March 6, 2026

Mandatory and Optional Enrollees and Services in Medicaid

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Medicaid and CHIP Payment and Access Commission

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Overview

- Background
- Methodology
- Results
  - Mandatory and optional enrollment
  - Mandatory and optional spending
- Key takeaways
- Next steps

Background

Background

- Federal statute and regulations mandate coverage of certain populations and benefits and define optional populations and services states may cover in their Medicaid programs
- States use federal authorities, such as state plan amendments or waiver authorities, to design their programs and obtain approval from the Centers for Medicare & Medicaid Services (CMS) for populations and benefits they propose to cover
  - States design their programs within federal requirements to meet specific needs and priorities
  - States can request CMS approval for program changes at any time

Medicaid Eligibility

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 • 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[1] • Certain working individuals with disabilities • Certain low-income Medicare enrollees (e.g., QMBs, SLMBs, QIs)	• Low-income children, pregnant enrollees, and parents above federal minimum standards • Elderly and disable individuals with incomes above federal minimum standards or who receive long-term services and supports in the community • Medically needy • Adults without dependent children[2] • HCBS and Section 1115 waiver enrollees • Enrollees covered only for specific diseases or services, such as breast and cervical cancer or family planning services

Notes: AFDC is Aid to Families with Dependent Children. SSI is Supplemental Security Income. QMB is Qualified Medicare Beneficiary. SLMB is Specified Low-Income Medicare Beneficiary. QI is Qualifying Individual. HCBS is home- and community-based services. AFDC is the cash assistance program that was replaced by Temporary Assistance to Needy Families (TANF) by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA, P.L. 104-193).

[1] Section 209(b) states can establish more restrictive criteria, both financial (such as income or assets limits) and non-financial (such as the definition of disability) criteria for determining eligibility than the SSI program. However, these criteria may not be more restrictive than those in effect in the state on January 1, 1972.

[2] Although this group is defined by statute as mandatory, the U.S. Supreme Court ruling in *National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566 (2012), effectively made coverage of the group optional for states.

Source: MACPAC, 2026, analysis of the Social Security Act and the *Code of Federal Regulations*.

Medicaid Benefits

- States design their Medicaid benefit package within federal guidelines to cover mandatory and optional services
- Certain benefits are mandatory, including inpatient services, physicians services, family planning, nursing facilities, federally qualified health centers (FQHCs), rural health centers, and medical transportation
  - Medically necessary services for children under age 21 in Medicaid are considered mandatory through the early and periodic screening, diagnostic, and treatment (EPSDT) benefit
- Many benefits are optional, including prescription drugs, clinic services, dental services, intermediate care facilities for individuals with intellectual disabilities, and home- and community-based services (HCBS)

Methodology

Methodology

- Analyzed fiscal year (FY) 2023 data from Transformed Medicaid Statistical Information System (T-MSIS) and CMS-64 net financial management report
  - This analysis updates MACPAC's 2017 study, which used FY 2013 Medicaid Statistical Information System (MSIS) data
- Updated and improved the methodology to assign mandatory and optional enrollment and spending
  - Adjusted T-MSIS spending to match benefit spending reported in CMS-64
  - Used age, eligibility group, dual eligible status, and benefits code to classify enrollees as mandatory or optional
  - Classified claims into MACStats service categories (i.e., acute hospital, institutional LTSS, non-institutional LTSS, drugs, acute other, and managed care) and created subcategories for mandatory and optional assignment
  - Applied distribution of mandatory and optional spending from encounter data to capitation payments

