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## Medicaid

The following are brief summaries of complex subjects as of November 1, 2013. They should be used only as overviews and general guides to the Medicare and Medicaid programs. The views expressed herein do not necessarily reflect the policies or legal positions of the Centers for Medicare & Medicaid Services (CMS) or the Department of Health and Human Services (HHS). These summaries do not render any legal, accounting, or other professional advice, nor are they intended to explain fully all of the provisions or exclusions of the relevant laws, regulations, and rulings of the Medicare and Medicaid programs. Original sources of authority should be researched and utilized.<sup>1</sup>

### Overview

Title XIX of the Social Security Act is a federal and state entitlement program that pays for medical assistance for certain individuals and families with low incomes and resources. This program, known as Medicaid, became law in 1965 as a cooperative venture jointly funded by the federal and state governments (including the District of Columbia and the territories) to assist states in furnishing medical assistance to eligible needy persons. Medicaid is the largest source of funding for medical and health-related services for America's poorest people.

Within broad national guidelines established by federal statutes, regulations, and policies, each state establishes its own eligibility standards; determines the type, amount, duration, and scope of services; sets the rate of payment for services; and administers its own program. Medicaid policies for eligibility, services, and payment are complex and vary considerably, even among states of similar size or geographic proximity. Thus, a person who is eligible for Medicaid in one state may not be eligible in another state, and the services provided by one state may differ considerably in amount, duration, or scope from services provided in a similar or neighboring state. In addition, state legislatures may change Medicaid eligibility, services, and/or reimbursement at any time.

Title XXI of the Social Security Act, the Children's Health Insurance Program (CHIP, known from its inception until March 2009 as the State Children's Health

Insurance Program, or SCHIP), is a program initiated by the Balanced Budget Act (BBA) of 1997 (Public Law 105-33). The BBA provided \$40 billion in federal funding through fiscal year 2007 to furnish health care coverage for low-income children—generally those in families with income below 200 percent of the federal poverty level (FPL)—who did not qualify for Medicaid and would otherwise be uninsured. Subsequent legislation, including the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 (Public Law 111-3) and the Patient Protection and Affordable Care Act (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152)—collectively referred to as the Affordable Care Act—extended CHIP funding through fiscal year 2015. Under CHIP, states may elect to provide coverage to qualifying children by expanding their Medicaid programs or through a state program separate from Medicaid. A number of states have also been granted waivers to cover parents of children enrolled in CHIP.

### Medicaid Eligibility

Until 2014, when the Affordable Care Act will expand Medicaid eligibility, Medicaid does not provide medical assistance for all poor persons. Under the broadest provisions of the federal statute, Medicaid does not currently provide health care services even for very poor persons unless they are in one of the groups designated below. Low income is only one test for Medicaid eligibility for most of those within these groups; their financial resources also are tested against threshold levels (as determined by each state within federal guidelines).

States generally have broad discretion in determining which groups their Medicaid programs will cover and the financial criteria for Medicaid eligibility. To be eligible for federal funds, however, states are required to provide Medicaid coverage for certain individuals who receive federally assisted income-maintenance payments, as well as for related groups not receiving cash payments. In addition to their Medicaid programs, most states have additional "state-only" programs to provide medical assistance for specified poor persons who do not qualify for Medicaid. Federal funds are not provided for state-only programs. The following enumerates the mandatory Medicaid "categorically needy" eligibility groups for which federal matching funds are provided:

- Limited-income families with children, as described in section 1931 of the Social Security Act, are generally eligible for Medicaid if they meet the requirements for the Aid to Families with Dependent Children

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(AFDC) program that were in effect in their state on July 16, 1996.

- Children under age 6 whose family income is at or below 133 percent of the FPL. (As of January 2013, the FPL has been set at \$23,550 for a family of four in the continental U.S.; Alaska and Hawaii's FPLs are \$29,440 and \$27,090, respectively.)
- Pregnant women whose family income is below 133 percent of the FPL. (Services to these women are limited to those related to pregnancy, complications of pregnancy, delivery, and postpartum care.)
- Infants born to Medicaid-eligible women, for the first year of life with certain restrictions.
- Supplemental Security Income (SSI) recipients in most states (or aged, blind, and disabled individuals in states using more restrictive Medicaid eligibility requirements that pre-date SSI).
- Recipients of adoption or foster care assistance under Title IV-E of the Social Security Act.
- Special protected groups (typically individuals who lose their cash assistance under Title IV-A or SSI because of earnings from work or from increased Social Security benefits, but who may keep Medicaid for a period of time).
- All children under age 19, in families with incomes at or below the FPL.
- Certain Medicare beneficiaries (described later).

