Navigating Policy Changes in Medicare and Medicaid: Sustaining and Scaling Care for High-Need Older Adults

Roundtable Summary

On May 21, 2025, the Duke-Margolis Institute for Health Policy, in collaboration with West Health, convened a multi-stakeholder roundtable to discuss the state of providing care for high-need older adults with a focus on dual-eligible beneficiaries and the near dual population, and potential policy solutions for improving care models. The aim of the roundtable was to identify strategies to advance integration and care improvement through population-based (e.g., ACOs) and population-specific models (D-SNPs), explore opportunities for public-private partnerships, and promote alignment in federal and state efforts. This roundtable focused on practical, short-term opportunities given the dynamic policy environment with the Centers for Medicare and Medicaid Services newly outlining their strategic direction under the Trump-Vance administration and states facing uncertainty with anticipated Medicaid coverage and payment changes. Below we summarize key takeaways from the discussion, including implications for policy efforts to advance Medicare-Medicaid integration and potential policy interventions to advance accountable care for dual-eligible beneficiaries and the near dual population.

Considerations for Medicare-Medicaid Integration

Participants explored major challenges and strategic considerations for advancing integration efforts.

- **Achieving full integration remains complex, encompassing financial, administrative, and care-related components.** Participants discussed the differing definitions of integration, implications for each component, and the beneficiary experience as a priority for Medicare-Medicaid integration. A key challenge facing integration is the lack of a single payer or source of funds across the two programs, which participants noted as a crucial step in operationalizing administrative integration. However, some states pursing exclusively aligned enrollment have been able to support more seamless care experiences for beneficiaries through unified grievance and appeals processes. Prior authorization denials is an issue for the dual-eligible population, with denial rates for D-SNPs being double that of all MA plans.
- **Multiple coverage pathways result in complexity and beneficiary confusion.** Coverage pathways include Traditional Medicare (TM) or MA combined with either Medicaid FFS or a Medicaid managed care product, resulting in multiple coverage arrangements for dual-eligible beneficiaries. The combinations of enrollment options across FFS and managed care contributes to beneficiary confusion and a complex regulatory environment. Additionally, enrollment in integrated products such as Programs of All-Inclusive Care for the Elderly (PACE) and Applicable Integrated Plans (AIPs) remains low, with the majority of dual-eligible beneficiaries in TM and Medicaid FFS. Addressing this fragmentation requires multiple policy interventions tailored to the state context and diverse combinations of coverage.
- **Current evaluations for integrated models are insufficient.** Participants discussed the difficulty evaluating integrated care models given the heterogeneous nature of the population and differing policy environments across states and plan arrangements. Participants discussed the need for research that clearly defines a population and types of interventions, such as dual-eligible beneficiaries using Long Term Services and Supports (LTSS), to assess outcomes more effectively

across integration models and to identify and develop strategies for improvement. Further, there are gaps in evidence on how accountable care organizations (ACOs) and other Special Needs Plans (e.g., Chronic Condition Special Needs Plans) are serving dual-eligible beneficiaries.

- **Limited state capacity and Medicare expertise hinder integration efforts.** In any given state Medicaid agency, there are rarely more than a few staff who understand the Medicare program and regulatory requirements for integration. Further, states have competing priorities and limited resources, which may further be constrained with forthcoming Medicaid changes in the Federal Budget Reconciliation package. Given these concerns, participants emphasized the value of targeting "low-hanging fruit" or incremental, practical policy opportunities to build momentum for integration in the near term within constrained state environments.

Policy Areas to Explore

A key objective of the roundtable was to solicit feedback and strategic guidance from experts across various health perspectives on policies and practices that require further research to improve care systems for high-need older adults. Below we highlight the most viable policy areas for further action based on our conversation with a focus on dual-eligible beneficiaries.

Understand the growing number of care models serving high-need older adults. There are multiple care models serving dual-eligible beneficiaries and other high-need older adults. For instance, during the roundtable, participants discussed the following care models enrolling dual-eligible beneficiaries: PACE, TM ACOs, AIPs, coordination only D-SNPs, and other special needs plans such as C-SNPs. The discussion explored how to strike a balance between affording beneficiaries choice of different options and avoiding unnecessary complexity. Each of these models vary in terms of financial, administrative, benefits, and care integration. Participants discussed opportunities to leverage navigators such as State Health Insurance Assistance Programs (SHIP) counselors or Area Agencies on Aging to help beneficiaries make informed decisions about the product that is best for them. Potential next steps include:

- Develop a framework of care models serving high-need older adults and considerations for serving sub-populations of Medicare-eligible beneficiaries.
- Develop a compendium of strategies to improve care navigation for dual-eligible beneficiaries, including leveraging community resources (e.g., AAAs).

