on home and community-based waiver services and other home care.

Figure 16—Mandatory and Optional Medicaid Spending by Service



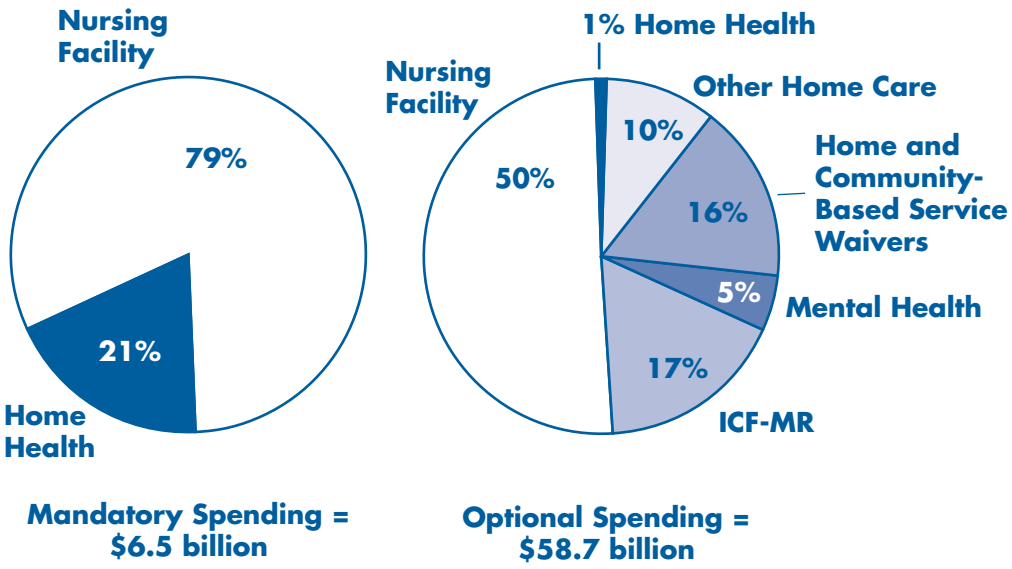
NOTE: Expenditures do not include disproportionate share hospital (DSH) payments, administrative costs, or accounting adjustments.
SOURCE: Urban Institute estimates, based on data from federal fiscal year 1998 HCFA 2082 and HCFA-64 reports, 2001.

Figure 17—Mandatory and Optional Medicaid Spending by Service



NOTE: Expenditures do not include disproportionate share hospital (DSH) payments, administrative costs, or accounting adjustments.
SOURCE: Urban Institute estimates, based on data from federal fiscal year 1998 HCFA 2082 and HCFA-64 reports, 2001.

Figure 18—Long-Term Care Medicaid Spending by Service, 1998



NOTE: Expenditures do not include disproportionate share hospital (DSH) payments, administrative costs, or accounting adjustments.
SOURCE: Urban Institute estimates, based on data from federal fiscal year 1998 HCFA 2082 and HCFA-64 reports, 2001.

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, a key component of medical treatment, in their Medicaid benefits. Despite broad coverage, spending for prescription drugs comprised only 11 percent of all optional spending, with the majority of prescription drug spending (60%) for the disabled.

Issues in Medicaid Reform

Since its enactment in 1965, Medicaid has improved access to health care for the low-income population and stood as the primary source of financial assistance for long-term care. Throughout its history, policymakers at the federal and state level have turned to Medicaid to expand coverage for the uninsured and address gaps in the U.S. health financing system. Most recently, 33 states and the District of Columbia have taken advantage of CHIP funding to broaden the reach of their Medicaid program to cover more low-income children. As a result, Medicaid today is the nation's primary program that assures access to health care for low-income children and their parents, the disabled and the elderly. Improving Medicaid's ability to reach and cover low-income Americans who are without health insurance and maintaining Medicaid's essential role for the current beneficiary populations is a challenge for both federal and state government.

