MACPAC

Congressionally Requested Study on Mandatory/Optional Benefits and Populations

Review of Methods, Limitations, and Policy Issues

Medicaid and CHIP Payment and Access Commission

Martha Heberlein

Overview

- Congressional request
- Prior analysis
- Methodology and limitations
- Key assumptions
- Policy issues

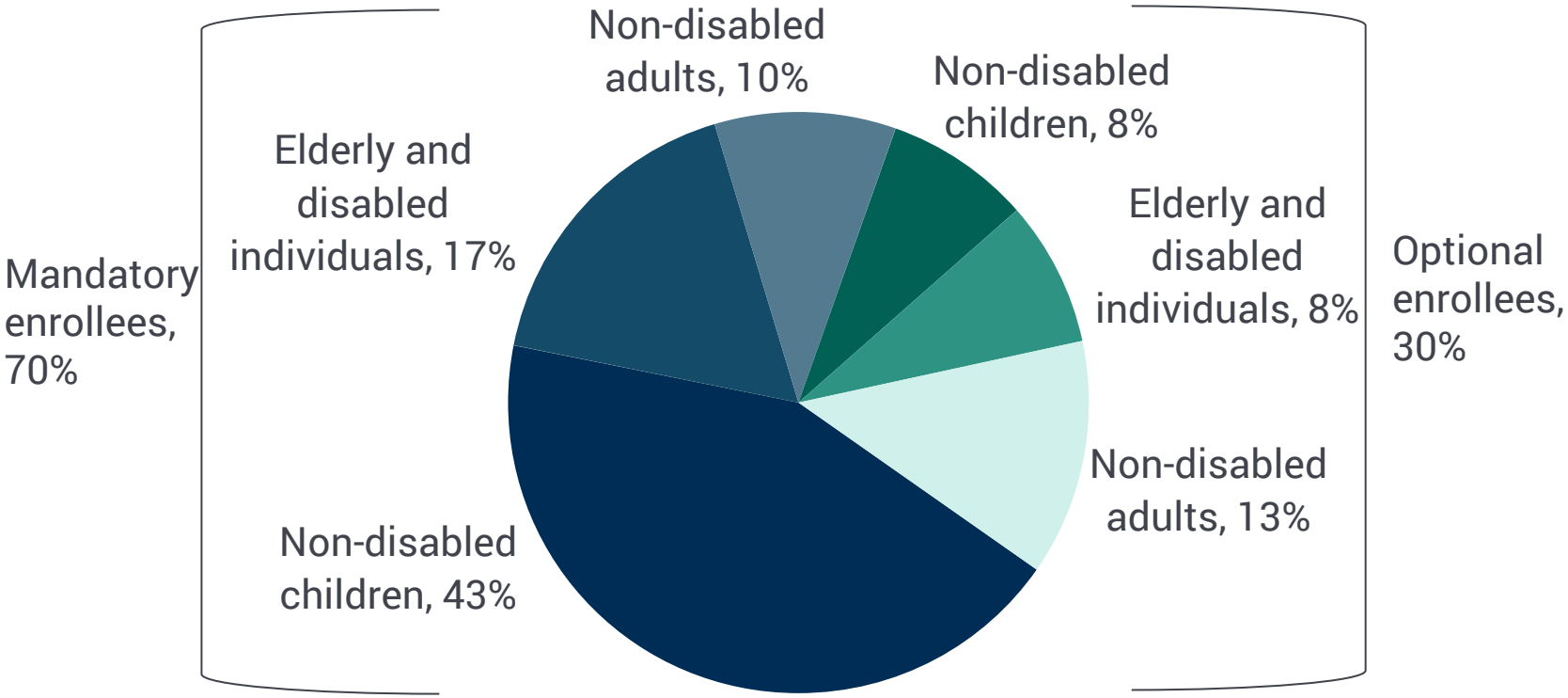
Congressional Request

- January 2017 letter from our committees of jurisdiction requested the following:
  - the intersection of coverage of optional eligibility groups and the receipt of optional benefits for those groups;
  - number of people covered by each state who qualify through an optional eligibility category; and
  - the federal and state expenditures for each category of optional populations and optional benefits

