



Health Terms and Practices Resource Glossary November 2012

The Affordable Care Act provides many new and exciting opportunities to connect mainstream health resources with supportive housing. However, along with that comes the need for supportive housing providers to become familiar with a new set of terms and practices. This glossary is meant to be a resource and tool as supportive housing providers build relationships with the health care system.

Affordable Care Act (ACA): The Obama Administration's health care reform legislation that was passed and signed into law in 2010. Under the legislation, states have the option to expand Medicaid health insurance eligibility to all those up to 133 percent of the federal poverty level (FPL). This provides the opportunity for all supportive housing residents to become Medicaid beneficiaries. The legislation also includes a Medicaid state plan amendment option to develop health homes for those with chronic illnesses, improved home and community based services benefits, increased access to integrated primary and behavioral health care services and a variety of provider incentives to improve care and reduce costs for vulnerable Americans with complex health conditions.

ACO: An Accountable Care Organization is a type of payment and delivery reform model that seeks to tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients. A group of coordinated health care providers form an ACO, which then provides care to a group of patients. The ACO may use a range of payment models (capitation, fee-for-service where a Medicaid payment provider is reimbursed for each individual service provided usually in 15 minutes increments, etc.). The ACO is accountable to the patients and the third-party payer for the quality, appropriateness, and efficiency of the health care provided.

ACT: Assertive Community Treatment is an intensive and highly integrated approach for community mental health service delivery. ACT programs serve people whose symptoms of mental illness result in serious functioning difficulties in several major areas of life, such as work, social relationships, residential independence, money management, physical health and wellness..

Authority, as in Medicaid Authority: Using the word 'Authority' is the casual way to refer to the parameters with which the Medicaid agency can make decisions regarding eligibility and benefits. Medicaid agencies apply to the Center for Medicare and Medicaid Services (CMS) through waivers or state plan amendments to alter their Medicaid program.

Bundled Payment: Bundled payment, sometimes also referred to as a case rate, allows providers to be paid for a set of defined services based on expected costs. It does not require providers to bill the health insurance payer for each discrete services. Instead, a provider receives a set payment for a specific set of services the person may use and it is up to the provider to coordinate care appropriately.

Capitated payment or capitated rate: A payment system where healthcare service providers are paid a set amount for each enrolled person assigned to that physician or group of physicians, whether or not that person actually seeks care, per period of time.

Care coordination/Care Management: The deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care.

Categorical Eligibility: The federal legislation which created the Medicaid program lists groups of people who are either mandatorily or optionally eligible for Medicaid. These groups have been termed 'categories'. Therefore, people who are categorically eligible for Medicaid fit in one of these groups. The mandatory categorically eligible for Medicaid populations include: low income families with children, low income pregnant women, and persons who are aged, blind or disabled. There are a wide variety of optional categorically eligible populations that states may decide to provide Medicaid insurance to, these include: pregnant women, infants and children with household incomes between 133 and 185 percent of the federal poverty level, low income children who are eligible for the Children's Health Insurance Program (CHIP), individuals receiving home and community based services, and low income families.

Community Health Centers: Community Health Centers are funded through the Federal Department of Health and Human Services' (HHS) Health Resources and Services Administration (HRSA). They provide health care, mostly primary care, to medically underserved, vulnerable populations throughout the U.S. There are also different types of CHCs - Federally Qualified Health Centers (FQHCs) which are located in underserved areas and receive enhanced Medicaid reimbursement (determined by the state), FQHC look alike which meet the definition of a health center but do not receive HRSA funding, and outpatient clinics in tribal areas. There are several designations specific health centers receive based on population served – Migrant and Seasonal Farmworkers, Health Care for the Homeless, Public Housing, and Native Hawaiians.

CMS: Centers for Medicare and Medicaid Services is the agency of the U.S. Department of Health and Human Services responsible for overseeing the Medicaid and Medicare programs. Formerly called the Health Care Financing Administration (HCFA).

CMMI: The Center for Medicare and Medicaid Innovation was created under the Affordable Care Act as a way to "test innovative payment and service delivery models to reduce program expenditures, while preserving or enhancing the quality of care" for those who get Medicare, Medicaid or CHIP benefits. CMMI will issue grants and other resources to states, local governments and providers evaluate various new models and promote lessons learned across the country.

Cost neutrality: Cost neutrality is typically referred to in the context of Medicaid and applying for Medicaid waivers from CMS. For 1115 and 1915 waivers, the federal government requires that the state's proposed changes not result in additional costs to the federal government. Occasionally, states implement self-imposed state cost neutrality but this is not required by the federal statute. State plan amendment requests do not have the federal cost neutrality requirement.