The NGA approach turns to Medicaid as the vehicle to potentially expand coverage to the low-income uninsured population and give states greater flexibility and enhanced federal spending for their programs. The approach could, however, result in substantial changes to the current program structure, particularly with regard to services for the disabled and elderly. The proposal would eliminate many of the current protections under Medicaid and invite greater state variation in the coverage and scope of benefits available under Medicaid. While the NGA reform agenda also calls for enhanced federal matching dollars to provide incentives to maintain or improve coverage, it is unclear whether federal fiscal relief would be forthcoming, or in the way proposed by the NGA. It is therefore important to assess the potential impact of programmatic features of the NGA approach without the enhanced match, particularly as the NGA approach to restructuring eligibility and benefits could serve as a framework as states seek waivers of federal law in the absence of increased federal spending.

Key questions that emerge in considering this proposal include:

- **What would be the impact on beneficiaries and providers if the federal guidelines that apply to optional spending were eliminated or substantially altered?** Optional spending comprises 65% of total Medicaid spending. Under current law, states have substantial flexibility to cover optional population groups and to provide optional benefits. The Medicaid statute assures that when a state opts to extend coverage, the benefit package is comprehensive. Current law also assures that when benefits are offered, they are available to all beneficiary groups and that the scope of services offered is sufficient to meet beneficiaries' medical needs.

These protections are integral to Medicaid's role in serving vulnerable and low-income population groups who may have extensive health and long-term care needs.

- **How would the elimination or substantial alteration of federal guidelines on the structure of optional benefits affect access to care for mandatory beneficiary groups?** In 1998, Medicaid spent $32 billion (21% of total spending) to cover optional services for mandatory populations. Current law requires that if a state offers an optional benefit, the same package of services be available to all beneficiaries. If federal requirements were eliminated, would states vary optional benefits by population group? For example, would greater cost-sharing be imposed on the disabled for optional benefits, such as prescription drugs?
- **How would the elimination or substantial alteration of federal guidelines over the structure of optional and mandatory benefits affect access to care for optional beneficiary groups?** In 1998, Medicaid spent $68 billion (44% of total spending) to provide services to optional eligibility groups. States are required to include mandatory services as part of the benefit package. If federal requirements were eliminated, would states reduce the scope of current mandatory benefits or impose greater cost-sharing? How would access to nursing home care, predominately covered under optional spending, be affected? Would elderly and disabled beneficiaries, who are primarily covered through optional eligibility groups, lose access to, or would they or their families be responsible for greater cost-sharing for, critical services, such as nursing home care? Would children of different ages in the same family be covered by different benefit packages under the Medicaid program? For example, would a five year-old in a family at 150 percent of poverty lose the entitlement to the EPSDT services for which a five year-old in a family at 133 percent of poverty would still be covered? Would this flexibility result in expansions or contractions of health coverage for low-income populations?
- **How much more state variation in Medicaid coverage is desired?** It is likely that the NGA approach would lead to greater state variation in who is eligible for Medicaid coverage and what benefits are provided across and within states. Under current law, substantial disparities exist across states in the proportion of low-income families, the elderly and the disabled covered by Medicaid and in the types of acute and long-term care services covered. While some states have demonstrated a desire to broaden coverage, others would likely trim back or eliminate coverage categories.
- **What would happen to Medicaid's protections for low-income families, the elderly and the disabled if the flexibility sought by the NGA were granted without the enhanced federal match?** A key element of the NGA proposal is the enhanced match on current and new spending. The enhanced match provides incentives for states to maintain and improve coverage when coupled with greater flexibility. Reducing federal protections in the absence of increased federal funding could lead some states to limit, rather than expand, coverage and benefits. Is this policy direction desirable? What additional reform strategies should be explored to facilitate fiscal stability in the program and expanded coverage?

