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The Bush Administration's Medicaid Reform Proposal: Using Data to Estimate Mandatory and Optional Beneficiaries and Expenditures

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Summary

Medicaid, a health insurance program jointly funded by federal and state governments, is facing a period of escalating costs and rising enrollment among the population it serves — low-income individuals with disabilities, families and the elderly. The downturn in the economy since 2000 coupled with rising Medicaid costs and increasing enrollment and utilization are driving legislative attention both at the state and federal levels. Medicaid expenditures are a significant portion of most states' budgets and are a contributor to the current fiscal crises. However, it is a challenge for states to cut back Medicaid programs because some of the high cost components (such as nursing facility care) are statutorily required for certain beneficiaries, while other optional services (such as prescription drugs) may be important for beneficiaries' well-being.

In response to these fiscal pressures, on January 31, 2003, Secretary Tommy Thompson of the Department of Health and Human Services (HHS) announced a proposal to change the Medicaid program and provide additional flexibility to states. The Administration's proposal would give states the option to receive federal funds that combine Medicaid and the State Children's Health Insurance Program (SCHIP) into two lump-sum annual allotments, one for acute care and one for long-term care. While many details surrounding the proposal are still unknown, the Administration has indicated that current mandatory eligibility groups would retain their entitlement to mandatory benefits, and states would have considerably greater flexibility to change coverage of currently optional eligibility groups and optional benefits.

The Administration's Medicaid reform proposal is based on a policy design principle that requires the ability to identify those individuals who would maintain their entitlement to Medicaid. The primary federal data source to differentiate between mandatory and optional expenditures is the Medicaid Statistical Information System (MSIS). MSIS contains national enrollment and service use data on the Medicaid population and are the most comprehensive federal data available. However, overlapping Medicaid's complex rules with MSIS data does not support a detailed analysis of mandatory and optional people or spending. National estimates that attempt to separate mandatory from optional individuals and expenditures using MSIS must rely on a significant number of underlying assumptions. These assumptions are important to understand as they influence the estimates. This report provides:

- A brief overview of the Administration's proposal;
- Key features of the current Medicaid program and MSIS;
- An analysis of how Medicaid's complex program structure and MSIS data limitations create significant challenges in the ability to distinguish between mandatory and optional Medicaid spending.

This report will be updated as new information becomes available.

Contents

Background 1

Medicaid Reform Proposal 3

Current Program Structure 4
Eligibility 4
Services 5

The Medicaid Statistical Information System (MSIS) 6
MSIS Eligibility Categories 7
MSIS Service Categories 9
Medicaid Managed Care 11
Available State-Level Data 14
A State-Specific Example of Analysis 16

Considerations for Congress 17

List of Figures

Figure 1. Medicaid Eligibility: Analysis of Mandatory vs. Optional Beneficiaries Using State and Federal Data Systems 9
Figure 2. Medicaid Services: Analysis of Mandatory vs. Optional Service Expenditures Using State and Federal Data Systems 10
Figure 3. Medicaid Managed Care: Analysis of Mandatory vs. Optional Service Expenditures Using State, Federal and Managed Care Data 13
Figure 4. State Medicaid Data: Analysis of Mandatory vs. Optional Service Expenditures Under Fee-for-Service and Managed Care 15

List of Tables

Appendix 1. Selected Major Mandatory and Optional Eligibility Groups by MSIS Category 18
Appendix 2. Mandatory and Optional Services as Classified in MSIS by Eligibility Group 21
Appendix 3. Excerpt from Oklahoma's Analysis of Mandatory Versus Optional Populations 23

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Background

Medicaid is a program to finance health care services that is jointly funded by the states and the federal government. Within broad federal guidelines, each state designs and administers its own program.

The states establish eligibility requirements such as age, income, and resources through a combination of federal requirements and state options. Generally, eligibility is limited to certain categories or groups of low-income individuals; namely, children, pregnant women, members of families with dependent children, people with disabilities, and the elderly. In FY2000, there were 44.3 million Medicaid enrollees including 21.8 million children, 10.7 million adults, 4.3 million elderly, and 7.5 million individuals who were blind or had a disability.[1]

Within broad federal guidelines, states can also design the scope and availability of Medicaid benefits. Medicaid law requires states to provide certain services including, for example, hospital and physician services. Within federal guidelines, states may opt to cover other services and limit the amount, duration or scope of any Medicaid service. For example, a state may limit Medicaid coverage of a particular service to a certain number of hours or days or make a service available only to those with a particular condition.

The federal government shares in states' Medicaid service costs by means of a statutory formula designed to provide a higher federal matching rate to states with lower per capita incomes. The federal share is referred to as the federal medical assistance percentage (FMAP). Because Medicaid is an individual entitlement, there is no annual ceiling on federal expenditures; however, in order to continue receiving federal payments the state must contribute its share of the matching funds. In FY2001, combined federal and state Medicaid expenditures grew 11.1% over FY2000 spending to $228 billion.[2]

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[1] FY2000 MSIS. The basis of eligibility of 3.7 million of the 42.8 million Medicaid enrollees was not available.

[2] CRS analysis of Centers for Medicare and Medicaid Services (CMS), Form 64, FY2001.

Preliminary FY2002 data show total Medicaid expenditures grew 13.2% over FY2001 to $258.2 billion (spending for Medicaid benefits grew 15%).[3] The federal share was $146.6 billion; states spent $111.6 billion.[4] This represents the fastest annual rate of growth for Medicaid since 1992. CBO projects average annual growth in federal expenditures for Medicaid to continue at a rate of 8% (9% for Medicaid benefits) per year for the period between FY2002 and FY2013.[5]

The recent expenditure trends have been particularly burdensome for the states because Medicaid enrollment and health care costs have been increasing while state revenues have been decreasing.[6] However, it is a challenge for states to cut back Medicaid programs because some of the high cost components (such as nursing facility care) are statutorily required for certain beneficiaries, while other optional services (such as prescription drugs) are perceived to be necessary for the well-being of the beneficiaries.[7] Cutbacks may not always result in a dollar for dollar savings in Medicaid because cutting or eliminating a service may result in increases in spending for other remaining services. For example, if a state no longer offers podiatry services, beneficiaries may seek the same care from their general practitioner. Further, cutting the program when unemployment is increasing and the number of uninsured is growing is often politically unpopular.

This is not the first time that Medicaid has been a major contributor to fiscal hardship. Throughout most of the 1980s, the growth of the Medicaid program was less than 10% per year. But starting in 1989, the growth in Medicaid expenditures increased significantly and peaked at a 29.1% annual growth rate in FY1992. In response, the Congress passed legislation (104th Congress, H.R.2491) to transform the Medicaid program into a fixed grant program. President Clinton vetoed this effort. The recent period of economic growth in the late 1990s temporarily relieved some of the fiscal pressures, but with the current economic situation, they have returned.

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[3] Total Medicaid expenditures include spending on health care services, administration, and disproportionate share hospital payments for hospitals that serve a large number of low-income and low-income uninsured individuals. Benefit spending is associated with spending on health care services only.

[4] CRS analysis of Centers for Medicare and Medicaid Services (CMS), Form 64, FY2002.

[5] CBO projects that spending growth will drop from 13% (in FY2002) to an average of 8% beginning in FY2003 (through 2008) as a result of: (1) slower growth in enrollment; (2) smaller increases in provider payment rates; and (3) restrictions on upper payment limit (UPL) spending. See Congressional Budget Office, *The Budget and Economic Outlook: Fiscal Years 2004-2013*, Jan. 29, 2003.