States also have the option of providing Medicaid coverage for other “categorically related” groups. These optional groups share characteristics of the mandatory groups (that is, they fall within defined categories), but the eligibility criteria are somewhat more liberally defined. The broadest optional groups for which states can receive federal matching funds for coverage under the Medicaid program include the following:

- Infants up to age 1 and pregnant women not covered under the mandatory rules whose family income is no more than 185 percent of the FPL. (The percentage amount is set by each state.)
- Children under age 21 who meet criteria more liberal than the AFDC income and resources requirements that were in effect in their state on July 16, 1996.
- Institutionalized individuals, and individuals in home and community-based waiver programs, who are eligible under a “special income level.” (The amount is set by each state—up to 300 percent of the SSI federal benefit rate.)

- Individuals who would be eligible if institutionalized, but who are receiving care under home and community-based services waivers.
- Certain aged, blind, or disabled adults who have incomes above those requiring mandatory coverage, but below the FPL.
- Aged, blind, or disabled recipients of state supplementary income payments.
- Certain working-and-disabled persons with family income less than 250 percent of the FPL who would qualify for SSI if they did not work.
- Tuberculosis-infected persons who would be financially eligible for Medicaid at the SSI income level if they were in a Medicaid-covered category. (Coverage is limited to tuberculosis-related ambulatory services and tuberculosis drugs.)
- Certain uninsured or low-income women who are screened for breast or cervical cancer through a program administered by the Centers for Disease Control and Prevention. The Breast and Cervical Cancer Prevention and Treatment Act of 2000 (Public Law 106-354) provides these women with medical assistance and follow-up diagnostic services through Medicaid.
- “Optional targeted low-income children” included in the CHIP (formerly SCHIP) program established by the BBA.
- “Medically needy” persons (described below).

The medically needy (MN) option allows states to extend Medicaid eligibility to additional persons. These persons would be eligible for Medicaid under one of the mandatory or optional groups, except that their income and/or resources are above the eligibility level set by their state for those groups. Persons may qualify immediately or may “spend down” by incurring medical expenses greater than the amount by which their income exceeds their state's MN income level.

Medicaid eligibility and benefit provisions for the medically needy do not have to be as extensive as for the categorically needy, and may be quite restrictive. Federal matching funds are available for MN programs. However, if a state elects to have an MN program, it must meet federal requirements that certain groups (including children under age 19 and pregnant women) be covered and that certain services (including prenatal and delivery care for pregnant women and ambulatory care for children) be provided. A state may elect to provide MN eligibility to certain additional groups and may elect to provide certain additional services as part of its MN program. As of 2010, 34 states plus the District of Columbia have elected to have an MN program and are

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providing services to at least some MN beneficiaries. All remaining states utilize the “special income level” option to extend Medicaid to the “near poor” in medical institutional settings.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104-193)—known as the “welfare reform” bill—made restrictive changes regarding eligibility for SSI coverage that affected the Medicaid program. For example, legal resident aliens and other qualified aliens who entered the United States on or after August 22, 1996 are ineligible for Medicaid for 5 years. States have the option of providing Medicaid coverage for most aliens entering before that date and coverage for those eligible after the 5-year ban; emergency services, however, are mandatory for both of these alien coverage groups. For aliens who lose SSI benefits because of these restrictions regarding SSI coverage, Medicaid benefits can continue only if these persons can be covered under some other eligibility status (again with the exception of emergency services, which are mandatory). Public Law 104-193 also affected a number of disabled children, who lost SSI as a result of the restrictive changes; however, their eligibility for Medicaid was reinstated by Public Law 105-33, the BBA.

In addition, welfare reform repealed the open-ended federal entitlement program known as Aid to Families with Dependent Children (AFDC) and replaced it with Temporary Assistance for Needy Families (TANF), which provides states with grants to be spent on time-limited cash assistance. TANF generally limits a family’s lifetime cash welfare benefits to a maximum of 5 years and permits states to impose a wide range of other requirements as well—in particular, those related to employment. However, the impact on Medicaid eligibility has not been significant. Under welfare reform, persons who would have been eligible for AFDC under the AFDC requirements in effect on July 16, 1996 are generally still eligible for Medicaid. Although most persons covered by TANF receive Medicaid, it is not required by law.

