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DUAL-ELIGIBILE HEADQUARTERS

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PENNSYLVANIA

DUAL-ELIGIBLE HQ STATE REPORT

UPDATED APRIL 2025

Pennsylvania's Dual-Eligible Program provides coordinated healthcare coverage for individuals who qualify for both Medicare and Medicaid. Through the program, Pennsylvania ensures coordinated care, including medical services, long-term supports, behavioral health, and prescription drug coverage for approximately 400,000 dual-eligible individuals.

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MEDICAID PROGRAM OVERVIEW

Pennsylvania's Medicaid program is called Medical Assistance (MA). It provides healthcare coverage to low-income individuals, including children, pregnant women, seniors, and individuals with disabilities.

Administered by the Pennsylvania Department of Human Services, the program offers comprehensive benefits such as hospital care, physician services, prescription drugs, and long-term care.

While MA is the overall Medicaid program that covers 3 million Pennsylvanians, HealthChoices, Community HealthChoices, and Behavioral HealthChoices are specific managed care delivery systems within Medicaid.

HealthChoices

HealthChoices is Pennsylvania's mandatory managed care program for most Medicaid recipients. Instead of receiving fee-for-service (FFS) Medicaid, enrollees choose from state-contracted Managed Care Organizations (MCOs), which coordinate and provide their healthcare services. It covers most Medicaid populations except those who qualify for Community HealthChoices.

Community HealthChoices

Community HealthChoices (CHC) is Pennsylvania's managed care program **specifically for dual-eligible individuals** (those who qualify for both Medicare and Medicaid) and individuals requiring long-term services and supports (LTSS). CHC coordinates both medical and non-medical care, including behavioral health and HCBS to ensure seniors and individuals with disabilities get the services they require.

Behavioral HealthChoices

Behavioral HealthChoices (BHC) is Pennsylvania's managed care program for individuals enrolled in Medicaid (Medical Assistance) who require mental health and substance use disorder services. This program ensures that Medicaid recipients receive high-quality, coordinated behavioral health care through county-based oversight and Behavioral Health Managed Care Organizations (BH-MCOs).

STATE MEDICAID OVERVIEW

ELIGIBILITY REQUIREMENTS & PROGRAM DIFFERENCES

The programs utilize MCOs to provide coverage for members. The commonwealth pays the MCOs a capitated monthly rate (like a premium for each member), and the MCOs coordinate the health care needs for their members. However, there are distinct differences between the programs, including:

DUAL-ELIGIBLE COVERAGE

MA, CHC, and BHC provide coverage for participants eligible for both Medicare and Medicaid. This means that the MCOs will have to coordinate closely with Medicare to ensure participants have access to comprehensive services. MCOs will also have the ability to provide Medicare coverage (called D-SNPs) to participants who would like their Medicaid and Medicare services coordinated by the same entity.

LONG-TERM SERVICES AND SUPPORTS

CHC provides LTSS to those needing the level of care provided in a nursing home. Participants who meet this criteria will receive LTSS services and physical health services from their CHC-MCO, including nursing facility care.

HealthChoices MCOs cover the first 30 days of nursing facility care. If a participant continues to need that level of care, the participant applies for CHC.

DIFFERENT MCO AVAILABILITY

A competitive procurement was completed for MCOs.

Consumers choose the CHC plan they would like to administer their Medical Assistance. They can also choose their physical health providers, including the options of FFS, Medicare Advantage, and D-SNPs.

For Behavioral HealthChoices, each county contracts with a state-approved BH-MCO to manage and deliver behavioral health services.

ELIGIBILITY REQUIREMENTS

HEALTHCHOICES

- Children up to, and including, 20 years old
- Adults
- Pregnant women
- Some women with breast and/or cervical cancer
- Lawfully present immigrants might be eligible
- Must meet the federal poverty level requirement

COMMUNITY HEALTHCHOICES

- Individuals ages 21 and older who are dually eligible for Medicare and Medicaid
- Individuals ages 21 and older who need the level of care provided by a nursing facility
- Must meet the federal poverty level requirement

BEHAVIORAL HEALTHCHOICES

- If an individual is already enrolled in Medicaid they can be automatically enrolled in the HealthChoices Behavioral Health program in the county they reside in.
- Must meet the federal poverty level requirement

STATE MEDICAID OVERVIEW

INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

In Pennsylvania, services for individuals with intellectual and developmental disabilities (IDD) are primarily administered through a county-based system, rather than being integrated into the state's Medicaid managed care programs. It is the only major program that is not included in managed care.

