

NCI® Data Brief: Healthcare use and service coordination among dual eligible respondents

Medicare is typically for people age 65 and older, but people with disabilities who are under 65 can sometimes qualify for both Medicare and Medicaid. When someone qualifies for both Medicare and Medicaid services, they have “dual eligibility.” This can help cover more healthcare costs and services.

Approximately 12.8 million people qualify for both Medicare and Medicaid.¹ Understanding the needs of this group will help state agencies who oversee services to improve the experience of dual eligibles and help make sure all needs are met.² **This data brief looks at what NCI data tells us about respondents who are dual enrolled in Medicare and Medicaid.** We refer to this group as “NCI dual eligibles.”

NCI-IDD respondents are people with intellectual and developmental disabilities who receive publicly funded services from their state developmental disability system. NCI-AD respondents are older adults and people with disabilities who receive publicly funded long-term services and supports through their state aging and disability systems.

NCI Dual Eligibles are older and live in congregate settings at higher rates



About 3 out of 4 (74%) of NCI-AD³ respondents have Medicaid and Medicare

Average age of NCI-AD dual eligibles **67**

Average age of NCI-AD non-dual eligibles **52**

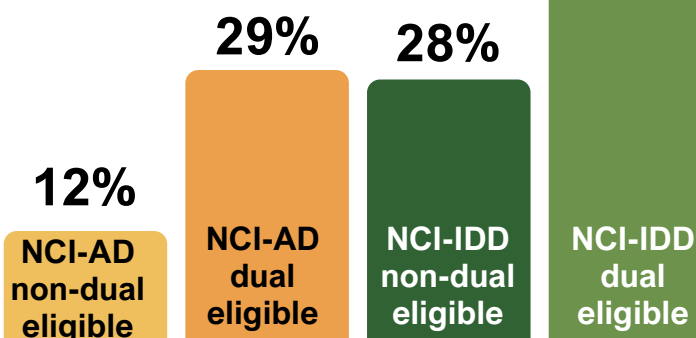


More than 2 out of 4 (55%) of NCI-IDD⁴ respondents have Medicaid and Medicare

Average age of NCI-IDD dual eligibles **49**

Average age of NCI-IDD non-dual eligibles **34**

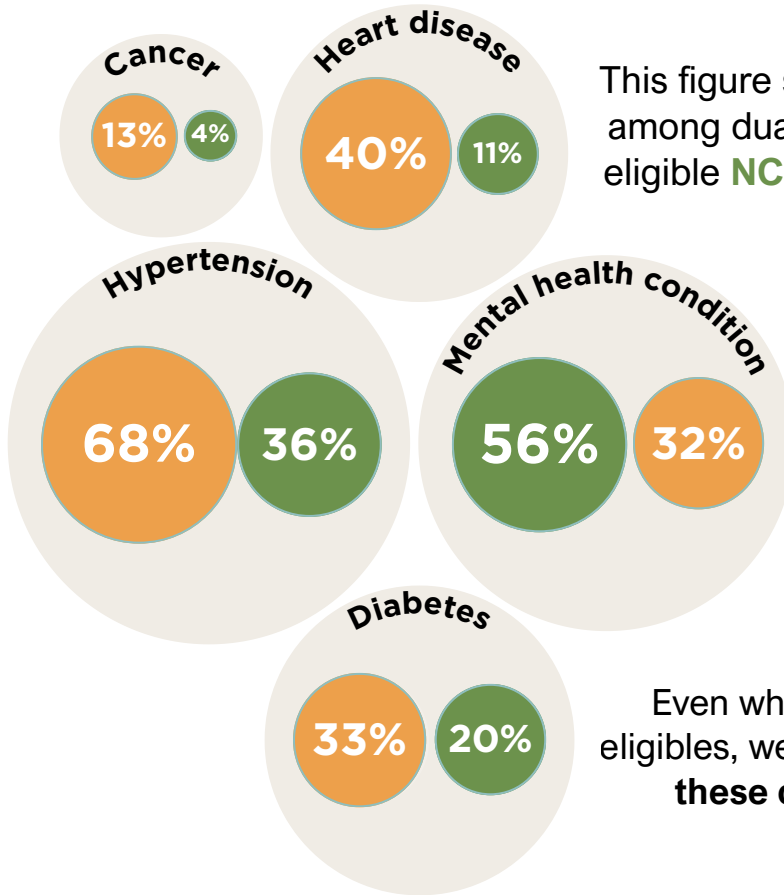
Percent of NCI respondents who live in congregate settings by dual eligible group



People who are dual eligible have **higher rates of living in congregate settings** (institutions and group homes) than non-dual eligible peers, with NCI-IDD duals having the highest rates of living in congregate settings.

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NCI dual eligibles have high rates of chronic conditions






This figure shows the rates of five chronic conditions among dual eligible **NCI-AD respondents** and dual eligible **NCI-IDD respondents** with valid responses.

In general, **NCI-AD dual eligibles have higher rates of chronic conditions than NCI-IDD dual eligibles**, with the exception of co-occurring mental health conditions.




