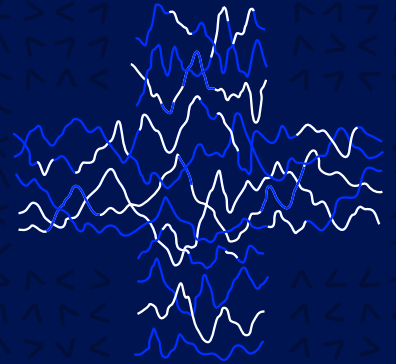


Complex Care Research Agenda




APPROACH

Arnold Ventures seeks to address some of the most pressing policy challenges facing our country. Our work within the health care sector is driven by a belief that our current system costs too much and struggles to adequately care for people with one condition, let alone a complex array of conditions.

There is no population for whom this is truer than those who are dually eligible for Medicare and Medicaid. Dual-eligible individuals account for a disproportionate share of Medicare and Medicaid spending,¹ yet the outcomes we get for these dollars are poor. They are more likely to have inpatient stays, visit emergency rooms, and use nursing homes than their Medicare-only counterparts.² That is why in July 2019, we launched a new effort centered around funding research, technical assistance, and policy solutions aimed at improving the systems that deliver care to this vulnerable population.

Our work aims to accomplish three policy objectives: (1) increase integration between Medicare and Medicaid through existing or new models, as necessary; (2) increase enrollment in integrated coverage options; and (3) ensure that dual-eligible individuals get services that lead to better patient experiences, higher quality of care, and reduced health care costs.

More and better research will bring greater depth of thought to our policy agenda and advance broader policy conversations. We seek to fund research guided by the following principles:

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-  **Policy relevance:** Research should tackle the most pressing questions that can affect policy decisions and contribute the most value to the field, given the existing state of the literature;
 -  **Rigor and independence:** Research must be conducted with integrity, research designs must be crafted thoughtfully based on a thorough understanding of the landscape using the best data possible, and methodologies must be clear and publicly available; and
 -  **Alignment with our strategy:** Research projects should be directly aligned with our research agenda and the broader Arnold Ventures strategy

To assist researchers with this third principle in particular, we have identified the following priorities and questions based on gaps we have identified in the evidence. We encourage researchers interested in helping us to answer these questions or other aligned questions to reach out to info@arnoldventures.org.

Objective 1: *More Integration Between Medicare and Medicaid Financing and Care Delivery Models*

Priority: Illustrating the impact integrated models have on cost and quality, including as it relates to sub-populations.

Key questions: Integrated Care Models

1. Using both Medicare and Medicaid data, what are the impacts of integrated care under the following models on total cost of care, utilization, quality, and health disparities:
 - a. Program of All-Inclusive Care for the Elderly (PACE),
 - b. Financial Alignment Initiatives (FAI) (considering evaluations already being conducted through CMMI and its evaluators),
 - c. Managed fee-for-service models, and
 - d. Dual-eligible special needs plans (D-SNPs) – as a whole, as well as among them by degree of integration.
2. How does access to integrated plans vary according to sub-population? What kind of financial incentives can be used to reduce inequalities in access, and towards whom should they be directed?
3. How does spending on and utilization within integrated programs change over time? Is there a difference in spending and utilization after initial implementation of a program or does it take time for the model to show savings given all of the upfront investments in system changes required? If the latter, what is the time horizon?
4. How do integrated programs compare to one-another? How do they differ in target populations, eligibility criteria, provider participation, etc.? Is one type of integrated model more effective than another (i.e., in terms of impact to cost, quality, and health disparities)?
5. How do the ways in which states design their integrated care programs impact outcomes on quality and costs, if they have any impact at all (e.g., full inclusion of behavioral health services, comprehensive coverage of home health aides, passive enrollment, etc.)?
6. How do the provider and care delivery models vary within and among integrated models and what is their impact on outcomes (e.g., approaches to care management, types of services included in the model, provider network composition, etc.)? What types of entities are best at delivering these models (e.g., Medicare Advantage plans, accountable care organization, primary care providers, etc.)?
7. What are the budget impacts to the government of integrated v. non-integrated programs?
8. What role is private equity playing as it relates to the PACE model in particular? What is motivating these investments and how does it impact the way in which a PACE model operates?