ADMINISTRATION

These services are through each county's **Mental Health/Intellectual Disabilities (MH/ID) program offices**. County MH/ID offices serve as a referral source and most services are delivered by local agencies under contract with the county office. The county MH/ID office determines a person's eligibility for service funding and, if eligible, connects them to a supports coordinator.

ELIGIBILITY

Eligibility for intellectual disability services through ODP requires a diagnosis of an intellectual disability based on the results of objective standardized testing. The Office of Developmental Programs (ODP) is the entity within DHS responsible for the oversight of IDD services in Pennsylvania. The local county mental health/intellectual disabilities (MH/ID) programs' role is to verify eligibility for ID services through ODP.

ENROLLMENT

DHS' Office of Developmental Programs serves more than 58,000 Pennsylvanians with intellectual disabilities and autism.

MEDICAID & WAIVER SERVICES

Some IDD services require you to be eligible for Medicaid.

Medicaid for Children with Special Needs (PH95) provides full and free Medical Assistance (MA) coverage to children up to age 18 with disabilities whose parents make too much money to qualify for traditional Medicaid categories.

Pennsylvania also offers several HCBS waivers that fund services enabling individuals with IDD to live in community settings rather than institutional environments. A link for services can be found on the **Home and Community Services Information System website.**

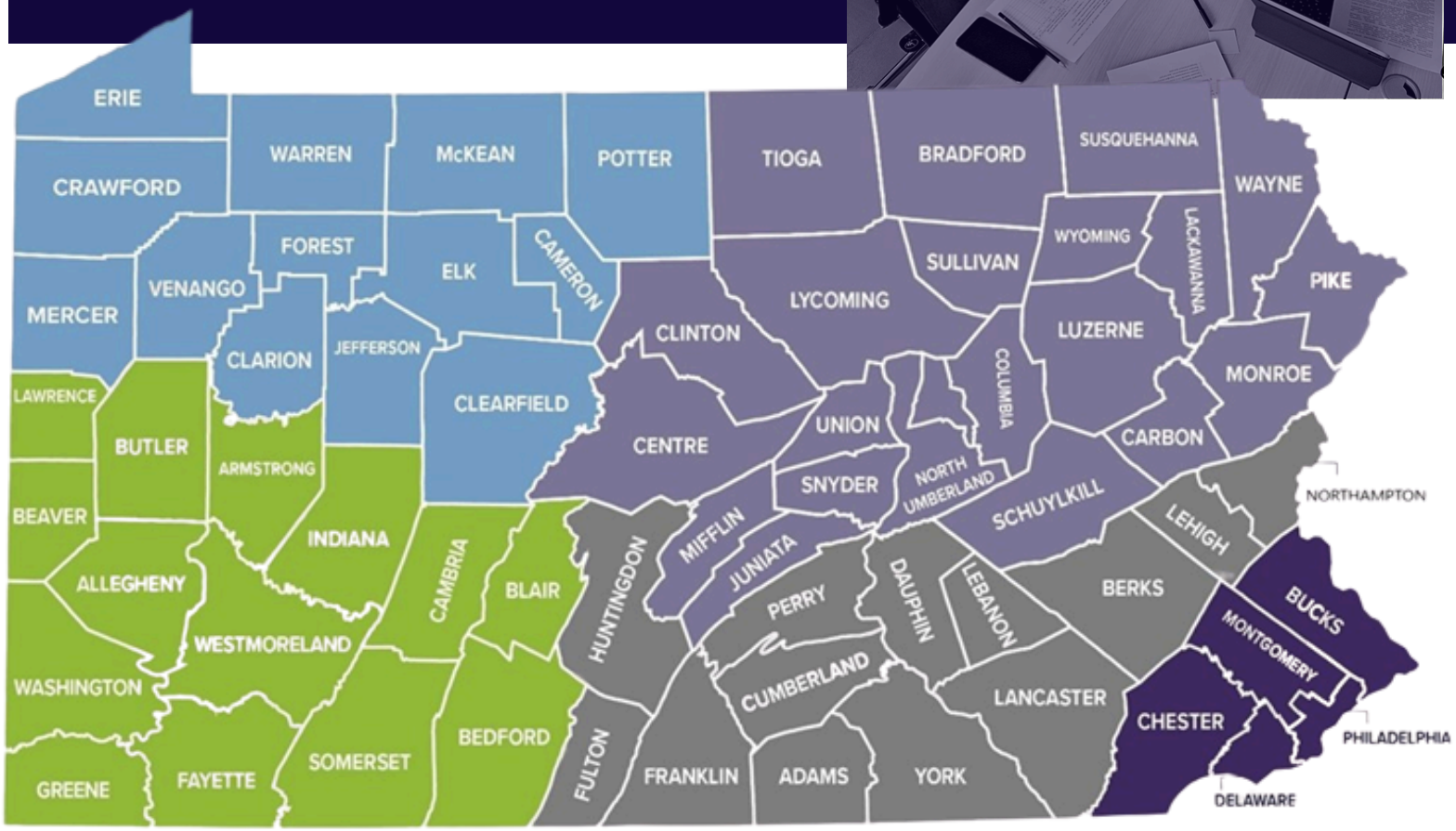
STATE MEDICAID OVERVIEW

MEDICAID MANAGED CARE PROGRAM REGIONS

PA Department of Human Services divides Pennsylvania into five regions for the financing and delivery of managed care.

The regions for Physical HealthChoices and Community HealthChoices are the same, but the health plans providing services in each program differ.

Both managed care programs are available statewide, with different MCOs available by region.



NORTHWEST REGION **NORTHEAST REGION** **SOUTHWEST REGION**

LEHIGH CAPITAL REGION **SOUTHEAST REGION**

DUAL-ELIGIBLE OVERVIEW

DUAL-ELIGIBLE PROGRAM OVERVIEW

Community HealthChoices is PA's managed care program for individuals who are dual-eligible for Medicare and Medicaid.

Questions? Reach out!

QUICK FACTS

Design

The program was developed to **improve service coordination, enhance access to home and community-based services**, and ensure that participants **receive high-quality, integrated care.**

Eligibility

