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DUAL-ELIGIBILE HEADQUARTERS

Strategic Business Development XTRAGLOBEX

KANSAS

DUAL-ELIGIBLE HQ STATE REPORT

UPDATED MARCH 2025

Kansas' Dual-Eligible Program provides integrated healthcare coverage for individuals who qualify for both Medicare and Medicaid. Through the program, Kansas ensures coordinated care, including medical services, long-term supports, and prescription drug coverage for approximately 40,000 full-benefit dual-eligible individuals.

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MEDICAID PROGRAM OVERVIEW

As of February 2025, approximately 450,000 Kansans are enrolled in the state's Medicaid program. The program provides healthcare coverage to low-income individuals, including children, pregnant women, seniors, and individuals with disabilities.

In Kansas, the majority of Medicaid consumers are enrolled in managed care. Kansas's Medicaid managed care program is called KanCare.

Through Medicaid, consumers can obtain comprehensive benefits and services such as hospital care, physician services, prescription drugs, and long-term care.

Medicaid FFS

Kansas's Medicaid Fee-for-Service (FFS) system had 30,145 enrollees as of January 2024, which accounts for less than 7% of all Medicaid enrollees.

Available statewide, in the fee-for-service model, the State pays the provider directly for medical services.

Questions? Reach out!

Medicaid Managed Care

Launched in 2013, KanCare is administered by the Kansas Department of Health and Environment (KDHE) and the Kansas Department for Aging and Disability Services (KDADS).

The program is available statewide, through three MCOs, that consumers are either assigned to, or select during the annual open enrollment.

In February 2025, there were 413,103 total enrollees in KanCare.

STATE MEDICAID OVERVIEW

PROGRAM ADMINISTRATION AND MANAGEMENT

KanCare is provided to all Medicaid and CHIP consumers. Kansas has contracted with three health plans, or managed care organizations (MCOs), to coordinate health care for nearly all beneficiaries.

The program is administered by the Kansas Department of Health and Environment (KDHE) and the Kansas Department for Aging and Disability Services (KDADS).

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

Main Responsibilities:

- Maintains financial management and contract oversight of the KanCare program.
- Sets eligibility policy, within federal guidelines, to allow people to apply for Medicaid
- Contracts for Medicaid Management Information System (MMIS)
- Contracts with the Medicaid Managed Care Organizations (MCOs)
- Responsible for compliance with federal laws/rules
- Contact with CMS at federal level

KANSAS DEPARTMENT FOR AGING AND DISABILITY SERVICES

Main Responsibilities:

- Administers the state's seven Home and Community-Based Services (HCBS) waivers that include:
  - Frail Elderly
  - Physical Disability
  - Autism
  - IDD
  - Serious Emotional Disturbance
  - Technology Assisted
  - Brain Injury

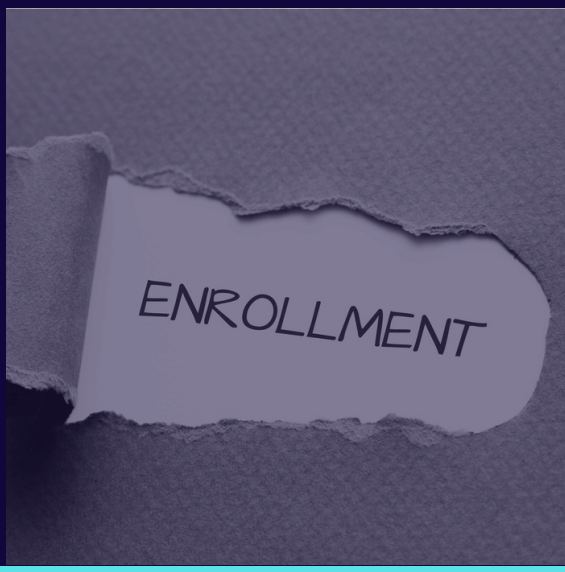
The Kansas Department of Health and Environment recently went through re-procurement and selected 3 managed care organizations to operate KanCare, out of seven bidders.

As of January 1, 2025, KanCare MCOs include two incumbents, Sunflower Health Plan and United Healthcare Community Plan, and one new organization, Healthy Blue. These contracts will run through December 31, 2027.

These MCOs are responsible for enrolling providers and paying for services. In exchange for providing services, they recevie a monthly payment for each individual enrolled in KanCare. Due to capitated per member per month (PMPM) payments, they are at financial risk for almost all the costs of care for KanCare members.

STATE MEDICAID OVERVIEW

ELIGIBILITY & PLAN AVAILABILITY



The Kansas Department of Health and Environment (KDHE) Division of Health Care Finance (DHCF) offers medical assistance to help cover health care costs.