Even when we account for the older age of dual eligibles, we see significantly **higher rates of many of these chronic conditions for dual eligibles** compared to non-dual peers.

NCI Dual eligibles are significantly more likely to use preventative healthcare than non-dual peers, but still have significantly higher rates of emergency room visits

Compared to non-dual eligible peers,* **dual eligible NCI-AD respondents** have:

-  6% higher odds of having a **vision exam in the past year**
-  11% higher odds of having a **flu vaccine in the past year**
-  16% higher odds of having an **ER visit in the past year due to a fall**

Compared to non-dual eligible peers,* **dual eligible NCI-IDD respondents** have:

-  40% higher odds of having a **physical exam in the past year**
-  17% higher odds of having a routine **dental exam in the past year**
-  23% higher odds of having an **ER visit in the past year** for any reason

**note: all odds ratios control for age. In other words, the rates of healthcare use are significantly higher even when we account for older age of those who are dual eligible. All significance is tested at 0.05 level.*

Questions or comments? Email us: nci@nationalcoreindicators.org

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Experience of service coordination for NCI dual eligibles and non-dual peers is similar, with a few notable differences

Compared to non-dual eligible peers, **dual eligible NCI respondents** have similar experiences in being able to reach their case manager when they want to talk with them, service plans reflecting their preferences, and reporting that services meet their needs.

Some significant differences were observed in a few areas of service coordination, as described below.

Compared to non-dual eligible peers, **NCI-AD dual eligibles** have:

8% less likely to say that their case manager/care coordinator changes more often than they like

13% more likely to say they worked with someone to reduce risk of falls

Compared to non-dual eligible peers, **NCI-IDD dual eligibles** have:

31% more likely to have met or spoken with their case manager/service coordinator

18% more likely to feel like their case manager/service coordinator knows what is important to them

14% more likely to help make their service plan

Conclusions

These data underscore that individuals who are dual eligible require more integrated and intensive supports than peers who are not dual eligible. For both the NCI-AD and NCI-IDD samples, national data suggest that people who are dual eligible are:

- **Significantly older**
- **More likely to live in congregate settings, and subsequently less likely to live in community-based settings**
- **More likely to have chronic conditions, and**
- **Have high utilization of preventive AND acute healthcare**

These takeaways point to the importance of good care coordination. However, NCI data shows some key differences in outcomes and experiences for duals and non-duals, as well as NCI-AD and NCI-IDD samples. States looking to improve integrated care for duals may seek to include NCI-AD and NCI-IDD data as part of quality monitoring contracts with managed care entities.

References

1. https://www.nasddds.org/wp-content/uploads/2025/06/508_NASDDDS-IDD-Dual-Eligibility-Toolkit-THE-WHY-Infographic.pdf
2. https://www.nasddds.org/wp-content/uploads/2025/06/508_NASDDDS-IDD-Dual-Eligibility-Toolkit-State-Policy-Considerations.pdf
3. https://nci-ad.org/upload/reports/NCI-AD-National-Report-23-24_20250321.pdf
4. <https://idd.nationalcoreindicators.org/survey-reports-insights-2/>

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Considerations and opportunities to use data for quality improvement

You may be wondering how to use your state's data on dual eligibles for quality improvement. Below are two examples of using data. In one case, NCI data point to an opportunity to adopt immediate actions. In the other case, NCI data raise questions that the state needs more information about to develop a targeted action plan. If you aren't sure how to get started using data, reach out to us at nci@nationalcoreindicators.org.

Getting started with using data on dual eligibles

Scenario 1: Reducing fall risks

State A NCI-AD Data on Dual Eligibles



6 out of 10 dual eligibles have a history of frequent falls



4 out of 10 dual eligibles have gone to the ER due to a fall in the past year



2 out of 10 dual eligibles need home modifications but do not have them

The data to the left demonstrate to State A that they may want to work on reducing falls among dual eligibles. After speaking with their advisory groups about the opportunities to reduce falls, State A considers the following actions:

1. **Review state assessment protocols** to ensure that staff regularly evaluate for possible home modifications (e.g., grab bars), assistive devices (e.g., walkers), and technology solutions (e.g., sensors) that may help to address falls.
2. **Work with state Medicaid agency** to direct organizations that operate Dual Eligible Special Needs Plans to focus on fall prevention programs.

Scenario 2: Improving Diabetes management

The data to the right are for State B. They may need to improve diabetes management with their dual eligibles. **To understand how to implement solutions, they need more information.** They meet with their state advocacy council and provider membership network to ask about:

State B NCI-IDD Data on Dual Eligibles



4 out of 10 have diabetes



1 out of 10 dual eligibles with IDD had an unexpected hospitalization due to seizure

- Do people with IDD, their families, and **staff have the necessary knowledge** about nutrition and physical activity to promote diabetes management?
- Do **providers have appropriate protocols** to monitor diabetes medication adherence?
- Are there any opportunities to **use remote supports and technology** to assist with diabetes care?
- How can the state support embedding **diabetes care in person-centered planning**?