CHC provides **physical health services and LTSS to dual-eligibles over the age of 21, or individuals in need of LTSS**, except those enrolled in the OBRA waiver.

Services

CHC services include **medical care, behavioral health services, nursing facility care, and home and community-based services** (HCBS) to help individuals live independently.

Launch

CHC was **launched in a phased rollout**, beginning in January 2018 in southwestern Pennsylvania. It became fully implemented statewide by January 2020.

Admin

CHC is **operated by three managed care organizations** (MCOs): Keystone First CHC, PA Health & Wellness, and UPMC Community HealthChoices. There is a **procurement pending to add two more MCOs.**

VBP

In 2025, **25% of the medical portion of capitation must be through value-based payment agreements**. For Behavioral HealthChoices, the VBP requirement is 20%.

Enrollment

As of January 2025, **Community HealthChoices had a total enrollment of 387,440 participants**. Approximately 85.5% of program participants are dual-eligible.

DUAL-ELIGIBLE OVERVIEW

PHYSICAL HEALTH SERVICES

There are approximately 300,000 dual-eligibles considered "well duals" who are not Nursing Facility Clinically Eligible (NFCE), but still receive physical health services through CHC, in addition to their Medicare coverage.

SERVICES FOR ALL PARTICIPANTS

The following physical health benefits are an example of services available to CHC participants, when deemed medically necessary:

- Preventative/routine care
  - Routine dental cleaning and exams
  - Routine eye exam
  - Primary Care Provider
  - Women's routine and preventive care
- Services for when you are sick
  - Your Primary Care Provider
  - 24/7 nurse call line
  - Emergency room
  - Urgent care centers
  - Specialist visits
- Pharmacy (prescription) benefits
  - Find a pharmacy
  - Find a medicine
  - Prescription medicine
  - Over-the-counter medicines
  - Medicine reimbursement

Each health plan is required to offer certain services, but also offer additional benefits. Participants can check with their MCO for a list, but these can include:

- Smoking cessation
- Care management
- Maternity care
- Family planning services

There are also physical health services that are not covered. **Participants need to check with their health plan to determine if services are covered, or request prior authorization.**

COVERAGE OF SERVICES

Medicare is the primary payer for these services. Community HealthChoices is the secondary Medical Assistance payer. That means dual-eligibles must use their Medicare benefits before using CHC benefits.

