Dually Eligible Individuals - Categories

People who are dually enrolled in both Medicare and Medicaid, also known as dually eligible individuals, fall into several eligibility categories. These individuals may either be enrolled first in Medicare and then qualify for Medicaid, or vice versa.

Dually eligible individuals are enrolled in Medicare Part A (Hospital Insurance) and/or Part B (Supplemental Medical Insurance), and are also enrolled in full-benefit Medicaid and/or the Medicare Savings Programs (MSPs) administered by each individual state. MSPs assist low income Medicare beneficiaries with some or all of their Medicare Parts A and B expenses.

Medicare Coverage

Medicare coverage has four parts:

- Part A (Hospital Insurance) helps cover inpatient care in hospitals, as well as skilled nursing facility, hospice, and home health care. Most individuals qualify for premium-free Part A (i.e., those who have worked the requisite quarters to qualify for Social Security benefits). However, individuals who lack a sufficient work history can pay a monthly premium to enroll in Part A. The MSP may pay the premium for certain individuals who must pay a premium to enroll in Part A. Applicants must live in the U.S. and either be a U.S citizen or a Legal Permanent Resident who has lived in the U.S. continuously for five years prior to the application.
- Part B (Supplemental Medical Insurance) helps cover doctor and other health care providers' services, outpatient care, durable medical equipment, home health care, and some preventive services. All beneficiaries pay a monthly Part B premium except for those enrolled in a MSP that pays their Part B premium.
- Part C (Medicare health plans – also called Medicare Advantage) provides Part A and Part B benefits to people with Medicare who enroll in these plans. Medicare Advantage is offered by private companies that contract with Medicare to provide Part A and Part B benefits, and in most cases, Part D. Dually eligible beneficiaries may also get help with Medicare Part C costs.
    - Plans that integrate Medicare coverage with Medicaid include Programs of All-inclusive Care for the Elderly (PACE), Medicare-Medicaid Plans (MMPs), Fully Integrated Dual Eligible Special Needs Plans, and Highly Integrated Dual Eligible Special Needs Plans.
- Part D (outpatient prescription drugs) provides coverage of prescription drug costs through private plans. Beneficiaries who qualify for Medicaid or an MSP in a state automatically qualify for Extra Help (also known as the Low-Income Subsidy program) to help pay for the costs — monthly premiums, annual deductibles, and prescription copayments — related to Medicare Part D.

Medicaid Coverage

Medicaid provides health coverage to millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities. Medicaid is a state-based program that is funded jointly by states and the federal government. Within broad national guidelines established by federal statutes, regulations, and policies, each state has the flexibility to:

- Establish its own eligibility standards;
- Determine the type, amount, duration, and scope of services;

- Set the rate of payment for services; and
- Administer its own program.

Medicare and Medicaid cover many of the same services. All providers, including Medicare providers, must enroll in their Medicaid system for Medicaid claims review, processing, and payment of Medicare cost-sharing. Providers should contact the state Medicaid agency or additional information regarding Medicaid provider enrollment.

Medicare pays first for Medicare-covered services that are also covered by Medicaid because Medicaid is generally the payer of last resort. Medicaid may cover care that Medicare does not cover (such as a variety of long term services and supports).

Table 1 - Eligibility Categories and Assistance with Medicare Part A and Part B Costs

This section summarizes the eligibility categories for dually eligible individuals, including the degree to which individuals in each category receive assistance with Medicare Parts A and B premiums and cost sharing. Each eligibility category is mutually exclusive.

