IssueBrief

MACPAC

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Mandatory and Optional Enrollees and Services in Medicaid

Medicaid is a partnership between the federal and state governments. Federal law establishes broad requirements for the program, including mandated coverage of certain populations and benefits, and mechanisms for accountability for the use of federal dollars. Financing is shared, with the federal government matching state spending on allowable expenses. Within these statutory parameters, states make policy decisions regarding many program features, including determining which optional eligibility pathways and services to cover. They also administer the program on a day-to-day basis.

Over time, Medicaid has evolved in terms of the populations and services it covers. Originally focused on financing medical care for individuals receiving cash welfare payments, the program has expanded to cover around103 million low-income individuals in fiscal year (FY) 2023, including children and their parents, pregnant women, frail elderly individuals, people with disabilities, and adults without dependent children (Figure 2).[1] These changes reflect federal policy decisions to extend coverage to additional populations and to allow states to expand coverage to others in need. Medicaid's list of mandatory and optional benefits has also evolved, reflecting the advancement of medical care, changes in disease patterns, and a shift to provide services and supports in the community. Within the federal framework, states vary in the extent to which they have adopted eligibility pathways and optional benefits, reflecting state policy decisions related to the health needs of their residents, and the cost of paying for their care.

This issue brief is an update to the June 2017 report to Congress chapter (MACPAC 2017).

Background

Federal statute and regulations mandate the coverage of certain populations and benefits and define the optional populations and services states may cover. States make policy decisions regarding their program's parameters within these federal requirements to meet their specific needs and priorities. States use various federal authorities, such as state plan amendments or waiver authorities, to design their Medicaid programs and to obtain approval from the Centers for Medicare & Medicaid Services (CMS) for the populations and benefits they propose to cover. For example, states may expand Medicaid eligibility for a specific population by amending their state plan or they can use Section 1115 demonstration authority to design and implement approaches that differ from federal requirements. States can seek CMS approval to modify their Medicaid programs at any time, provided the proposed changes remain within the federal framework that outlines mandatory and optional components of coverage. Below, we describe the mandatory and optional eligibility pathways, and the distinction between mandatory and optional benefits.

Eligibility

Medicaid eligibility is typically defined in terms of both categorical eligibility (the populations covered) and financial eligibility (the income levels or thresholds at which individuals within these populations can be covered). In general, states must cover children and pregnant women up to specified income levels; parents with dependent children with incomes up to the state's 1996 Aid to Families with Dependent Children (AFDC) standards; individuals who are either elderly or disabled and receive Supplemental Security Income (SSI); and certain low-

income Medicare enrollees (Table 1). In some cases, states have the option to cover individuals in these groups with incomes higher than the federal minimum standard. States can also extend Medicaid to other groups of people, such as those with high medical expenses.[2] (For more detail on the federal eligibility requirements and state options, see MACPAC's fact sheet: Federal Requirements and State Options: Eligibility.)

TABLE 1. Mandatory and Optional Medicaid 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 • Children with Title IV-E adoption assistance, foster care, or guardianship care and children aging out of foster care • Elderly and individuals with disabilities 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 individuals with disabilities 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.

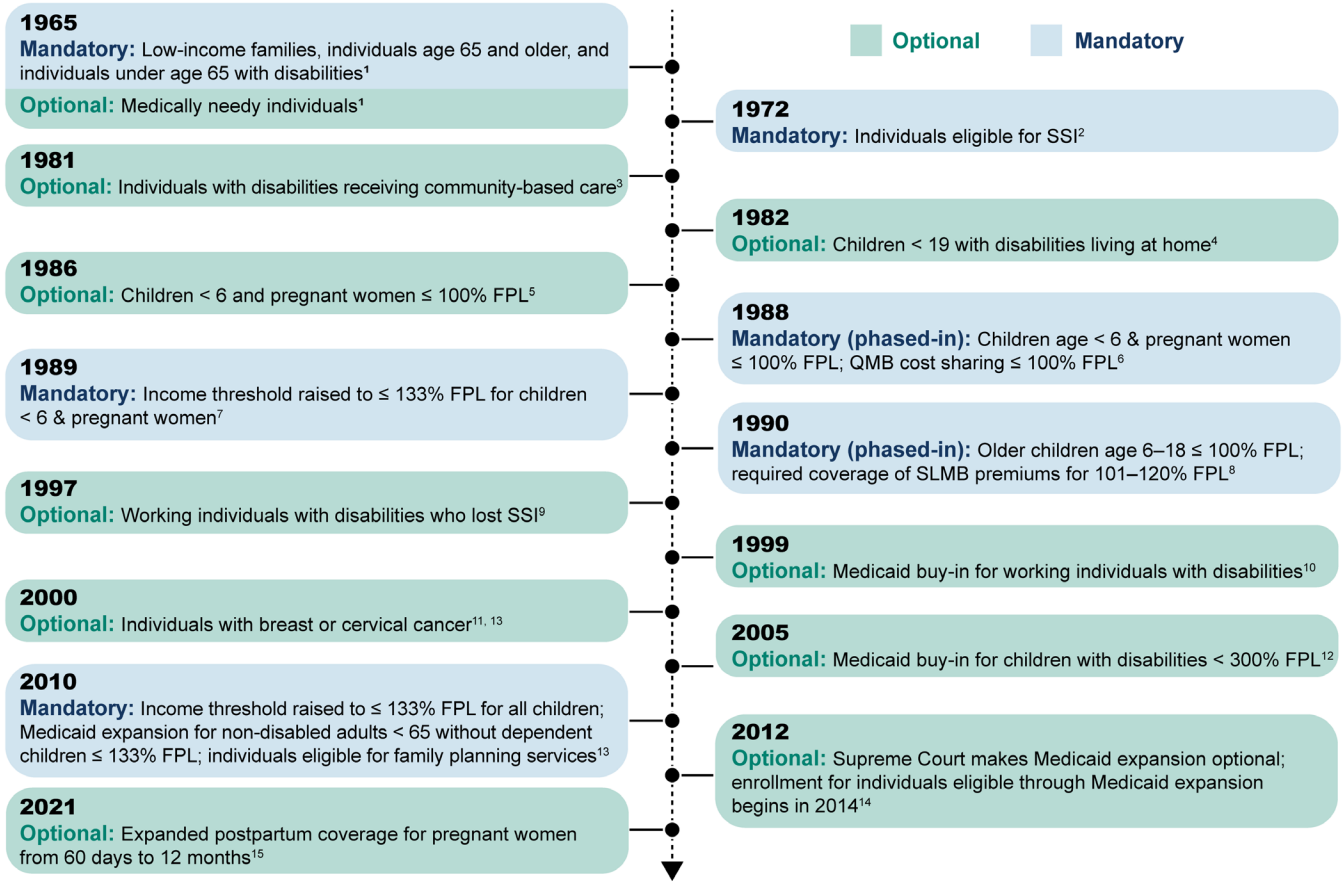
[2] Although this group is defined by statute as mandatory, the U.S. Supreme Court ruling in *National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566 (2012), effectively made coverage of the group optional for states.

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

Evolution of Medicaid eligibility. At enactment, Medicaid eligibility was limited to certain low-income groups. Over time, federal policymakers have expanded coverage to additional populations through a combination of mandatory and optional eligibility pathways (Figure 1). Initially, states were required to cover three groups of low-income individuals: families (including children, parents, and pregnant women), people age 65 and older, and people under age 65 with disabilities.[3,4] States could also choose to cover optional groups of medically needy individuals who fell within one of the population categories eligible for federal cash assistance (aged, blind or disabled, and families with dependent children) but whose higher incomes made them ineligible for such assistance.[5,6] Congress has expanded coverage by both broadening Medicaid eligibility within existing populations, such as raising income limits for children and pregnant women, and by establishing optional eligibility pathways to expand coverage to other groups, such as people with disabilities, specific health conditions, or

particular service needs. Figure 1 outlines the federal legislative milestones that have expanded Medicaid coverage of mandatory and optional groups.

FIGURE 1. Key Medicaid Eligibility Federal Legislative Milestones for Coverage of Mandatory and Optional Groups, 1965–2026



Notes: DC is District of Columbia. FPL is federal poverty level. SSI is Supplemental Security Income. QMB is Qualified Medicare Beneficiary. SLMB is Specified Low-Income Medicare Beneficiary. QI is Qualifying Individual. Medically needy individuals are those fell within one of the population categories eligible for federal cash assistance (aged, blind or disabled, and families with dependent children) but whose higher incomes made them ineligible for such assistance.

[1] Title XIX of the Social Security Act (the Act, P.L. 89-97)

[2] Social Security Amendments of 1972, P.L. 92-603

[3] These are individuals who would not otherwise be eligible or who would be eligible for Medicaid if they were in an institution. Omnibus Reconciliation Act of 1981, P.L. 97-35

[4] Tax Equity and Fiscal Responsibility Act of 1982, P.L. 97-248

[5] Omnibus Reconciliation Act of 1986, P.L. 99-509

[6] Medicare Catastrophic Coverage Act of 1988, P.L. 100-360

[7] Omnibus Reconciliation Act of 1989, P.L. 101-239

[8] Omnibus Reconciliation Act of 1990, P.L. 101-508

[9] Balanced Budget Act of 1997, P.L. 105- 33

[10] Ticket to Work and Work Incentives Improvement Act of 1999, P.L. 106-170

[11]Breast and Cervical Cancer Treatment and Prevention Act of 2000, P.L. 106-354

[12] Deficit Reduction Act of 2005, P.L. 109-171

[13] Patient Protection and Affordable Act, P.L. 111-148, as amended

[14] National Federation of Independent Business v. Sebelius, 132 S. Ct. 2566 (2012). As of February 2026, 40 states and DC have adopted Medicaid expansion (KFF 2026a).

[15] American Rescue Plan Act of 2021, P.L. 117-2 made this option available to states for five years, but the option was made permanent by the Consolidated Appropriations Act of 2022 (P.L. 117-103). As of February 2026, 48 states and DC have adopted postpartum expansion (KFF 2026b).

Source: MACPAC, 2026, analysis of applicable federal statutes.

Adoption of optional eligibility pathways among states varies considerably; for a state-by-state breakdown, see MACStats' tables for Medicaid and State Children's Health Insurance Program (CHIP) eligibility. Below, we summarize common optional pathways that states can adopt to expand Medicaid coverage to additional groups:

- **New adult.** The new adult group includes non-disabled adults without dependent children who are newly eligible for Medicaid under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) and some adults who were previously eligible in states that expanded Medicaid prior to the ACA.
- **Age and disability-related poverty level.** Under the poverty level option (§1902(a)(10)(A)(ii)(X)), states may choose to provide Medicaid coverage to individuals who are age 65 and older or have disabilities and whose income is above the SSI or Section 209(b) level but is less than or equal to the federal poverty level (FPL).[7]
- **Medically needy.** Under the medically needy option, individuals with higher incomes can spend down to the medically needy income level by deducting incurred medical expenses from the amount of income that is counted for Medicaid eligibility purposes.
- **Individuals eligible for but not receiving cash assistance.** This eligibility group covers individuals who meet the eligibility requirements of one or more cash assistance programs but do not actually receive cash assistance (§1902(a)(10)(A)(ii)(I)).
- **Individuals eligible for family planning services.** This option covers family planning and related services for non-pregnant individuals with income equal to or below the highest standard for pregnant women (1902(a)(10)(A)(ii)(XXI)). If a state chooses not to use this option, the state can use the 1115 expansion eligibility group to cover family planning services.