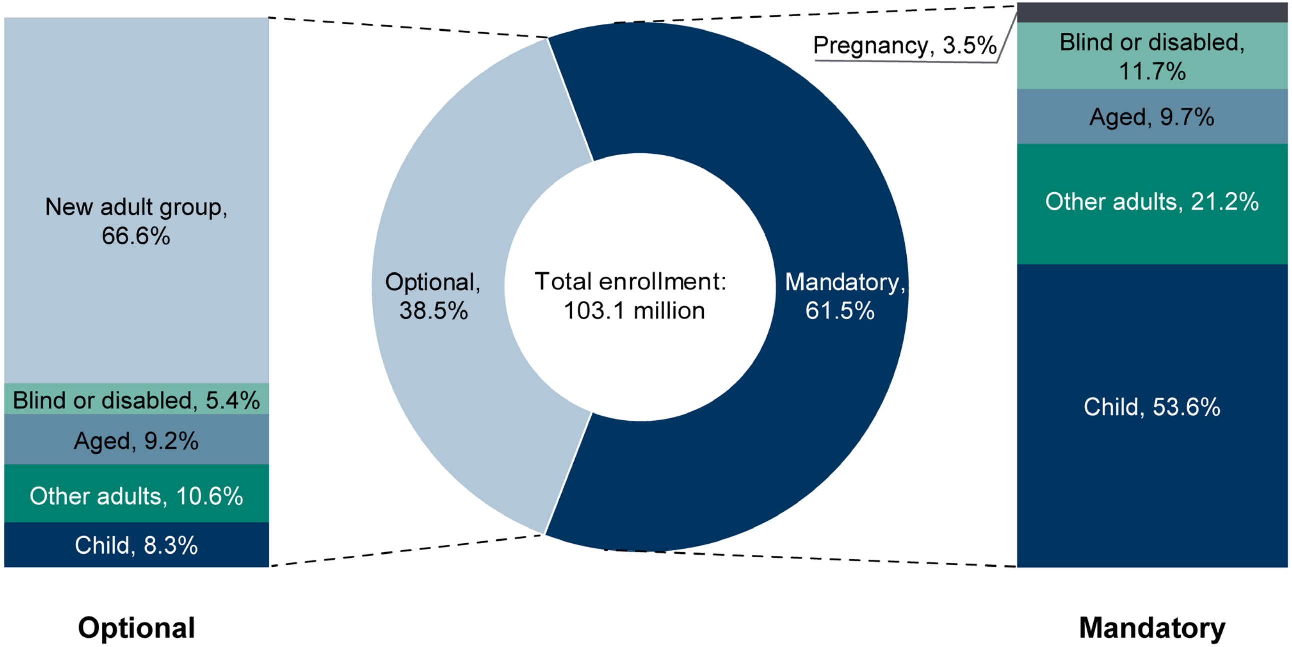
Data limitations

- Findings from this analysis are not directly comparable to previous analysis
- T-MSIS does not have a reliable data element that specifies mandatory or optional services
- Because service types in T-MSIS and CMS-64 data do not align, services were aggregated into broad categories for comparability
  - CMS-64 adjustment factor was applied at broad service category levels
- T-MSIS encounter data may exclude certain managed care payments
  - This analysis does not account for how these payments may be allocated differently across mandatory and optional services