Medicaid coverage may begin as early as the third month prior to application—if the person would have been eligible for Medicaid had he or she applied during that time. Medicaid coverage generally stops at the end of the month in which a person no longer meets the criteria of any Medicaid eligibility group. The BBA allows states to provide 12 months of continuous Medicaid coverage (without reevaluation) for eligible children under age 19.

The Ticket to Work and Work Incentives Improvement Act of 1999 (Public Law 106-170) provides or continues Medicaid coverage to certain disabled beneficiaries who work despite their disability. Beneficiaries with

higher incomes may pay a sliding scale premium based on income.

The Deficit Reduction Act (DRA) of 2005 (Public Law 109-171) refined eligibility requirements for Medicaid beneficiaries by tightening standards for citizenship and immigration documentation and by changing the rules concerning long-term care eligibility—specifically, the look-back period for determining community spouse income and assets was lengthened from 36 months to 60 months, individuals whose homes exceed \$500,000 in value are disqualified, and the states are required to impose partial months of ineligibility.

Beginning in 2014, the Affordable Care Act will give states the option to extend Medicaid eligibility to all individuals under age 65 in families with income below 138 percent of the FPL. (Technically, the income limit is 133 percent of the FPL, but the Act also provides for a 5-percent income disregard.) In addition to the higher level of allowable income, the new legislation expands eligibility to people under age 65 who have no other qualifying factors that would have made them eligible for Medicaid under prior law, such as being under age 18, disabled, pregnant, or parents of eligible children. Because individuals are not required to be parents of eligible children under the new law, nondisabled non-aged adults comprise the category expected to have the greatest increase in Medicaid enrollment. In *National Federation of Independent Business v. Sebelius (2012)*, the U.S. Supreme Court ruled that states could not be required to expand Medicaid eligibility to 138 percent of the FPL as a condition of continuing to operate the existing Medicaid program and receiving Federal financial participation. This ruling has made the eligibility expansion effectively optional for each state’s Medicaid program. Thus, it is possible that some states would choose not to expand Medicaid eligibility in 2014 and that the individuals who would potentially be newly eligible would remain ineligible in those states.

## Scope of Medicaid Services

Title XIX of the Social Security Act allows considerable flexibility within the states’ Medicaid plans. However, some federal requirements are mandatory if federal matching funds are to be received. A state’s Medicaid program must offer medical assistance for certain basic services to most categorically needy populations. These services generally include:

- Inpatient hospital services;
- Outpatient hospital services;
- Pregnancy-related services, including prenatal care and 60 days postpartum pregnancy-related services;
- Vaccines for children;

- Physician services;
- Nursing facility services for persons aged 21 or older;
- Family planning services and supplies;
- Rural health clinic services;
- Home health care for persons eligible for skilled nursing services;
- Laboratory and x-ray services;
- Pediatric and family nurse practitioner services;
- Nurse-midwife services;
- Federally qualified health center (FQHC) services, and ambulatory services of an FQHC that would be available in other settings; and
- Early and periodic screening, diagnostic, and treatment (EPSDT) services for children under age 21.

States may also receive federal matching funds to provide certain optional services. Some of the most common currently approved optional Medicaid services are:

- Diagnostic services;
- Clinic services;
- Intermediate care facility services;
- Prescribed drugs and prosthetic devices;
- Optometrist services and eyeglasses;
- Nursing facility services for children under age 21;
- Transportation services;
- Rehabilitation and physical therapy services;
- Hospice care;
- Home and community-based care to certain persons with chronic impairments; and
- Targeted case management services.

The BBA included a state option known as Programs of All-inclusive Care for the Elderly (PACE). PACE provides an alternative to institutional care for persons aged 55 and older who require a nursing-facility level of care. The PACE team offers and manages all health, medical, and social services and mobilizes other services as needed to provide preventive, rehabilitative, curative, and supportive care. This care, provided in day health centers, homes, hospitals, and nursing homes, helps the person maintain independence, dignity, and quality of life. PACE functions within the Medicare program as well. Regardless of source of payment, PACE providers receive payment only through the PACE agreement and must make available all items and

services covered under both Titles XVIII and XIX, without amount, duration, or scope limitations and without application of any deductibles, copayments, or other cost sharing. The individuals enrolled in PACE receive benefits solely through the PACE program.

## Amount and Duration of Medicaid Services

Within broad federal guidelines and certain limitations, states determine the amount and duration of services offered under their Medicaid programs. States may limit, for example, the number of days of hospital care or the number of physician visits covered. Two restrictions apply: (1) limits must result in a sufficient level of services to reasonably achieve the purpose of the benefits, and (2) limits on benefits may not discriminate among beneficiaries based on medical diagnosis or condition.