Benefits

States have considerable flexibility in the design of the benefit package for their Medicaid enrollees within federal guidelines. Certain benefits, such as inpatient and outpatient hospital services, physician services, and services at rural health clinics and federally qualified health centers (FQHCs) are mandatory under federal law, but many benefits may be provided at the discretion of the state (Table 2). States also have the flexibility to design the scope of their benefits and how they are administered, including the delivery system and utilization management techniques, such as defining medical necessity. (For more detail on the federal benefit requirements and state options, see MACPAC's factsheet: Federal Requirements and State Options: Benefits.)

TABLE 2. Mandatory and Optional Medicaid Benefits

Mandatory benefits	Optional benefits
• Inpatient hospital • Outpatient hospital • Rural health clinic • Federally qualified health center (FQHC) • Laboratory and X-ray • Nursing facility services (age 21 and older) • Family planning services and supplies • Tobacco cessation counseling and prescription drugs for pregnant women • Physician services • Adult vaccines recommended by the Advisory Committee on Immunization Practices • Nurse-midwife services • Certified pediatric and family nurse practitioner services • Freestanding birth centers • Home health • Medical transportation[1] • Early and periodic screening, diagnostic, and treatment (EPSDT) services • Medications for opioid use disorder • Pregnancy-related services • Routine patient costs for items and services for beneficiaries enrolled in a qualifying clinical trial	• Prescription drugs • Dental services • Intermediate care facilities for individuals with intellectual disabilities (ICF/ID) • Services in an institution for mental disease (IMD)[2] • 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 (HCBS, §§ 1915(i), (j), (k)) • Community supported living arrangements • Personal care services • Private duty nursing services • Primary care case management • Health homes for enrollees with chronic conditions • Other licensed practitioner services (e.g., podiatrist, optometrist) • Services for certain diseases (e.g., tuberculosis, sickle cell disease) • Chiropractic services • Program for All-Inclusive Care for the Elderly (PACE) services • Certified community behavioral health clinic

Notes: Although the benefit category may be covered, the amount and scope of coverage available can vary by state and plan. Benefit categories are broad and may not include coverage of specific benefits. Some benefits are available only when determined medically necessary. As such, although a benefit may be covered, this does not guarantee that an individual will be able to obtain it.

[1] Although medical transportation is not listed as a required benefit in Section 1902(a)(10)(A) of the Social Security Act (the Act), states must ensure necessary transportation for beneficiaries to and from Medicaid-covered services (§ 1902(a)(4) of the Act, 42 CFR 431.53 and 440.170).

[2] Services provided in an IMD are optional services that states can cover for children under age 21 or adults age 65 and older. Services provided to adults age 21–64 are not generally not eligible for federal matching funds; however, states may pay for IMD services in limited circumstances through Section 1115 demonstrations, state plan option for treatment of substance use disorder, and in-lieu-of services under managed care.

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

As the standards of care have evolved and the health needs of Medicaid-eligible populations have changed, Congress has added services to the Medicaid statute and provided states with the option to cover them. States have also made changes in their benefit design, for example, adopting or abolishing coverage for particular services, adjusting preferred drug lists, and establishing prior authorization requirements. These changes reflect both the needs of enrollees and state decisions regarding available resources.

Statutory benefit changes. Congress has added new benefits, mandatory and optional, for a variety of reasons. For example, hospice care, an optional benefit, did not exist at the time of the program's enactment. Some of the added services, such as those received at FQHCs and freestanding birth centers, or those provided by nurse-midwives, primarily reflect an expansion of the types of providers from whom enrollees can obtain services. Others, such as home- and community-based services (HCBS) and family planning services and supplies, could initially be offered only under a waiver. Targeted case management, primary care case management, and health homes reflect a shift towards more integrated care.

Some of the most significant changes to the benefit structure reflect the shift from serving people with disabilities in institutions to serving them in community settings. In 1971, Congress established optional benefits to cover services provided in intermediate care facilities and intermediate care facilities for people with intellectual and developmental disabilities that were previously financed with state-only funds (Paradise et al. 2015). In 1981, states were given a new waiver authority under Section 1915(c) to provide HCBS to individuals who would otherwise be served in an institution (OBRA 1981). *In Olmstead v. L.C.*, 527 S. Ct. 581 (1999), the U.S. Supreme Court ruled that individuals with disabilities have the right to reside in the least restrictive environment possible, leading to an increased focus on providing HCBS (Paradise et al. 2015, HCFA 2000). Section 1915(i), established under the Deficit Reduction Act of 2005, (DRA, P.L. 109-171) and expanded by the ACA, allows states to offer HCBS as part of the state plan benefit package instead of through a waiver (CMS 2014a). Although coverage of HCBS benefits is optional, all states have chosen to cover them and have worked to rebalance their long-term services and supports (LTSS) systems by expanding access to HCBS and reducing reliance on institutional LTSS (Carpenter et al. 2025). As a component of LTSS, Medicaid spending on HCBS surpassed spending on institutional care starting in FY 2013 (CMS 2023). In CY 2021, Medicaid programs spent approximately $82.5 billion on HCBS compared to about $66.6 billion on institutional care (MACPAC 2025).

In 2018, Congress required state Medicaid programs to cover all forms of Food and Drug Administration-approved medications for opioid use disorder (MOUD) and related counseling and behavioral therapies for five years, beginning October 1, 2020 (2018 Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act, SUPPORT Act, P.L. 115-271). Congress later made the MOUD benefit mandate permanent with the passage of the Consolidated Appropriations Act, 2024 (CAA 2024, P.L. 118-42). The SUPPORT Act also established an option for states to cover services for beneficiaries age 21 to 64 receiving withdrawal management or substance use disorder treatment services in institutions for mental disease under the state plan. The authority was time limited until Congress permanently extended it under the CAA 2024.

Beyond treatment for SUD conditions, Congress has also expanded mandatory Medicaid benefits in other areas of care. As part of the Consolidated Appropriations Act, 2021 (P.L. 116-260), states are required to cover routine costs for items and services furnished in connection with participation in a qualifying clinical trial beginning on January 1, 2022. The Inflation Reduction Act of 2022 (P.L. 117-169) required states to cover adult vaccines recommended by the Advisory Committee of Immunization Practices beginning on October 1, 2023.

Scope of coverage. When determining their benefit packages, states consider the health needs of enrollees and the cost of services. For example, all states cover prescription drugs, reflecting the integral role of pharmaceuticals in treating and slowing the progression of disease. Coverage for other services, such as chiropractic services or health homes that coordinate care for enrollees with chronic diseases, are less common (KFF 2018).

In general, states must offer the same coverage to all enrollees (the comparability rule) and offer the same benefits throughout the state (the "statewideness" rule), but there are exceptions for states that implement managed care or expand HCBS in certain geographic areas. States also have flexibility in defining how much of a service an enrollee can receive. For adults, states may limit the extent to which a covered benefit is available by defining both medical necessity criteria and the amount, duration, and scope of services. As such, state coverage of a particular benefit does not guarantee that an individual will be able to obtain it. However, under the early and periodic screening, diagnostic, and treatment (EPSDT) requirements for children under age 21 enrolled through the categorically needy pathway, states must provide a comprehensive set of prevention, diagnostic, and treatment services, including access to any Medicaid-coverable service in any amount that is medically necessary, regardless of whether the service is covered in the state plan (42 CFR 441.56).[8]

Alternative benefit plans. As an alternative to traditional Medicaid benefits, states were given authority under the DRA to enroll state-specified groups in benchmark and benchmark-equivalent benefit packages (§ 1937 of the Act). States can offer what are now known as alternative benefit plans (ABPs) to all enrollees and are required to enroll the new adult eligibility group covered through the ACA in ABPs. However, some groups are excluded from mandatory enrollment.[9] Coverage under an ABP must include at least the 10 essential health benefits as specified under Section 1302(b) of the ACA.[10]

Methodology

MACPAC examined enrollment and spending for mandatory and optional individuals and services using data from the Transformed Medicaid Statistical Information System (T-MSIS) and CMS-64 net financial management report for fiscal year (FY) 2023. Compared to Medicaid Statistical Information System (MSIS) data from our previous 2017 analysis, T-MSIS data, which replaced MSIS, have more granular information on eligibility pathways and more complete submission of managed care encounter data. We calculated the Medicaid benefit spending amounts for mandatory and optional services based on T-MSIS data that have been adjusted to match total benefit spending reported by states in CMS-64 data.[11] To the greatest extent possible, this analysis reflects assumptions and adjustments that MACPAC routinely makes in MACStats and outlined in its technical guide.[12] See Appendix A for a more detailed description of the methodology.

Classification of enrollees

The study population includes individuals from the 50 states and the District of Columbia enrolled in Medicaid at any point during FY 2023. We excluded CHIP enrollees from this analysis, and Medicaid enrollees with missing age and missing eligibility group codes who cannot be assigned a mandatory or optional enrollment status.[13] We classified enrollees based on the following characteristics:

- **Eligibility group category.** We classified enrollees into the following eligibility group categories: child, new adult group, other adult, pregnancy, blind or disabled, and aged.[14,15]
- **Age.** We classified enrollees into three age categories: 0–20 years, 21–64 years, and 65 years and older.
- **Dual status.** We assigned enrollees' dual eligibility status as full, partial, and Medicaid only.
- **Restricted benefits status.** We classified enrollees as receiving full benefits or limited benefits.

For most enrollees, MACPAC assigned mandatory and optional eligibility categories based on the classification of each eligibility group code assigned in the T-MSIS analytic file technical documentation, and adjusted for certain limited benefit and dually eligible enrollees.

Classification of services

We examined Medicaid service claims for enrollees in the study cohort and classified them using service categories from MACStats: acute hospital, institutional LTSS, non-institutional LTSS, drugs, acute other, and managed care.[16] For certain MACStats service categories, we created subcategories to further classify services. For example, claims in the non-institutional LTSS category were further sorted into subcategories for home health, HCBS, personal care, and other. We classified each service as mandatory or optional using the service category and subcategory, as well as enrollee information on age, eligibility group, dual status, and restricted benefits status.

Managed care expenditures

T-MSIS includes records of each capitation payment made on behalf of an enrollee to a managed care plan, as well as records of each service received by the enrollee from a provider under contract with a managed care plan (also referred to as encounter data). After assigning mandatory and optional classifications to managed care encounter claims, we applied the distribution of mandatory and optional spending from encounter data to the capitation payments by state and eligibility group.