Mandatory and Optional Enrollment

MACPAC

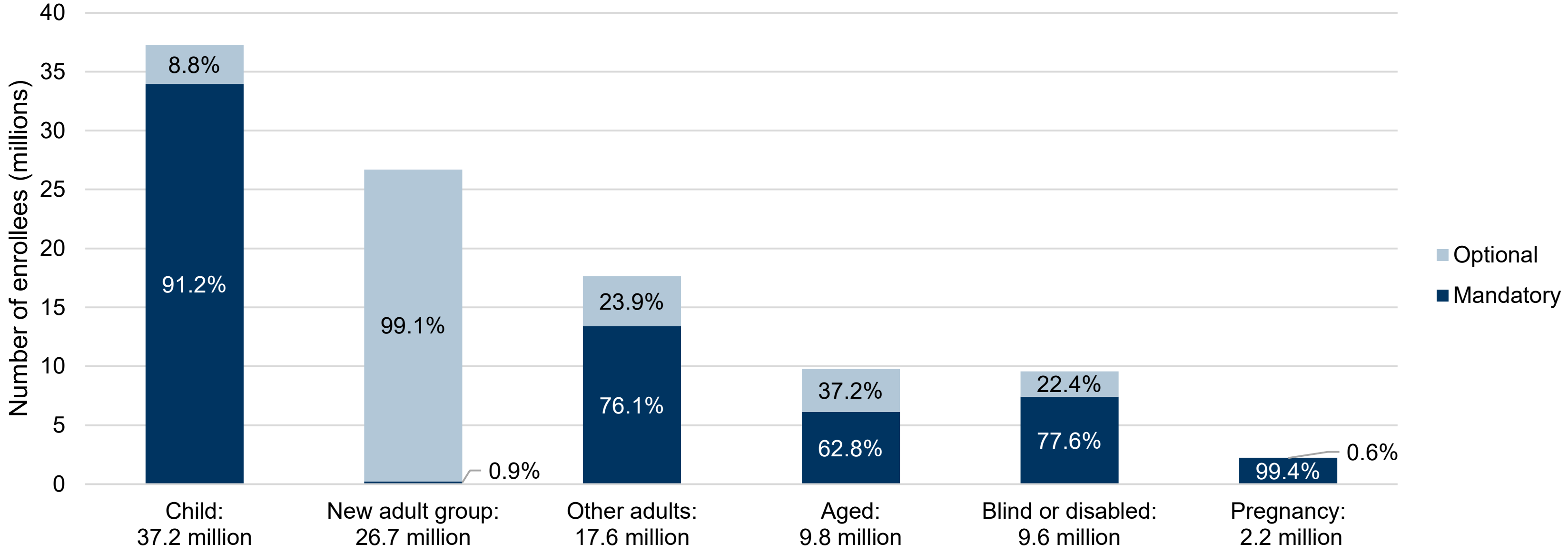
Distribution of Mandatory and Optional Enrollment, Total and by Eligibility Group, FY 2023



Notes: FY is fiscal year. The new adult group includes enrollees who are eligible under Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act. Enrollment numbers generally include individuals ever enrolled in Medicaid-financed coverage during the year, even if for a single month. Excludes individuals enrolled in CHIP and enrollees in the territories. Excludes approximately 6,000 individuals who cannot be classified as mandatory or optional due to missing age. The enrollment counts shown here may include duplicates of individuals who were enrolled in more than one state during the year. Enrollees in the new adult group represented less than one percent of mandatory enrollees and pregnant-eligible enrollees represented less than 0.5 percent of optional enrollees; neither group is shown in the figure.

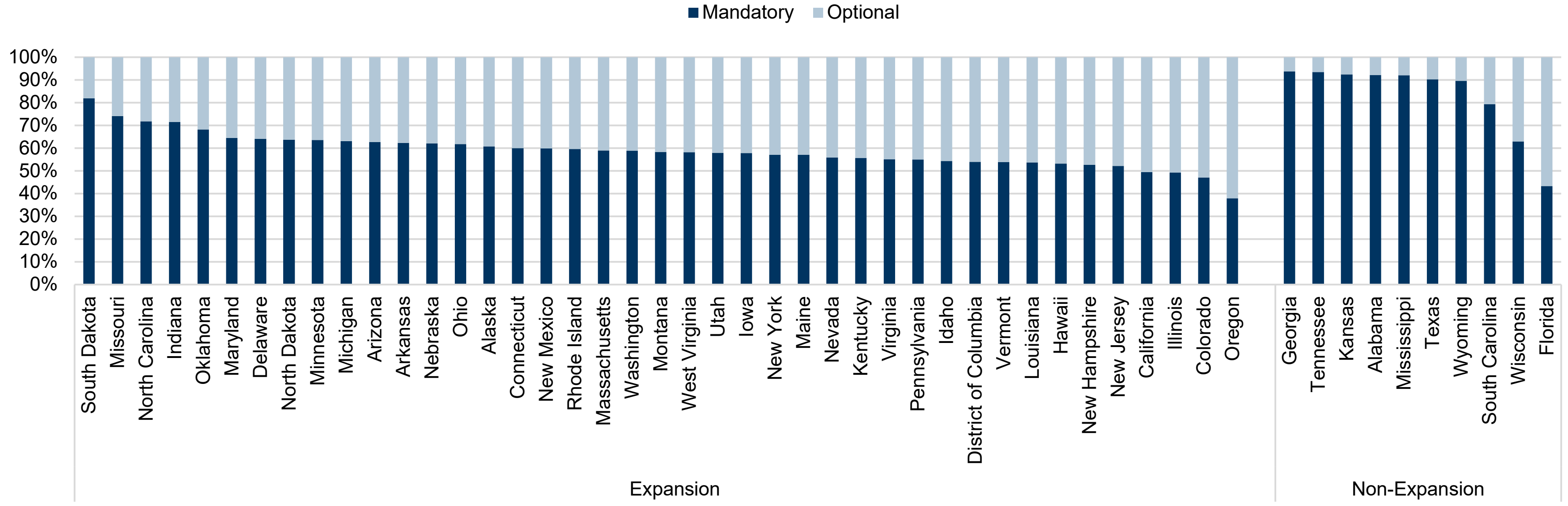
Source: MACPAC, 2025, analysis of Transformed Medicaid Statistical Information System (T-MSIS) data.

