

## **Proposed priority--National Institute on Disability, Independent Living, and Rehabilitation Research**

SUMMARY: The Director of the National Institute on Disability, Independent Living, and Rehabilitation Research (NIDILRR) proposes a priority for a Disability and Rehabilitation Research Project (DRRP) entitled: Innovative and Emerging Health Service Delivery Models

Invitation to Comment: We invite you to submit comments regarding this proposed priority. To ensure that your comments have maximum effect in developing the final priority, we urge you to identify clearly the specific topic within the priority that each comment addresses. Please note that we are only accepting comments on the priority. We are not accepting comments on the background section that precedes the priority.

DATES: We must receive your comments on or before May 27, 2016.

ADDRESS: Address all comments about this notice to Marlene Spencer, at [Marlene.Spencer@acl.hhs.gov](mailto:Marlene.Spencer@acl.hhs.gov). You must include the phrase “Proposed Priority for Innovative and Emerging Health Service Delivery Models DRRP” in the subject line of your electronic message.

### **Title: Disability and Rehabilitation Research Projects (DRRP) Program: Innovative and Emerging Health Service Delivery Models**

#### ***Background***

People with disabilities, especially those with severe disabilities, are the most expensive and hard to serve population within today’s health system (National Council on Disability, 2009; Iglehart, 2011; Kaiser, 2011). Unfortunately, given historically low provider reimbursement rates, there has been little financial incentive to serve this population well. This has resulted in fragmented and duplicative care, preventable secondary conditions, and poorer health outcomes, all of which compromise cost containment and quality of life goals (Iglehart, 2011).

Many individuals with disabilities can thrive in the community if they have the appropriate long term services and supports (LTSS) (Putnam, 2014; Putnam & Freiden, 2014; Kaye, 2015). But these supports vary significantly by state and at times have no reimbursement source. For example, assistive technology (such as wheelchairs or orthotics) may be reimbursable if it is found to be medically necessary as defined by the state or health plan. But a technology that creates opportunities for community involvement and social interaction (such as a cell phone, or environmental control for the

home) might not meet that narrow definition. A complex web of traditional and non-traditional funding sources exists that often creates challenging barriers for individuals with disabilities (Wallace, 2011).

Other creative community-based services such as helping individuals with a disability find appropriate housing or an accessible wellness programs have similar reimbursement barriers (Malone, et al, 2012; Rimmer, 2010). Many individuals with disabilities and the aged with LTSS needs, especially those forced to enroll in the Medicaid program, are often only as independent as their state publicly funded health programs allow them to be. Unless ways can be identified to make delivery of health care to this population more efficient, policy makers may be unable to avoid funding cuts that will further compromise well-being of individuals with disabilities and the aged with LTSS needs (Livermore, et al, 2011). More research is needed to explore creative health service delivery models, especially those offering LTSS that historically have had no – or a limited – source of reimbursement.

Recent developments in law and policy have altered the national landscape for health service delivery models. The Affordable Care Act of 2010 (ACA) created new incentives for reducing the cost of care delivery while both increasing its quality and supporting successful health outcomes for the individual. A deliberate move away from fee-for-service toward evidence-based models and value-based purchasing has pushed health systems toward greater accountability for care, cost, and quality (Patient Protection and Affordable Care Act, 2010; U.S. Department of Health and Human Services, 2015).

The first wave of the ACA's innovation built on pre-existing models like Patient-Centered Medical Homes (PCMHs) which stress advanced primary care, including acute and chronic medical care, prevention, and wellness (Agency for Healthcare Research and Quality, Defining the PCMH, 2016). While PCMHs are promising, providers have found they are not always compensated for the full range of care and coordination they supply (Agency for Healthcare Research and Quality, PCMH Foundations, 2016). PCMHs may serve as a foundation for creative service model development, but are

insufficient as a financial incentive to serve individuals with significant disabilities.

Accountable Care Organizations (ACOs) are the ACA's attempt to combine PCMHs with a risk-based financial model that provides financial incentives for achieving positive health outcomes. In ACOs, networks of providers agree to accept some level of financial and medical responsibility for a defined population of Medicare enrollees (Centers for Medicare and Medicaid Services, Accountable Care Organizations (ACOs), 2016). If an ACO reduces costs, it can share the savings with Medicare, but ACOs that see no savings can be responsible for any extra cost or might suffer other financial penalties (Kaiser Health News, 2016).

The focus of ACO models built upon primary care and care coordination is Medicare recipients with high-cost chronic diseases such as congestive heart failure, diabetes, coronary artery disease, or chronic pulmonary disease. But this Medicare-focused chronic disease model largely ignores the disabled population's reliance on Medicaid, a vital program for nearly nine million non-elderly individuals with disabilities (Centers for Medicare and Medicaid Services, Individuals with Disabilities, 2016). It is Medicaid, not Medicare, that often provides critical community-based services that contribute to independent living and social integration for individuals with disabilities. More recently, attention has been shifting to include the Medicaid population in new demonstrations and grants by the Centers for Medicare and Medicaid Services (CMS) like State Innovation Model (SIM) grants, Center for Medicare and Medicaid Innovation (CMMI) grants, and Duals demonstrations.

