Medicare/Medicaid Dual Eligibles – updated for 2018

Medicare is health insurance for people 65 or older, people under 65 with certain disabilities, and people of any age with End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant). Medicare consists of several parts:

- Medicare Part A (Hospital Insurance) helps cover Inpatient care in a hospital, Skilled nursing facility care, Hospice Care and home health care, within limits.

- Medicare Part B (Medical Insurance) helps cover services from doctors and other health providers, Outpatient care, Home health care, Durable Medical Equipment (DME) such as wheel chairs and some preventive health care services.

- Medicare Part C (Medicare Advantage) includes all the services and benefits of A & B above, often includes Medicare prescription drug coverage (Part D) as part of the plan, and may include extra benefits and services at an extra cost.

- Medicare Part D (Medicare prescription drug coverage) helps cover cost of prescription drugs, is run by Medicare-approved private insurance companies and it may help lower costs and help protect against future cost increases.

For help in selecting a plan with the combination of benefits and costs go to www.medicare.gov/find-a-plan/ or call 1-800-633-4227 (1-800-MEDICARE).

Medicaid provides health coverage in all States for some low-income people, families and children, pregnant women, the elderly, and people with disabilities. In some states the program covers all low-income adults below a certain income level.

- First, find out if your state is expanding Medicaid and learn what that means for you.
- If your state is expanding Medicaid, use this chart to see what you may qualify for based on your income and family size.

Medicaid programs must follow federal guidelines, but they vary somewhat from state to state. Coverage and costs to you may be different from state to state. Some Medicaid programs pay for your care directly. Others use private insurance companies to provide Medicaid coverage.
Some state Medicaid programs have names that don't say "Medicaid." In California it is called Medi-Cal, Hawaii calls it QUEST. Other State names include PrimeCare, SALUD!, TennCare and New Jersey Care 2000.

Medicaid and Children's Health Insurance Program (CHIP) provide health coverage to nearly 60 million Americans, including children, pregnant women, parents, seniors and individuals with disabilities. In

order to participate in Medicaid, federal law requires states to cover certain population groups (mandatory eligibility groups) and gives them the flexibility to cover other population groups (optional eligibility groups). States set individual eligibility criteria within federal minimum standards. States can apply to the Federal Centers for Medicare and Medicaid (CMS) for a waiver of federal law to expand health coverage beyond these groups. Many states have expanded coverage, particularly for children, above the federal minimums. The Affordable Care Act of 2010, signed by President Obama on March 23, 2010, created a national Medicaid minimum eligibility level of 133% of the federal poverty level ($29,700 for a family of four in 2011) for nearly all Americans under age 65. This Medicaid eligibility expansion went into effect on January 1, 2014.

"DUAL ELIGIBLES" (from Medicaid.gov)

In 2013, an estimate 10.2 million Americans were eligible to receive benefits under both Medicare and Medicaid. For some, lower income Medicaid recipients may "age into" Medicare when they reach 65 years of age. Others may be Medicare beneficiaries, but spend their savings and assets down to levels that qualify for Medicaid. Individuals that qualify for dual eligibility will be paid first by Medicare and the remainder will be paid by Medicaid.

Medicare enrollees who have limited income and resources may get help paying for their premiums and out-of-pocket medical expenses from Medicaid (e.g. MSPs, QMBs, SLBs, and QIs). Medicaid also covers additional services beyond those provided under Medicare, including nursing facility care beyond the 100-day limit or skilled nursing facility care that Medicare covers, prescription drugs, eyeglasses, and hearing aids. Services covered by both programs are first paid by Medicare with Medicaid filling in the difference up to the state's payment limit.

The Federal Standards for dual eligibility are:

2018 Dual Eligible Standards
(Based on Percentage of Federal Poverty Level)

Qualified Medicare Beneficiary (QMB):

Monthly Income Limits: (100% FPL + $20)*

Region	Individual	Couple
All States and DC (Except Alaska & Hawaii)	$1,032	$1,392
Alaska	$1,285	$1,735

Hawaii	$1,184	$1,598
Asset Limits	$7,560	$11,340

*$20 = Amount of the Monthly SSI Income Disregard

Specified Low-Income Medicare Beneficiary (SLMB):

Monthly Income Limits: (120% FPL + $20)*

Region	Individual	Couple
All States and DC (Except AK & HI)	$1,234	$1,666
Alaska	$1,538	$2,078
Hawaii	$1,416	$1,913
Asset Limits	$7,560	$11,340

*$20 = Amount of the Monthly SSI Income Disregard

Qualifying Individual (QI):

Monthly Income Limits: (135% FPL + $20)*

Region	Individual	Couple
All States and DC (Except AK & HI)	$1,386	$1,872
Alaska	$1,728	$2,336

Hawaii	$1,591	$2,150
Asset Limits	$7,560	$11,340

*$20 = Amount of the Monthly SSI Income Disregard

Qualified Disabled Working Individual (QDWI):