This analysis of mandatory and optional eligibility groups and services highlights the flexibility inherent in the Medicaid program. States have used optional categories to go substantially beyond federal minimum requirements to reach and provide services for low-income populations. In particular, states' decisions to broaden Medicaid coverage for elderly and disabled beneficiary groups is the major factor that contributes to optional spending. Optional

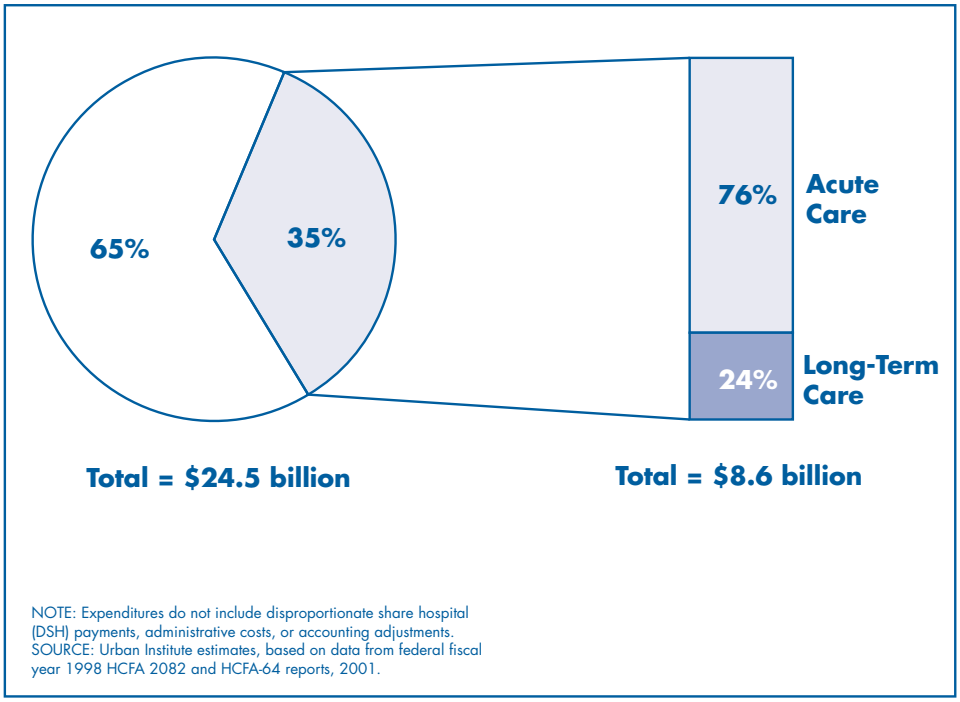
spending for these groups is driven primarily by long-term institutional care. In comparison, Medicaid spending for low-income families who are more likely to be covered under a mandatory group and rely on the program mainly for health insurance coverage, remains a relatively small share of overall spending, and comprises less than 20 percent of optional spending.

The Medicaid program today plays a critical role in ensuring access to care for the low-income population. Building on Medicaid to broaden coverage of the low-income population makes sense from an administrative, as well as a fiscal perspective. Developing strategies to improve coverage and access to care for the low-income population and assessing the impact of proposed changes is vital to moving forward. The Commission will continue to conduct analysis of Medicaid reform proposals, including further analysis of the NGA approach, as well as additional proposals that emerge to expand coverage to the uninsured, and/or restructure the Medicaid program.

This briefing packet was prepared by The Kaiser Commission on Medicaid and the Uninsured. The data is based on analysis conducted for the Commission by John Holahan and Brian Bruen of the Urban Institute. Information on Medicaid eligibility and benefits is drawn from the *Medicaid Resource Book*, Forthcoming 2001, The Kaiser Commission on Medicaid and the Uninsured.