[6] For a more detailed analysis of expenditure growth in the Medicaid program and its impact on state budgets, see CRS Report RL31773, *Medicaid and the Current State Fiscal Crisis*, by Christine Scott.

[7] MSIS 2000 shows the four largest spending categories as a percentage of all Medicaid spending to be: (1) nursing home care (20%); (2) inpatient hospital (14%); (3) prescribed drugs (12%); and (4) managed care payments (15%).

The 108th Congress has provided some fiscal relief to the states. On May 28, 2003, the *Jobs and Growth Tax Relief Reconciliation Act of 2003* (P.L. 108-027) included a temporary increase in the FMAP for the last two quarters of FY2003 and the first three quarters of FY2004. The Bush Administration has also proposed various options to control Medicaid spending and increase state flexibility such as encouraging states to apply for demonstration waivers through the Health Insurance Flexibility and Accountability (HIFA) initiative,[8] and through the Medicaid reform proposal described below.

Medicaid Reform Proposal

On January 31, 2003, Secretary Tommy Thompson of the Department of Health and Human Services (HHS) announced a Medicaid and State Children's Health Insurance Program (SCHIP)[9] reform proposal that would significantly alter current law. The Bush Administration's proposal would give states the option to receive federal funds combining Medicaid and SCHIP through two lump-sum annual allotments, one for acute care and one for long term care. The President's FY2004 *Budget in Brief* explains that the allotments would be based on a given state's spending in FY2002 that would be increased annually using a specified trend rate. States would be able to transfer up to 10% of the funds between each allotment.

The Administration has indicated that current mandatory eligibility groups under Medicaid would retain their entitlement to mandatory benefits under this new option. Furthermore, the reform proposal would give states considerably greater flexibility to change coverage of currently optional eligibility groups and optional benefits, and to add health insurance options for uninsured populations. The Administration would provide an estimated $3.25 billion in extra federal funding for Medicaid in FY2004, with $12.7 billion in extra funding over the 7-year period from FY2004 through FY2010. This $12.7 billion would be "recouped" in the following 3 years, FY2011 through FY2013, by limiting the federal matching payments to a rate of growth lower than current Medicaid growth estimates, resulting in an overall reform proposal that is budget neutral over 10 years.

The proposal would require states to maintain a level of spending based on FY2002 expenditures that increased annually, although at a lower rate than that for the federal allotments. This requirement is often referred to as a state "maintenance of effort." For example, if a state spent $100 million on Medicaid in FY2002 and the

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[8] The HIFA initiative is designed to encourage states to extend Medicaid and SCHIP to the uninsured, with a particular emphasis on statewide approaches that maximize private health insurance coverage options and target populations with income below 200% of the federal poverty level (FPL). These demonstration waivers use the authority of Section 1115 of the *Social Security Act*. For more information see CRS report RS21054, *Medicaid and SCHIP Section 1115 Research and Demonstration Waivers,* by Evelyne Baumrucker.

[9] The Balanced Budget Act of 1997 (BBA 97; P.L. 105-33) established the State Children's Health Insurance Program (SCHIP) under a new Title XXI of the Social Security Act. In general, the program offers federal matching funds to states and territories to provide health insurance to certain low-income children.

annual trend rate was 5% of total expenditures, that state would be required to spend $110.25 million in FY2004.

The National Governor's Association (NGA) convened a bi-partisan Medicaid Reform Task Force of 10 Governors to evaluate the Administration's proposal and generate recommendations for Medicaid reform. The Task Force was unable to reach consensus on the principles for Medicaid reform. The Republican Governors on the Task Force, among other recommendations, supported the idea of separate program requirements based on mandatory and optional spending.[10] The Democratic Governors on the Task Force recommended several changes to the Medicaid program, but did not specifically address modifying policies based on mandatory versus optional spending.[11]

Any Medicaid reform proposal that differentiates mandatory and optional groups and services presents a number of problems in terms of analyzing impact. The limitations of the primary federal data source (MSIS) and the complex program structure of Medicaid create significant difficulties in identifying individuals, benefits and program spending as either mandatory or optional. These limitations are described further in this report.

Current Program Structure

Eligibility

In general, the Medicaid statute limits the categories of individuals that can be covered and establishes specific eligibility rules for groups within those broad categories.[12] Some eligibility groups must be covered by all states, while others may be covered at the state's option. Mandatory Medicaid eligibility categories generally include the following low-income individuals: children, certain pregnant women, members of families with dependent children, and persons with a disability and the elderly who are eligible for the Supplemental Security Income (SSI) program.[13] There are also optional eligibility groups including the "medically needy" who generally have higher income and who face large costs for medical care.[14] The

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[10] Letter to Secretary Tommy Thompson from the Republican Governors on the National Governor's Association bi-partisan, Medicaid Reform Task Force, June 10, 2003.

[11] *Joint Statement from the Democratic Governors on the NGA Medicaid Reform Task Force,* June 12, 2003.

[12] The two broad categories describe in statute are categorically needy and medically needy. Categorically needy refers to low-income families and children, aged, or individuals who are blind or have a disability, and certain pregnant women who are eligible for Medicaid. Medically needy individuals are persons who fall into one of the categorically needy groups but whose income and resources are too high to qualify as categorically needy. (Medicaid Regulations, 42 CFR §435.4).

[13] SSI refers to the Supplemental Security Income program which is a monthly cash benefit and, in most states, provides automatic Medicaid eligibility.

[14] States with medically needy programs *are required* to include certain children under age

(continued...)

Medicaid statute identifies over 50 separate mandatory and optional eligibility groups.

Services

The Medicaid statute identifies the services states must cover as well as those that may be covered at the state's option. Services are grouped under broad categories which may include several specific types of services. The statute also requires states to provide specific services to certain eligibles. Specifically, federal law distinguishes between individuals who are "categorically needy" versus "medically needy." Most eligibility groups (both mandatory and optional) qualify as categorically needy. The medically needy group includes individuals who would be a member of one of the broad Medicaid groups (i.e., are aged, have a disability or are in families with children), but have higher income or resources. The distinction between categorically needy and medically needy has become somewhat outdated, but it continues to be important in identifying a mandatory versus optional service because of the way in which the Medicaid statute is written. For example, inpatient hospital services are a mandatory service for categorically needy individuals, but for medically needy individuals they are only mandatory if they are pregnancy-related.

Within these broad federal guidelines, each state may define its own package of covered medical services resulting in considerable variation in the types of services covered and the amount of care provided across states. In addition to choosing whether or not the service is covered, states may also limit the amount, duration, or scope of services, meaning that they can limit the number of hours, days, or type of coverage for a particular service. For example, a state may specify that payment for inpatient hospital services cannot exceed 40 days of coverage in a 12-month period.

There are two primary systems for delivering Medicaid services — fee-for-service and managed care. These systems differ in how the state pays for Medicaid services. Under fee-for-service, an individual generally can receive a service from any certified provider, and the provider is reimbursed by the state. Under managed care, the state contracts with an organization(s) to provide an agreed upon set of services. The organization receives the Medicaid funding from the state and pays the individual providers associated with it. Most states use a combination of these systems to deliver Medicaid services. These systems also differ in how data about Medicaid service utilization is tracked.