Category	**Monthly Income as of 2021***	**Assets as of 2021***	**Covers Part A premium (when applicable)**	**Covers Part B premium**	**Covers Parts A & B cost sharing**	**Full Medicaid coverage****
QMB only	Individual: $1,094; Married Couple: $1,472	Individual: $7,970; Married Couple: $11,960	X	X	X***	
QMB plus	Individual: $1,094; Married Couple: $1,472	Individual: $7, 970; Married Couple: $11, 960	X	X	X***	X
SLMB only	Individual: $1,308; Married Couple: $1,762	Individual: $7,970; Married Couple: $11,960		X		
SLMB plus	Individual: $1,308; Married Couple: $1,762	Individual: $7,970; Married Couple: $11,960		X	Varies by state *****	X
QI	Individual: $1,469; Married Couple: $1,980	Individual: $7,970; Married Couple: $11,960		X		
QDWI	Individual: $4,379; Married Couple:	Individual: $4,000; Married Couple:	X			

Category	Monthly Income as of 2019*	Assets as of 2019*	Covers Part A premium (when applicable)	Covers Part B premium	Covers Parts A & B cost sharing	Full Medicaid coverage**
	$5,892	$6,000				
Full – benefit Medicaid (only)**	Determined by state	Determined by state		Varies by state****	Varies by state *****	X

* The income and resource limits for the MSPs are released annually by the Centers for Medicare & Medicaid Services (CMS). The income limit for QDWI includes an earned income disregard of $65. The asset limit calculation for QMBs, SLMBs, and QIs is 3 times the SSI resource limit, adjusted annually by increases in the Consumer Price Index (effective January 1, 2010). States can effectively raise the federal floor for income and resources standards under the authority of section 1902(r)(2) of the Social Security Act, which generally permits state Medicaid agencies to disregard income and/or resources that are counted under certain standard financial eligibility methodologies. Some states have used the authority of section 1902(r)(2) of the Act to eliminate any resource criteria for the MSP groups.

** "Full-benefit" Medicaid coverage generally refers to coverage for a range of items and services, beyond coverage for Medicare premiums and cost-sharing, that certain individuals are entitled to when they qualify under certain eligibility categories included in the State Medicaid Plan (state plan). Individuals who are QMB/SLMB "plus" receive full-benefit Medicaid in addition to Medicare cost-sharing and premiums coverage. Individuals who receive full-benefit Medicaid only are entitled to Medicare Part A and/or enrolled in Part B, and qualify for full-benefit Medicaid benefits, but not the QMB or SLMB programs

*** While individuals enrolled in QMB do not pay Medicare deductibles, coinsurance, or copays, they may have a small Medicaid copay for certain Medicaid-covered services.

**** States pay the Part B premiums if they include all Medicaid categories in their Part B buy-in coverage group..

***** Beneficiary pays no more than amount allowed by the state plan for services covered by both Medicare and Medicaid. Also, all Medicare providers (regardless of Medicaid participation) must accept the Medicare-allowed amount as payment in full for Part B services furnished to dual eligible beneficiaries.

Qualified Medicare Beneficiaries (QMBs) without other Medicaid (QMB Only – also known as QMB "partial benefit") are enrolled in Medicare Part A (or if uninsured for Part A, have filed for premium Part A on a conditional basis), have income up to 100% of the federal poverty level (FPL) and resources that do not exceed three times the limit for supplementary security income (SSI) eligibility with adjustments for inflation, and are not otherwise eligible for full-benefit Medicaid coverage. Medicaid pays their Medicare Part A premiums, if any, and Medicare Part B premiums. Medicare providers may not bill QMBs for Medicare Parts A and B cost sharing amounts, including deductibles, coinsurance and, copays. Providers can bill Medicaid programs for these amounts, but states have the option to reduce or eliminate the state's Medicare cost sharing payments by adopting policies that limit payment to the lesser of (a) the Medicare cost sharing amount, or (b) the difference between the Medicare payment and the Medicaid rate for the service.