In general, states are required to provide comparable amounts, duration, and scope of services to all categorically needy and categorically related eligible persons. There are two important exceptions: (1) medically necessary health care services that are identified under the EPSDT program for eligible children, and that are within the scope of mandatory or optional services under federal law, must be covered even if those services are not included as part of the covered services in that state's plan, and (2) states may request waivers to pay for otherwise uncovered home and community-based services for Medicaid-eligible persons who might otherwise be institutionalized. As long as the services are cost effective, states have few limitations on the services that may be covered under these waivers (except that states may not provide room and board for the beneficiaries, other than as a part of respite care). With certain exceptions, a state's Medicaid program must allow beneficiaries to have some informed choices among participating providers of health care and to receive quality care that is appropriate and timely.

## Payment for Medicaid Services

Medicaid operates as a vendor payment program. States may pay health care providers directly on a fee-for-service basis, or states may pay for Medicaid services through various prepayment arrangements, such as health maintenance organizations (HMOs). Within federally imposed upper limits and specific restrictions, each state for the most part has broad discretion in determining the payment methodology and payment rate for services. Generally, payment rates must be sufficient to enlist enough providers so that covered services are available at least to the extent that comparable care and services are available to the general population within that geographic area. Providers participating in Medicaid must accept Medicaid payment rates as payment in

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full. States must make additional payments to qualified hospitals that provide inpatient services to a disproportionate number of Medicaid beneficiaries and/or to other low-income or uninsured persons under what is known as the “disproportionate share hospital” (DSH) adjustment. From 1988 to 1991, excessive and inappropriate use of the DSH adjustment resulted in rapidly increasing federal expenditures for Medicaid. Legislation passed in 1991 and 1993, and amended in the BBA of 1997 and later legislation, capped the federal share of payments to DSH hospitals.

States may impose nominal deductibles, coinsurance, or copayments on some Medicaid beneficiaries for certain services. The following Medicaid beneficiaries, however, must be excluded from cost sharing: pregnant women, children under age 18, and hospital or nursing home patients who are expected to contribute most of their income to institutional care. In addition, all Medicaid beneficiaries must be exempt from copayments for emergency services and family planning services. Under the DRA, new cost sharing and benefit rules provided states the option of imposing new premiums and increased cost sharing on all Medicaid beneficiaries except for those mentioned above and for terminally ill patients in hospice care. The DRA also established special rules for cost sharing for prescription drugs and for nonemergency services furnished in emergency rooms.

The federal government pays a share of the medical assistance expenditures under each state’s Medicaid program. That share, known as the Federal Medical Assistance Percentage (FMAP), is determined annually by a formula that compares the state’s average per capita income level with the national income average. States with a higher per capita income level are reimbursed a smaller share of their costs. By law, the FMAP cannot be lower than 50 percent or higher than 83 percent. In fiscal year 2013, the FMAPs varied from 50 percent in 19 states and the territories to 73.4 percent in Mississippi and averaged 59.5 percent overall. The BBA permanently raised the FMAP for the District of Columbia from 50 percent to 70 percent. For children covered through the CHIP program, the federal government pays states a higher share, or “enhanced” FMAP, which averaged 71.4 percent in fiscal year 2013.

The American Recovery and Reinvestment Act (ARRA) of 2009 (Public Law 111-5) provided states with an increase in their Medicaid FMAPs of up to 14 percentage points, depending on state unemployment rates, for the first quarter of fiscal year 2009 through the first quarter of fiscal year 2011. Section 201 of Public Law 111-226 (referred to as the Education, Jobs, and Medicaid Assistance Act of 2010) extended these increases for the second and third quarters of fiscal year 2011, but at lower levels than those under ARRA.

The federal government also reimburses states for 100 percent of the cost of services provided to American Indians and Alaska Natives through facilities of the Indian Health Service, for 100 percent of the cost of the Qualifying Individuals (QI) program (described later), and for 90 percent of the cost of family planning services, and shares in each state’s expenditures for the administration of the Medicaid program. Most administrative costs are matched at 50 percent, although higher percentages are paid for certain activities and functions, such as development of mechanized claims processing systems.