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[14] (...continued)
18 and pregnant women who, except for income and resources, would be eligible as categorically needy. They *may choose* to provide coverage to other medically needy persons: aged, individuals with blindness or a disability; certain relatives of children deprived of parental support and care; and certain other financially eligible children up to age 21.

The Medicaid Statistical Information System (MSIS)

The Medicaid Statistical Information System (MSIS) is one of the primary federal data sources for the Medicaid program.[15] MSIS is a national Medicaid enrollment and claims repository and includes information on demographic characteristics of beneficiaries, service utilization by enrollment group, and payments for benefits. The MSIS consists of standardized, quarterly submittals of eligibility and claims files from each state to the federal government.[16] These submissions contain data extracted from states' claims processing systems, called the Medicaid Management Information Systems (MMIS). Since 1999, all states have been required to participate in MSIS.

The rich information contained in this data system allows for a more detailed level of analysis than was available prior to 1999.[17] However, the data have some significant limitations in analyzing major components of the Administration's Medicaid reform proposal including:

- **available data**: FY2000 is the most recent MSIS data available for the Medicaid program which may not accurately reflect the current status of the program given a downturn in the economy since 2000 and state fiscal crises.[18]
- **mandatory versus optional eligibility**: MSIS does not provide sufficient detail to categorize most beneficiaries as either mandatory or optionally eligible.
- **mandatory versus optional services**: MSIS does not provide sufficient detail to categorize many Medicaid services as either mandatory or optional.

Cost estimates to break out mandatory versus optional spending can be prepared using MSIS, but because of the above limitations those estimates must rely on a number of assumptions about program trends, eligibility and services. CMS program officials report that an estimate of mandatory versus optional spending is currently under development. One important consideration for those evaluating CMS' results

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[15] Another major source of Medicaid statistical data is the Centers for Medicare and Medicaid Services (CMS) Form 64. The CMS Form 64 is an expenditure report that includes aggregate state and federal spending on benefits and program administration by type of service and administrative categories. This form does not provide any data on beneficiaries.

[16] To facilitate analysis by outside groups, such as CRS, CMS has made available person-level MSIS files subject to a data use agreement. CMS retains a claims-level database which has additional variables not available to external groups.

[17] MSIS is an electronic reporting alternative to the CMS-2082. Data from Form 2082 includes state-level demographic, eligibility and enrollment information, utilization information and spending by enrollment group and type of service. This data set does not include person-level or claims-level details.

[18] CMS has posted 2001 MSIS files to their web site, however data are not yet available for all states.

will be the explicit assumptions the Centers for Medicare and Medicaid Services (CMS) uses, and the sensitivity of the overall estimate to their assumptions (i.e., how the estimate changes based on one set of assumptions versus another). These data limitations and the types of assumptions that would have to be made to evaluate the impact of the Administration's Medicaid reform proposal are described in more detail below.

In 2001, the Urban Institute analyzed the FY1998 state-reported CMS-2082 data to develop an estimate of mandatory versus optional spending. This estimate was published in a 2001 report for the Kaiser Family Foundation.[19] Key findings from this analysis were that in FY1998 one-third of national Medicaid spending was for mandatory services for mandatory groups, and the remaining two-thirds was for optional spending. The authors provided a brief discussion of their methodology for arriving at their estimates. Included in this discussion were some of the major assumptions they relied on to separate out mandatory versus optional spending. The Urban Institute intends to update their analysis of the break between mandatory and optional groups and services based on FY2000 person-level MSIS data. As with their previous CMS-2082 based analysis, assumptions will have to be made to disaggregate mandatory and optional eligibility groups as well as mandatory and optional spending.

MSIS Eligibility Categories

Individuals who meet state-specific eligibility criteria and who are enrolled in the Medicaid program are each assigned an eligibility code. In many states, somewhere between 70 and 150 different eligibility codes exist to categorize that individual's eligibility pathway into Medicaid. At the federal level, states are required to report an enrollee's Medicaid eligibility status to CMS based on 23 broad MSIS eligibility categories (as shown in **Appendix 1**).

Specifically, Medicaid eligibility groups captured in MSIS are broken down using two general criteria: (1) maintenance assistance status or MAS (i.e., cash, poverty-related, medically needy, Section 1115, and other); and (2) basis of eligibility or BOE (i.e., aged, blind/disabled, children, adult and foster care). Individuals are grouped into a MAS/BOE category depending upon how they become eligible for Medicaid.[20,21] For example, an elderly individual receiving SSI would be categorized

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[19] J. Holahan, *Restructuring Medicaid Financing: Implications of the NGA Proposal*, Kaiser Commission on Medicaid and the Uninsured, June 2001, at [http://www.kff.org/content/2001/2257/2257.pdf]

[20] Section 1902(a)(19) of the Social Security Act provides that eligibility determinations will be made in a manner consistent with simplicity of administration and the *best interest* of the recipients. Further, states cannot deny Medicaid coverage to individuals with completed applications, or terminate existing coverage, until all avenues of eligibility have been explored and evaluated. For individuals who would be eligible under more than one category, Medicaid regulations specify that the individual will be determined eligible for the category he (or she) selects (42 CFR §435.404).

[21] For individuals who would be eligible under more than one category, the state may assign

(continued...)

as "cash/aged," whereas an elderly individual who is *only* Medicaid eligible because she is in a nursing facility would be considered "other/aged." Because there are many more state-specific Medicaid eligibility groups than federal MAS/BOE combinations, states are provided instructions on how to assign state-specific eligibility groups to each MAS and BOE category.

Most of the MSIS MAS/BOE categories contain a combination of mandatory and optional Medicaid eligibility groups. **Appendix 1** illustrates this grouping by identifying the major mandatory and optional eligibility groups included in each MSIS MAS/BOE category. The combining of eligibility groups into these broad MAS/BOE categories *does not* permit separation of individuals into their specific mandatory or optional eligibility group (see **Figure 1**). For example, pregnant women with family income below 133% of the federal poverty level (FPL) are members of a mandatory Medicaid group.[22] By contrast, pregnant women with family income between 134% and 185% FPL are eligible at state option. Because the person-level and claims-level MSIS data do not include a family income variable, it is very difficult to accurately determine whether a pregnant woman enrolled in the Medicaid program is a mandatory or optional beneficiary. Because the MSIS eligibility classifications aggregate the mandatory and optional groups for pregnant women into one MAS/BOE category, depending on the state such an individual may be categorized in MSIS as a "poverty-related adult," or if under age19 as a "poverty-related child."[23] Without more detailed eligibility information (e.g., income, pregnancy status), analysts must make assumptions regarding whether a given individual in a specific MAS/BOE category is part of a mandatory or optional Medicaid subcategory. The accuracy of these underlying assumptions will impact the precision of any projections that attempt to analyze the impact of proposed changes to Medicaid that rely on the ability to break out individuals belonging to mandatory versus optional eligibility groups.