Key questions: Sub-Populations

1. The dual-eligible population is not homogenous—do integrated models produce better quality and cost outcomes for some types of beneficiaries than others? Are certain integrated models better for certain types of beneficiaries?
 2. Are there ways to meaningfully segment the dual-eligible population that can be used to direct policy outside of the ones that have already been identified?
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Objective 2: *Greater Enrollment in Integrated Care Models*

Priority: Growing the understanding of what dual-eligible people want out of their coverage in order to increase enrollment and keep people enrolled.

Key questions

1. What are the characteristics of the people who select integrated options as compared to those who do not? How do health care utilization patterns differ in integrated vs. non-integrated coverage options? What factors drive those differences?
2. Why do (and don't) dual-eligible individuals select integrated models?
3. What were the characteristics of beneficiaries who opted out when automatically (i.e., passively) enrolled into an integrated option? Did previous service utilization have any impact (e.g., nursing homes)?



↑ 2X MORE

THE TOTAL SPENDING FOR DUAL-ELIGIBLE INDIVIDUALS IS ALMOST DOUBLE THEIR NON-DUAL-ELIGIBLE COUNTERPARTS AT \$30,510 VERSUS \$15,630 RESPECTIVELY.

4. How and where are beneficiaries enrolling / becoming dually eligible? Does where / how enrollment happens have an impact on whether an integrated option is selected?
5. What impact do specific passive enrollment strategies (e.g., “default enrollment” or “automatic enrollment”) have on enrollment and retention? Do some enrollment strategies reduce enrollment inequities more than others? How can they be most effectively implemented?
6. What are the patterns of enrollment over time? What makes certain sub-populations less likely or able to enroll in integrated plans? What impact do coverage gaps have on beneficiaries, in particular on long-term services, supports, and out-of-pocket expenses? How do these impact health disparities and quality and cost outcomes?

Objective 3: *Improve the Mix of Services to Achieve Better Outcomes*

Priority: Identifying ways to pay at-risk entities accurately to ensure they are encouraged to serve the dual-eligible population.

Key questions

1. Do payments to organizations that operate integrated models reflect the underlying costs associated with serving the population? What characteristics of dual-eligible individuals contribute most to their health care utilization and associated costs? Are these accurately captured in today's payment structures?
 2. How do we appropriately account for frailty of individuals in the way that at-risk entities are paid?
 3. What financial mechanisms are most powerful at incentivizing better outcomes when serving a vulnerable population? What kind of financial incentives can be used to reduce inequities, and towards whom should they be directed?
 4. Is risk adjustment the best approach for accounting for the underlying risk of a population? Are there other mechanisms we could leverage that may more effectively and efficiently adjust payments to at-risk entities to account for underlying risk?
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Priority: Better understanding the most efficient mixes of acute and long-term care support services.

Key questions: Long-term care services

1. What effect do home and community-based services have on long-term care services and supports utilization and outcomes for dual-eligible individuals? How do those impacts vary by type of service and by sub-population?
2. How does place of residence affect outcomes and spending for individuals who are dual-eligible individuals (e.g., assisted living facilities, HUD supported low-income housing)?
3. To what extent are there unmet long-term care needs among the dual-eligible population, both in terms of gaps in coverage and gaps in access?
4. What is the impact of a managed care approach to long-term services and supports on spending, utilization, and patient outcomes?
5. How do various policy constraints (e.g., caps on the number of people with access to home and community-based waiver services) change home and community-based services, long-term services and supports, and broader outcomes?

Key questions: Support services

1. What are the associated cost and quality outcomes of the various roles that the health care system plays in social supports, (e.g., referrals, coordination of existing services, direct payment)?
2. Which support services do dual-eligible individuals use the most? How does this vary among dual-eligible individuals? What impact do specific support services have on health, utilization, and spending?
3. What are the most significant unmet social support needs within the dual-eligible population? How does this vary by beneficiary characteristic?
4. Does the way in which social supports are incorporated into payment models (e.g., increased flexibility in how plans can use dollars under medical loss ratio, supplemental benefits in Medicare, and in lieu of benefits in Medicaid) have an impact on plan benefit designs or impact patient outcomes?

ENDNOTES

1. Centers for Medicare and Medicaid Services, *Fact Sheet: People Dually Eligible for Medicare and Medicaid*. Available online at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_Factsheet.pdf
2. Kaiser Family Foundation, *What Could a Medicaid Per Capita Cap Mean for Low-Income People on Medicare?* March 2017. Available online at: <https://www.kff.org/medicare/issue-brief/what-could-a-medicare-per-capita-cap-mean-for-low-income-people-on-medicare/>