**Issues and Concerns for People with Intellectual and Developmental Disabilities who are dually eligible for Medicaid and Medicare**

**Background**

Approximately 9.2 million people are dually eligible for Medicaid and Medicare. These are vulnerable people, sometimes referred to as “Duals” who have high needs and are very poor. Duals are not a homogeneous group. They include frail seniors living in nursing homes; seniors with up to five chronic health conditions, including dementia and Alzheimer’s disease, and older Americans with no chronic health conditions. Nearly 40% of people who are dually eligible for Medicaid and Medicare are individuals with disabilities under the age of 65. The “younger” duals have physical disabilities, intellectual and developmental disabilities (I/DD), and mental illness.

**How Does the Duals System Work?**

**Medicare**, a federal program, covers most acute care (e.g., doctor’s visits, hospitalization, X‐rays) and prescription drug costs. **Medicaid**, a joint federal/state program run by the states, pays for most long term services and supports (e.g., help getting dressed, bathing, preparing food, transportation; reminders to take medications) and covers Medicare premiums and cost sharing.

**Why Is Congress Concerned about Duals?**

**Cost**: Duals represent 21% of Medicare beneficiaries and account for 36% of Medicare costs. Similarly,

duals constitute 15% of Medicaid enrollees, but account for 39% of the program’s costs.

**Lack of coordination**: Duals must negotiate two complex systems that have different rules, regulations,benefits, and providers who often do not communicate with one another, resulting in uncoordinated care and avoidable costs and inadequate or unnecessary care.

**Is Anything Being Done to Address These Challenges?**

Yes, in partnership with the Centers for Medicare and Medicaid Services (CMS), 26 states are developing coordinated integrated models to provide better and more cost efficient care for duals. The models are designed to integrate Medicare and Medicaid funds, improve outcomes, and reduce costs. These state‐level demonstrations, most of which involve different types of managed care, will provide policymakers with data about what works well to improve health outcomes and reduce costs – data needed to inform decisions. Even in the absence of data, some policymakers believe that duals should be required to participate in managed care believing that there are cost efficiencies available through better integration and coordination of care. ***The duals financial alignment demonstrations occurring in the states should be allowed to continue before policy decisions affecting this vulnerable population, such as requiring that they participate in managed care, are made****.*

**What Do We Know about Managed Care for Duals?**

The data concerning managed care are limited and mixed. Most Medicaid managed care plans do not cover long term services and supports for individuals who have I/DD. Some Medicaid managed care plans actually have cost more than current fee‐for‐service Medicaid. Managed care plans in Medicare have historically cost more, not less, than the fee‐for‐service system. Medicare special needs plans (SNPs) only cover certain categories of recipients and few coordinate with Medicaid. Many Medicare SNPs have not been able to demonstrate improved outcomes.

**Why Is The Arc Concerned about the Rush To Managed Care of Long Term Services and Supports (LTSS) for People with I/DD?**

Managed care organizations have little to no experience working with individuals with I/DD. Typically, managed care has not included LTSS. There is little evidence that managed care will improve quality for people with I/DD receiving LTSS and at the same time save money. Historically, people with intellectual and developmental disabilities have been excluded from managed care programs. In part this has occurred because:

\_ **The LTSS system for people with I/DD already is to some extent a “managed” service system**. States designed their developmental disabilities (DD) service systems to include individual care plans and service coordinators who are responsible for monitoring their clients’ individual plans. States have worked hard over many years to build a system that provides more community based alternatives to costly institutional care for people with I/DD.

\_ **Managed Care Organizations (MCOs) follow a “medical model” and have very limited knowledge and experience with long term services and supports for people with I/DD.** The medical and acute care health systems have not had great success in serving the I/DD community (availability of specialists, physical accessibility, ability to work with individuals who have I/DD). MCOs have little experience with or understanding of the long term services and supports needs of people with I/DD that include social, vocational, and independent living needs.

\_ **A key issue and the largest cost driver for people with I/DD is their long term services and supports needs which usually last for a lifetime.** Unlike the older duals population, the bulk of costs for people with I/DD is not repeat hospitalizations, over‐utilization of emergency rooms, or nursing home care. Their primary needs revolve around supports needed to participate fully in their communities over many years or decades, and there is an infrastructure in place in the states to provide those services and supports to people with I/DD (although some states have met this challenge far better than others).