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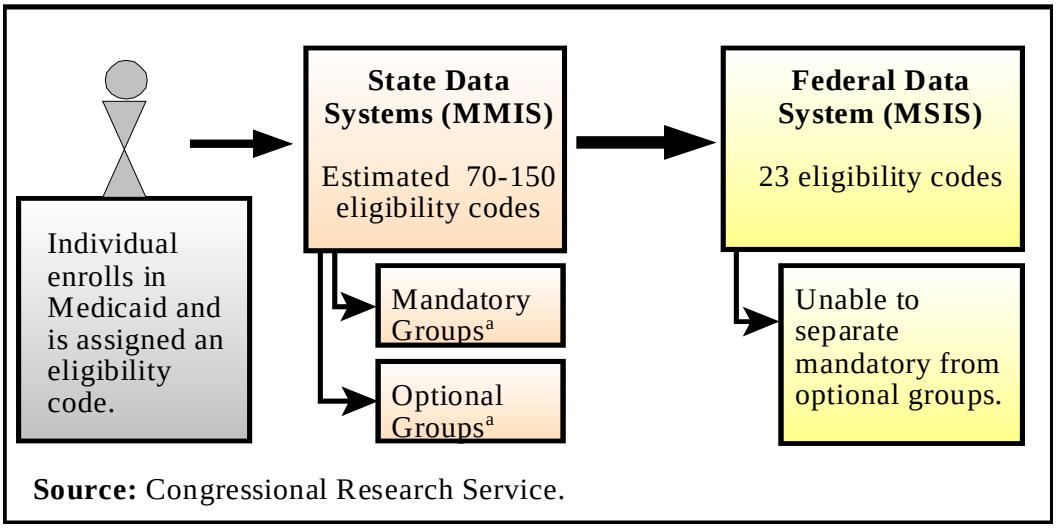
[21] (...continued)
eligibility based on a pre-determined eligibility hierarchy. With regard to state reporting systems, if no eligibility category is selected the system may be programed to default to a specified eligibility category.

[22] Under the pregnant women eligibility category, states are not required to provide the full range of mandatory Medicaid services, but rather must provide pregnancy-related services including: prenatal services, services associated with the birth of the child, and 60 days of postpartum care.

[23] Some states classify pregnant women under age 19 as adults, based on the notion that they are considered the "head of household" for the purposes of determining Medicaid eligibility. On the contrary, other states focus strictly on age to classify pregnant women in the appropriate MAS/BOE category.

Figure 1. Medicaid Eligibility: Analysis of Mandatory vs. Optional Beneficiaries Using State and Federal Data Systems



Source: Congressional Research Service.

[a] Medicaid regulations specify that in each applicant's case record the Medicaid agency must include facts to support the agency's decision on his (or her) application (42 CFR §435.913), and to verify the applicant's eligibility or amount of medical assistance payment (42 CFR 435.952). While states *must* maintain the detailed eligibility information that would be necessary to distinguish between mandatory and optional eligibility groups, some states may need to complete additional steps such as linking MMIS with their eligibility determination system to categorize enrollees in this way.

MSIS Service Categories

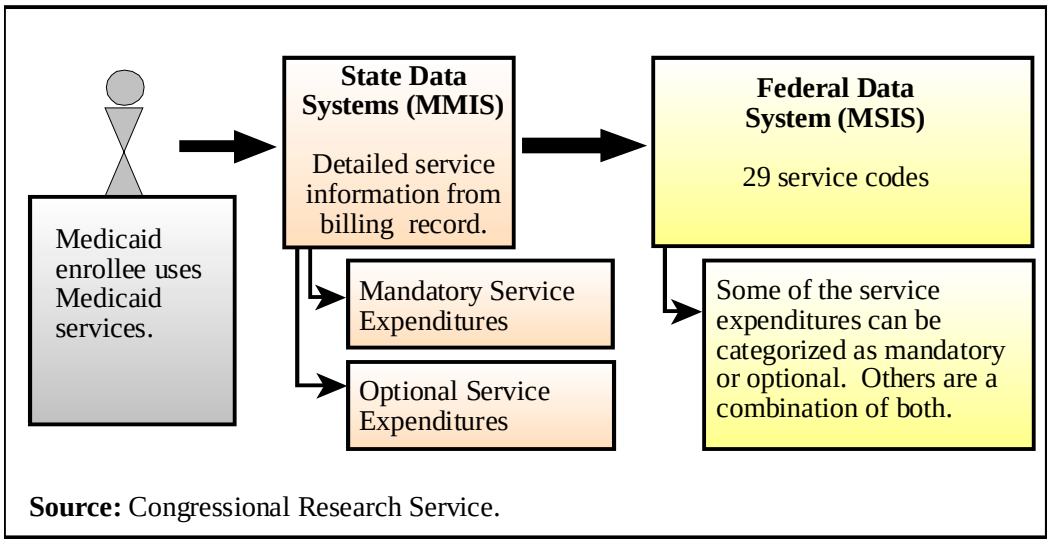
Similar limitations apply to service spending in terms of the ability to use MSIS to distinguish between mandatory and optional Medicaid spending. Because the Administration's proposal would impose separate requirements for mandatory and optional services, the ability to accurately break out mandatory versus optional service spending would be important for evaluating the impact of this proposal and/or for implementing this (or other similar) proposal(s).

MSIS classifies medical care and services into 29 different service categories. Like the MSIS eligibility groups, many of the 29 service categories contain several specific services bundled together within one category. **Appendix 2** lists each of the MSIS service categories and identifies which are mandatory, optional, or a combination of the two based on who is receiving the service, (i.e., a categorically needy individual; or a medically needy individual).[24] In cases where the service category is a combination of both mandatory and optional elements, MSIS may not

[24] Categorically needy groups include the following MAS categories listed in **Appendix 1**: (1) cash; (2) poverty related; and (3) other. Individuals in each of these MAS groups can be either mandatory or optional eligibles. Medically needy is a separate MAS category and is always optional.

provide sufficient detail including age or needed level of care to separate those expenditures.[25] (See **Figure 2**.)

Figure 2. Medicaid Services: Analysis of Mandatory vs. Optional Service Expenditures Using State and Federal Data Systems



Source: Congressional Research Service.

Certain groups of individuals are subject to special benefit rules which entitle them to a different package of services than other groups. For individuals in these groups (e.g., children, qualified aliens, and individuals who are eligible as medically needy and reside in a institution for individuals with a mental disease or an intermediate care facility for individuals with mental retardation), Medicaid statute specifies mandatory services differently than for other Medicaid groups. The examples provided below illustrate the difficulty in matching the current program structure and MSIS to the framework of the Administration's proposal which would have separate requirements for mandatory and optional services.

- **Medically Needy.** If a state chooses to cover medically needy populations, in general, Medicaid law specifies what services must be covered. However, if the state covers medically needy persons in institutions for mental disease or in intermediate care facilities for persons with mental retardation, then Medicaid law gives states a choice of covering either a subset of the mandatory services, or alternatively, any seven services from a list of mandatory and optional services identified in Medicaid statute.

MSIS does not separately identify which services the state has chosen as mandatory and which would be optional for these two groups of individuals.

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[25] To receive some Medicaid services, individuals must require assistance of a certain type and/or amount referred to as a "level of care." These needs may include assistance with activities of daily living (such as eating or bathing) or instrumental activities of daily living (such as grocery shopping or laundry).

- **Early and Periodic Screening, Diagnosis and Treatment (EPSDT).** Special benefit rules apply to children under the age of 21 who are entitled to the program of preventive child care referred to as EPSDT. Under EPSDT, if an optional service is determined to be a necessary treatment to correct or ameliorate conditions identified through screening, states are *required* to provide that service, even if the service is not covered under the state Medicaid plan.

