ONLINE APPENDIXES 6

Care needs for dual-eligible beneficiaries

ONLINE APPENDIX 6-A

Additional background information on dual-eligible beneficiaries

TABLE 6–A1

Medicare Savings Program (continued next page)

Medicare Savings Program	Partial or full dual	
Qualified Medicare beneficiaries (QMB)	QMB only (partial dual):	*Who is eligible?:* An individual who has Medicare Part A, has income that does not exceed 100 percent of the FPL, and whose assets do not exceed three times the SSI limit. These individuals are otherwise ineligible for Medicaid in their state.
		Benefit: Medicaid payment of Medicare premiums, deductibles, coinsurance, and copayment amounts (excluding Part D). However, being a QMB deems a person eligible for the Part D LIS.
		Payment: Medicaid payment of the Medicare premium (Part A + Part B), Medicare deductibles, Medicare coinsurance, and Medicare copayment amounts (except for Part D) through the Medicare Savings Program. Providers may not bill a QMB for either the balance of the Medicare rate or the provider's customary charges for Part A or Part B services.
	QMB plus (full dual):	*Who is eligible?* Individuals who meet all the criteria of a QMB only but also meet the financial criteria for full Medicaid coverage because they have lower assets. These individuals often qualify for full Medicaid coverage by meeting the medically needy standards.
		Benefit: Entitled to all benefits available to a QMB only as well as all benefits available under the state Medicaid plan.
		Payment: Medicaid payment of the Medicare premium (Part A + Part B), Medicare deductibles, Medicare coinsurance, and Medicare copayment amounts (except for Part D) through the Medicare Savings Program. Providers may not bill a QMB for either the balance of the Medicare rate or the provider's customary charges for Part A or Part B services.
Specified low-income Medicare beneficiaries (SLMB)	SLMB only (partial dual):	*Who is eligible?* Those who have Medicare Part A and have income that exceeds 100 percent of the FPL—but is less than 120 percent of the FPL—and whose assets do not exceed three times the SSI limit. They are otherwise ineligible for Medicaid in their state.
		Benefit: Coverage of their Medicare Part B premiums. This also means they are deemed eligible for the Part D LIS.
		Payment: Medicaid payment of Medicare Part B premium through Medicare Savings Program (eligible for federal match).
	SLMB plus (full dual):	*Who is eligible?* Those who meet the criteria to be a SLMB but also meet the criteria for full Medicaid coverage because they have lower assets.
		Benefit: Coverage of their Medicare Part B premiums plus full Medicaid benefits.
		Payment: Medicaid payment of Medicare Part B premium through Medicare Savings Program (eligible for federal match).

TABLE 6–A1

Medicare Savings Program (continued)

Medicare Savings Program	Partial or full dual	
Qualified individuals (QIs)	Partial dual	*Who is eligible?* Those who have Medicare Part A, have income that is at least 120 percent of the FPL but less than 135 percent of the FPL, and have assets that do not exceed three times the SSI limit. They are otherwise ineligible for Medicaid in their state. People cannot qualify for QI if they are a QMB or a SLMB.
		Benefit: Medicare payment of the Medicare Part B premium.
		Payment: Expenditures for any QI are 100 percent federally funded and the total expenditures are limited by statute. QIs are also deemed eligible for the Part D LIS.
Qualified disabled and working individuals (QDWI)	Partial dual	*Who is eligible?* Those who lost Medicare Part A benefits due to returning to work but are eligible to enroll in and purchase Medicare Part A, do not have income that exceeds 200 percent of the FPL, and do not have assets that exceed three times the SSI limit. The person may not otherwise be eligible for Medicaid.
		Benefit: Payment of Medicare Part A premiums.
		Payment: This is a Medicaid payment (eligible for federal match) of the Part A premiums.

Note: FPL (federal poverty limit), (SSI) supplemental security income, LIS (low-income subsidy). Other dual-eligible beneficiaries qualify for full Medicaid benefits but do not qualify through the Medicare Savings Program.