KanCare under the Medicaid plan is the largest program. It covers people with limited income, which may include pregnant women, children up to age 19, adult caretaker of children, persons aged out of foster care, persons with disabilities and senior citizens to list a few.

Medical assistance is only available to certain groups of people, and only to those who are residents of Kansas. If people do not fall into one of the groups listed below, they don't qualify.

- Children up to age 19, including those who are in foster care.
- Persons under age 26 who were in foster care at the time of their 18th birthday.
- Pregnant women.
- Persons who are blind or disabled by Social Security rules.
- Persons aged 65 or older.
- Persons receiving inpatient treatment for tuberculosis.
- Low-income families with children under age 19.
- Persons screened and diagnosed with breast or cervical cancer through EDW program.
- Persons currently receiving SSI payments.

All 3 KanCare MCOs provide service statewide. They all cover the same basic Medicaid services, but some of the extra services they provide are different.

DUAL-ELIGIBLE OVERVIEW

DUAL-ELIGIBLE PROGRAM OVERVIEW

QUICK FACTS

Design

Kansas delivers service to dual-eligibles through specialty health plans. These specialty plans are required to have a care coordination program designed for each population's needs.

Eligibility

Full-benefit duals are required to enroll in the managed care program unless they meet one of the FFS exclusion criteria or are enrolled in PACE.

Services

Medicare covers most acute medical services, while Medicaid, the payer of last resort, covers long-term services and supports and non-physician behavioral health services.

Launch

Launched in January, 2013, KanCare delivers whole-person, integrated care. The state completed a re-procurement and selected 3 MCOs to deliver services beginning January 2025.

Admin

Medicaid Managed Care is administered by 3 full-risk health plans that are available statewide**. KDADS oversees the state's seven Home and Community-Based Services (HCBS) waivers.**

VBP

The MCO contracts effective January 2025 include a 3% quality withhold that can be earned back based on performance. **Health plans must also implement VBP arrangements.**

Enrollment

As of March 2024, **total full dual-eligible enrollment was 43,640**. Partial dual-eligible enrollment was 25,933. Dual-eligible **enrollment in managed care was 41,183 in March 2025**.

DUAL-ELIGIBLE OVERVIEW

PHYSICAL HEALTH SERVICES

All medical assistance programs provide prescription drugs, mental health services and medical (doctor) coverage. Inpatient hospital, hearing, dental, and eye-wear coverage is also included for most persons.

MANDATORY SERVICES

KanCare offers basic medical services for all eligible members. Some of the services in KanCare include:

- Doctor's office visits
- Vaccines and check-ups
- Hospital services
- Blood work and lab services
- Pharmacy and prescription drugs
- Eye doctor visits
- Behavioral health services
- Dental care for children
- Dental care for adults (periodontal care, silver diamine fluoride treatments and some restorative procedures)
- Transportation to medical appointments
- Home and community based services.
- Nursing facility services
- Heart and lung transplants for adults
- Weight-loss surgery
- Value-added services

VALUE ADDED SERVICES

Under the new KanCare program effective January 1, 2025, each MCO agreed to provide a set of additional, previously non-covered services to beneficiaries at no cost to the State.

- All three MCOs are providing an adult preventive dental benefit as part of their value-added services.
- Other services provided by one or more MCOs include things such as rewards programs for healthy behaviors, additional respite care for certain beneficiaries, and career development services for people with disabilities.

Find more info here:
www.kancare.ks.gov/members/benefits-services

CARE COORDINATION

KanCare health plans are required to coordinate all of the different types of care a consumer receives. The goals of the KanCare program are to improve overall health outcomes while slowing the rate of cost growth over time. This will be accomplished by providing the right care, in the right amount, in the right setting, at the right time. The health plans focus on ensuring that consumers receive the preventive services and screenings they need and ongoing help with managing chronic conditions.

KanCare has case managers available to enrollees. This is someone who works for the KanCare health plan and makes sure enrollees get the medical care and community services they need to stay healthy and take care of any conditions they have.

DUAL-ELIGIBLE OVERVIEW

LONG-TERM SERVICES AND SUPPORTS

Through KanCare, Kansas delivers long-term services and supports in a managed care environment, ensuring that individuals who need help with daily living activities receive coordinated, personalized, and community-based care.

LTC PROGRAM ADMINISTRATION

LTSS are often provided under one of seven Home and Community Based Service (HCBS) waivers. HCBS waivers are KanCare programs that provide services to a person in their community instead of an institution, such as a nursing home or state hospital. In Kansas, KDADS oversees the HCBS waivers.