  MSIS includes a special code to identify services offered as part the EPSDT program, but these codes do not separately identify mandatory versus optional services. First, only the services received during the *initial* screening are flagged; follow-up services for necessary treatment are not identified. Second, the MSIS person-level file does not provide service-by-service spending under EPSDT, although this type of analysis is possible using the MSIS claims-level files.[26]

In each of these cases, assumptions would need to be made to separate service expenditures identified on MSIS claims into mandatory versus optional categories. MSIS does not provide enough detail to break out expenditures in this way as would be required by the Administration's policy proposal.

Medicaid Managed Care

As described earlier, many states have developed managed care programs to deliver Medicaid services. Currently, all states except Alaska, Mississippi, and Wyoming have implemented various types of managed care programs. Beneficiary participation varies widely from state to state. For example, as of June 2002, South Carolina enrolled only 6.5% of its Medicaid population in managed care, while Michigan reported that 100% of its Medicaid population was enrolled in managed care for at least some of their services.[27]

Under a managed care program, states pay an organization a fixed, monthly payment to provide all the services specified under the managed care contract. Many managed care enrollees fall into both mandatory and optional eligibility groups, and many managed care contracts contain both mandatory and optional services. In general, data reported to the federal government through MSIS show only the fixed, monthly payment amount. MSIS does not identify person-specific service utilization

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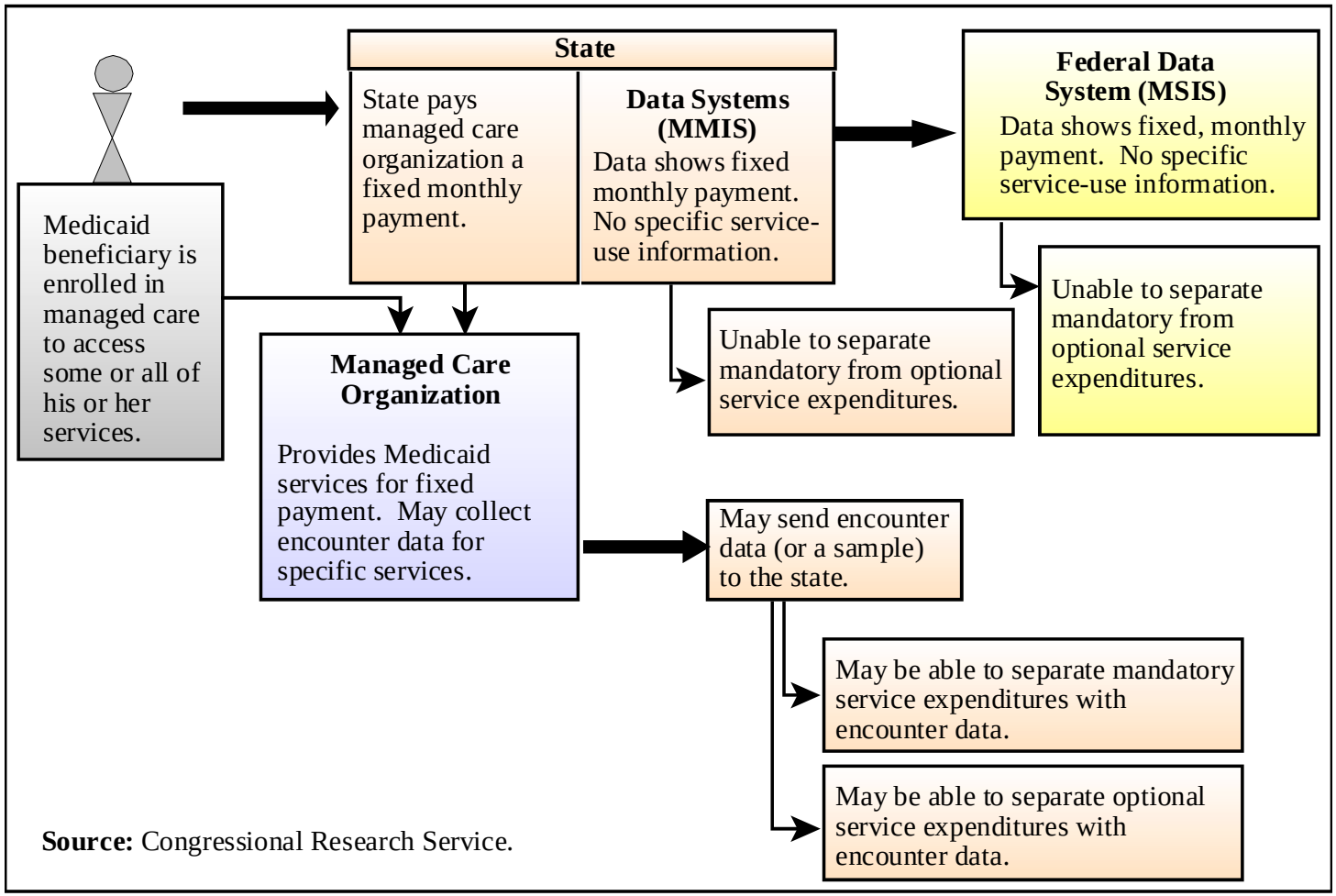
[26] On the person-level files (as well as publicly-reported data), all spending associated with the EPSDT program is combined and reported as EPSDT spending. It is not possible to break out service-by-service spending offered as a part of an EPSDT program on the person-level file. Conversations with program specialists at CMS confirmed that expenditures associated with the program-type flags can be broken out across services on the claims-level file; however, they cautioned that these breakouts were not particularly useful for determining mandatory versus optional service spending on the FY2000 MSIS file as states did not use the program-type flags accurately or consistently.

[27] [http://www.cms.gov/medicaid/managedcare/mcsten02.pdf].

to determine whether or not the delivered service is mandatory or optional, and the fixed monthly fee cannot be partitioned into mandatory versus optional spending.

In some cases states may have access to encounter data, (i.e., service-use data), for their Medicaid managed care programs which identifies the specific services a managed care enrollee is using. These data may help to identify whether that service is mandatory or optional. In other cases, the state may have to assume what services the managed care enrollee is using based on identifying individuals with similar eligibility characteristics who are receiving care under the Medicaid fee-for-service system. (See **Figure 3**.)

Figure 3. Medicaid Managed Care: Analysis of Mandatory vs. Optional Service Expenditures Using State, Federal and Managed Care Data



Available State-Level Data

As described above, Medicaid's complex program structure and current data limitations create significant challenges in analyzing the Administration's Medicaid reform proposal or similar proposals based on reform principles that require the ability to distinguish between mandatory and optional Medicaid spending. Given that the MSIS person level files do not contain the level of detail required to easily determine breaks between mandatory and optional eligibility groups or service expenditures, we explored the availability and usefulness of state-level data that may help to inform this issue. The following section provides background information regarding the type of eligibility and expenditure detail that may be available at the state-level.

States have access to some person-level eligibility information as well as claims-level data through their Medicaid Management Information Systems (MMIS).[28] Data from these files are extracted and submitted to CMS for MSIS. In some cases, states may provide CMS with additional eligibility code designations with more detail than the MAS/BOE categories described earlier.[29]

In order to assess whether state-level data would inform analysis to break out Medicaid mandatory versus optional spending, we completed a brief web search to identify states that: (1) posted state-level analyses that break out mandatory versus optional spending, or (2) states that may have access to eligibility detail that would assist in breaking out mandatory versus optional spending and counts of beneficiaries. While the search was not exhaustive, we identified several states that meet at least one of these criteria.