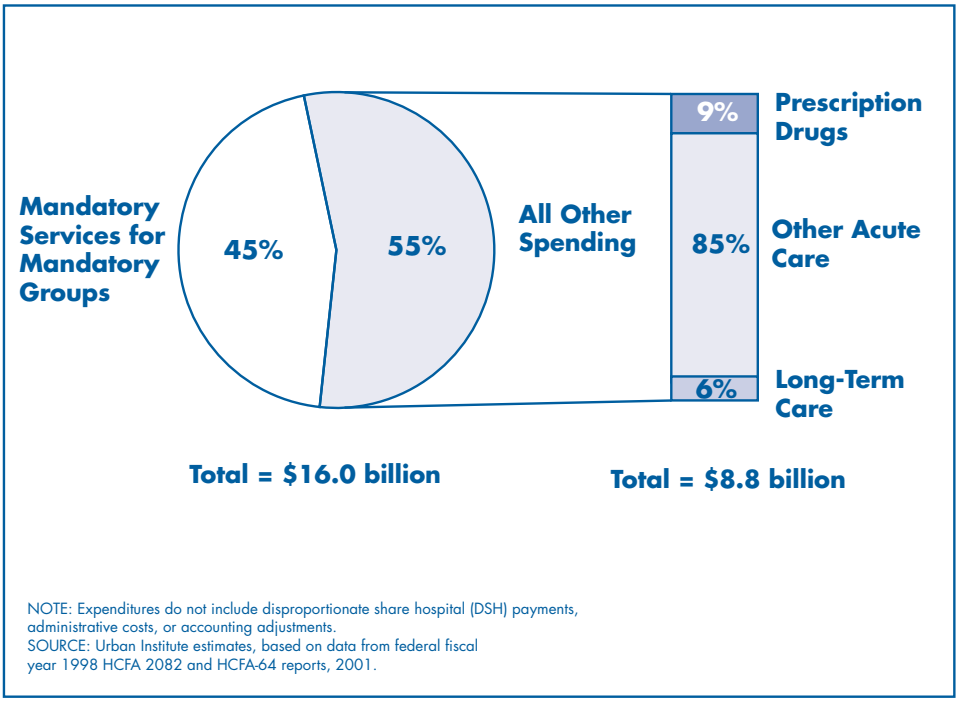
Appendix

Figure A-1—Distribution of Medicaid Spending for Children by Type of Service, 1998



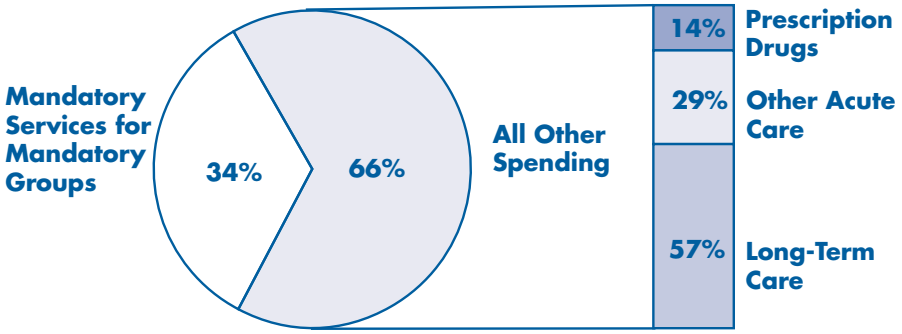
NOTE: Expenditures do not include disproportionate share hospital (DSH) payments, administrative costs, or accounting adjustments.
SOURCE: Urban Institute estimates, based on data from federal fiscal year 1998 HCFA 2082 and HCFA-64 reports, 2001.

Figure A-2—Distribution of Medicaid Spending for Parents by Type of Service, 1998



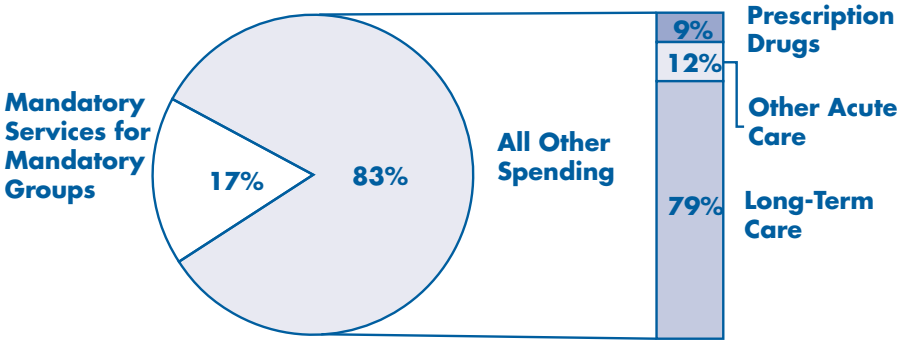
NOTE: Expenditures do not include disproportionate share hospital (DSH) payments, administrative costs, or accounting adjustments.
SOURCE: Urban Institute estimates, based on data from federal fiscal year 1998 HCFA 2082 and HCFA-64 reports, 2001.