COORDINATION OF SERVICES

All CHCs must offer a D-SNP program (an insurance product that manages both Medicare and Medicaid). CHCs must also offer the basic Medicaid Adult benefit package

Although the CHC must offer the two options noted above, those enrolled in the CHC program can choose to get their health care through a D-SNP program offered through a different health plan or get the health benefit through a traditional Medicare plan.

DUAL-ELIGIBLE OVERVIEW

LONG TERM SERVICES AND SUPPORTS

CHC provides LTSS to participants who need the level of care provided in a nursing home. Participants who meet this criteria will receive LTSS and physical health services from their CHC-MCO, including nursing facility care.

HealthChoices MCOs will cover the first 30 days of nursing facility care. If a participant continues to need that level of care, the participant will apply for CHC.

ELIGIBILITY FOR LTSS

The PA DHS determines if participants are eligible for LTSS. In order to be able to get LTSS, enrollees need to have a "clinical eligibility determination" that shows they need the type of services provided in a nursing home, even if they are getting or could get the services at home or in another community setting. This is called being "Nursing Facility Clinically Eligible," also called "NFCE."

The **PA Independent Enrollment Broker (IEB)** is a contracted statewide entity that determines eligibility and assists with the enrollment process for those seeking LTSS.

HOME AND COMMUNITY BASED SERVICES (HCBS)

Participants who have LTSS are often eligible for HCBS. The PA DHS determines if Participants are eligible for LTSS benefits. AmeriHealth Caritas PA CHC helps eligible Participants with LTSS get access to home- and community-based services. Services include help with activities of daily living, or ADLs (ex. eating and bathing) and instrumental activities of daily living, or IADLs (ex. preparing meals and grocery shopping).

LTSS SERVICES PROVIDED

The following benefits are an example of services available to LTSS participants:

- Adult daily living services
- Assistive technology
- Behavior therapy
- Benefits counseling
- Cognitive rehabilitation therapy
- Community integration
- Community transition services
- Counseling
- Employment skills development
- Financial management services
- Home adaptations
- Home delivered meals
- Home health aide
- Home health – nursing
- Job coaching & finding
- Nutritional counseling
- Participant-directed community supports
- Participant-directed goods and services
- Personal assistance services
- Personal emergency response system
- Pest eradication
- Residential habilitation
- Respite
- Service coordination
- Structured day habilitation
- TeleCare
- Vehicle modifications

DUAL-ELIGIBLE OVERVIEW

BEHAVIORAL HEALTH

Behavioral Health services for dual-eligibles are delivered through Behavioral HealthChoices. Behavioral Health Managed Care Organizations (BH-MCOs) are specialized entities responsible for managing and delivering behavioral health services to those enrolled in the managed care program, including dual-eligibles.

Each HealthChoices consumer is assigned a Behavioral Health Managed Care Organization (BH-MCO) based their county of residence. Members, then, have a choice of Behavioral Health Care providers within the BH-MCO's network.

BH-MCO	Counties Served
Community Behavioral Health	Philadelphia
Community Care Behavioral Health Organization (UPMC)	Adams, Allegheny, Bedford, Bradford, Berks, Blair, Cameron, Carbon, Centre, Chester, Clarion, Clearfield, Clinton, Columbia, Delaware, Elk, Erie, Forest, Greene, Huntingdon, Jefferson, Juniata, Lackawanna, Luzerne, Lycoming, McKean, Mifflin, Montour, Monroe, Northumberland, Pike, Potter, Schuylkill, Snyder, Sullivan, Somerset, Susquehanna, Tioga, Union, Warren, Wayne, Wyoming, York
Magellan Behavioral Health of Pennsylvania (Centene Corporation)	Bucks, Lehigh, Montgomery, Northampton, Cambria
PerformCare (AmeriHealth Caritas)	Cumberland, Dauphin, Franklin, Fulton, Lancaster, Lebanon, Perry
Carelon Health of PA, Inc (Elevance Health)	Armstrong, Beaver, Butler, Crawford, Fayette, Indiana, Lawrence, Mercer, Washington, Westmoreland, Venango