SERVICE DELIVERY

All KanCare members, including those eligible for LTSS, are enrolled in one of the contracted MCOs. These organizations are responsible for delivering and coordinating all Medicaid services, including LTSS.

LTC ELIGIBILITY

Persons must have a medical need for the special care. There must be an open space in the HCBS program, and the individual must be determined eligible for Medicaid. The resource limit is $2,000 for a single person and there are special resource provisions for those individuals who have a spouse. People on HCBS may also share in the cost of care. Persons with income more than $2,901 a month help pay for their care.

Questions? Reach out!

FRAIL & ELDERLY WAIVER

The Frail Elderly (FE) waiver provides Kansas seniors an alternative to nursing home care. The program promotes independence within the community and helps to offer residency in the most integrated environment.

Services under this HCBS waiver include:

- Specialized Medical Equipment/Supplies
- Home and Environmental Modifications
- Vehicle Modification Services
- Adult Day Care
- Personal Care Services
- Comprehensive Support
- Financial Management Services
- Home Telehealth
- Medication Reminder
- Nursing Evaluation Visit
- Oral Health Services
- Personal Emergency Response
- Enhanced Care Services
- Wellness Monitoring

FRAIL & ELDERLY WAIVER

Eligibility for the FE waiver includes:

1. Must be 65 years old;
2. Meet the Medicaid nursing facility threshold score;
3. Be financially eligible for Medicaid.

DUAL ELIGIBLE OVERVIEW

INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

Home and Community Based Service (HCBS) waivers are KanCare programs that provide services to a person in their community instead of an institution, such as a nursing home or state hospital. In Kansas, there are currently seven HCBS waivers, one of which, is the Intellectual/Developmental Disability (IDD) Waiver.

Questions? Reach out!

ELIGIBILITY

To be eligible for the IDD Waiver, an individual must meet the following criteria: :

- Must be 5 years of age or older
- Have Intellectual Disability diagnosed before the age of 18, OR
- Have a diagnosis of a Developmental Disability that began before the age of 22
- Must be determined program eligible by the Community Disability Determination Organization
- Meet the Medicaid long-term care institutional threshold score

SERVICES PROVIDED

Below are the services offered through the IDD waiver. Final services are based on need and will be determined by a Managed Care Organization (MCO).

- **Assistive Services:** Supports or items like adaptive equipment, assistive technology, or home modifications to enhance independence.
- **Adult Day Supports (18+):** Out-of-home activities to maintain or improve abilities, productivity, independence, integration, and community participation.
- **Financial Management Services:** Administrative and payroll services for individuals self-directing some or all of their services.
- **Medical Alert (rental):** Electronic devices with portable buttons providing 24-hour access to assistance or emergency help.
- **Overnight Respite:** Temporary direct care and supervision to provide relief to families and caregivers.
- **Personal Care Services (PCS):**
  - **Self-Directed:** Supervision and/or physical assistance with daily living activities, health maintenance, and socialization.
  - **Agency-Directed:** One-on-one assistance for individuals living with family or foster family, aiding in daily activities and socialization.

PROGRAM ADMINISTRATION

The Kansas Department for Aging and Disability Services (KDADS) oversees the HCBS waivers.

DUAL-ELIGIBLE OVERVIEW

BEHAVIORAL HEALTH

For individuals who are dually eligible for both Medicare and Medicaid, coverage of behavioral health services is coordinated between the two programs to ensure comprehensive care.

Medicare Coverage	Medicaid Coverage
Outpatient Mental Health Services Medicare Part B covers services such as individual and group therapy, psychiatric evaluations, medication management, and certain preventive services like depression screenings.	**Supplemental Behavioral Health Services** Medicaid may cover additional behavioral health services not fully covered by Medicare, including certain counseling services, case management, and community-based mental health services.
Inpatient Psychiatric Care Medicare Part A covers inpatient psychiatric hospital stays, subject to specific limitations.	**Long-Term Services and Supports (LTSS)** For those requiring long-term support, Medicaid can cover services like personal care assistance and other community-based supports.

INTEGRATION OF BEHAVIORAL HEALTH SERVICES

To enhance care coordination, Kansas Medicaid used to offer OneCare Kansas (OCK), that provided extra support and coordination of care for KanCare members with certain serious health conditions, including serious mental illness. OCK employed the medical home model, also known as Behavioral Health Homes, to provide core services including comprehensive care management, care coordination, health promotion, transitional care, individual and family support, and referrals to community and social support services. MCOs collaborate with community providers, referred to as Health Home Partners, to deliver these integrated services.