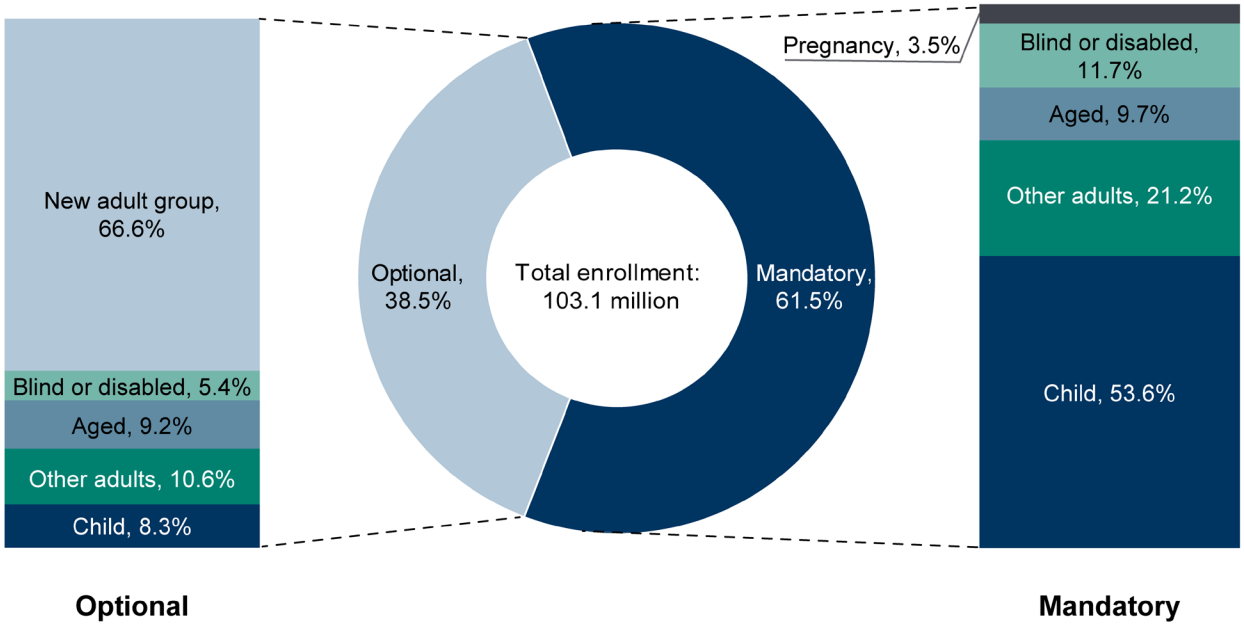
Results

In FY 2023, most enrollees (61.5 percent) were eligible on a mandatory basis, and 61.2 percent of total Medicaid spending was for mandatory services (Figure 2 and Figure 7). Mandatory and optional enrollment varied widely across eligibility groups, dual status, and states. Mandatory enrollment was most prominent among children and pregnancy-eligible enrollees, and optional enrollment was most prominent among enrollees in the new adult group (an optional eligibility group) and enrollees age 65 and older (Figure 3). Full-benefit dually eligible enrollees had a slightly higher share of optional enrollees than enrollees in Medicaid only (Figure 4). States' shares of mandatory and optional enrollees varied, with differences by states' Medicaid expansion status (Figure 5).

Enrollment of mandatory and optional populations

In total, 103.1 million individuals were enrolled in Medicaid in FY 2023 (Figure 2).[17] The majority (61.5 percent) of enrollees were mandatory, and 38.5 percent were optional. Children represented more than half of mandatory enrollees and the new adult group represented approximately two-thirds of optional enrollees (66.6 percent).

FIGURE 2. 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 the State Children's Health Insurance Program 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 pregnancy-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.

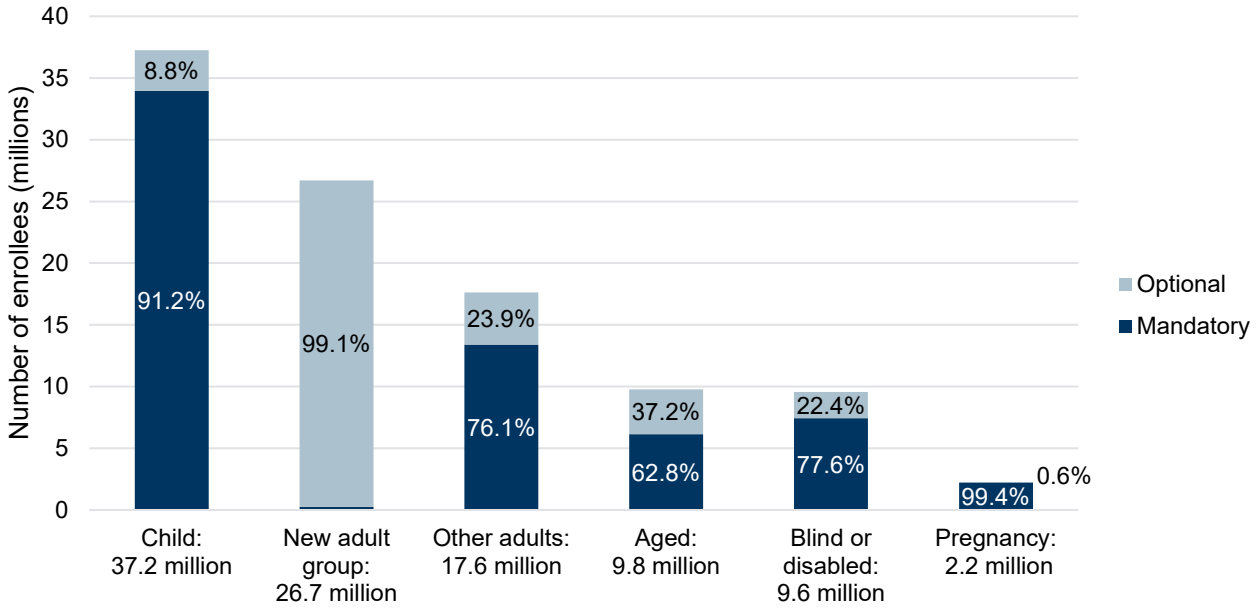
Enrollment by eligibility group. The share of enrollees eligible under mandatory and optional pathways varied by eligibility group (Figure 3). Across all eligibility groups, except for the new adult group, most enrollees were mandatory. Children represented the largest group out of all enrollees (37.2 million) and nearly all were mandatory (91.2 percent), illustrating the key role that Medicaid plays in covering most low-income children (MACPAC 2026c). Most optional children qualified through the medically needy option for children under 18.

More than 26 million non-disabled adults younger than age 65 were enrolled in the new adult group, which had the largest share of optional enrollees (99.1 percent) (Figure 3). The small share (less than 1 percent) of enrollees in the new adult group considered mandatory were primarily those eligible for limited benefits through emergency Medicaid.[18] The remaining share of non-disabled adults younger than age 65 were in the other adult group (e.g., parents and caretakers), where most enrollees were mandatory (76.1 percent). Among optional adults in this group, most qualified for family planning services through the optional eligibility pathway or an 1115 expansion waiver.[19]

Enrollees in the blind or disabled eligibility group also had a large share of mandatory enrollment (77.6 percent), which includes enrollees who receive SSI based on their low incomes, and certain working individuals with disabilities (Figure 3). Optional enrollees in this group most commonly qualified through the poverty level pathway, which is an optional pathway for individuals age 65 and older or have disabilities with income above SSI but below or equal to 100 percent of the FPL.

While a majority of enrollees in an aged eligibility group (i.e., individuals age 65 and older) were mandatory (62.8 percent), there was a larger share of optional enrollees for the aged group than the child, other adult, and blind or disabled eligibility groups (Figure 3). This may be because individuals age 65 and older are more likely to need long-term care and HCBS, which may be the basis for Medicaid eligibility through optional pathways. Similar to enrollees in the blind or disabled eligibility group, states are required to cover individuals age 65 and older if they qualify for SSI, but states can also elect to cover this population through optional pathways, such as the poverty level option, medically needy option, and being eligible for but not receiving cash assistance.

FIGURE 3. Distribution of Mandatory and Optional Medicaid Enrollment, by Eligibility Group, FY 2023

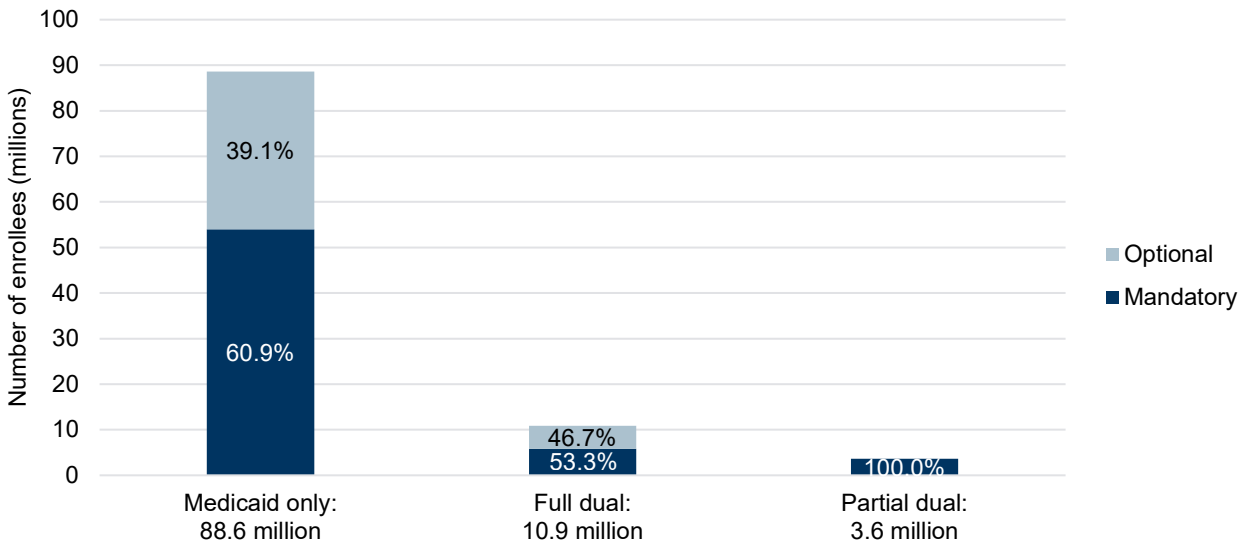


Notes: FY is fiscal year. The new adult group includes enrollees who are eligible under Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (the Act). Enrollment numbers generally include individuals ever enrolled in Medicaid-financed coverage during the year, even if for a single month. However, 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.

Enrollment by dual status. In total, 14.5 million enrollees were dually eligible for Medicaid and Medicare, including both full-benefit and partial-benefit enrollees (Figure 4). Overall, most dually eligible enrollees were mandatory, although the share of mandatory enrollees varied by dual status. More than half (53.3 percent) of full-benefit dually eligible enrollees were mandatory, while all partial-benefit dually eligible enrollees were mandatory because partial-benefit dually eligible enrollees qualify for some Medicaid cost-sharing benefits through mandatory eligibility pathways known as Medicare Savings Programs. Full-benefit dually eligible enrollees, however, qualify for full Medicaid benefits through other pathways, such as the mandatory SSI pathway. Optional pathways for full-benefit dually eligible enrollees include medically needy individuals and those eligible for but not receiving cash assistance.