Except for the CHIP program, the QI program, DSH payments, and payments to territories, federal payments to states for medical assistance have no set limit (cap). Rather, the federal government matches (at FMAP rates) state expenditures for the mandatory services, as well as for the optional services that the individual state decides to cover for eligible beneficiaries, and matches (at the appropriate administrative rate) all necessary and proper administrative costs.

## Summary and Trends

Medicaid was initially formulated as a medical care extension of federally funded programs providing cash income assistance for the poor, with an emphasis on dependent children and their mothers, the disabled, and the elderly. Over the years, however, Medicaid eligibility has been incrementally expanded beyond its original ties with eligibility for cash programs. Legislation in the late 1980s extended Medicaid coverage to a larger number of low-income pregnant women and poor children and to some Medicare beneficiaries who are not eligible for any cash assistance program. Legislative changes also focused on increased access, better quality of care, specific benefits, enhanced outreach programs, and fewer limits on services.

In most years since its inception, Medicaid has had very rapid growth in expenditures. This rapid growth has been due primarily to the following factors:

- The increase in size of the Medicaid-covered populations as a result of federal mandates, increased state coverage of optional groups, general population growth, and economic recessions;
- The expansion of coverage and utilization of services;
- The DSH payment program, coupled with its inappropriate use to increase federal payments to states;
- The increase in the number of very old and disabled persons requiring extensive acute and/or long-term health care and various related services;

- The results of technological advances to keep a greater number of very low birth-weight babies and other critically ill or severely injured persons alive and in need of continued extensive and very costly care;
- The increase in drug costs and the availability of new expensive drugs; and
- The increase in payment rates to providers of health care services, when compared with general inflation.

As with all health insurance programs, most Medicaid beneficiaries incur relatively small average expenditures per person each year, and a relatively small proportion incurs very large costs. Moreover, the average cost varies substantially by type of beneficiary. National data for 2012, for example, indicate that Medicaid payments for services for 28.3 million children, who constituted 49 percent of all Medicaid beneficiaries, averaged \$2,623 per child. Similarly, for 14.6 million nondisabled adults, who represented 25 percent of beneficiaries, payments averaged \$4,458 per person. However, other groups had much larger per-person expenditures. Medicaid payments for services for 5.1 million aged, who constituted 9 percent of all Medicaid beneficiaries, averaged \$15,990 per person; for 9.7 million disabled, who represented 17 percent of beneficiaries, payments averaged \$16,781 per person. When expenditures for these high- and lower-cost beneficiaries are combined, the 2012 payments to health care vendors for 57.6 million Medicaid beneficiaries averaged \$6,641 per person.

Long-term care is an important provision of Medicaid that will be increasingly utilized as our nation's population ages. The Medicaid program paid for nearly 40 percent of the total cost of nursing facility care in 2010. National data for 2010 show that Medicaid payments for nursing facility services (excluding intermediate care facilities) totaled \$49.7 billion for more than 1.5 million beneficiaries of these services—an average expenditure of \$32,153 per nursing home beneficiary. The national data also show that Medicaid payments for home health services totaled \$4.8 billion for 1.1 million beneficiaries—an average expenditure of \$4,196 per home health care beneficiary. With the percentage of our population who are elderly or disabled increasing faster than that of the younger groups, the need for long-term care is expected to increase.

Another significant development in Medicaid is the growth in managed care as an alternative service delivery concept different from the traditional fee-for-service system. Under managed care systems, HMOs, prepaid health plans (PHPs), or comparable entities agree to provide a specific set of services to Medicaid enrollees, usually in return for a predetermined periodic payment per enrollee. Managed care programs seek to enhance access to quality care in a cost-effective

manner. Waivers may provide the states with greater flexibility in the design and implementation of their Medicaid managed care programs. Waiver authority under sections 1915(b) and 1115 of the Social Security Act is an important part of the Medicaid program. Section 1915(b) waivers allow states to develop innovative health care delivery or reimbursement systems. Section 1115 waivers allow experimental statewide health care reform demonstrations to cover uninsured populations and to test new delivery systems without increasing costs. Finally, the BBA provided states a new option to use managed care without a waiver. According to the *Medicaid Managed Care Enrollment Report*, the share of Medicaid beneficiaries enrolled in some form of managed care program grew steadily from 48 percent of enrollees in 1997 to 74 percent in 2011.