DUAL-ELIGIBLE DELIVERY SYSTEM

Dual-eligible individuals can get care through various programs, including:

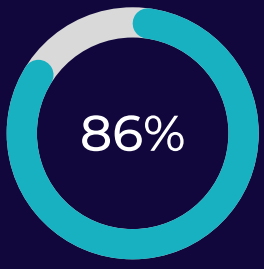
- Community HealthChoices (CHC)
- Program of All-Inclusive Care for the Elderly (PACE) also known as LIFE in PA
- Dual-Eligible Special Needs Plans (D-SNPs)

	CHC	PACE/LIFE	D-SNP
What Is It?	PA's mandatory Medicaid managed care program for dual-eligibles.	An alternative for dual-eligible seniors (55+) who need a high level of care.	A Medicare Advantage plan that coordinates Medicare & Medicaid benefits for dual-eligibles.
Who Must Enroll?	Full-benefit dual-eligibles & LTSS recipients.	Optional for dual-eligibles (55+) who need nursing home-level care.	CHC participants can but are not required to enroll.
Medicare's Role	Pays for acute medical services like hospital, doctor, and drug coverage.	Medicare & Medicaid funding combined into one program. Providers receive a capitated payment from Medicare and Medicaid and must cover necessary care.	Manages Medicare benefits for dual-eligibles.
Medicaid's Role	Pays for LTSS, some behavioral health, and other Medicaid services.		Coordinates with Medicaid (if aligned with CHC MCO).
Program Interplay	Works with D-SNPs to integrate care.	Do not need a D-SNP since their benefits are already integrated.	Care is better integrated and coordinated.

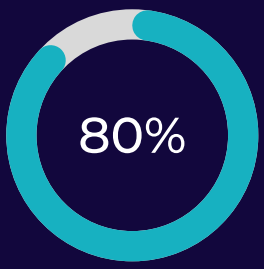
ENROLLMENT NUMBERS

DUAL-ELIGIBLE ENROLLMENT

As of March 2024, total dual-eligible enrollment was 405,608.



Approximately 86% of CHC participants are dual-eligibles.



D-SNP enrollment over the last 5 years is up 80%.

Dual eligibles are automatically enrolled in CHC whether they need LTSS or not. However, dual-eligibles in need of LTSS may enroll in the PACE program instead of CHC.

Dual Status Codes	Count of Dual Enrollees (as of March 2024)
Qualified Medicare Beneficiaries (QMB)-only	8,667
QMB plus Full Medicaid Benefits	307,666
Specified Low-income Medicare Beneficiaries (SLMB)-only	47,763
SLMB plus Full Medicaid Benefits	21,337
Qualified Disabled and Working Individuals (QDWI)	0
Qualifying Individuals (QI)	32,271
Other Dual Full Medicaid Benefit	76,605

Total dual-eligible enrollment including partial duals, as of March 2024 was 494,309.

Questions? Reach out!

MORE INFORMATION

DualEligibleHQ.com (DEHQ) is a comprehensive resource designed to provide up-to-date information, research, and insights on dual-eligible individuals. Our platform offers in-depth state profiles, policy updates, program analyses, and industry trends, helping stakeholders understand the complexities of dual eligibility. Whether you're a healthcare provider, policy analyst, or consumer, DEHQ serves as a go-to destination for data-driven insights and expert perspectives.

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Founder

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If you're looking for more information on dual-eligible programs, state-specific policies, or the latest developments in Medicare-Medicaid integration, contact us today. Our team is ready to provide tailored insights and guidance to help you navigate the evolving landscape of dual eligibility.

OUR CONTACT

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GLOSSARY OF TERMS

We've provided a glossary to help readers understand key terms and acronyms related to dual-eligibility, Medicaid, Medicare, and managed care. You can find a full glossary with clear definitions on our website at https://www.dualeligiblehq.com/.