FIGURE 4. Distribution of Mandatory and Optional Medicaid Enrollment, by Dual Status, FY 2023

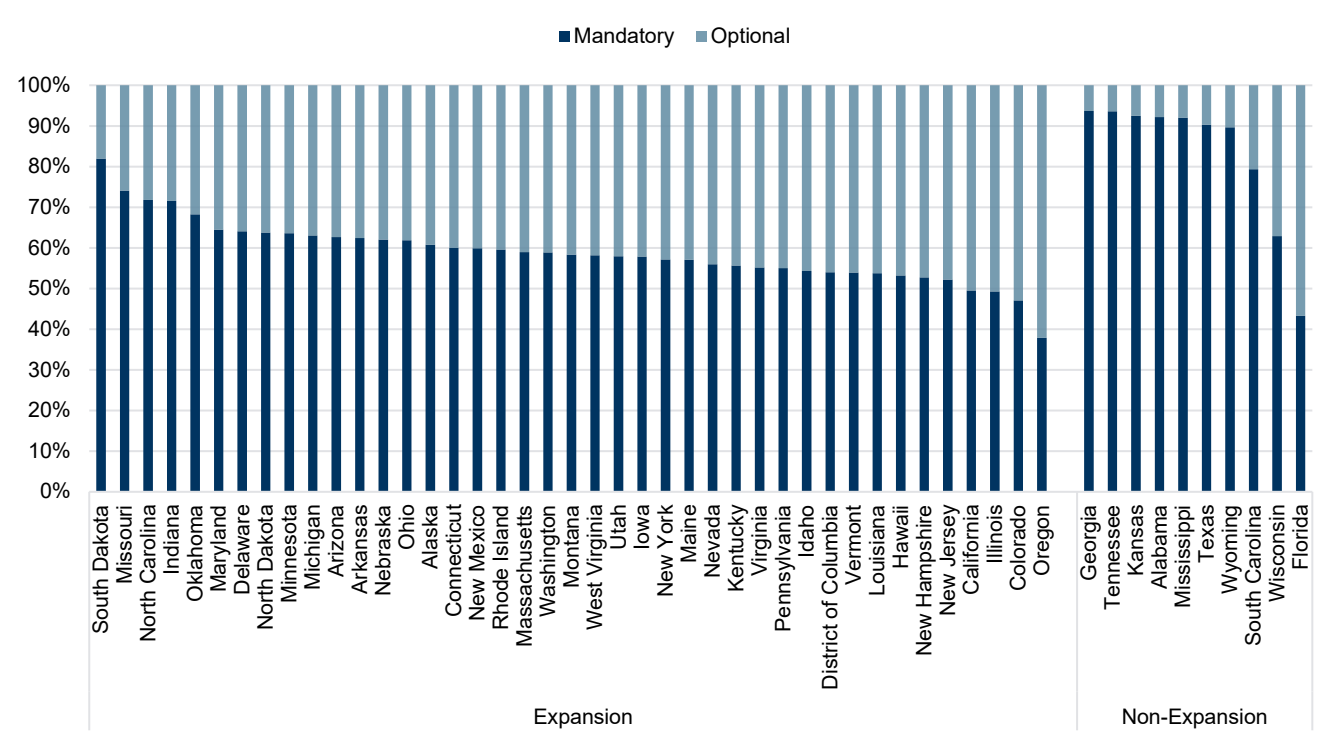


Notes: FY is fiscal year. Enrollment numbers generally include individuals ever enrolled in Medicaid-financed coverage during the year, even if for a single month. However, in the event individuals were also enrolled in State Children's Health Insurance Program (CHIP)-financed Medicaid coverage (i.e., 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.

Enrollment by state. The distribution of mandatory and optional enrollment varies by state, reflecting both state decisions to adopt optional pathways and the demographics and income of each state (Figure 5). Across states, the share of Medicaid enrollees eligible through a mandatory pathway ranged from a high of 93.7 percent in Georgia to a low of 37.9 percent in Oregon. States that expanded Medicaid coverage to adults without dependent children tend to have more optional enrollees because enrollees in this group are included in the optional population. For more detailed state enrollment data, see Appendix Table B-1.

FIGURE 5. Mandatory and Optional Enrollment in Medicaid, by State and Expansion Status, FY 2023



Notes: FY is fiscal year. Expansion refers to states that have expanded Medicaid eligibility to low-income adults under the Patient Protection and Affordable Care Act (P.L. 111-148, as amended). 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 State Children's Health Insurance Program (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.

Spending on mandatory and optional populations and services

The amount of mandatory and optional spending differed by service and population characteristics. In FY 2023, federal and state Medicaid spending for mandatory and optional services totaled $823.1 billion, most of which was for mandatory service spending (Table 3).[20] Mandatory services represented a larger share of managed care spending compared with fee-for-service (FFS) spending (Figure 6). More than 40 percent of mandatory spending was for acute hospital services and half of optional spending was for non-institutional LTSS (Figure 7). Acute hospital services and other acute services represented the largest share of total spending, and the majority of spending for those services was mandatory (Figure 8). Spending on children and adults was largely for mandatory services, but the majority of spending for people age 65 and older and people eligible on the basis of disability were for optional services (Figure 9). Most spending across both mandatory and optional services was for mandatory enrollees (Table 4). The distribution of mandatory and optional spending varied by state and expansion status, with expansion states spending a larger share on optional services than non-expansion states (Figure 10).

Spending by service and population. The majority (61.2 percent) of total spending was for mandatory services, and 38.8 percent was for optional services (Table 3). The distribution of spending differed across mandatory and optional populations. Mandatory services represented the majority of total spending for both mandatory (62.5 percent) and optional (59.6 percent) populations. Within the optional populations, spending on mandatory services also represented a larger share of spending for the new adult group (69.6 percent) compared to other optional populations (49.4 percent).

TABLE 3. Medicaid Spending on Mandatory and Optional Populations and Services, FY 2023 (billions)

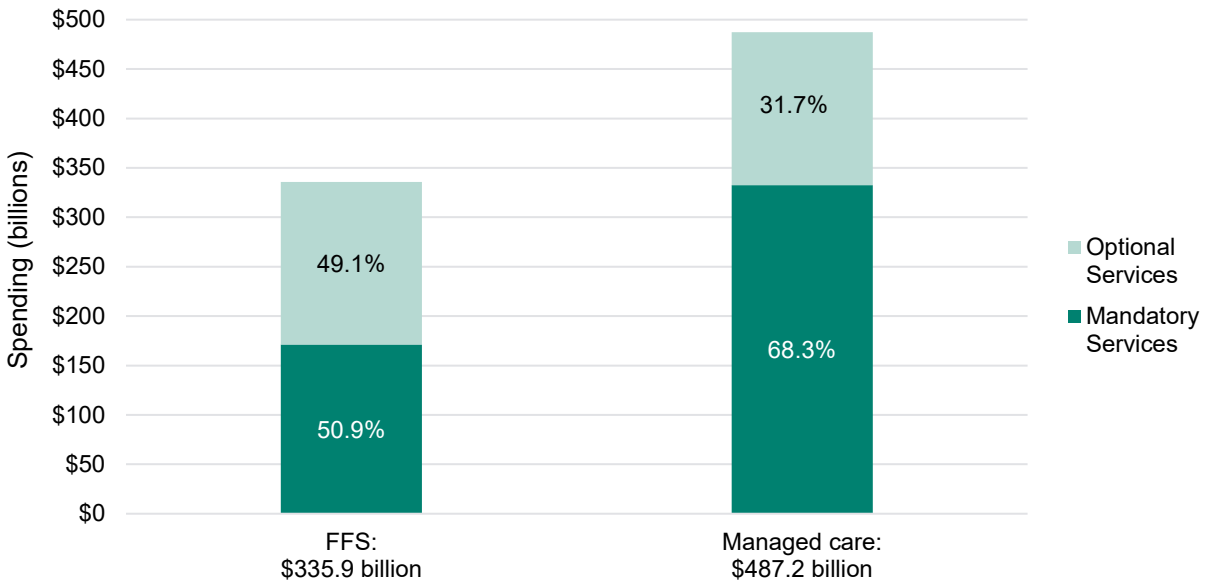
Enrollment	Total spending (billions)	Mandatory service spending		Optional service spending	
		Dollars (billions)	Percent of total	Dollars (billions)	Percent of total
Total	**$823.1**	$503.6	61.2%	$319.4	38.8%
Mandatory population	**$449.4**	$280.9	62.5	$168.5	37.5
Optional population	**$373.7**	$222.7	59.6	$150.9	40.4
New adult group	**$188.8**	$131.4	69.6	$57.4	30.4
Other optional	**$184.8**	$91.3	49.4	$93.5	50.6

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.

Spending by delivery system. Mandatory and optional spending differed by delivery system. Mandatory services represented 68.3 percent of total managed care spending (Figure 6). FFS spending, however, was nearly evenly divided between mandatory services (50.9 percent) and optional services (49.1 percent). This variation across delivery systems may be due to differences in populations covered and services provided through managed care and FFS. For example, optional services, such as HCBS and certain long-term care services, are often delivered through FFS arrangements.

FIGURE 6. Medicaid Spending on Mandatory and Optional Services, by Delivery System, FY 2023

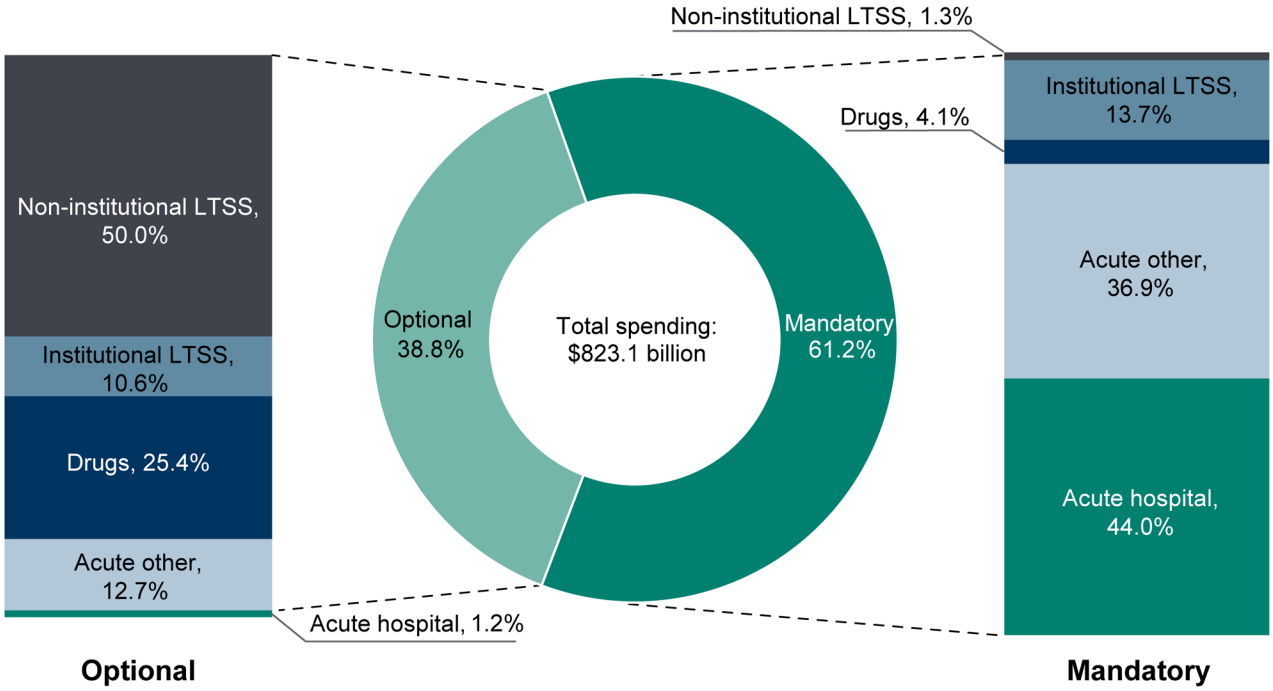


Notes: FY is fiscal year. FFS is fee for service. Includes federal and state funds. Excludes spending for administration, the territories, and Medicaid-expansion CHIP enrollees. Benefit spending from Transformed Medicaid Statistical Information System (T-MSIS) data has been adjusted to reflect CMS-64 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 FY 2023 T-MSIS data and CMS-64 net financial management report.