Source: Centers for Medicare & Medicaid Services 2012.

TABLE 6–A2

Mandatory and optional Medicaid benefits

Mandatory benefits	Optional benefits
Inpatient hospital services	Prescription drugs
Outpatient hospital services	Clinic services
Early and periodic screening, diagnostic, and treatment services	Physical therapy
Nursing facility services	Occupational therapy
Home health services	Speech, hearing, and language disorder services
Physician services	Respiratory care services
Rural health clinic services	Other diagnostic, screening, preventive, and rehabilitative services
Federally qualified health center services	Podiatry services
Laboratory and X-ray services	Optometry services
Family planning services	Dental services
Nurse midwife services	Dentures
Certified pediatric and family nurse practitioner services[a]	Prosthetics
Freestanding birth center services	Eyeglasses
Transportation to medical care	Chiropractic services
Tobacco cessation counseling for pregnant women	Other practitioner services
Tobacco cessation	Private duty nursing services
	Personal care
	Hospice
	Case management
	Services for individuals age 65 or older in an institution for mental disease
	Services in an intermediate care facility for the mentally retarded
	State plan home- and community-based services[b]
	Self-directed personal assistance services[b]
	Community first choice option[b]
	TB-related services
	Inpatient psychiatric services for individuals under age 21
	Other services approved by the Secretary[c]

Note: TB (tuberculosis). Mandatory benefits can vary across states.
[a] When licensed or otherwise recognized by the state.
[b] Indicates waiver is available.
[c] Includes services furnished in a religious nonmedical health care institution, emergency hospital services by a non–Medicare-certified hospital, or critical access hospital.

Source: Centers for Medicare & Medicaid Services 2013.

TABLE 6–A3

Services paid for by Medicare and Medicaid for dual-eligible beneficiaries

Medicare	Medicaid
• Acute care (hospital) services • Outpatient, physician, and • other supplier services • Skilled nursing facility services • Home health care • Dialysis • Prescription drugs • Durable medical equipment • Hospice	*Mandatory services:* • Medicare cost sharing (Part A and Part B deductibles, Part B premiums and coinsurance) • Coverage for hospital and skilled nursing facility services if Part A benefits are exhausted • A portion of the cost of prescription drugs • Nursing home care • Home health care not covered by Medicare • Transportation to medical appointments • Durable medical equipment not covered by Medicare *Optional services:* • Dental • Vision • Hearing • Home- and community-based services • Personal care

Source: Medicare Payment Advisory Commission 2010.

Eligibility for Medicaid differs across states

Another contributing factor to the lack of homogeneity among dual eligibles is the fact that eligibility requirements vary across states. Each state is able to make its own policy decisions about which criteria it uses to determine Medicaid eligibility. However, there are certain categories of people at specified income levels that all states with a Medicaid program must cover (meaning they are categorically eligible), and there are optional groups states may extend Medicaid coverage to and receive federal matching funds for. These groups can be generalized to children, pregnant women, adults in families with dependent children, individuals with disabilities, and the elderly. When people in one of the groups listed above have limited income and resources, they may be eligible for state Medicaid coverage. Income and resource eligibility criteria vary across states depending on the eligibility category.

Medicaid coverage can also vary within a state, because states determine a person's eligibility category, and therefore Medicaid coverage level, using an income test. For pregnant women, children, and working disabled individuals, income eligibility is based on specified percentages of the federal poverty level. For the elderly category, income eligibility standards are often based on federal assistance programs, such as being within 300% of the Supplemental Security Income limits.

While Medicaid coverage for low-income children (and also pregnant women) is strong across many states, coverage for low-income adults and parents is more limited. Only nine states provide full Medicaid coverage to low-income adults. Seventeen states provide more limited coverage to adults. Washington, DC, and Vermont provide Medicaid coverage to adults with incomes above 133 percent of the federal poverty level, and 12 states provide more limited Medicaid coverage to adults above 133 percent of the federal poverty level (Kaiser Family Foundation 2012). ■

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