In fiscal year 2012, net outlays for the Medicaid program (federal and state) were \$431.9 billion, including direct payment to providers of \$251.9 billion, payments for various premiums (for HMOs, Medicare, etc.) of \$132.5 billion, payments to disproportionate share hospitals of \$14.1 billion, administrative costs of \$22.6 billion, and various adjustments totaling \$7.2 billion. In addition, there were \$3.6 billion in expenditures for the Vaccines for Children Program under Title XIX. With no other changes to the Medicaid program except for those already prescribed by current law (including the Affordable Care Act), spending is projected to reach \$667 billion by fiscal year 2018.

Expenditures under the CHIP program in fiscal year 2012 were \$12.3 billion. CHIP is currently funded through fiscal year 2015.

## The Medicaid-Medicare Relationship

Medicare beneficiaries who have low incomes and limited resources may also receive help from the Medicaid program. For such persons who are eligible for full Medicaid coverage, the Medicare health care coverage is supplemented by services that are available under their state's Medicaid program. These additional services may include, for example, nursing facility care beyond the 100-day limit covered by Medicare, eyeglasses, and hearing aids. For persons enrolled in both programs, any services that are covered by Medicare are paid for by the Medicare program before any payments are made by the Medicaid program, since Medicaid is always the "payer of last resort."

Certain other Medicare beneficiaries may receive help with Medicare premium and cost-sharing payments through their state Medicaid program. Qualified Medicare Beneficiaries (QMBs) and Specified Low-Income Medicare Beneficiaries (SLMBs) are the best-known categories and the largest in numbers. QMBs are those

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Medicare beneficiaries who have financial resources at or below twice the standard allowed under the SSI program and incomes at or below 100 percent of the FPL. For QMBs, Medicaid pays the Hospital Insurance (HI, or Part A) and Supplementary Medical Insurance (SMI) Part B premiums and the Medicare coinsurance and deductibles, subject to limits that states may impose on payment rates. SLMBs are Medicare beneficiaries with resources like the QMBs but with incomes that are higher, though still less than 120 percent of the FPL. For SLMBs, the Medicaid program pays only the Part B premiums. A third category of Medicare beneficiaries who may receive help consists of disabled-and-working individuals. According to Medicare law, disabled-and-working individuals who previously qualified for Medicare because of disability, but who lost entitlement because of their return to work (despite the disability), are allowed to purchase Medicare Part A and Part B coverage. If these persons have incomes below 200 percent of the FPL but do not meet any other Medicaid assistance category, they may qualify to have Medicaid pay their Part A premiums as Qualified Disabled and Working Individuals (QDWIs).

For Medicare beneficiaries with incomes above 120 percent and less than 135 percent of the FPL, states receive a capped allotment of federal funds for payment of Medicare Part B premiums. These beneficiaries are known as Qualifying Individuals (QIs). Unlike the QMBs and SLMBs, who may be eligible for other Medicaid benefits in addition to their QMB/SLMB benefits, the QIs cannot be otherwise eligible for medical assistance under a state plan. The QI benefit is 100 percent federally funded, up to the state's allotment. The QI program was established by the BBA for fiscal years 1998 through 2002 and has been extended numerous times, most recently through the end of December 2013.

The Centers for Medicare & Medicaid Services (CMS) estimates that, in 2012, Medicaid provided some level of supplemental health coverage for 9.6 million Medicare beneficiaries.

In January 2006, a new Medicare prescription drug benefit began that provides drug coverage for Medicare beneficiaries, including those who also receive coverage from Medicaid. In addition, under this benefit, individuals eligible for both Medicare and Medicaid receive a low-income subsidy for the Medicare drug plan premium and assistance with cost sharing for prescriptions. Medicaid no longer provides drug benefits for Medicare beneficiaries.

Because the Medicare drug benefit and low-income subsidy replace a portion of state Medicaid expenditures for drugs, states see a reduction in Medicaid expenditures. To offset this reduction, the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 (Public Law 108-173) requires each state to make a monthly payment to Medicare representing a percentage of the projected reduction. For 2006, this payment was 90 percent of the projected 2006 reduction in state spending. The percentage has decreased by 1 2/3 percent per year since 2006 and will continue decreasing to 75 percent for 2015 and beyond.

Note: Medicaid data are based on the projections of the *2013 Actuarial Report on the Financial Outlook for Medicaid* (forthcoming at <http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Actuarial-Report-on-Financial-Outlook-for-Medicaid.html>) and are consistent with data received from the states through the Medicaid Statistical Information System (MSIS) and forms CMS-37 and CMS-64. Medicaid managed care enrollment data are from the *Medicaid Managed Care Enrollment Report*, available at <http://www.medicare.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/2011-Medicaid-MC-Enrollment-Report.pdf>.

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