Distribution of Mandatory and Optional Medicaid Enrollment, by Eligibility Group, FY 2023



Notes: FY is fiscal year. The new adult group includes enrollees who are eligible under Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (the Act). Enrollment numbers generally include individuals ever enrolled in Medicaid-financed coverage during the year, even if for a single month. However, in the event individuals were also enrolled in CHIP-financed Medicaid coverage (i.e., Medicaid-expansion CHIP) during the year, they are excluded if their most recent enrollment month was in Medicaid-expansion CHIP. Excludes individuals enrolled only in Medicaid-expansion CHIP during the year and enrollees in the territories. Excludes approximately 6,000 individuals who cannot be classified as mandatory or optional due to missing age. MACPAC's analysis uses state-specific identification numbers to identify Medicaid enrollees. The enrollment counts shown here may include duplicates of individuals who were enrolled in more than one state during the year.
Source: MACPAC, 2025, analysis of Transformed Medicaid Statistical Information System (T-MSIS) data.

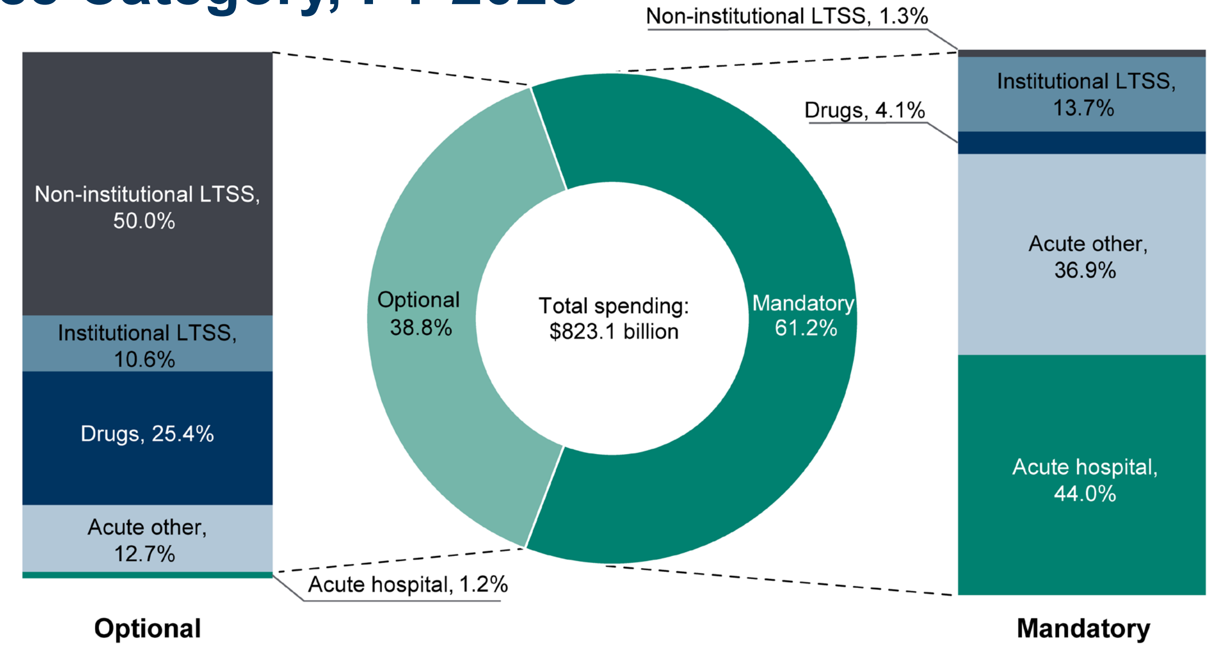
Distribution of Mandatory and Optional Medicaid Enrollment, by State and Expansion Status, FY 2023