Explore opportunities to scale PACE-like models, or virtual integration of PACE elements, to improve care for high-need older adults. Participants agreed that PACE is a gold standard in many regards, especially its care model, though it is hard to scale. Further, participants agreed that it is not feasible to serve the entire dually eligible population through PACE. Participants highlighted the opportunity to explore key elements or best practices of PACE that could be scaled across other models, including scaling PACE-like models through virtual integration. Potential next steps include:

- Conduct qualitative interviews with PACE experts to identify successful components of PACE that should be scaled across other models.
- Convene a roundtable to explore existing and needed policies that support the virtual integration of PACE-like models for high-need older adults not enrolled in traditional PACE programs.

Explore policy levers to advance accountable care for dual-eligible beneficiaries. As noted above, states may not have the bandwidth to prioritize integration in the absence of a federal requirement. In addition

to policies to advance Medicare-Medicaid integration, there is opportunity to explore policy interventions to better align Medicare and Medicaid programs in the short term given the increasing role of TM ACOs, such as the ACO REACH model High Needs track, in serving dual-eligible beneficiaries. During the roundtable, participants highlighted the opportunity to explore CMMI waiver authority as a policy intervention to improve care systems without requiring a new model. This could include waiving National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) to enable accountable entities to provide durable medical equipment (DME) to high-need populations more effectively. Potential next steps include:

- Convene a roundtable to explore CMMI waiver authority and benefit enhancements that could improve care for high-need older adults.
- Develop a roadmap for advancing accountable care for dual-eligible beneficiaries, accounting for different state experiences and approaches to integration.

Identify "low-hanging fruit" opportunities to improve care for high-need older adults. Participants acknowledged that there are a number of strains on states (e.g., staff capacity) that impact how states can further integration. States are also preparing for additional resource constraints with changes to Medicaid in recently passed One Big Beautiful Bill Act. Given this, participants discussed the value in short-term policy interventions focusing on incremental, practical efforts that states could more easily take to improve integration and care models. In particular, participants highlighted how State Medicaid Agency Contracts (SMACs) are an example of a less burdensome pathway for states to drive integration as they are a requirement for D-SNPs to operate in a state. However, states may require further guidance from CMS or other states as they develop their SMACs to drive meaningful transformation. Additionally, participants discussed opportunity to explore how states could leverage SMACs to establish accountable relationships and achieve shared savings through improved outcomes and long-term care rebalancing, though states have not fully tested what is feasible through a SMAC. This may be of increasing importance to states in the coming years as states see reductions to Medicaid budgets. Potential next steps include:

- Conduct qualitative interviews with state Medicaid staff and health plans to understand challenges and considerations for developing SMACs that improve the beneficiary experience.
- Convene a roundtable with state Medicaid staff to facilitate learnings and best practices for advancing integration.

Establish partnerships for LTSS. LTSS are a crucial service for high-need older adults. Participants discussed the opportunity for ACOs or other risk-bearing entities to both better coordinate with and potentially partner with states to cover LTSS for attributed beneficiaries. There is precedent for states to potentially use managed care direct contracting for managed LTSS (MTLSS). Participants also discussed the opportunity to explore innovative pathways to cover LTSS for the near dual population who do not qualify for full Medicaid benefits. Participants raised also CMMI waiver authority as an avenue to explore to support additional community-based services, in addition to Medicare Advantage supplemental benefits. Potential next steps include:

- Convene a roundtable to explore innovative approaches to providing LTSS for near dual populations.
- Develop a framework for risk-bearing entities to partner with states to cover LTSS.

Engage beneficiaries in their care and decision making. In alignment with recent CMMI strategy, participants discussed beneficiary empowerment as an area for further research. For instance, there is need to investigate the role of AI or other technology to engage beneficiaries in their care and decision-

making. However, this is likely an area to explore through a longer-term project. Participants also discussed the need to balance accountability for states/providers while also providing flexibility to innovate. For example, default enrollment is a tool states can use to advance a more seamless care experience for beneficiaries by enrolling them into an aligned D-SNP product operated by the parent entity of their Medicaid managed care organization. However, default enrollment requires CMS approval and there are concerns with restricting beneficiary choice. There is also opportunity to explore how beneficiaries are attributed and churn through models and policies to advance care navigation. Potential next steps include:

- Conduct qualitative interviews with beneficiaries and caregivers to understand experiences with and needed improvements to care planning and decision-making tools.
- Hold a roundtable with technology innovators to understand regulatory barriers to scaling tools that support beneficiaries.

Next steps

Duke-Margolis and West Health will use learnings and insights from the May 21st roundtable to scope out research priorities and activities under our collaboration to advance value-based care. We will continue to engage leaders from this meeting as we refine a project to explore these ideas further and create a public-facing deliverable to advance care systems for high-need older adults (anticipated publication in Fall 2025). For additional feedback or questions, please contact Monty Smith (montgomery.smith@duke.edu)