(SIM grants have the goal of helping states develop new payment or service delivery models that can lower the cost of Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) without a loss in quality. These grants can pay for planning, testing, and evaluation of new models as well as infrastructure necessary for system transformation. Many states are looking at ways to integrate traditional medical and LTSS services, at times incorporating non-traditional community-based services (Centers for Medicare and Medicaid Services, State Innovation Models Initiative, 2016).

A series of grant-funded opportunities from the Center for Medicare and Medicaid Innovation (CMMI) focus on providers who are implementing new ideas to achieve the CMS triple aim—better health, better care, and lower cost—for enrollees in Medicare, Medicaid, and CHIP. These grants are especially targeted at providers who serve populations with the highest health care needs across the health continuum (Center for Medicare and Medicaid Innovation, 2016).

Finally, Duals demonstration grants through the CMS Medicare-Medicaid Coordination Office create partnerships between CMS and states to provide individuals who are dually eligible for Medicare and Medicaid with access to and coordination of the benefits of these divergent programs. These demonstrations are intended to eliminate conflict and cost shifting between the programs while simplifying access and improving care coordination (Centers for Medicare and Medicaid Services, About the Medicare-Medicaid Coordination Office, 2016). They acknowledge the full continuum of care and the need to integrate traditional medical and clinical interventions with home and community-based services.

Various states are using one or more of these models to create dynamic new approaches to care. For example, Oregon's Community Care Organizations build upon the ACO model's risk-based payment and quality requirements, but include both the Medicare and Medicaid populations in an attempt to achieve greater cost savings and elimination of health disparities (Oregon Health Policy Board, 2016; Health Affairs, 2015; Broffman & Brown, 2015).

The current competitive and innovative environment has spawned new interest in LTSS that go beyond traditional service delivery and coordinated care models. Early state or plan models often offered limited non-medical benefits like home care, personal care attendant services, and some case management of non-medical services, with options varying greatly from program to program and state to state (U. S. Department of Health and Human Services, 2016). New models often expand upon the previous benefits, with diverse offerings that can include environmental adaptations such as air

conditioning, extended availability of assistive technologies, service animals and veterinary expenses (Texas Health and Human Services Commission, 2016), GED training, gym memberships, financial training, cell phones, wellness programs (Iowa Department of Human Services, 2015), non-medical transportation, moving assistance, home maintenance and chores, various forms of counseling and support (Hawaii Department of Health, 2013), and supported employment (Hawaii Department of Health, Developmental Disabilities Division, 2013).

While there is significant research exploring the effectiveness of improved primary care and coordination (Brown et al., 2012), there is limited research on how effective the new community service and policy options are at meeting the triple aim of better health, better care, and lower cost. Nor is there much research on how these models and innovations – especially those that are paying for goods and services that historically have had no reimbursement source – might impact individuals with significant disabilities or complex needs who are generally underserved by traditional delivery models.

NIDILRR is currently funding work at the Community Living Policy Center (CLPC) of the University of California, San Francisco to identify innovative approaches that managed care organizations in California and Illinois are using to improve health care and long-term services and supports. Preliminary findings suggest that Illinois MCOs' use of “relentless engagement” (Thresholds, 2014) for high-risk behavioral health patients may greatly reduce hospital admissions and re-admissions (Heller et al., 2015). Regardless of financing mechanism (i.e., health plan, fee-for-service, or provider-based risk arrangement), the shift to new ways of providing health services across the continuum and the concomitant incentives create an exciting and powerful opportunity to identify and investigate innovation occurring at the provider level.

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### ***2016 Priority Disability and Rehabilitation Research Projects (DRRP) Program Health Service Delivery Models***

The Administrator of the Administration for Community Living establishes a priority for a Disability and Rehabilitation Research Projects (DRRP) grant on Innovative and Emerging Health Service Delivery Models. The DRRP must conduct rigorous research and dissemination activities that contribute to improved health outcomes, community participation, and community living for persons with disabilities. Under this priority, the DRRP must contribute to these outcomes by:

(a) Increasing knowledge of emerging promising practices in health services delivery for individuals with disabilities that incorporate:

(1) community-based interventions, services, and supports. Interventions include any strategy, practice, program, policy, or tool that, when implemented as intended, contributes to improvements in outcomes for individuals with disabilities;

(2) Historically non-reimbursed community-based services or products;

The DRRP must contribute to this outcome by conducting a comprehensive and systematic review of the policy and research literature on such models to serve as the context for the research conducted under paragraph (b);

(b) Conducting at least one rigorous research study to test the effectiveness of innovative models incorporating interventions that are associated with desired health outcomes for

individuals with disabilities;

(c) Consulting with relevant stakeholders, including: NIDILRR grantees, individuals with disabilities and their representatives, disability organizations (including centers for independent living), state and federal agencies, service providers, health plans, manufacturers, and other interested parties to maximize the relevance and usability of the research products to be developed under this priority;

(d) Focusing its research on a specific stage of research, and clearly specify the stage in its application. If the DRRP is to conduct research that can be categorized under more than one stage, including research that progresses from one stage to another, those stages must be clearly specified. These stages: exploration and discovery, intervention development, intervention efficacy, and scale-up evaluation, are defined in this notice;

(e) Conducting knowledge translation activities (i.e., training, technical assistance, utilization, dissemination) in order to facilitate stakeholder use and benefit from the knowledge that results from the DRRP's research activities.