Notes: FY is fiscal year. The new adult group includes enrollees who are eligible under Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (the Act). Enrollment numbers generally include individuals ever enrolled in Medicaid-financed coverage during the year, even if for a single month. However, in the event individuals were also enrolled in CHIP-financed Medicaid coverage (i.e., Medicaid-expansion CHIP) during the year, they are excluded if their most recent enrollment month was in Medicaid-expansion CHIP. Excludes individuals enrolled only in Medicaid-expansion CHIP during the year and enrollees in the territories. Excludes approximately 6,000 individuals who cannot be classified as mandatory or optional due to missing age. MACPAC's analysis uses state-specific identification numbers to identify Medicaid enrollees. The enrollment counts shown here may include duplicates of individuals who were enrolled in more than one state during the year.
Source: MACPAC, 2025, analysis of Transformed Medicaid Statistical Information System (T-MSIS) data.

Mandatory and Optional Spending

Distribution of Mandatory and Optional Spending, Total and by Service Category, FY 2023

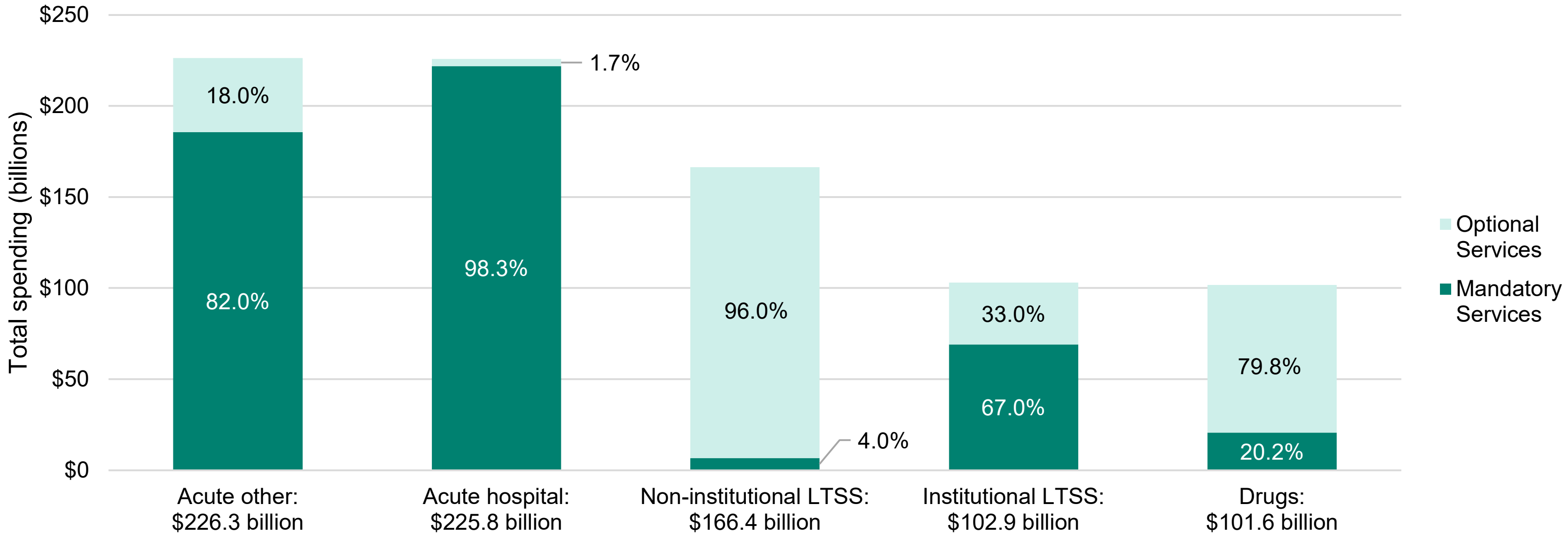