Spending by mandatory and optional services. Most Medicaid benefit spending was for mandatory services (61.2 percent) (Figure 7). Among mandatory services, acute hospital services accounted for nearly half (44.0 percent) of total mandatory spending, followed by other acute services (36.9 percent) and institutional LTSS (13.7 percent). Spending among optional services mainly consisted of non-institutional LTSS (50.0 percent) and drug spending (25.4 percent).

FIGURE 7. Medicaid Spending on Mandatory and Optional Services, Total and by Service Category, FY 2023

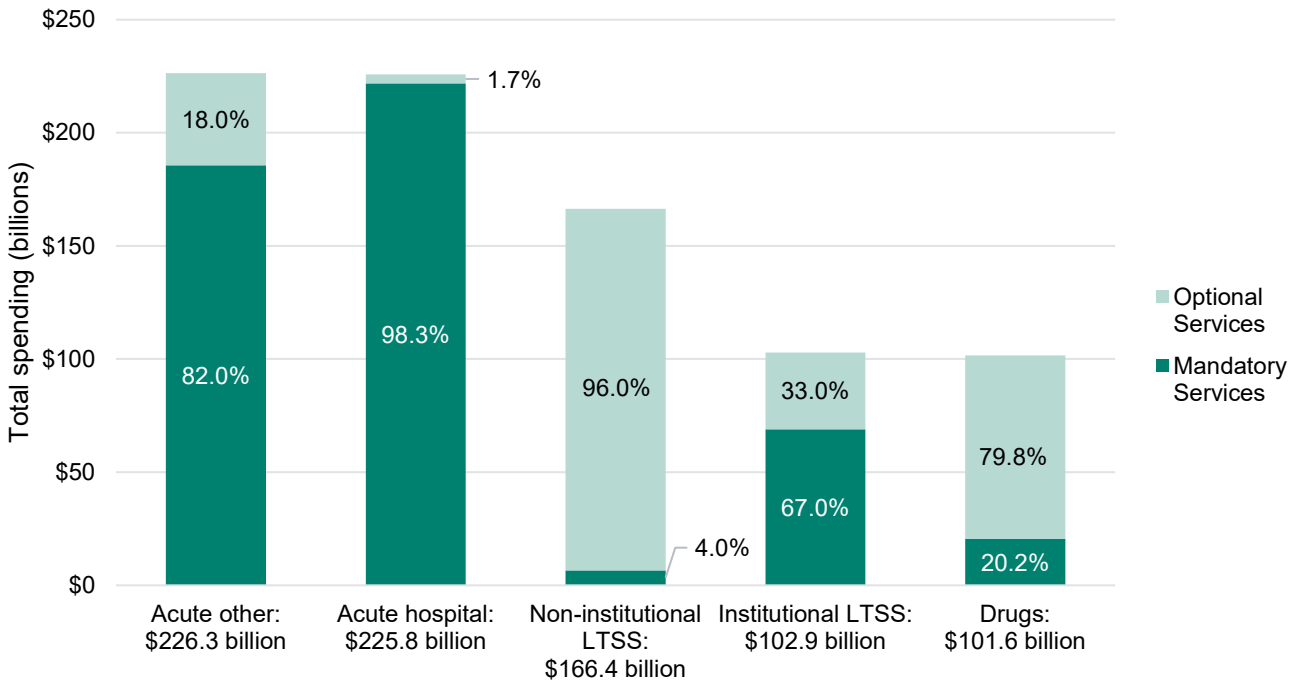


Notes: FY is fiscal year. LTSS is long-term services and supports. Includes federal and state funds. Excludes spending for administration, the territories, and Medicaid-expansion CHIP enrollees. Benefit spending from Transformed Medicaid Statistical Information System (T-MSIS) data has been adjusted 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.

Spending by service category. Mandatory and optional spending also varied across service categories (Figure 8). Overall, acute hospital services and other acute services accounted for the largest share of total spending. Spending on acute hospital services was nearly all (98.3 percent) mandatory while other acute spending was 82.0 percent mandatory. Optional spending comprised the vast majority (96.0 percent) of non-institutional LTSS spending, likely because HCBS are optional benefits, although all states choose to cover some HCBS benefits. Most spending on institutional LTSS spending was mandatory (67.0 percent) and 33.0 percent was optional. Drug spending represented the smallest share of total benefit spending compared to other service categories. The majority of drug spending was optional (79.8 percent), and 20.2 percent was mandatory. Mandatory drug spending was largely for children due to the EPSDT statutory requirement to cover all medically necessary services for children under age 21. For data on spending by service subcategory, refer to Appendix Table B-2.

FIGURE 8. Medicaid Spending on Mandatory and Optional Services by Service Category, FY 2023



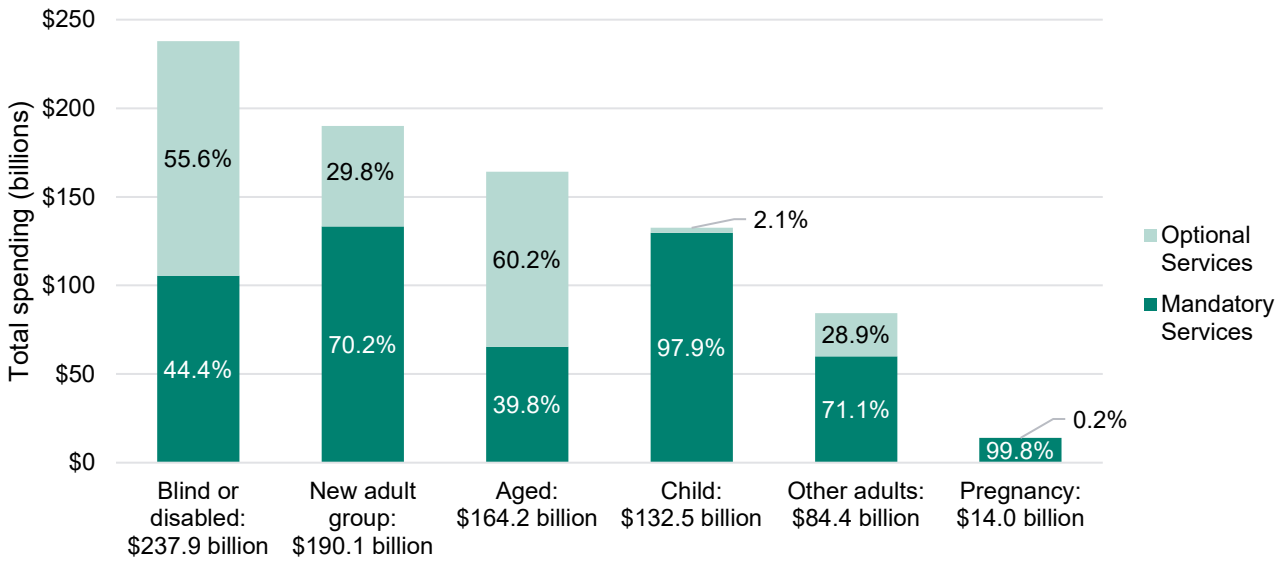
Notes: FY is fiscal year. LTSS is long-term services and supports. Includes federal and state funds. Excludes spending for administration, the territories, and Medicaid-expansion CHIP enrollees. Benefit spending from Transformed Medicaid Statistical Information System (T-MSIS) data has been adjusted 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.

Spending by eligibility group. Spending for mandatory and optional services also varied by eligibility group (Figure 9). Total spending was highest for enrollees in the disabled eligibility group and lowest for pregnant-eligible enrollees. Nearly all of spending for enrollees in the pregnancy-related (99.8 percent) and child (97.9 percent) eligibility groups was for mandatory services. Most spending for pregnancy-eligible enrollees was for inpatient services and physician services. Spending for children largely included acute care services, drugs, and institutional LTSS. All of the optional spending for children was for HCBS and state personal care services.

The share of mandatory spending was similar for the new adult (70.2 percent) and other adult (71.1 percent) eligibility groups (Figure 9). Acute care services represented the majority of mandatory spending for adults, while drugs and non-institutional LTSS accounted for most of the optional spending. Optional spending accounted for larger shares of total spending among enrollees age 65 and older (60.2 percent) and enrollees in the blind or disabled eligibility group (55.6 percent). Institutional LTSS and non-institutional LTSS made up the largest shares of spending for these groups.

FIGURE 9. 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.

Spending by eligibility group and service category. Most spending across both mandatory and optional services was for mandatory enrollees (Table 4). Mandatory spending for acute care services (acute hospital and other acute categories) represented the largest share of total spending for both mandatory (52.3 percent) and optional enrollees (45.4 percent). However, this share varies by eligibility group. For mandatory children, adults, and pregnancy-eligible enrollees, mandatory acute spending was 70–90 percent of spending; whereas it was only 39.2 percent of total spending for the mandatory blind or disabled group and 18.4 percent for the mandatory aged group. Similar patterns exist for optional enrollees, except mandatory acute care is even a smaller proportion of spending for the optional blind or disabled group (24.6 percent) and optional aged group (8.9 percent).

Optional services were less than half of spending for both mandatory and optional populations, with the spending concentrated in optional LTSS (e.g., HCBS) and drugs (Table 4). Optional LTSS was 23.7 percent of overall spending for all mandatory populations, and over one-third of total spending for the mandatory blind or disabled group (36.5 percent) and almost half of total spending for the mandatory aged group (46.4 percent). Similar distributions exist for optional populations, with optional LTSS being approximately half of overall spending for optional aged (48.4 percent) and blind or disabled (53.1 percent) enrollees. Optional drug spending was 8.9 percent of total spending for mandatory populations and 12.8 percent of total spending for optional populations. Drugs were the second largest category of spending for both mandatory and optional adults. For mandatory adults, it was 19.6 percent of spending for the other adult group. For optional adults, it was 13.6 percent of

spending for the other adult group and 22.4 percent of spending for the new adult group. Optional acute services were only about 5 to 6 percent of total spending for mandatory and optional populations, and only up to about 10 percent for any particular eligibility group.

TABLE 4. Medicaid Spending on Mandatory and Optional Services by Service Category and Eligibility Group, FY 2023

Eligibility group	Total spending (billons)	Mandatory services			Optional services		
		Acute	LTSS	Drugs	Acute	LTSS	Drugs
Mandatory enrollment	**$449.4**	**52.3%**	**6.9%**	**3.4%**	**4.9%**	**23.7%**	**8.9%**
Aged	**71.8**	18.4	23.6	0.0	9.5	46.4	2.1
Child	**122.4**	85.5	3.1	9.3	–	2.1	–
Blind or disabled	**166.1**	39.2	6.0	2.1	5.1	36.5	11.1
Other adult	**73.9**	70.1	1.5	0.5	5.2	3.1	19.6
Pregnancy	**13.9**	92.2	0.2	7.4	–	0.2	–
Other emergency Medicaid[1]	**1.2**	91.1	0.3	2.1	0.8	0.4	5.2
Optional enrollment	**$373.7**	**45.4%**	**12.9%**	**1.3%**	**5.9%**	**21.7%**	**12.8%**
Aged	**92.4**	8.9	29.3	0.0	10.6	48.4	2.7
Child	**10.1**	75.2	4.7	17.2	–	2.9	–
Blind or disabled	**71.8**	24.6	11.5	1.6	5.6	53.1	3.6
Other adult	**10.5**	54.2	3.8	6.3	9.7	12.4	13.6
Pregnancy	**0.1**	95.2	0.5	3.5	–	0.9	–
New adult group	**188.8**	66.8	2.8	0.4	5.1	2.5	22.4

Notes: FY is fiscal year. Acute includes acute hospital and other acute care services. LTSS is long-term services and supports and includes institutional and non-institutional LTSS. 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.