Under the new KanCare beginning January 2025, OCK will no longer be covered under Kansas Medicaid. Other options for behavioral health services and care coordination under the new program include:

- Certified Community Behavioral Health Clinics (CCBHCs)
- Targeted Case Management (Members with IDD Diagnosis):
- Community Health Workers (CHW)
- MCO Care Management Programs:
- TCM, CCBHC, and MCO Care Coordination

DUAL-ELIGIBLE DELIVERY SYSTEM

In Kansas, individuals who are dually eligible for both Medicare and Medicaid receive coordinated healthcare coverage through a combination of services from both programs.

	KANCARE	PACE	D-SNP
What Is It?	Kansas' Medicaid managed care program.	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 duals unless they meet FFS exclusion criteria or are enrolled in PACE.	Optional for dual-eligibles (55+) who need nursing home-level care.	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 all necessary care.	Manages Medicare benefits for dual-eligibles to enhance care coordination.
Medicaid's Role	Secondary payor for LTSS and non-physician behavioral health services.		Coordinates with Medicaid.
Plan Availability	Statewide	Only offered in 23 counties.	Offered by multiple health plans.

DUAL-ELIGIBLE DELIVERY SYSTEM

DUAL-ELIGIBLE SPECIAL NEEDS PLANS (D-SNPs)

D-SNPs are specialized Medicare Advantage plans designed for dual-eligibles, offering integrated care that combines Medicare and Medicaid benefits, including behavioral health services. These plans can provide additional benefits beyond standard Medicare coverage, such as care coordination, which can be particularly beneficial for managing behavioral health needs.

About 36% of full-benefit dual-eligibles in Kansas are enrolled in a D-SNP.

BACKGROUND

D-SNPs are plans run by private insurance companies who contract with CMS to provide Medicare (and sometimes Medicaid) benefits through managed care. All D-SNPs are required to coordinate an enrollee's Medicare benefits with their Medicaid benefits to some level.

ELIGIBILITY & ENROLLMENT REQUIREMENTS

To enroll in a D-SNP, individuals must be eligible for Medicare, and be eligible for Kansas Medicaid coverage. They must also live in one of the counties served by one of the Medicare Advantage Organizations (MAOs) managing a D-SNP. Enrollees are not required to enroll with the same insurance company (D-SNP) that they have for their Medicaid (KanCare) coverage. Dually eligible individuals are also not required to enroll in a D-SNP and can choose between Traditional FFS Medicare, Medicare Advantage health plans, and PACE. The decision to join a D-SNP is an individual one based on a person's health care needs and provider preferences, the D-SNP's network of contracted providers, prescription drug availability, etc. One key difference between Traditional Medicare and a D-SNP is that enrollees are required to see providers that are contracted with the health plan or agree to accept payment from the plan. The D-SNP provider directory will include the list of providers members can see for their care.

PLAN AVAILABILITY

Multiple health plans offer D-SNPs across Kansas. You can find more information on the three MCOs offering D-SNPs by **clicking here.**

Healthy Blue | sunflower health plan | United Healthcare Community Plan

SERVICES

Medicaid Services not covered by Medicare are required to be provided through D-SNPs, including but not limited to, dental, vision and hearing. Plans can also provide **additional benefits** beyond standard Medicare coverage, like care coordination, which can be particularly beneficial for managing behavioral health needs. Most D-SNPs have a $0 premium, $0 coinsurance and $0 co-pay.

DUAL-ELIGIBLE ENROLLMENT

DUAL-ELIGIBLE ENROLLMENT

According to CMS, as of March 2024, total full dual-eligible enrollment was 43,640.

According to KDHE, as of March 2025, there were 41,183 dual-eligibles enrolled in KanCare.

Full-benefit duals are required to enroll in KanCare, the state's managed care program unless they meet one of the FFS exclusion criteria or enroll themselves in PACE.

Dual Status Codes	Count of Dual Enrollees (as of March 2024)
Qualified Medicare Beneficiaries (QMB)-only	13,892
QMB plus Full Medicaid Benefits	25,083
Specified Low-income Medicare Beneficiaries (SLMB)-only	7,640
SLMB plus Full Medicaid Benefits	4,553
Qualified Disabled and Working Individuals (QDWI)	0
Qualifying Individuals (QI)	4,401
Other Dual Full Medicaid Benefit	14,004

Questions? Reach out!

Total dual-eligible enrollment including partial duals, as of March 2024 was 69,573.

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 REPORTs, 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.

FADY SAHHAR,
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	ABBRV.	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.

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 REPORTs, 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.

OUR CONTACT

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