Notes: FY is fiscal year. LTSS is long-term services and supports. Includes federal and state funds. Excludes spending for administration, the territories, and Medicaid-expansion CHIP enrollees. Benefit spending from Transformed Medicaid Statistical Information System (T-MSIS) data has been adjusted to reflect CMS-64 totals. Spending totals exclude disproportionate share hospital (DSH) and certain incentive and uncompensated care pool payments made under waiver expenditure authority of Section 1115 of the Social Security Act. Capitation spending is classified as mandatory or optional based on the distribution of mandatory and optional spending from encounter claims, which does not account for certain spending that is not paid on a claim basis, such as drug rebates or state directed payments made on a lump sum basis. As a result, our methodology does not account for how these payments may be allocated differently across mandatory and optional services and populations.

Source: MACPAC, 2025, analysis of T-MSIS data and CMS-64 net financial management report.

MACPAC

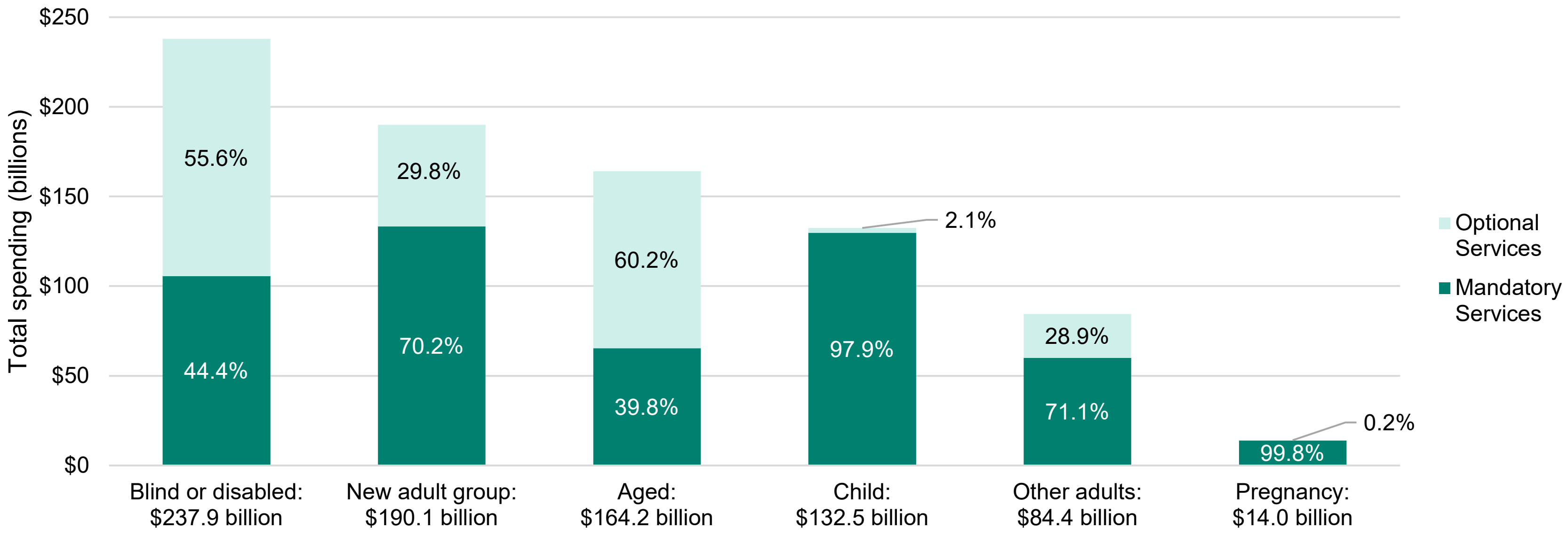
Medicaid Spending on Mandatory and Optional Services, by Service Category, FY 2023