QMBs with full–benefit Medicaid (QMB Plus) meet the QMB-related eligibility requirements described above and the eligibility requirements for a separate "categorical" eligibility group covered under the state Medicaid plan. In addition to the coverage for Medicare premiums and cost-sharing described above, QMB "Plus" individuals are entitled to the full range of Medicaid benefits applicable to the separate eligibility group for which they qualify. Medicaid pays their Medicare Part A premiums, if any, and Medicare Part B premiums. Medicare providers may not bill QMBs for Medicare Parts A and B cost sharing amounts, including deductibles, coinsurance, and copays. Providers can bill Medicaid programs for these amounts, but states have the option to reduce or eliminate the state's Medicare cost sharing payments by adopting policies that limit payment to the lesser of (a) the Medicare cost sharing amount, or (b) the difference between the Medicare payment and the Medicaid rate for the service. QMBs with full-benefit Medicaid pay no more than the Medicaid coinsurance (if applicable) for services covered in the state plan (i.e., care that is furnished by a Medicaid provider and that either: (1) Medicare and Medicaid, or (2) Medicaid, but not Medicare, cover).

Specified Low-Income Medicare Beneficiaries (SLMBs) without other Medicaid (SLMB-Only – also known as SLMB "partial-benefit") are enrolled in Part A and have income between 100 and 120 percent of the FPL, and resources that do not exceed three times the limit for supplementary security income (SSI) eligibility with adjustments for inflation. Medicaid pays only the Medicare Part B premiums for this group.

Specified Low-Income Medicare Beneficiaries (SLMBs) with full-benefit Medicaid (SLMB Plus – also known as SLMB "full benefit") meet the SLMB-related eligibility requirements described above, and the eligibility requirements for a separate "categorical" eligibility group covered under the individual's state Medicaid plan. In addition to the coverage for Medicare Part B premiums, these individuals receive full-benefit Medicaid coverage (i.e., the package of benefits provided to the separate eligibility group for which they qualify). SLMBs with full-benefit Medicaid pay no more than the Medicaid coinsurance (if applicable) for services covered in the state plan (i.e., care that is furnished by a Medicaid provider and that either: (1) Medicare and Medicaid, or (2) Medicaid, but not Medicare, cover). These individuals pay Medicare cost-sharing for Medicare-covered care not included in the state plan unless the state chooses to pay these costs.

Qualifying Individuals (QIs) are enrolled in Part A and have income of at least 120% but less than 135% of the FPL and resources that do not exceed three times the limit for supplementary security income (SSI) eligibility with adjustments for inflation. QIs are never eligible for a separate eligibility group covered under the state Medicaid plan. QIs receive coverage for their Medicare Part B premiums, to the extent their state Medicaid programs have available funding. The federal government makes annual allotments to states to fund the Part B premiums.

Qualified Disabled and Working Individuals (QDWIs – also known as QDWI "partial benefit") became eligible for premium-free Part A by virtue of qualifying for Social Security disability insurance, but lost those benefits, and consequently Premium-free Medicare Part A, because they returned to work. QDWIs have income that does not exceed 200% of the FPL, resources that do not exceed two times the SSI resource standard, and are not otherwise eligible for Medicaid. Medicaid pays the Medicare Part A premiums only.

Full-benefit Medicaid Only: These individuals are entitled to Medicare Part A and/or enrolled in Part B, and qualify for full Medicaid benefits, but not the QMB or SLMB programs. Full benefit Medicaid coverage refers to the package of services, beyond coverage for Medicare premiums and cost-sharing, that certain individuals are entitled to when they qualify under eligibility groups covered under a state's Medicaid program. Some of these coverage groups are ones states generally must cover (for example, supplemental security income (SSI) recipients) and some are ones states have the option to cover (for example, the "special income level" group for institutionalized individuals, home- and community- based services (HCBS) programs participants, and "medically needy" individuals). Some of the services in the Medicaid benefit package are ones Medicare does not cover, such as certain long-term services and supports (LTSS), behavioral health, transportation, and vision services. Medicaid benefits vary by state. A full-benefit Medicaid beneficiary pays no more than the Medicaid coinsurance (if applicable) for services covered in the state plan (i.e., care that is furnished by a Medicaid provider and that either: (1) Medicaid and Medicare, or (2) Medicaid, but not Medicare, cover). These individuals pay Medicare cost-sharing for Medicare-covered care not included in the state plan unless the state chooses to pay these costs.