TERM	ABBRV.	DEFINITION
Accountable Care Organization	ACO	A network of doctors, hospitals, and healthcare providers that collaborate to improve care coordination, enhance quality, and reduce costs for Medicare beneficiaries. ACOs share in savings or losses based on their performance in value-based care models like the MSSP.
Capitation		A payment model where healthcare providers or Managed Care Organizations (MCOs) receive a fixed amount per enrollee for a defined period, regardless of the services provided.
Capitated Rate		A fixed per-member-per-month (PMPM) payment made to a Managed Care Organization (MCO) or healthcare provider to cover a defined set of services for enrolled individuals, regardless of the actual number of services used.
Dual-Eligible		Individuals who qualify for both Medicare and Medicaid benefits, often due to age, disability, and low income.
Dual-Eligible Special Needs Plans	D-SNPs	A type of Medicare Advantage plan tailored for dual-eligible individuals, integrating Medicare and Medicaid services to provide coordinated care.
Federal Poverty Level	FPL	The Federal Poverty Level (FPL) is an income measure set by HHS to determine eligibility for Medicaid, Medicare Savings Programs (MSPs), and other assistance. It varies by household size and state, with many dual-eligible programs requiring income below a certain FPL percentage.
Fee-For-Service	FFS	A traditional healthcare payment model where providers are reimbursed for each service rendered, such as tests or procedures.

GLOSSARY OF TERMS

TERM	ABBRV.	DEFINITION
Full Dual-Eligible		A full dual-eligible individual qualifies for both Medicare and full Medicaid benefits. Medicaid covers Medicare premiums, deductibles, and cost-sharing, as well as additional services that Medicare does not, such as long-term services and supports (LTSS), home and community-based services (HCBS), and certain behavioral health benefits. Full dual-eligibles may also qualify for Medicare Part D Extra Help, which reduces prescription drug costs.
Full-Benefit Dual-Eligible Medicaid Recipients		These individuals are entitled to Medicare Part A and/or entitled to Part B, and qualify for full Medicaid benefits, but not the QMB or SLMB groups. Full-benefit Medicaid coverage refers to the package of services, beyond coverage for Medicare premiums and cost-sharing, that certain individuals are entitled to under 42 CFR 440.210 and 440.330. For Medicaid-covered services (i.e., services furnished by a Medicaid provider and that either: (1) Medicare and Medicaid, or (2) Medicaid, but not Medicare, cover), a full-benefit Medicaid beneficiary pays no more than the Medicaid coinsurance3 (if applicable). For Medicare-only covered services (i.e., services covered by Medicare, but not Medicaid), these individuals pay the Medicare cost-sharing unless the state chooses to cover Medicare cost-sharing for all Medicarecovered services for this eligibility group.
Home and Community-Based Services	**HCBS**	Medicaid services that assist individuals with daily activities, enabling them to live independently in their communities rather than in institutional settings.
Integrated Care		A healthcare approach that combines services from multiple providers to offer seamless and coordinated care, particularly beneficial for individuals with complex health needs.

GLOSSARY OF TERMS

TERM	ABBRV.	DEFINITION
Intellectual and Developmental Disability	**IDD**	An Intellectual and Developmental Disability is a lifelong condition that affects a person's cognitive, adaptive, or social functioning. IDDs include conditions such as Down syndrome, autism spectrum disorder, cerebral palsy, and intellectual disabilities diagnosed before adulthood. Individuals with IDD may require specialized healthcare, supportive services, assistive technology, and HCBS to promote independence and quality of life.
Long-Term Services and Supports	**LTSS**	A range of medical and personal care services assisting individuals with chronic illnesses or disabilities in performing daily activities over an extended period.
Managed Care		A healthcare delivery system where organizations manage cost, utilization, and quality by providing a network of contracted providers and services.
Managed Care Organization	**MCO**	Entities that deliver managed care services by contracting with healthcare providers to offer a comprehensive set of services to enrolled members.
Medicaid		A joint federal and state program offering health coverage to eligible low-income individuals, including children, pregnant women, seniors, and people with disabilities.
Medical Assistance	**MA**	Pennsylvania's Medicaid program that provides healthcare coverage to low-income individuals, including children, pregnant women, seniors, and individuals with disabilities. It is administered by the Pennsylvania Department of Human Services (DHS), providing comprehensive benefits like hospital care, physician services, prescription drugs, and long-term care.
Medicare		A federal health insurance program primarily for individuals aged 65 and older, as well as some younger individuals with disabilities. Coverage has four parts, Part A, B, C, and D.