Notes: FY is fiscal year. LTSS is long-term services and supports. Includes federal and state funds. Excludes spending for administration, the territories, and Medicaid-expansion CHIP enrollees. Benefit spending from Transformed Medicaid Statistical Information System (T-MSIS) data has been adjusted to reflect CMS-64 totals. Spending totals exclude disproportionate share hospital (DSH) and certain incentive and uncompensated care pool payments made under waiver expenditure authority of Section 1115 of the Social Security Act. Capitation spending is classified as mandatory or optional based on the distribution of mandatory and optional spending from encounter claims, which does not account for certain spending that is not paid on a claim basis, such as drug rebates or state directed payments made on a lump sum basis. As a result, our methodology does not account for how these payments may be allocated differently across mandatory and optional services and populations.

Source: MACPAC, 2025, analysis of T-MSIS data and CMS-64 net financial management report.

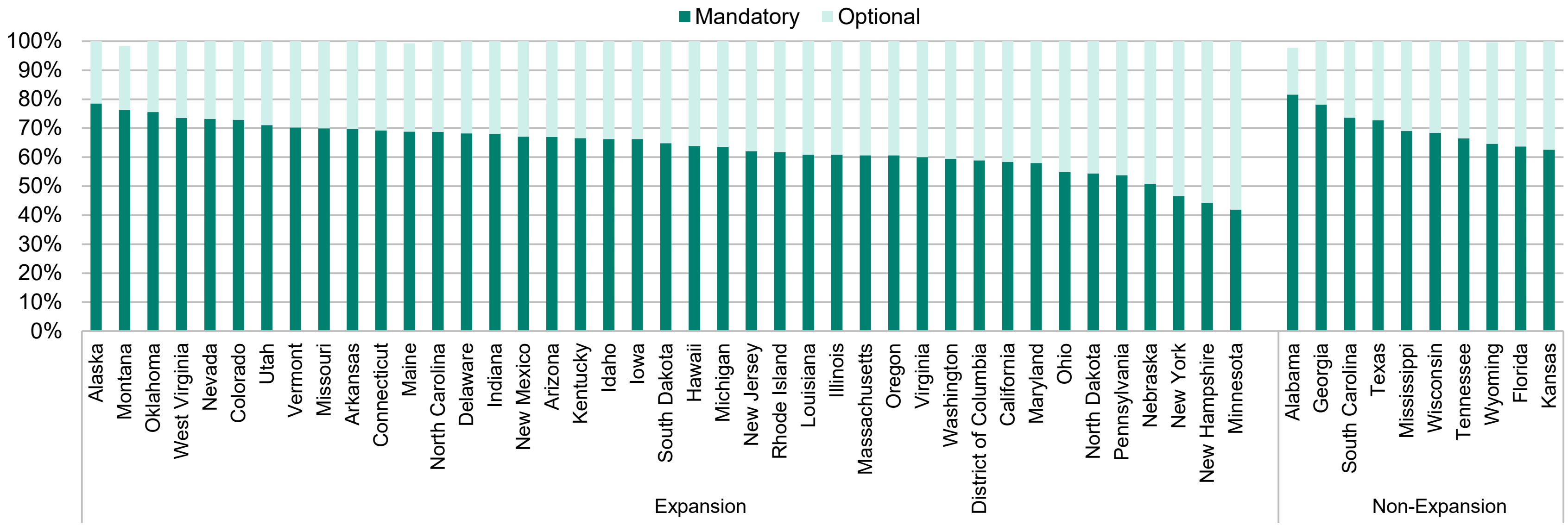
Medicaid Spending on Mandatory and Optional Services, by Eligibility Group, FY 2023