Figure A-3—Distribution of Medicaid Spending for the Disabled by Type of Service, 1998



NOTE: Expenditures do not include disproportionate share hospital (DSH) payments, administrative costs, or accounting adjustments.
SOURCE: Urban Institute estimates, based on data from federal fiscal year 1998 HCFA 2082 and HCFA-64 reports, 2001.

Figure A-4—Distribution of Medicaid Spending for the Elderly by Type of Service, 1998



NOTE: Expenditures do not include disproportionate share hospital (DSH) payments, administrative costs, or accounting adjustments.
SOURCE: Urban Institute estimates, based on data from federal fiscal year 1998 HCFA 2082 and HCFA-64 reports, 2001.

Table 1
Medicaid Expenditures by Beneficiary Group and Type of Service, 1998 United States (in millions)

Beneficiary Group	Total	Optional Spending			
		Mandatory Spending for Mandatory Populations	Total Optional Spending	Optional Spending for Mandatory Populations	All Spending for Optional Populations
Total	**$154,354**	**$53,960**	**$100,393**	**$32,011**	**$68,382**
Elderly	46,148	7,917	38,231	4,516	33,715
Blind and Disabled	67,677	22,916	44,762	21,668	23,094
Adults	15,999	7,153	8,847	2,212	6,635
Children	24,530	15,975	8,555	3,617	4,938

SOURCE: Urban Institute estimates (2001), based on data from federal fiscal year 1998 HCFA-2082 and HCFA-64 reports.
Notes: Does not include the U.S. Territories. Enrollees are people who participate in Medicaid for any length of time during the federal fiscal year. Some enrollees may not actually use any Medicaid services. Expenditures do not include disproportionate share hospital (DSH) payments, administrative costs, or accounting adjustments. For methodology explaining the allocations between mandatory and optional categories, see notes attached to Table 2.

Table 2
Medicaid Expenditures by Beneficiary Group and Type of Service, 1998
United States (expenditures in millions)

		Acute Care Services				Long-Term Care Services	
		Mandatory		Optional			
Beneficiary Group	**Enrollees** (in millions)	**Mandatory Services[1]**	**Payments to Medicare**	**Prescription Drugs[2]**	**Optional Services[3]**	**Mandatory Services[4]**	**Optional Services[5]**
Total (services only)	**40.3**	**$60,525**	**$4,419**	**$10,172**	**$14,088**	**$36,315**	**$28,835**
Mandatory Eligibility[6]	28.6	43,059	n/a	6,221	9,863	6,482	15,927
Optional Eligibility[7]	11.7	17,466	n/a	3,951	4,225	29,833	12,907
Elderly	**4.1**	**$4,909**	**$2,651**	**$3,298**	**$2,182**	**$28,332**	**$4,777**
Mandatory Eligibility	1.8	2,454	n/a	1,340	1,056	2,812	2,120
Optional Eligibility	2.3	2,455	n/a	1,958	1,125	25,520	2,657
Blind and Disabled	**6.9**	**$23,435**	**$1,768**	**$6,081**	**$7,127**	**$7,699**	**$21,567**
Mandatory Eligibility	5.4	17,642	n/a	4,343	5,294	3,506	12,030
Optional Eligibility	1.5	5,793	n/a	1,738	1,833	4,193	9,537
Adults	**8.7**	**$12,312**	**$0**	**$794**	**$2,297**	**$164**	**$431**
Mandatory Eligibility	5.0	7,077	0	539	1,468	76	205
Optional Eligibility	3.7	5,236	0	255	830	88	226
Children	**20.6**	**$19,869**	**$0**	**n/a**	**$2,482**	**$120**	**$2,059**
Mandatory Eligibility	16.4	15,886	0	n/a	2,045	89	1,572
Optional Eligibility	4.2	3,983	0	n/a	437	31	487