GLOSSARY OF TERMS

TERM	ABBR V.	DEFINITION
Medicare Advantage	MA	Medicare Advantage plans are approved by Medicare but are run by private companies. These companies provide Medicare Part A and Part B covered services and may include Medicare drug coverage too. Medicare Advantage plans are sometimes called “Part C” or “MA” plans. MA plans are not supplemental insurance.
Medicare Advantage Organization	MAO	A private insurance company that contracts with the federal government to offer Medicare Advantage (Part C) plans. These plans cover all Medicare Part A and Part B benefits, and many include additional services like prescription drug coverage, dental, vision, and hearing. MAOs receive a capitated payment from Medicare to manage and deliver care and are responsible for coordinating services to improve quality, efficiency, and member satisfaction.
Medicare Part A	Part A	Medicare Part A is the hospital insurance portion of Medicare. It covers inpatient care in hospitals, skilled nursing facility care, hospice care, and some home health services. Most people do not pay a premium for Part A if they or their spouse paid Medicare taxes while working.
Medicare Part B	Part B	Medicare Part B is the medical insurance portion of Medicare. It covers outpatient services such as doctor visits, preventive care, lab tests, mental health services, durable medical equipment, and some home health care. Beneficiaries typically pay a monthly premium and are responsible for deductibles and coinsurance.
Medicare Part C	Part C	Medicare Part C, also known as Medicare Advantage, is an alternative to Original Medicare (Parts A and B) offered by private insurance companies approved by Medicare. These plans often include additional benefits such as vision, dental, hearing, and prescription drug coverage, and may feature care coordination services.

GLOSSARY OF TERMS

TERM	ABBRV.	DEFINITION
Medicare Part D	Part C	Medicare Part D provides prescription drug coverage. It is offered through standalone drug plans or included in some Medicare Advantage (Part C) plans. Part D helps cover the cost of medications, and individuals with limited income may qualify for Extra Help to reduce their out-of-pocket costs.
Medicare Savings Programs	MSP	MSPs help low-income Medicare beneficiaries by covering Medicare premiums, deductibles, and cost-sharing. There are four MSP categories: Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), Qualifying Individual (QI), and Qualified Disabled and Working Individual (QDWI). Eligibility is based on income and asset limits, with Medicaid administering the benefits.
Medicare Shared Savings Program	MSSP	The Medicare Shared Savings Program (MSSP) is a value-based initiative where Accountable Care Organizations (ACOs) coordinate care to improve quality and reduce costs for Medicare. ACOs share in savings or losses based on performance.
Partial Dual-Eligible		A partial dual-eligible individual qualifies for Medicare and receives limited Medicaid assistance through a Medicare Savings Program (MSP). Medicaid helps pay for some or all of their Medicare premiums, deductibles, and coinsurance but does not provide full Medicaid benefits. Partial dual-eligibles do not receive coverage for services like long-term care or HCBS unless they qualify under another program.
Program of All-Inclusive Care for the Elderly	PACE	A Medicare and Medicaid program that helps people meet their health care needs in the community instead of going to a nursing home or other care facility. KSCE covers all Medicare- and Medicaid-covered care and services, and anything else the health care professionals in your KSCE team decide you need to improve and maintain your health. This includes prescription drugs and any medically necessary care.

GLOSSARY OF TERMS

TERM	ABBRV.	DEFINITION
Qualified Disabled and Working Individuals	QDWI	QDWI individuals) became eligible for premium-free Part A by virtue of qualifying for Social Security Disability Insurance (SSDI) benefits, but lost those benefits, and subsequently premium-free Medicare Part A, after returning to work. QDWIs have income that does not exceed 200 percent of the FPL, have 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.
Qualifying Individuals	QI	QIs are entitled to Part A and have income of at least 120 but less than 135 percent of the FPL, resources that do not exceed three times the limit for SSI eligibility with adjustments for inflation and are not eligible for any other eligibility group under the state plan. QIs receive coverage for their Medicare Part B premiums, to the extent their state Medicaid programs have available slots. The federal government makes annual allotments to states to fund the Part B premiums. Individuals in the limited Part B-ID benefit may also qualify for the QI eligibility group with coverage limited to the Part B-ID premium and/or cost sharing.
Qualified Medicare Beneficiaries Only	QMB-Only	QMB-Only are entitled to Medicare Part A, have income up to 100 percent of the FPL and resources that do not exceed three times the limit for 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. 1 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. Individuals in the limited Part B Immunosuppressive Drug (Part B-ID) benefit may also qualify for the QMB eligibility group with coverage limited to the Part B-ID premium and/or cost-sharing, a status known as QMB-Part B-ID.