For example, a manual from California identifies over 140 state-specific eligibility codes (MSIS groups these into 23 categories).[30] It also identifies which persons in each eligibility category have access to the full set of Medicaid benefits, or if restrictions are applied, how the benefit package is limited.[31] In addition, some states may also have access to managed care encounter data as described above. (See **Figure 4**.)

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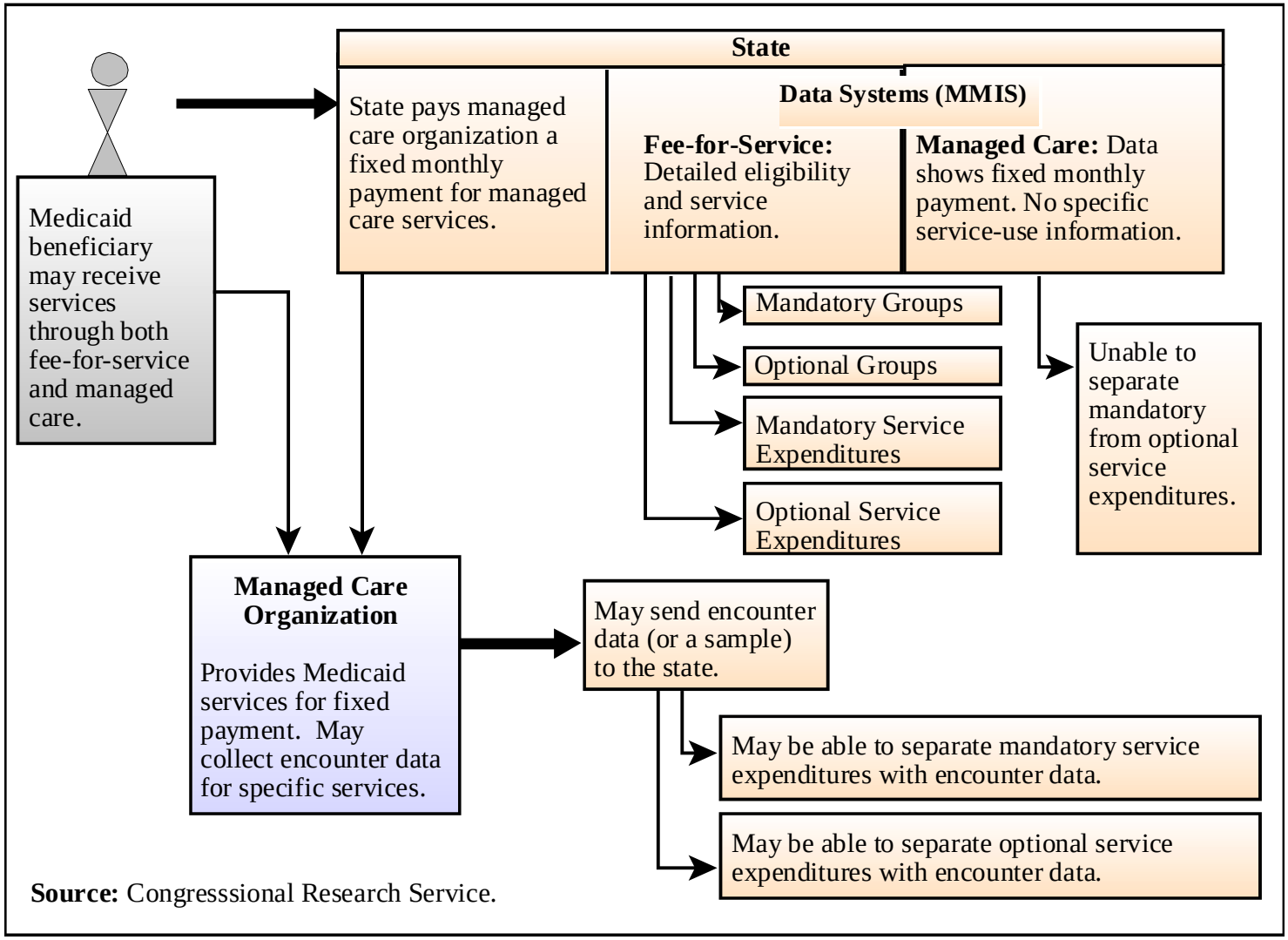
[28] The state may also have an eligibility information system that contains additional individual level detail such as income, earnings, etc.

[29] CMS program specialists caution against the usefulness of these eligibility codes to break out mandatory versus optional eligibility populations. For FY2000, CMS estimated that approximately half of the states provided a very limited set of codes to distinguish specific eligibility groups, and in four states this data were not provided. CMS points to the complexity of the programming required to extract this information from the state-reporting systems as the main cause for the incomplete data.

[30] [http://files.medi-cal.ca.gov/pubsdoco/publications/masters-MTP/Part1/aidcodes_z01.doc].

[31] California has created a tool that permits users to summarize and analyze the state's data interactively. Eligibility counts in this system are based on the state's Medi-Cal Eligibility File. Also included, is a sheet labeled "Aid Category Tree" which shows the relationships between the federal Medicaid eligibility rules for the beneficiary and the state's eligibility categorization scheme. California's data can be accessed at the following website: [http://www.dhs.ca.gov/mcss/RequestedData/Special_Family/spec_fam.htm].

Figure 4. State Medicaid Data: Analysis of Mandatory vs. Optional Service Expenditures Under Fee-for-Service and Managed Care



Source: Congresssional Research Service.

A State-Specific Example of Analysis. In the CRS review of selected states, Oklahoma, stood out as an example of having data available that could allow the identification of mandatory versus optional eligibility and service use at a very detailed level. Oklahoma has created a mapping system to cross person-level eligibility criteria with claims-level service use data at a much more detailed level than is possible in MSIS. To capture mandatory versus optional Medicaid spending, the state generated a table where the rows (50 total) identify service categories broken out by mandatory versus optional and the columns (73 total) identify state-specific eligibility criteria such as income, age, and eligibility status with enough detail to identify individuals as either mandatory or optional. Additional eligibility details such as pregnancy status were also captured. Each Medicaid claim from the state's MMIS was then mapped into this cross tabulation. From there, data programmers generated a table where each resulting cell (3,650 total) contains expenditures that can be identified as either mandatory or optional based on the intersection of the individual's eligibility status and the service. (See **Appendix 3** for an excerpt from this table.)

The state did not have access to encounter data for its managed care program. To determine a break out of mandatory versus optional spending for those receiving services through managed care, the state identified individuals with similar eligibility characteristics to those receiving care in their fee-for-service setting. The state then assumed that service use between mandatory versus optional groups would break out in a similar fashion for individuals in managed care.

The state then grouped each of the cells that identified mandatory spending for mandatory groups ($944 million) and optional spending for mandatory groups ($452 million); as well as mandatory spending for optional groups ($339 million) and optional spending for optional groups ($193 million).[32] (Expenditure groupings not shown in **Appendix 3**.)