SOURCE: Urban Institute estimates (2001), based on data from federal fiscal year 1998 HCFA-2082 and HCFA-64 reports.
Notes: Does not include the U.S. Territories. Expenditures do not include disproportionate share hospital (DSH) payments, administrative costs, or accounting adjustments. Because of EPSDT requirements, we assume that 100% of expenditures for children for dental services, other practitioners, health clinics, and prescribed drugs is mandatory, and that 50% of expenditures for unspecified services ("other care") is mandatory. States are required to pay all or part of the Medicare premiums, deductibles, and copayments for certain low-income people age 65 and older and younger persons with disabilities who qualify for Medicare. No distinction is made between payments to mandatory and optional populations in this table because states are required to make these payments regardless of whether the individual is eligible for additional Medicaid benefits through a mandatory or optional eligibility category.

Notes for Table 2

1) Mandatory acute care services include inpatient and outpatient hospital services, FQHC and rural health clinic services, physician services, laboratory and radiology services, early and periodic screening, diagnostic, and treatment (EPSDT) services, family planning (including sterilizations), nurse midwife, and nurse practitioner services. This analysis assumes that 80% of expenditures of prepaid health care services (e.g., HMO, HIO, and PHP programs) are for mandatory acute care services. This analysis also assumes that 100% of expenditures for children for dental services, other practitioners, health clinics, and prescribed drugs is mandatory due to EPSDT requirements, and that 50% of expenditures for unspecified services ("other care") is mandatory.

2) Because of EPSDT, prescription drug spending for children is included under mandatory spending.

3) Optional acute care services include other practitioners' services (e.g., podiatrists, optometrists, chiropractors), private duty nursing, clinic services (except FQHC and rural clinic services), dental services, physical therapy, occupational therapy, speech, hearing, and language disorder services, dentures, prosthetic devices, eyeglasses, rehabilitative services, Christian Science practitioners, hospice services, targeted case management, primary care case management (PCCM), emergency hospital services, and other services as allowed by state Medicaid plans.

4) Mandatory long-term care services include nursing facility services for people age 21 and older and home health services.

5) Optional long-term care services include nursing facility services for people under age 21, intermediate care facility services for the mentally retarded (ICF-MR), inpatient psychiatric services for people under age 21, inpatient hospital services and nursing facility services for people over age 65 in mental institutions, personal care services, home- and community-based services for functionally disabled elderly individuals, home- and community-based waiver services, targeted case management, and private duty nursing.

6) Mandatory coverage groups include people receiving SSI (or in states using more restrictive criteria, people age 65 and older and younger people with disabilities who meet criteria which are more restrictive than those of the SSI program), low-income families with children who meet certain of the eligibility requirements in the state's AFDC plan in effect on July 16, 1996, infants (up to age 1) born to Medicaid-eligible pregnant women, children under age 6 and pregnant women with family incomes at or below 133 percent of the Federal poverty level (FPL), and children under age 19 and born after September 30, 1983, with family incomes at or below the FPL, recipients of adoption assistance and foster care under Title IV-E of the Social Security Act, certain Medicare beneficiaries, and special protected groups who may keep Medicaid for a period of time after a change in status.

7) Optional enrollees include infants up to age one and pregnant women not covered under the mandatory rules with family incomes below 185 percent of the FPL, optional targeted low income children, certain people over age 65 and younger people with disabilities who have incomes above those requiring mandatory coverage but below the FPL, children under age 21 who meet income and resource requirements for AFDC, but who are not otherwise eligible for AFDC, institutionalized individuals with income and resources below specified limits, people who would be eligible if institutionalized but are receiving care under home and community-based services waivers, recipients of state supplementary payments, and certain TB-infected individuals.