Monthly Income Limits: (200% FPL + $20)*
(Figures include additional earned income disregards)

Region	Individual	Couple
All States and DC (Except AK & HI)	$4,132	$5,572
Alaska	$5,145	$6,945
Hawaii	$4,739	$6,395
Asset Limits	$4,000	$6,000

*$20 = Amount of the Monthly SSI Income Disregard

Being Dual eligible helps lower the financial costs for patients in receiving needed care, but also increases complexity. Patients may be shifted from one care setting to another to change how provider reimbursements are handled, not necessarily for the patient's best outcome. CMS has estimated that 45% of (expensive) hospitalizations could have been avoided in 2005 with earlier treatment in more cost effective settings. Much of the complexity is lack of coordination of benefits between the two programs. Coordinated care can provide better levels of care for consumers at significantly less cost to State and Federal governments.

The Affordable Care Act created a new office within CMS to do this – the Medicare-Medicaid Coordination Office. Pursuant to Section 2602 of the Affordable Care Act, the Office is charged with:

1. Providing dual eligible individuals full access to the benefits to which such individuals are entitled to under the Medicare and Medicaid programs.

2. Simplifying the processes for dual eligible individuals to access the items and services they are entitled to under the Medicare and Medicaid programs.

3. Improving the quality of health care and long-term services for dual eligible individuals.

4. Increasing dual eligible individuals' understanding of and satisfaction with coverage under the Medicare and Medicaid programs.

5. Eliminating regulatory conflicts between rules under the Medicare and Medicaid programs.

6. Improving care continuity and ensuring safe and effective care transitions for dual eligible individuals.

7. Eliminating cost-shifting between the Medicare and Medicaid program and among related health care providers.

8. Improving the quality of performance of providers of services and suppliers under the Medicare and Medicaid programs.

Medicaid Eligibility Categories

D-SNPs are open to beneficiaries in all Medicaid eligibility categories, including:

Medicaid Eligibility Category	Description
Qualified Medicare Beneficiary without other Medicaid (QMB only)	An individual entitled to Medicare Part A, with an income of 100% Federal poverty level (FPL) or less and resources that do not exceed twice the limit for Supplementary Social Security Income (SSI) eligibility, and who is not otherwise eligible for full Medicaid benefits through the State. Medicaid pays their Medicare Part A premiums, if any, Medicare Part B premiums, and Medicare deductibles and coinsurance for Medicare services provided by Medicare providers to the extent consistent with the Medicaid State Plan.
QMB+	An individual who meets the standards for QMB eligibility, and who also meets the criteria for full Medicaid benefits. Medicaid pays their Medicare Part A premiums, if any, Medicare Part B premiums, Medicare deductibles and coinsurance, and provides full Medicaid benefits to the extent consistent with the State Plan. These individuals often qualify for full Medicaid benefits by meeting Medically Needy standards, or by spending down excess income to the Medically needy level.
Specified Low-Income Medicare Beneficiary without other Medicaid (SLMB only)	An individual entitled to Medicare Part A, with an income that exceeds 100% FPL but less than 120% FPL, with resources that do not exceed twice the SSI limit, and who is not otherwise eligible for Medicaid. These individuals are eligible for Medicaid payment of the Medicare Part B premium only. They do not qualify for any additional Medicaid benefits.
SLMB+	An individual who meets the standards for SLMB eligibility, and who also meets the criteria for full State Medicaid benefits. These individuals are entitled to payment of the Medicare Part B premium, in addition to full State Medicaid benefits. These individuals often qualify for Medicaid by meeting Medically Needy standards or by spending down excess income to the Medically Needy level.

Qualifying Individual (QI)	An individual entitled to Medicare Part A, with an income at least 120% FPL but less than 135% FPL, and resources that do not exceed twice the SSI limit, and who is not otherwise eligible for Medicaid benefits. This individual is eligible for Medicaid payment of the Medicare Part B premium.
Qualifying Disabled and Working Individual (QDWI)	An individual who has lost Medicare Part A benefits due to a return to work, but is eligible to enroll in and purchase Medicare Part A. The individual's income may not exceed 200% FPL and resources may not exceed twice the SSI limit. The individual may not be otherwise eligible for Medicaid. These individuals are eligible for Medicaid payment of the Part A premium only.
Other full benefit dual eligible (FBDE)	An individual who does not meet the income or resource criteria for QMB or SLMB, but is eligible for Medicaid either categorically or through optional coverage groups based on Medically Needy status, special income levels for institutionalized individuals, or home and community-based waivers.

Source: https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/DualEligibleSNP.html#s1

Information on Dual Eligible Special Needs Plans can be found here:

www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/DualEligibleSNP.html

Footnotes

1 Medicare-Medicaid Coordination Office. Data Analysis Brief: Medicare-Medicaid Dual Enrollment from 2006 through 2011. February 2013