In sum, an estimated 49% of Oklahoma's Medicaid expenditures would be for mandatory services for mandatory groups, and the remaining 51% would be for services for optional populations or optional spending for mandatory populations. Although spending patterns across states may not match these Oklahoma figures, these estimates, based on the state's Medicaid data, differ from the commonly-cited national estimates that show that one-third of Medicaid spending is for mandatory services for mandatory groups, and the remaining two-thirds is for optional spending.[33]

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[32] CRS analysis of Oklahoma's FY2003 state budget request for both federal and state spending sent by Oklahoma Medicaid data specialists.

[33] J. Holahan, *Restructuring Medicaid Financing: Implications of the NGA Proposal*, Kaiser Commission on Medicaid and the Uninsured, June 2001, at [http://www.kff.org/content/2001/2257/2257.pdf]

Considerations for Congress

If Congress chooses to create legislation that is consistent with the Administration's Medicaid reform proposal, then the following features would need to be developed:

- **Program Structure and Entitlement.** An important feature in this type of Medicaid reform proposal is identifying those individuals, if any, who would maintain their entitlement to Medicaid. Using current federal Medicaid data to identify the number of people in mandatory versus optional groups and the expenditures associated with these groups is not a straight forward task. MSIS allows for access to far more program detail regarding beneficiary counts and expenditures than was available previously. However, the unit of analysis available on these files collapses eligibility groups and benefit expenditure detail in ways that make it very difficult, if not impossible, to accurately determine how many individuals might be affected by different policy options or what the fiscal impact might be.
- **Allotment Formula.** The Bush Administration's proposal does not provide information on whether spending for mandatory services for mandatory beneficiaries would be reimbursed under the current system (i.e., federal reimbursement based on the state's actual expenditures for services based on a specific matching rate) or be combined with optional spending under the proposed, capped federal allotments. If these allotments include only optional services, determining the amount of the allotment for each state would be a challenge. If mandatory spending is part of the capped allotments, states might have to modify the amount of funding available for optional beneficiaries and optional services if mandatory spending changed.
- **State Maintenance-of-Effort.** As described earlier, the state maintenance- of-effort provision would require a state to continue its fiscal effort based on a particular point in time. The Bush Administration proposes that state maintenance-of-effort be based on state spending in FY2002, increased annually at a lower rate than that for the federal capped allotments. Due to the limitations in MSIS described above, if the maintenance-of-effort requires the separation of mandatory from optional Medicaid spending, federal oversight of this type of provision would be a significant challenge.

While MSIS allows for a more detailed level of analysis than was available prior to 1999, Medicaid program data at the federal level have limited value in analyzing the impact of the Administration's proposal or related proposals because a key feature of these proposals is to separate mandatory from optional spending. Medicaid program data at the state level varies in their usefulness by state, and many components are not collected across states. Given these limitations, drafting legislative language to identify mandatory populations, distributing dollars for beneficiaries across states, and understanding the effect of the Bush Administration's reform proposal on each state could be a challenging task.

Appendix 1. Selected Major Mandatory and Optional Eligibility Groups by MSIS Category

MSIS Eligibility Categories (23)		**Specific Eligibility Groups as Classified in MSIS**	
Basis of eligibility	**Maintenance assistance status[a]**	**Mandatory eligibility group** ***(total number of eligibility groups in each MSIS category)***	**Optional eligibility groups** ***(total number of eligibility groups in each MSIS category)***
Aged	Cash (C)	Individuals who receive Supplemental Security Income (SSI). (Three groups)	Individuals who receive *only* state supplementation to SSI. (One group)
	Poverty-related (C)	Low-income Medicare beneficiaries in which Medicaid pays part/all of the Medicare premium. (Three groups)	Aged up to 100% of the federal poverty level. (One group)
	Medically-needy (O)		Aged medically needy groups. (Two groups)
	Other (C)	Individuals deemed to be receiving SSI. Essential spouses. (Seven groups)	Individuals receiving home and community-based waiver services but eligible if in an institution. (Six groups)
	1115 (O)[b]		Aged individuals made eligible under a Section 1115 waiver due to poverty-related eligibility expansions. (One group)
Blind/ Disabled	Cash (C)	Individuals who receive SSI. (Three groups)	Individuals who receive *only* state supplementation to SSI. (One group)
	Poverty-related (C)	Low-income Medicare beneficiaries in which Medicaid pays part/all of the Medicare premium. (Four groups)	Individuals up to 100% of the federal poverty level. (One group)
	Medically-needy (O)		Blind/Disabled medically needy groups. (Three groups)
	Other (C)	Individuals who receive SSI and who would continue to be eligible except for cost-of-living increases to cash benefits under Title II of the *Social Security Act*. (12 groups)	Individuals receiving home and community-based waiver services who would be eligible if in an institution. (Eight groups)
	1115 (O)[b]		Individuals who are blind or have a disability who were made eligible under a Section 1115 waiver due to poverty-related eligibility expansions. (One group)
Children	Cash (M)	Low income children qualifying under the former AFDC program rules. (Three groups)	
	Poverty-related (C)	Infants and children up to age 6 with income at or below 133% federal poverty level (FPL). Children under 19 with income at or below 100% FPL. (Two groups)	Infants and children up to age 6 with income between 134% and 185% FPL. (Two groups)

MSIS Eligibility Categories (23)		Specific Eligibility Groups as Classified in MSIS	
Basis of eligibility	**Maintenance assistance status[a]**	**Mandatory eligibility group** *(total number of eligibility groups in each MSIS category)*	**Optional eligibility groups** *(total number of eligibility groups in each MSIS category)*
	Medically-needy (O)		Child-medically needy groups. (Four groups)
	Other (C)	Children in families receiving up to 12 months of extended benefits due to employment. Aliens receiving emergency services. (Six groups)	Individuals who meet the income and resource requirement for the former AFDC program. Children who would be eligible if work-related child care costs were paid from earnings. "Ribicoff kids." Individuals covered through HCB waivers. (Eight groups)
	1115 (O)[b]		Children made eligible under a Section 1115 waiver due to poverty-related eligibility expansions. (One group)
Adult	Cash (M)	Individuals eligible through Section 1931 of the Social Security Act. Other eligible adults such as pregnant women with no other eligible children and child-less adults. AFDC-related groups. (Three groups)	
	Poverty-related (C)	Certain pregnant women. (One group)	Women after the pregnancy with family income below 185% FPL. Caretaker relatives and pregnant women made eligible more liberal income and resource requirements of Section 1902(r)(2). (Two groups)
	Medically-needy (O)		Adult medically needy groups. (Three groups)
	Other (C)	Families receiving up to 12 months of extended benefits due to employment. Women where eligible based on pregnancy status. Aliens receiving emergency services. (Six groups)	Individuals who meet the income and resource requirement for the former AFDC program. Children who would be eligible if work-related child care costs were paid from earnings. (Eight groups)
	1115 (O)[b]		Caretaker relatives and pregnant woman made eligible under a Section 1115 waiver due to poverty-level-related eligibility expansions. (One group)
Unemployed parent- child	Categorically needy-cash/Section 1931 (M)	Adults in unemployed parent program. Certain children regularly attending school. (Two groups)	
Unemployed parent-adult	Categorically needy-cash Section 1931 (M)	Certain adults in adult-only units. (Three groups)	

MSIS Eligibility Categories (23)		Specific Eligibility Groups as Classified in MSIS	
Basis of eligibility	**Maintenance assistance status[a]**	**Mandatory eligibility group** ***(total number of eligibility groups in each MSIS category)***	**Optional eligibility groups** ***(total number of eligibility groups in each MSIS category)***
Foster children	Other (C)	Children for whom the state makes adoption assistance or foster care payments under Title IV-E. (One group)	Special needs children covered under adoption assistance or foster care which does not involve Title IV-E. (One group)

Source: CRS analysis of Medicaid Statute and Regulations.