– Dash indicates zero. A percentage value of 0.0 indicates there is spending but it is less than 0.5 percent.

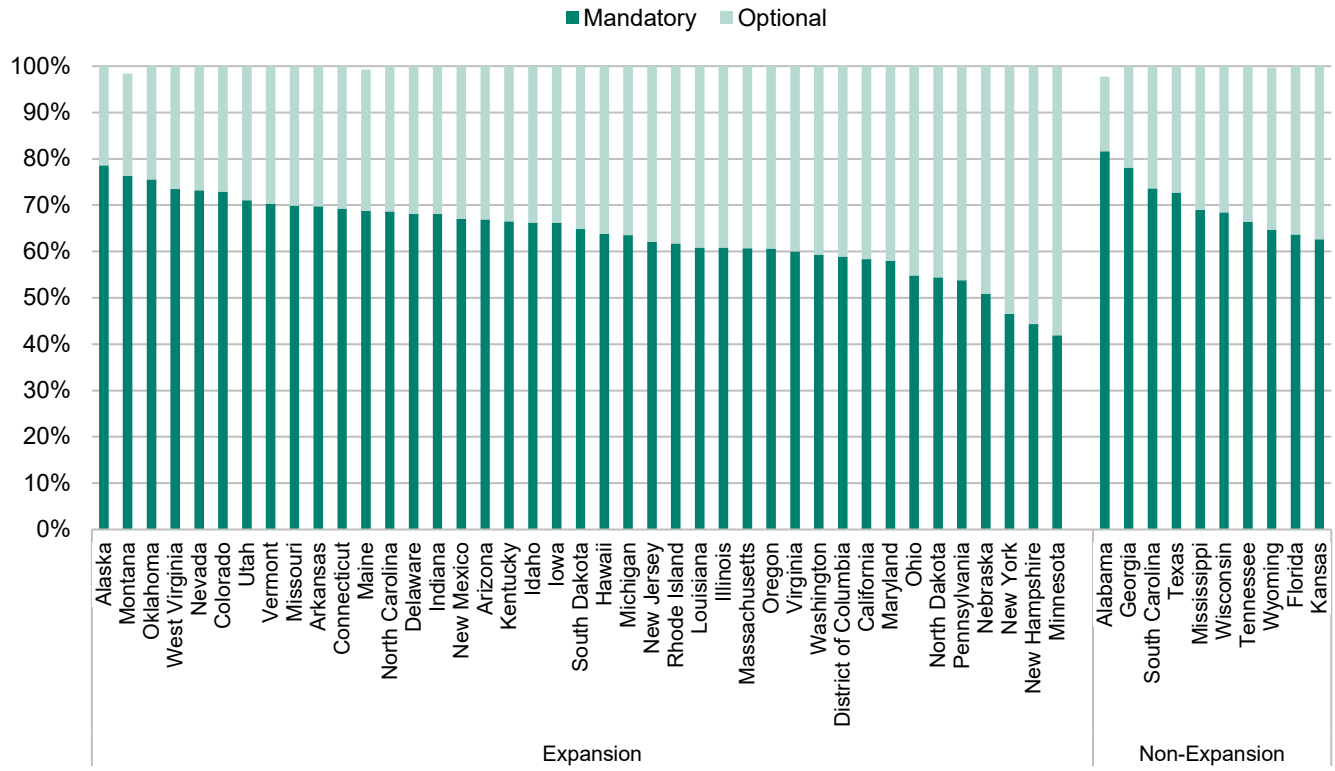
[1] This group includes enrollees who received emergency Medicaid due to their immigration status, who otherwise would have been eligible for the new adult group. Emergency Medicaid is a mandatory eligibility category that provides limited coverage of emergency medical services for individuals who would have met the criteria for another Medicaid eligibility pathway if not for their immigration status. Other mandatory eligibility groups shown include enrollees who received emergency Medicaid and would have been eligible within that eligibility pathway if not for their immigration status.

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

Spending by state. The distribution of mandatory and optional spending varied by state. Across states, the share of spending on mandatory services ranged from a high of 81.6 percent in Alabama to a low of 41.9 percent in Minnesota (Figure 10). These differences in spending reflect state flexibilities on the breadth of coverage for

optional services, particularly for non-institutional LTSS. For example, states that provide more LTSS through HCBS, an optional benefit, than nursing facilities, a mandatory benefit, would likely have greater optional spending. Other factors that affect state spending include the demographic and health status characteristics of state residents, as well as the geographic differences in the cost of medical care. For specific state-by-state spending data, see Appendix Table B-3.

FIGURE 10. Medicaid Spending on Mandatory and Optional Services, 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.

Key Takeaways

This analysis found that in FY 2023, most spending and enrollment in Medicaid supported mandatory populations and benefits. More than one-third of federal and state Medicaid spending were for mandatory services for mandatory enrollees, and spending for optional enrollment and optional services represented the smallest share of total spending (18.3 percent) (Table 5). Most enrollees in Medicaid were eligible through mandatory pathways; children represented the largest share or mandatory enrollees and the new adult group accounted for the largest share of optional enrollees. Most spending was for mandatory services; acute hospital services and other acute services accounted for the largest share of mandatory spending, while non-institutional LTSS and drugs represented the largest share of optional spending.

This analysis provides data that describes how states have exercised flexibility in designing their programs, but it does not provide clear direction for states or the federal government in considering how to make the program more efficient or how to set priorities for spending. For example, some optional services exist to encourage use of more efficient services or provide care in a preferred setting. HCBS can delay the use of, and be more cost-effective than, institutional care (MACPAC 2025). Prescription drugs are integral to the provision of medical care and can reduce the need acute care such as hospitalization (B. Muralidharan et al. 2025). As a result, reduced access to these optional services may shift spending to mandatory services, such as acute hospital or nursing facility services.

TABLE 5. Medicaid Spending on Mandatory and Optional Populations and Services, FY 2023 (billions)

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.

Data Limitations

Due to changes in the data source and methodology, the findings based on T-MSIS reported in this analysis may not be directly comparable to earlier analyses that were based on MSIS data. Prior MACPAC reports have noted the limitations of T-MSIS administrative data, including the variation of data quality across states and inconsistencies in reporting (MACPAC 2026, 2025). Some states, for instance, have missing or inconsistent T-MSIS data. The CMS-64 net financial management report provides a more complete accounting of state and federal spending than T-MSIS, but cannot be used for analyses of benefit spending by eligibility group and other enrollee characteristics. Therefore, we adjusted T-MSIS data to match total benefit spending reported by states in CMS-64 data. Other methodologies—for example, using the proportion of spending across eligibility groups in T-MSIS to allocate CMS-64 spending to these groups—may produce different results because of data anomalies in T-MSIS.

T-MSIS does not have a reliable data element that specifies the mandatory or optional status of service claims. To classify services as mandatory or optional, we developed an algorithm based on service categories from MACStats and assigned respective subcategories, but data elements used for classifying services may have limitations in characterizing each claim as one specific service category and subcategory. In addition, certain service categories that are traditionally optional Medicaid benefits are mandatory for the new adult group because expansion states must provide benchmark or benchmark-equivalent benefit packages that include essential health benefits, such as prescription drugs and behavioral health services. However, some of the essential health benefits are broadly defined (e.g., rehabilitative and habilitative services and devices) and do not map cleanly to existing service categories in T-MSIS.[10] Additionally, because states may choose different benchmark packages, the level of coverage of specific services within these essential health benefits may vary by state. Due to these complexities in accurately defining the breath of essential health benefits in each state, we applied the classification of these services under traditional Medicaid to the new adult group.

Because there is not a one-to-one correspondence of service types in T-MSIS and CMS-64 data, we aggregate service categories in both data sets into broad service categories that are comparable between the two sources. As such, we applied the same adjustment factor based on the CMS-64 to all service subcategories within a given service category. For example, within the non-institutional LTSS category in a given state, we applied the same CMS-64 adjustment factor to HCBS, home health, personal care, and other service subcategories. Additionally, a claim's mandatory or optional classification depends on its service category and subcategory, as well as enrollee age, eligibility group, dual status, and restricted benefits status (Appendix A). This resulted in differences in mandatory and optional assignments for the same service across different enrollee populations.

Furthermore, there are limited data on managed care spending. While T-MSIS includes spending from encounter claims, certain managed care payments that are not linked to a specific enrollee may be excluded. For example, encounter claims may not reflect lump sum supplemental payments paid through state directed payments. As noted above, we assumed that the distribution of managed care spending on mandatory and optional services mirrored the distribution of spending for encounter claims at an eligibility group, state, and service level. As a result, our methodology does not account for how these payments missing from the encounter data may be allocated differently across mandatory and optional services and populations and affect the overall distribution of mandatory and optional spending. Some states reported capitation spending but did not report encounter spending. In the absence of encounter spending, we were unable to determine the distribution of mandatory and optional spending for these capitation payments.

Endnotes

[1] The total enrollment count presented in this issue brief differs from those presented in the February 2026 *MACStats: Medicaid and CHIP Data Book*. The data in this issue brief sum up enrollment across the states whereas the MACStats exhibits based on T-MSIS data present a unduplicated national enrollment count that is lower than the sum of enrollment across states because an individual could be enrolled in more than one state during the year.

[2] However, in the final rules issued after the enactment of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) the Centers for Medicare & Medicaid Services (CMS) grouped these pathways together under one mandatory category (42 CFR 435.116).

[3] Medicaid eligibility for these groups was automatically linked to eligibility for certain federal cash assistance programs.

[4] In 2021, Congress gave states the option to extend postpartum coverage for pregnancy-eligible Medicaid enrollees from 60 days to 12 months, and made this option available to states for five years (American Rescue Plan Act of 2021, P.L. 117-2). The option was made permanent by the Consolidated Appropriations Act of 2023 (P.L. 117-328).

[5] Individuals in the medically needy groups could have their medical expenses deducted from their income when determining eligibility for Medicaid.

[6] Over time, the direct link to cash assistance has been eliminated from some, but not all, eligibility pathways. Medicaid eligibility for individuals who receive SSI benefits and for children in Title IV-E foster care remains tied to eligibility for those programs. However, as of 1996, eligibility for low- income families and children is based on the federal poverty level (FPL), a change resulting from the passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA, P.L. 104-193).