Table 3

Medicaid Expenditures for Mandatory and Optional Populations, Long-Term Care Services Only, 1998 United States

(expenditures in millions)

		Long-Term Care Services						
		Mandatory Services		Optional Services				
Beneficiary Group	**Total Expenditures**	**Nursing Facility (Age 21 and Up)**	**Home Health**	**Nursing Facility (Under Age 21)**	**ICF-MR[1]**	**Mental Health[2]**	**HCBS Waivers**	**Other Home Care[3]**
Total (services only)	**$65,149**	**$34,096**	**$2,218**	**$256**	**$9,988**	**$3,104**	**$9,439**	**$6,047**
Mandatory Eligibility[4]	22,409	5,092	1,390	147	3,704	1,741	6,068	4,267
Optional Eligibility[5]	42,740	29,005	828	109	6,284	1,363	3,372	1,780
Elderly	**$33,109**	**$27,676**	**$656**	**$0**	**$723**	**$957**	**$1,341**	**$1,756**
Mandatory Eligibility	4,932	2,499	313	0	243	283	591	1,002
Optional Eligibility	28,177	25,177	343	0	480	673	749	754
Blind and Disabled	**$29,267**	**$6,307**	**$1,392**	**$146**	**$9,164**	**$1,279**	**$7,732**	**$3,247**
Mandatory Eligibility	15,536	2,546	960	59	3,398	868	5,243	2,461
Optional Eligibility	13,731	3,761	432	87	5,766	410	2,489	785
Adults	**$595**	**$114**	**$50**	**$0**	**$39**	**$141**	**$99**	**$152**
Mandatory Eligibility	281	48	28	0	17	58	42	88
Optional Eligibility	314	66	22	0	23	82	57	64
Children	**$2,179**	**$0**	**$120**	**$111**	**$61**	**$728**	**$267**	**$892**
Mandatory Eligibility	1,660	0	89	89	46	531	191	715
Optional Eligibility	518	0	31	22	15	197	76	177

SOURCE: Urban Institute estimates (2001), based on data from federal fiscal year 1998 HCFA-2082 and HCFA-64 reports.

Notes: Does not include the U.S. Territories. Expenditures do not include disproportionate share hospital (DSH) payments, administrative costs, or accounting adjustments.

1) Intermediate care facilities for the mentally retarded.

2) This category is only supposed to include expenditures inpatient mental health services, but may include some expenditures for non-inpatient mental health care.

3) Includes personal care, home and community care for functionally disabled elderly individuals, targeted case management, and private duty nursing services.

4) Mandatory coverage groups include people receiving SSI (or in states using more restrictive criteria, people age 65 and older and younger people with disabilities who meet criteria which are more restrictive than those of the SSI program), low-income families with children who meet certain of the eligibility requirements in the state's AFDC plan in effect on July 16, 1996, infants (up to age 1) born to Medicaid-eligible pregnant women, children under age 6 and pregnant women with family incomes at or below 133 percent of the Federal poverty level (FPL), and children under age 19 and born after September 30, 1983, with family incomes at or below the FPL, recipients of adoption assistance and foster care under Title IV-E of the Social Security Act, certain Medicare beneficiaries, and special protected groups who may keep Medicaid for a period of time after a change in status.

5) Optional enrollees include infants up to age one and pregnant women not covered under the mandatory rules with family incomes below 185 percent of the FPL, optional targeted low income children, certain people over age 65 and younger people with disabilities who have incomes above those requiring mandatory coverage but below the FPL, children under age 21 who meet income and resource requirements for AFDC, but who are not otherwise eligible for AFDC, institutionalized individuals with income and resources below specified limits, people who would be eligible if institutionalized but are receiving care under home and community-based services waivers, recipients of state supplementary payments, and certain TB-infected individuals.

1450 G Street NW, Suite 250, Washington, DC 20005
Phone: 202-347-5270, *Fax:* 202-347-5274,
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