GLOSSARY OF TERMS

TERM	ABBRV.	DEFINITION
Qualified Medicare Beneficiaries with full-benefit Medicaid	QMB-Plus	QMB-Plus individuals meet the QMB-related eligibility requirements described above and the eligibility requirements for a separate categorical Medicaid eligibility group covered under the state plan. In addition to the coverage for Medicare premiums and Medicare cost-sharing described above, QMB-plus individuals receive 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 costs haring 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.
Serious Mental Illness	SMI	Refers to chronic and severe mental health conditions that significantly impair daily life and functioning. Examples include schizophrenia, bipolar disorder, major depressive disorder, and severe anxiety disorders. Individuals with SMI may require long-term treatment, crisis intervention, case management, and community-based services to manage their condition. Medicaid often provides additional behavioral health services for individuals with SMI beyond what Medicare covers.
Specified Low-Income Medicare Beneficiaries without other Medicaid	SLMB-Only	Entitled to 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. Individuals in the limited Part B-ID benefit may also qualify for the SLMB eligibility group with coverage limited to the Part B-ID premium and/or cost-sharing, a status known as SLMB-Part B-ID.

GLOSSARY OF TERMS

TERM	ABBRV.	DEFINITION
Specified Low-Income Medicare Beneficiaries with full-benefit Medicaid	**SLMB-Plus**	Individuals that meet the SLMB-related eligibility requirements described above, and the eligibility requirements for a separate categorical Medicaid eligibility group covered under the state plan. In addition to coverage for Medicare Part B premiums, these individuals receive full-benefit Medicaid coverage (i.e., the package of benefits provided to the separate Medicaid eligibility group for which they qualify). For Medicaid-covered services (i.e., services furnished by a Medicaid provider and that either: (1) Medicare and Medicaid, or (2) Medicaid, but not Medicare, cover), an SLMB-Plus beneficiary pays no more than a nominal Medicaid copay2 (if applicable).
Value-Based Care	**VBC**	Value-based care is a term that Medicare, doctors and other health care professionals sometimes use to describe health care that is designed to focus on quality of care, provider performance and the patient experience. The “value” in value-based care refers to what an individual values most. In value-based care, doctors and other health care providers work together to manage a person’s overall health, while considering an individual’s personal health goals.
Value-Based Payment	**VBP**	Under value-based payment (VBP) models, payments to healthcare providers are tied to quality, efficiency, and positive patient experience. The purpose of value-based programs is to improve care for individuals and lower healthcare costs simultaneously. With this delivery model, doctors, hospitals, and other health care providers are compensated based on the quality of care provided and patient outcomes.
Whole-Person Care		Whole person care is a healthcare approach that considers a patient's physical, mental, social, and spiritual health. It aims to improve health and well-being by addressing multiple factors that affect a person's health.

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State Medicaid Overview - Medicaid Program Overview

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State Medicaid Overview - Eligibility Requirements & Program Differences

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MORE INFORMATION

DualEligibleHQ.com (DEHQ) is a comprehensive resource designed to provide up-to-date information, research, and insights on dual-eligible individuals. Our platform offers in-depth state profiles, policy updates, program analyses, and industry trends, helping stakeholders understand the complexities of dual eligibility. Whether you're a healthcare provider, policy analyst, or consumer, DEHQ serves as a go-to destination for data-driven insights and expert perspectives.

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If you're looking for more information on dual-eligible programs, state-specific policies, or the latest developments in Medicare-Medicaid integration, contact us today. Our team is ready to provide tailored insights and guidance to help you navigate the evolving landscape of dual eligibility.

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