Notes: FY is fiscal year. Includes federal and state funds. Excludes spending for administration, the territories, and Medicaid-expansion CHIP enrollees. Children and adults under age 65 who qualify for Medicaid on the basis of disability are included in the disabled category. Individuals age 65 and older eligible through an aged, blind, or disabled pathway are included in the aged category. Benefit spending from Transformed Medicaid Statistical Information System (T-MSIS) data has been adjusted to reflect CMS-64 totals. Spending totals exclude disproportionate share hospital (DSH) and certain incentive and uncompensated care pool payments made under waiver expenditure authority of Section 1115 of the Social Security Act. Capitation spending is classified as mandatory or optional based on the distribution of mandatory and optional spending from encounter claims, which does not account for certain spending that is not paid on a claim basis, such as drug rebates or state directed payments made on a lump sum basis. As a result, our methodology does not account for how these payments may be allocated differently across mandatory and optional services and populations.

Source: MACPAC, 2025, analysis of T-MSIS data and CMS-64 net financial management report.

Distribution of Mandatory and Optional Medicaid Spending, by State and Expansion Status, FY 2023



Notes: FY is fiscal year. Includes federal and state funds. Excludes spending for administration, the territories, and Medicaid-expansion CHIP enrollees. Benefit spending from Transformed Medicaid Statistical Information System (T-MSIS) data has been adjusted to reflect CMS-64 totals. Spending totals exclude disproportionate share hospital (DSH) and certain incentive and uncompensated care pool payments made under waiver expenditure authority of Section 1115 of the Social Security Act. Capitation spending is classified as mandatory or optional based on the distribution of mandatory and optional spending from encounter claims, which does not account for certain spending that is not paid on a claim basis, such as drug rebates or state directed payments made on a lump sum basis. As a result, our methodology does not account for how these payments may be allocated differently across mandatory and optional services and populations. Excludes approximately $163.3 million from Alabama, $30.5 million from Maine, $36.8 million from Montana, and $2.6 million from Wyoming because the distribution of mandatory and optional spending cannot be determined for these amounts at the state level due to the absence of encounter claims.
Source: MACPAC, 2025, analysis of T-MSIS data and CMS-64 net financial management report.

Medicaid Spending on Mandatory and Optional Populations and Services, FY 2023

Mandatory enrollment and mandatory services		Mandatory enrollment and optional services		Optional enrollment and mandatory services		Optional enrollment and optional services	
Dollars	Percent	Dollars	Percent	Dollars	Percent	Dollars	Percent
$280.9	34.1%	$168.5	20.5%	$222.7	27.1%	$150.9	18.3%

Notes: FY is fiscal year. Includes federal and state funds. Excludes spending for administration, the territories, and Medicaid-expansion CHIP enrollees. Benefit spending from Transformed Medicaid Statistical Information System (T-MSIS) data has been adjusted to reflect CMS-64 totals. Spending totals exclude disproportionate share hospital (DSH) and certain incentive and uncompensated care pool payments made under waiver expenditure authority of Section 1115 of the Social Security Act. Capitation spending is classified as mandatory or optional based on the distribution of mandatory and optional spending from encounter claims, which does not account for certain spending that is not paid on a claim basis, such as drug rebates or state directed payments made on a lump sum basis. As a result, our methodology does not account for how these payments may be allocated differently across mandatory and optional services and populations.
Source: MACPAC, 2025, analysis of T-MSIS data and CMS-64 net financial management report.

Key Takeaways

Key Takeaways

- In FY 2023, most spending and enrollment in Medicaid was for mandatory populations and benefits
- Mandatory eligibility groups accounted for the majority of Medicaid enrollment
  - Children represented the largest share of mandatory enrollees (53.6 percent)
  - New adult group represented the largest share of optional enrollees (66.6 percent)
- Most spending was for mandatory services
  - Acute hospital services (44.0 percent) and other acute services (36.9 percent) accounted for the largest share of mandatory spending
  - Non-institutional LTSS (50.0 percent) and drugs (25.4 percent) represented the largest shares of optional spending

Next Steps

Next Steps

- Analysis will be published in an issue brief
- Staff welcome Commissioner questions or comments on findings presented today, specifically:
  - Are there any questions about the data or methodology?
  - Are there any additional findings from this analysis that should be included as a key takeaway?

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MARCH MEETING

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