[a] In the parentheses, M= All mandatory groups, O=All optional groups, C= Combination of both mandatory and optional groups.

[b] The MSIS 1115 MAS category is defined as including counts of individuals participating in a demonstration waiver as a result of an eligibility expansion (i.e., to individuals that would not otherwise be eligible for Medicaid), therefore all individuals in these groups would be considered optional eligibles.

Appendix 2. Mandatory and Optional Services as Classified in MSIS by Eligibility Group

MSIS service category (29)	Categorically needy[a,b,c]	Medically needy	Notes
Inpatient hospital	M	C	For medically needy group, hospital services are mandatory if pregnancy-related.
Mental health facility: Individuals under age 21	O	O[d]	
Mental health facility: Individuals over age 65	O	O[d]	
Nursing facility services	C	O[d]	For categorically needy groups, nursing facility services for individuals over the age of 21 are mandatory unless the individual is a resident of an institution for mental disease (IMD); for individuals under age 21, this service is optional. For all medically needy individuals, this service is optional subject to table note *d*.
Intermediate Care Facilities for Individuals with Mental Retardation (ICF/MR)	O	O[d]	
Physician's services	M	O[d]	
Outpatient hospital	M	O[d]	
Prescribed drugs	O	O[d]	
Dental	C	O[d]	For categorically needy groups, medical and surgical services of a dentist are mandatory; all other dental services are optional.
Other licensed practitioners	O	O[d]	
Clinic services	O	O[d]	
Lab and X-ray	M	O[d]	
Sterilizations	M	O[d]	
Home health services	C	C	This service is mandatory for all individuals who are entitled to nursing facility services in that state and optional for all others. Within home health services, nursing services, home health aide and medical equipment are required. Therapies (physical, occupational, etc.) are optional.
Personal care services	O	O	
Targeted case management	O	O	
Rehabilitative services	O	O[d]	
Therapies	O	O[d]	

MSIS service category (29)	Categorically needy[a,b,c]	Medically needy	Notes
Hospice	O	O	
Nurse midwife	M	O[d]	
Nurse practitioner	C	O	For categorically needy groups, certified pediatric and family nurse practitioner services are mandatory. Services of all other types of nurse practitioner are optional.
Private duty nursing	O	O[d]	
Religious non-medical health care institution	O	O	
Transportation	O	O	Although coverage for transportation is an optional Medicaid service, states are required to pay for transportation for medical appointments either through services or administration funds.
Abortions	M	O[d]	Considered as a physicians' services so long as in accordance with federal payment restrictions.
Other services	C	O[d]	Services identified in the MSIS definition are optional, but it includes a clause that this category may also include other services.
Health Maintenance Organization (HMO) or Health Insuring Organization (HIO)	C	C	Covered services are specified in the state's contract with the organization and may include both mandatory and optional services.
Prepaid Health Plan	C	C	Covered services are specified in the state's contract with the organization and may include both mandatory and optional services.
Primary Care Case Management (PCCM)	O	O	

Source: CRS analysis of Medicaid statute and regulations.

[a] M= Mandatory service; O= Optional service, C= Combination of both mandatory and optional features.

[b] Analysis of mandatory versus optional services does not apply to following eligibility groups who are entitled to a different set of services: (1) low-income Medicare beneficiaries who are only entitled to Medicare cost-sharing; (2) Qualified aliens who receive only emergency care; (3) Low-income pregnant women (not otherwise eligible for Medicaid) who receive just pregnancy-related services; (4) Children who are entitled to services under the EPSDT program; and (5) Individuals with tuberculosis (not otherwise eligible for Medicaid) who receive only tuberculosis-related services.

[c] Categorically needy includes all cash, poverty-related and other categories identified under the MSIS Maintenance Assistance Status column on **Appendix 1** and includes both mandatory and optional Medicaid eligibility groups.

[d] If a state has chosen to provide coverage for medically needy persons in institutions for mental disease or an intermediate care facility for individuals with mental retardation, the state is required to cover either most of the mandatory services, or alternatively, any seven of services listed in Medicaid law including both mandatory and optional services.

Appendix 3. Excerpt from Oklahoma's Analysis of Mandatory Versus Optional Populations

	Aged, blind, disabled and categorically needy and public assistance < age 1	Aged, blind, disabled and categorically needy and public assistance age 1 — 5	Aged, blind, disabled and categorically needy and public assistance age 6 — 18	Aged, blind, disabled and categorically needy and public assistance age 19 — 64	Aged, blind, disabled and categorically needy and public assistance age 65+	Aged, blind, disabled and categorically needy and public assistance Total	Other eligibility groups
Service Description	< 58%FPL	< 58% FPL	< 58% FPL	< 58% FPL	< 58% FPL		In addition to the six categories displayed here, Oklahoma used an additional 67 eligibility categories in its analysis.
Inpatient hospital general	$ 897,046	$1,916,956	$6,284,594	$29,074,272	$1,065,301	$39,238,169	
Inpatient hospital behavioral health	-	$ 311,835	2,782,815	27,510	159,025	3,281,185	
Inpatient hospital group practice	-	-	-	-	-	-	
Outpatient hospital	$ 33,425	282,429	1,215,351	5,403,036	190,548	7,124,788	
Skilled nursing	-	-	-		-	-	
ICF	-	-	-	-	-	-	
ICF/MR	-	-	-	-	-	-	
Home health	3,827	21,540	33,940	270,578	32,621	362,506	
Physician	111,897	479,349	1,796,384		344,825	11,554,452	
Clinic physician	-	-	-		-	-	
Clinic rural health	(60)	728	5,156	29,911	2,740	38,475	
Clinic	2,076	15,386	10,640	2,981	-	31,084	
Clinic speech and hearing	54	2,976	1,799	-	-	4,830	
Clinic free-standing ambulatory surgery center	267	5,601	8,759	115,459	4,930	135,016	
Clinic free-standing dialysis center	-	-	52,152	925,176	39,455	1,016,783	
Clinic early intervention services	58,782	241,345	-	-	-	300,128	
Clinic federally qualified health centers	173	882	19,547	245,771	8,542	274,916	
Clinic group practice	-				-	-	
Lab and X-ray	875	12,637	40,588	190,236	10,604	254,940	
Transportation	11,230	35,354	127,571	24,630	15,339	914,124	
Rx	192,341	2,051,113	11,389,537	49,719,527	25,832,013	89,184,531	
Other service categories. In addition to the 21 service categories shown here, Oklahoma used an additional 29 service categories in its analysis.							

Source: Oklahoma Health Care Authority; Medicaid Program FY2003 Budget Request, Mandatory Versus Optional Programs, OCHA Medical Only. Each cell from this excerpt of all Medicaid service spending contains expenditures that can be identified as either mandatory or optional based on the

intersection of the individual's eligibility status and the service. The state then grouped each of the cells associated with mandatory spending for mandatory groups and optional spending for mandatory groups; as well as mandatory spending for optional groups and optional spending for optional groups to generate an analysis of mandatory versus optional spending for its FY2003 budget request.