Prior Analysis

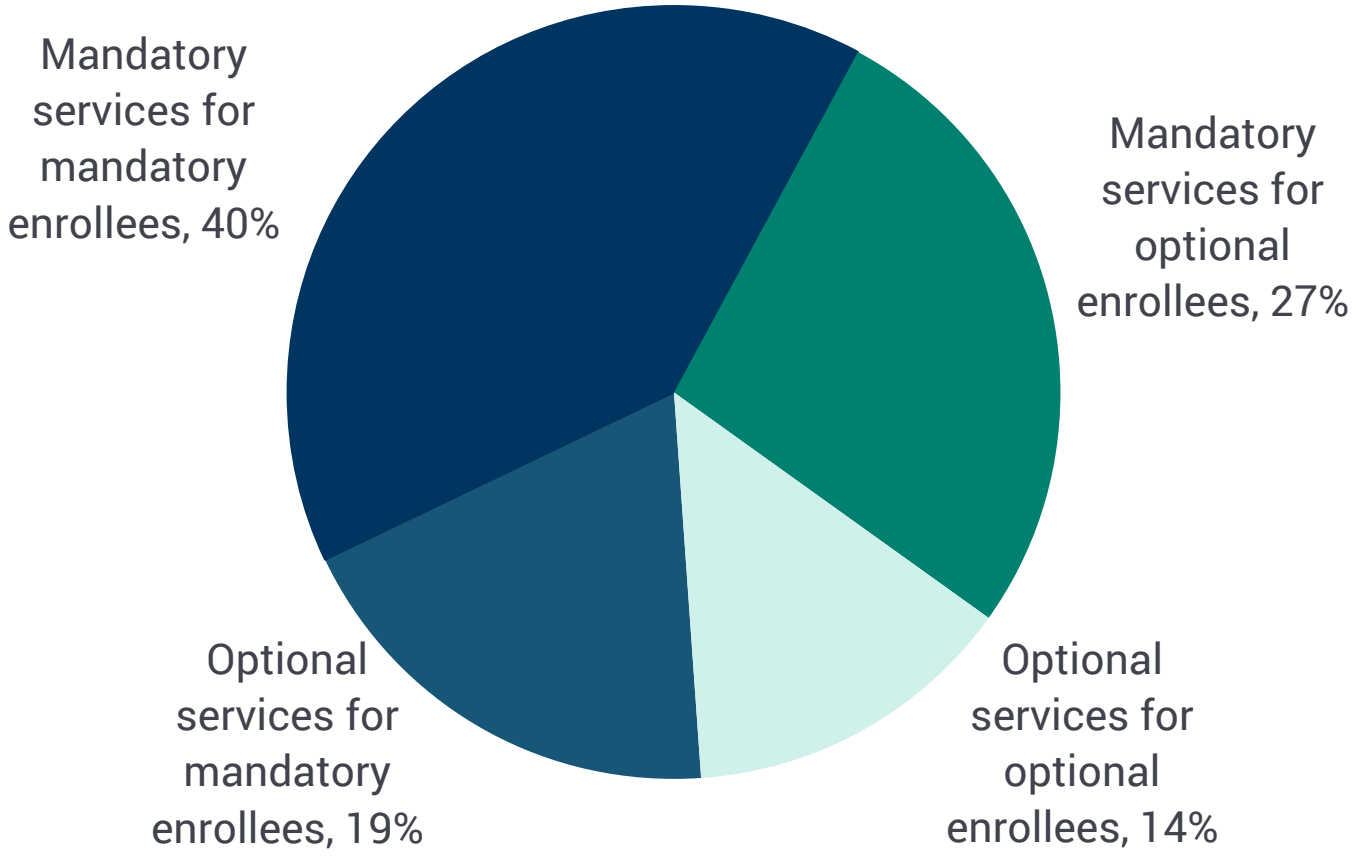
- Kaiser Commission on Medicaid and the Uninsured and Urban Institute
  - Published in 2012 using FY 2007 Medicaid Statistical Information System (MSIS) data and CMS-64 reports
  - Reported the proportion of enrollment and spending attributable to mandatory and optional beneficiaries and services

Medicaid Enrollment, by Eligibility Pathway and Group, FY 2007



Note: Non-disabled adult category includes pregnant women and individuals enrolled in family planning waivers.
Source: Courtot, et al. 2012.