[7] States may elect the Section 209(b) option to apply more restrictive eligibility criteria for individuals who are age 65 or older or who have blindness or a disability. Section 209(b) states may use eligibility criteria (related to income and assets, disability, or both) that are more restrictive than SSI program criteria, but they may not use more restrictive criteria than those in effect in the state on January 1, 1972. If a Section 209(b) state does not have a separate medically needy standard, it must allow individuals with higher incomes to spend down to the state's Section 209(b) income level by deducting incurred medical expenses from the amount of income that is counted for Medicaid eligibility purposes.

[8] Although EPSDT services are considered optional for medically needy children, if a state's medically needy coverage for any group includes services provided in institutions for mental diseases (IMD) or intermediate care facilities for individuals with intellectual disabilities (ICF/ID), then the state must include certain other services outlined in the statute, including EPSDT services (§1902(a)(10)(C)(iv) of the Social Security Act). If the EPSDT benefit is elected for the medically needy population, it must be made available to all Medicaid eligible individuals under age 21.

[9] Groups that are exempt from mandatory enrollment in ABPs include certain parents, pregnant women, individuals dually enrolled in Medicaid and Medicare, those who qualify for Medicaid on the basis of blindness or disability, enrollees receiving hospice care, those who are medically frail or have special medical needs, and children enrolled through child-welfare involved pathways (§ 1937(b) of the Social Security Act).

[10] The ACA requires non-grandfathered health insurance coverage in the individual and small group markets, particularly qualified health plans on the exchange, to cover essential health benefits (§ 1301(a)(1)(B) of the ACA). Essential health benefits include items and services in at least the following ten benefit categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care. The EHBs are required to be equal in scope to the benefits provided under a benchmark plan (e.g., typical employer plan), as determined by the HHS Secretary (§ 1302(b) of the ACA).

[11] Medicaid benefit spending reported here excludes amounts for Medicaid-expansion CHIP enrollees, the territories, administrative activities, the Vaccines for Children program (which is authorized by the Medicaid statute but operates as a separate program), and offsetting collections from third-party liability, estate, and other recoveries.

[12] MACPAC publishes MACStats annually, which is a data book that presents information on Medicaid and CHIP enrollment, spending, and key aspects of both programs. For more information on data methods and sources, please consult the Technical Guide to MACStats (MACPAC 2026a).

[13] Approximately 6,000 beneficiaries have missing age. The beneficiaries excluded for missing eligibility group codes were included in the MACStats cohort based on their Basis of Eligibility (BOE), which CMS has since retired in T-MSIS and replaced with the eligibility group code.

[14] The new adult group includes those enrollees who are eligible under Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act.

[15] Enrollees in a pregnancy eligibility group include those in a pregnancy-related eligibility group or eligible for postpartum coverage. Pregnant enrollees may be enrolled in Medicaid through non-pregnancy-related eligibility groups and may not be captured in this group, likely resulting in an undercount.

[16] This study excludes the Medicare Premiums service category, which is included in MACStats.

[17] MACPAC's analysis uses state-specific identification numbers to identify Medicaid enrollees, so the total number may include duplicates because individuals may be enrolled in more than one state during the year.

[18] States must provide limited coverage of emergency medical services to certain non-citizens who would qualify for full Medicaid benefits but for their immigration status (§ 1903(v)(2) of the Act, 42 CFR 435.139).

[19] States may adopt the optional eligibility group for individuals who qualify for family planning services (42 CFR 435.214). Individuals are eligible for the group if they are not pregnant, are not eligible for full coverage of Medicaid services, and have income within the state-established income limit for the group. Some states have also used Section 1115 waivers to provide family planning services to particular groups.

[20] This total excludes spending for administration, the territories, and Medicaid-expansion CHIP enrollees. The spending total also excludes disproportionate share hospital (DSH) payments and certain incentive and uncompensated care pool payments made under waiver expenditure authority of Section 1115 of the Social Security Act.

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APPENDIX A: Methodology

MACPAC examined enrollment and spending for mandatory and optional individuals and services using data from the Transformed Medicaid Statistical Information System (T-MSIS) and CMS-64 net financial management report for fiscal year (FY) 2023. Compared to Medicaid Statistical Information System (MSIS) data from our previous 2017 analysis, T-MSIS data, which replaced MSIS, have more granular information on eligibility pathways and more complete submission of managed care encounter data. The Medicaid benefit spending amounts for mandatory and optional services were calculated based on T-MSIS data that have been adjusted to match total benefit spending reported by states in CMS-64 data. Medicaid benefit spending reported here excludes amounts for State Children's Health Insurance Program (CHIP) enrollees, the territories, administrative activities, the Vaccines for Children program (which is authorized by the Medicaid statute but operates as a separate program), and offsetting collections from third-party liability, estate, and other recoveries. To the greatest extent possible, this analysis reflects assumptions and adjustments that MACPAC routinely makes in MACStats and outlined in its technical guide.

Classification of enrollees

The study population includes individuals enrolled in Medicaid at any point during FY 2023. We used enrollees from the 50 states and the District of Columbia. Enrollees from U.S. territories were excluded. We excluded those with missing age and those with missing eligibility group codes who cannot be assigned a mandatory or optional enrollment status. We used the following characteristics to classify enrollees as mandatory or optional:

Eligibility group category. We followed the MACStats methodology to aggregate eligibility codes from T-MSIS into larger grouping categories for child, new adult group, other adult, blind or disabled, and aged eligibility groups. The other adult group includes adults younger than age 65 who qualify through a pathway other than disability or Section 1902(a)(10)(A)(i)(VIII) of the Act (e.g., parents and caretakers). In addition to these MACStats eligibility categories, we added a category for pregnancy.

Age. We classified enrollees into three age categories: 0 through 20 years, 21 through 64 years, and 65 years and older.

Dual status. We determined whether an enrollee was dually eligible for both Medicare and Medicaid using the dual eligible code from T-MSIS data, which shows the enrollee's most recent status in the year. We assigned dual status as full, partial, and Medicaid only.

Restricted benefits status. We used a combination of dual eligible code, restricted benefits code, and eligibility group code to identify beneficiaries who receive a limited set of benefits. Enrollees receiving a limited set of benefits include those who receive coverage of only emergency services, family planning services, COVID-19 diagnostic products and testing-related services, or partial benefit dually eligible beneficiaries who receive assistance with Medicare premiums and cost sharing. States must provide limited coverage of emergency medical services to non-citizens who would qualify for full Medicaid benefits but for their immigration status (§ 1903(v)(2) of the Social Security Act).

For most enrollees, we assigned mandatory and optional eligibility categories based on the classification of each eligibility group code assigned in Appendix C in the T-MSIS analytic file technical documentation. We applied adjustments for certain limited benefit and dually eligible enrollees. Regardless of eligibility group code, all beneficiaries identified as limited benefit under the family planning pathway or uninsured eligible for COVID-19 testing were categorized as optional, and all beneficiaries identified as limited benefit under the emergency Medicaid pathway or partial dual eligible were categorized as mandatory. Because the data elements we used to make these adjustments may conflict, we prioritized dual eligible code, then restricted benefits code, and then

eligibility group code. This means that enrollees who met the criteria for optional eligibility pathways covered in their state, such as the new adult group or disabled with incomes above federal minimum standards, but received coverage through emergency Medicaid were classified as mandatory.

Classification of services

We included all types of service claims in this study, except for claims from the CHIP, and categorized them using the following MACStats service categories: acute hospital, institutional long-term services and supports (LTSS), non-institutional LTSS, drugs, acute other, and managed care. This study excludes the Medicare Premiums service category, which is included in MACStats. To classify claims into our service categories, we primarily relied on the type of service identified in T-MSIS. Because type of service is reported at the line level, it is possible for a single claim to include multiple types of service. To assign a single type of service to a claim, we applied the type of service associated with the greatest proportion of line-level spending.

For certain MACStats service categories, we created subcategories to further classify services. For example, claims in the non-institutional LTSS category were further sorted into subcategories for home health, home- and community- based services (HCBS), personal care, and other. We identified subcategories based on T-MSIS data elements for type of service, type of bill, place of service, billing and servicing provider taxonomy, program type, and benefit type.

We classified each service as mandatory or optional using the service category and subcategory, as well as enrollee information on age, eligibility group, dual status, and restricted benefits status (Table A-1). Almost all services for children age 0 through 20, regardless of eligibility pathway, were considered mandatory because of the statutory requirement to cover the early and periodic, screening, diagnostic, and treatment (EPSDT) benefit; services received by children under HCBS waivers were considered optional. For medically needy adults, all services were considered optional, including those for medically needy enrollees age 65 and older or eligible on the basis of disability. This service categorization applied to both fee-for-service claims and managed care encounter claims.

Managed care expenditures

T-MSIS includes records of each capitated payment made on behalf of an enrollee to a managed care plan, as well as records of each service received by the enrollee from a provider under contract with a managed care plan (also referred to as encounter data). After assigning mandatory and optional classifications to managed care encounter claims, we applied the distribution of mandatory and optional spending from encounter claims to the capitation payments at the state, eligibility group, and service level.

TABLE A-1. Mandatory and Optional Classification of Services

MACStats service category	Service subcategory	Mandatory and optional spending assignment			
		Children (under age 21) or pregnancy-eligible enrollees	Full-benefit adults, enrollees age 65 and older, or enrollees eligible on the basis of disability		Limited benefit adults, enrollees age 65 and older, or enrollees eligible on the basis of disability
			Categorically needy	Medically needy	
Acute hospital	Not applicable	Mandatory	Mandatory	Optional	Mandatory
Institutional LTSS	Nursing facility or skilled nursing facility	Mandatory	Mandatory	Optional	Mandatory
	IMD, inpatient psych	Mandatory	Optional	Optional	Mandatory
	ICF	Mandatory	Optional	Optional	Mandatory
	Other	Mandatory	Optional	Optional	Mandatory
Non-institutional LTSS	Home Health	Mandatory	Mandatory	Optional	Mandatory
	HCBS	Optional	Optional	Optional	Optional
	Personal care	Optional	Optional	Optional	Mandatory
	Other	Mandatory	Optional	Optional	Mandatory
Drugs	Not applicable	Mandatory	Optional	Optional	Mandatory
Acute other	FQHC/RHC	Mandatory	Mandatory	Optional	Mandatory
	Freestanding birth center	Mandatory	Mandatory	Optional	Mandatory
	Lab or x-ray	Mandatory	Mandatory	Optional	Mandatory
	Family planning	Mandatory	Mandatory	Optional	Mandatory
	Nurse-midwife services	Mandatory	Mandatory	Optional	Mandatory
	Certified pediatric and family nurse practitioner services	Mandatory	Mandatory	Optional	Mandatory
	Medical and surgical services by a dentist	Mandatory	Mandatory	Optional	Mandatory
	SUD treatment	Mandatory	Mandatory	Optional	Mandatory
	Nurse services	Mandatory	Mandatory	Optional	Mandatory
	Transportation	Mandatory	Mandatory	Optional	Mandatory
	Physician services	Mandatory	Mandatory	Optional	Mandatory
	Other	Mandatory	Optional	Optional	Mandatory

Notes: LTSS is long-term services and supports. IMD is institution for mental disease. ICF is intermediate care facilities. HCBS is home- and community-based services. FQHC is federally qualified health center. RHC is rural health center. SUD is substance use disorder. Mandatory indicates that the services were classified as mandatory for the specified eligibility group. Optional indicates that the services were classified as optional for the specified eligibility group.

Source: MACPAC, 2025, analysis of T-MSIS data dictionary, the Social Security Act, and the *Code of Federal Regulations*.

APPENDIX B: Supplemental Data Tables

TABLE B-1. Mandatory and Optional Enrollment in Medicaid, by State, FY 2023

State	Total enrollment	Mandatory enrollment		Optional enrollment	
		Number	Percent	Number	Percent
Alabama	**1,312,565**	1,210,107	92.2%	102,458	7.8%
Alaska	**277,169**	168,402	60.8	108,767	39.2
Arizona	**2,589,718**	1,622,867	62.7	966,851	37.3
Arkansas	**1,170,782**	730,337	62.4	440,445	37.6
California	**15,683,276**	7,764,383	49.5	7,918,893	50.5
Colorado	**1,834,190**	863,602	47.1	970,588	52.9
Connecticut	**1,345,594**	807,026	60.0	538,568	40.0
Delaware	**342,379**	219,431	64.1	122,948	35.9
District of Columbia	**308,614**	166,643	54.0	141,971	46.0
Florida	**6,118,128**	2,648,124	43.3	3,470,004	56.7
Georgia	**2,792,880**	2,616,653	93.7	176,227	6.3
Hawaii	**479,598**	255,026	53.2	224,572	46.8
Idaho	**493,686**	268,168	54.3	225,518	45.7
Illinois	**3,812,737**	1,878,290	49.3	1,934,447	50.7
Indiana	**2,282,720**	1,633,709	71.6	649,011	28.4
Iowa	**895,803**	518,506	57.9	377,297	42.1
Kansas	**516,073**	477,353	92.5	38,720	7.5
Kentucky	**1,734,931**	965,888	55.7	769,043	44.3
Louisiana	**1,954,375**	1,050,728	53.8	903,647	46.2
Maine	**488,645**	278,673	57.0	209,972	43.0
Maryland	**1,710,733**	1,103,474	64.5	607,259	35.5
Massachusetts	**2,331,759**	1,375,077	59.0	956,682	41.0
Michigan	**3,288,140**	2,073,733	63.1	1,214,407	36.9
Minnesota	**1,537,348**	978,292	63.6	559,056	36.4
Mississippi	**868,186**	798,983	92.0	69,203	8.0
Missouri	**1,628,403**	1,206,521	74.1	421,882	25.9
Montana	**326,069**	190,190	58.3	135,879	41.7
Nebraska	**396,169**	245,770	62.0	150,399	38.0
Nevada	**1,014,639**	567,698	56.0	446,941	44.0
New Hampshire	**273,422**	144,180	52.7	129,242	47.3
New Jersey	**2,238,052**	1,167,700	52.2	1,070,352	47.8
New Mexico	**1,029,242**	616,650	59.9	412,592	40.1
New York	**8,210,722**	4,688,933	57.1	3,521,789	42.9
North Carolina	**2,909,145**	2,087,843	71.8	821,302	28.2
North Dakota	**144,110**	91,866	63.7	52,244	36.3
Ohio	**3,437,726**	2,126,517	61.9	1,311,209	38.1

State	Total enrollment	Mandatory enrollment		Optional enrollment	
		Number	Percent	Number	Percent
Oklahoma	**1,443,240**	985,306	68.3	457,934	31.7
Oregon	**1,495,490**	566,732	37.9	928,758	62.1
Pennsylvania	**3,791,197**	2,084,945	55.0	1,706,252	45.0
Rhode Island	**365,111**	217,642	59.6	147,469	40.4
South Carolina	**1,564,759**	1,241,939	79.4	322,820	20.6
South Dakota	**155,750**	127,645	82.0	28,105	18.0
Tennessee	**1,917,604**	1,794,062	93.6	123,542	6.4
Texas	**6,864,918**	6,198,186	90.3	666,732	9.7
Utah	**551,065**	319,345	58.0	231,720	42.0
Vermont	**215,354**	116,070	53.9	99,284	46.1
Virginia	**2,167,638**	1,195,751	55.2	971,887	44.8
Washington	**2,425,208**	1,428,127	58.9	997,081	41.1
West Virginia	**699,474**	406,918	58.2	292,556	41.8
Wisconsin	**1,608,119**	1,011,760	62.9	596,359	37.1
Wyoming	**96,552**	86,594	89.7	9,958	10.3

Notes: FY is fiscal year. Expansion refers to states that have expanded Medicaid eligibility to low-income adults under the Patient Protection and Affordable Care Act (P.L. 111-148, as amended). 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 State Children's Health Insurance Program (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 data.

TABLE B-2. Medicaid Spending on Mandatory and Optional Services by Service Category and Subcategory, FY 2023

Service category and subcategory	Total spending (billions)	Mandatory service spending		Optional service spending	
		Dollars (billions)	Percent of service category total	Dollars (billions)	Percent of service category total
Total	**$823.1**	**$503.6**	**100%**	**$319.4**	**100%**
Acute Hospital	**225.8**	**221.8**	**100.0**	**3.9**	**100.0**
Acute Other	**226.3**	**185.6**	**100.0**	**40.6**	**100.0**
Certified pediatric and family nurse practitioner services	**6.2**	6.1	3.3	0.0	0.1
Family planning	**5.0**	4.9	2.7	0.0	0.1
FQHC/RHC	**12.2**	12.1	6.5	0.1	0.3

Service category and subcategory	Total spending (billions)	Mandatory service spending		Optional service spending	
		Dollars (billions)	Percent of service category total	Dollars (billions)	Percent of service category total
Freestanding birth center	**0.0**	0.0	0.0	0.0	0.0
Lab/x-ray	**7.5**	7.4	4.0	0.1	0.1
Medical and surgical services by a dentist	**1.7**	1.7	0.9	0.0	0.0
Nurse services	**0.7**	0.6	0.3	0.0	0.0
Nurse midwife services	**1.2**	1.2	0.7	0.0	0.0
Physician services	**119.4**	117.7	63.4	1.6	4.0
SUD treatment	**3.1**	3.1	1.7	0.0	0.0
Transportation	**11.2**	10.8	5.8	0.4	1.0
Other	**58.1**	19.8	10.7	38.3	94.2
Institutional LTSS	**102.9**	**69.0**	**100.0**	**34.0**	**100.0**
Intermediate care facility	**13.0**	0.6	0.8	12.4	36.5
IMD/inpatient psychiatric	**4.4**	3.0	4.4	1.3	3.9
Nursing facility or skilled nursing facility	**83.9**	65.2	94.6	18.7	54.9
Other	**1.7**	0.1	0.2	1.6	4.7
Non-Institutional LTSS	**166.4**	**6.6**	**100.0**	**159.8**	**100.0**
HCBS	**134.7**	–	0.0	134.7	84.3
Home health	**6.7**	6.4	96.8	0.2	0.1
Personal care	**23.4**	0.0	0.1	23.4	14.6
Other	**1.7**	0.2	3.1	1.5	0.9
Drugs	**101.6**	**20.5**	**100.0**	**81.1**	**100.0**

Notes: FY is fiscal year. FQHC is federally qualified health center. HCBS is home- and community-based services. IMD is institution for mental disease. LTSS is long-term services and supports. RHC is rural health center. SUD is substance use disorder. This table includes federal and state funds, and 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.

– Dash indicates zero. A dollar value of $0.0 indicates there is spending, but it is less than $100 million. A percentage value of 0.0 indicates there is spending but it is less than 0.5 percent.

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

TABLE B-3. Medicaid Spending on Mandatory and Optional Services by State, FY 2023 (billions)

State	Total spending (billions)	Mandatory Services		Optional Services	
		Spending (billions)	Percent	Spending (billions)	Percent
Alabama[1]	**$7.2**	$5.9	81.6%	$1.2	16.5%
Alaska	**2.5**	2.0	78.6	0.5	21.4
Arizona	**21.4**	14.3	66.9	7.1	33.1
Arkansas	**8.4**	5.8	69.8	2.5	30.2
California	**117.4**	68.5	58.4	48.9	41.6
Colorado	**12.5**	9.1	72.9	3.4	27.1
Connecticut	**9.8**	6.8	69.2	3.0	30.8
Delaware	**3.3**	2.2	68.2	1.0	31.8
District of Columbia	**4.0**	2.4	58.9	1.6	41.1
Florida	**30.0**	19.1	63.7	10.9	36.3
Georgia	**14.7**	11.5	78.1	3.2	21.9
Hawaii	**2.9**	1.9	63.8	1.1	36.2
Idaho	**3.5**	2.3	66.3	1.2	33.7
Illinois	**31.1**	18.9	60.8	12.2	39.2
Indiana	**16.7**	11.4	68.1	5.3	31.9
Iowa	**6.7**	4.4	66.3	2.3	33.7
Kansas	**4.9**	3.1	62.6	1.8	37.4
Kentucky	**15.9**	10.6	66.5	5.3	33.5
Louisiana	**15.4**	9.4	60.8	6.0	39.2
Maine[1]	**3.9**	2.7	68.8	1.2	30.4
Maryland	**16.1**	9.4	58.0	6.8	42.0
Massachusetts	**21.6**	13.1	60.7	8.5	39.3
Michigan	**21.9**	13.9	63.5	8.0	36.5
Minnesota	**18.2**	7.6	41.9	10.6	58.1
Mississippi	**5.8**	4.0	69.0	1.8	31.0
Missouri	**14.8**	10.4	69.9	4.5	30.1
Montana[1]	**2.3**	1.8	76.3	0.5	22.1
Nebraska	**3.7**	1.9	50.9	1.8	49.1
Nevada	**5.4**	3.9	73.2	1.4	26.8
New Hampshire	**2.1**	0.9	44.3	1.2	55.7
New Jersey	**20.9**	13.0	62.1	7.9	37.9
New Mexico	**7.9**	5.3	67.1	2.6	32.9
New York	**91.0**	42.4	46.6	48.6	53.4
North Carolina	**18.3**	12.6	68.7	5.7	31.3
North Dakota	**1.5**	0.8	54.4	0.7	45.6
Ohio	**30.2**	16.6	54.8	13.7	45.2
Oklahoma	**9.3**	7.0	75.5	2.3	24.5

State	Total spending (billions)	Mandatory Services		Optional Services	
		Spending (billions)	Percent	Spending (billions)	Percent
Oregon	**14.4**	8.7	60.6	5.7	39.4
Pennsylvania	**41.7**	22.4	53.8	19.3	46.2
Rhode Island	**2.3**	1.4	61.7	0.9	38.3
South Carolina	**8.0**	5.9	73.7	2.1	26.3
South Dakota	**1.1**	0.7	64.9	0.4	35.1
Tennessee	**11.1**	7.4	66.5	3.7	33.5
Texas	**48.2**	35.0	72.7	13.1	27.3
Utah	**4.5**	3.2	71.1	1.3	28.9
Vermont	**1.8**	1.3	70.3	0.5	29.7
Virginia	**21.1**	12.7	60.0	8.4	40.0
Washington	**28.3**	16.8	59.4	11.5	40.6
West Virginia	**5.2**	3.8	73.5	1.4	26.5
Wisconsin	**11.6**	7.9	68.4	3.7	31.6
Wyoming[1]	**0.7**	0.5	64.6	0.2	35.0

Notes: FY is fiscal year. Includes federal and state funds. Excludes spending for administration, the territories, and Medicaid-expansion State Children's Health Insurance Program 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.

[1] 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.