Medicaid Expenditures, by Eligibility Group and Type of Service, FY 2007



Source: Courtot, et al. 2012.

Methodology

- MSIS and CMS-64 data for FY 2013
- Classify enrollees based on their Medicaid Assistance Status/Basis of Eligibility (MAS/BOE) designation
- Classify services as mandatory or optional using the MSIS type of service (TOS) code
- Spending that is not directly related to services will be classified separately using CMS-64 data

Key Assumptions: Eligibility

- It is not possible to associate an individual with a specific eligibility pathway under a MAS/BOE, we must make assumptions about the distribution of mandatory and optional enrollees
- Sensitivity analysis:
  - Use T-MSIS data from about 20 states where it is available to test our assumptions

Key Assumptions: Managed Care

- Because the amounts paid for specific services are not available, we assume that the distribution of managed care spending on mandatory and optional services mirrors that in fee-for-service arrangements
- Alternatives or sensitivity analyses:
  - Apply the mandatory and optional shares in FFS by population
  - Apply the distribution of spending from predominantly FFS states instead of using the national shares
  - Establish a threshold for states that operate predominantly in managed care to determine which distribution to apply

Key Assumptions: MLTSS

- Spending on managed long-term services and supports (MLTSS) represents a small, but growing share (15 percent in FY 2014) of LTSS spending and overall managed care spending (12.5 percent in FY 2014)
- We assume all managed care spending is on acute services, despite these shifts in MLTSS
- Alternatives or sensitivity analyses:
  - In states that have MLTSS statewide or a large proportion of MLTSS, we could apply different distributions of mandatory and optional spending to acute care and LTSS

Policy Issues

- How does categorizing Medicaid enrollment and spending as either mandatory or optional help us determine who is most in need and assess the value of different types of services?
- What do current data on mandatory and optional enrollment and spending tell us about the choices that states are currently making?

Eligibility Groups

Mandatory Eligibility Groups	Optional Eligibility Groups
• Poverty-related infants, children, and pregnant women and deemed newborns • Low-income families (with income below the state's 1996 AFDC limit) • Families receiving transitional medical assistance • Adults without dependent children • Children with Title IV-E adoption assistance, foster care, or guardianship care and children aging out of foster care • Elderly and disabled individuals receiving SSI and aged, blind, and disabled individuals in 209(b) states • Certain working individuals with disabilities • Certain Medicare enrollees (e.g., QMBs, SLMBs, QIs)	• Low-income children, pregnant women, and parents above federal minimum standards • Elderly and disabled individuals with incomes above federal minimum standards or who receive services in the community • Medically needy • HCBS and Section 1115 waiver enrollees • Enrollees covered only for specific diseases or services, such as breast and cervical cancer or family planning services • Qualified immigrants residing in the country for at least five years who would otherwise be eligible for Medicaid, but for their immigration status

Benefits

Mandatory Benefits	Optional Benefits
• Inpatient hospital • Outpatient hospital • Rural health clinic • Federally qualified health center • Laboratory and X-ray • Nursing facility services (age > 21 years old) • Family planning services and supplies • Tobacco cessation counseling and prescription drugs for pregnant women • Physician services • Nurse midwife services • Nurse practitioner services • Freestanding birth centers • Home health • Medical transportation • Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services	• Prescription drugs • Dental services for adults • Intermediate care facilities for individuals with intellectual disabilities • Clinic services • Occupational therapy • Physical therapy • Speech, hearing, and language disorder services • Targeted case management • Prosthetic devices • Hospice services • Eyeglasses • Dentures • Other diagnostic, screening, preventive, and rehabilitative services • Respiratory care services • Home and community based services (§1915(i)) • Community supported living arrangements • Personal care services • Primary care case management • Health homes for enrollees with chronic conditions • Other licensed practitioners' services • Services for certain diseases (tuberculosis, sickle cell disease) • Chiropractic services

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