CST: A Community Support Team (also known as CSP – Community Support Program) is a recovery and resiliency oriented intensive, community based rehabilitation and outreach service for adults and youth. It is team-based and consists of mental health rehabilitation interventions and supports necessary to assist the recipient in achieving and maintaining rehabilitative, resiliency and recovery goals. A Community Support Team is designed to meet the educational, vocational, residential, mental health, financial, social, and other treatment support needs of the recipient in addition to addressing their possible co-occurring disorders (mental health/substance use, mental health/developmental disability, mental health/chronic health condition). Interventions are provided primarily in natural

settings, and are delivered face to face, by telephone, or by video conference with individual recipients and their family/significant others as appropriate, to the primary well-being and benefit of the recipient. A Community Support Team assists in the development of optimal developmentally appropriate community living skills, and in setting and attaining recipient (and family in the case of children) defined recovery/resiliency goals. It is available 24 hours per day, 7 days per week.

Dual Eligibles: Dual eligibles refer to are individuals who are in receipt of medical coverage from both Medicare and Medicaid.

Essential Benefits Package: Beginning in 2014, certain health plans will be required to provide members with a minimum set of benefits. The Affordable Care Act detailed 10 categories that must be included in the essential benefits package: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care.

FMAP: Federal Medical Assistance Percentages or the Federal Financial Participation in State Assistance Expenditures are the amount of Federal matching funds a state receives to fund the Medicaid program. Medicaid is a federal/state partnership and each state receives federal support. The level of support varies by state (from 50 percent to 83 percent) and is determined via a formula that is based on the state's per capita income level.

Health Care for the Homeless (HCH) Programs: Health Care for the Homeless Clinics are part of the Community Health Center program and automatically receives 8.7% of the entire CHC budget. Sometimes they are stand-alone clinics but often they are part of a hospital or larger Community Health Center. These programs can also be overseen and operated by county health departments. The foundational funding is provided by HRSA, same as with Community Health Centers, but these clinics have additional requirements. The major differences between HCH and CHCs are that HCH programs must provide substance use treatment and must include people experiencing homelessness on their board of directors.

Health and Medical Home Concepts:

Medical Home or Patient Centered Medical Home:

A PCMH integrates patients as active participants in their own health and well-being. Patients are cared for by a physician who leads the medical team that coordinates all aspects of preventive, acute and chronic needs of patients using the best available evidence and appropriate technology. Typically focuses on primary/physical health needs.

Health Home: Builds on the Medical Home concept and expands the provider network beyond primary care. Health homes are designed to be person-centered systems of care that facilitate access to and coordination of the full array of primary and acute physical health services, behavioral health care, and long-term community-based services and supports. The model aims to

The current Health Home concept began as 'Medical Home' provider networks created in the 1960s to improve services and outcomes for children with special health care needs. Medical homes were largely primary/physical health care focused.

Over time, the lessons learned from these medical homes have been applied to adults. The new Health Home language shows recognition that behavioral health treatment and social issues must be addressed to deliver patient-centered services and

improve health care quality and clinical outcomes as well as the patient care experience, while also reducing per capita costs through more cost-effective care.

Health Home State Plan Option: The State Option to Provide Health Homes for Enrollees with Chronic Conditions, section 2703 of the Affordable Care Act (ACA), will provide enhanced federal funding for states that are planning to expand or implement a health home initiative that will serve individuals with chronic conditions – provided certain criteria are met. This new Medicaid option was established as part of the Affordable Care Act (ACA) as a means of reducing costs and improving health outcomes for people who have chronic diseases by better integrating and coordinating primary, acute, behavioral health and long-term care services. States electing this option will receive an enhanced Medicaid federal reimbursement for 8 fiscal quarters for health home services to chronically ill populations. These services can be delivered by a designated provider, a team of health care professionals partnering with a designated provider or through a health team.

HIE: Health Information Exchange is the mobilization of healthcare information electronically across organizations within a region, community or hospital system. HIE provides the capability to electronically move clinical information among disparate health care information systems while maintaining the meaning of the information being exchanged. The goal of HIE is to facilitate access to and retrieval of clinical data to provide safer and more timely, efficient, effective, and equitable patient-centered care. HIE is also useful to public health authorities to assist in analyses of the health of the population.

HIX: Health Insurance Exchanges were created under the ACA and protected by the Supreme Court's health reform decision in June 2012. Each state will create (or elect to use one created by the federal government) a Health Insurance Exchange which will allow individuals who cannot afford their own health insurance through the private market to purchase health insurance from the state. Under federal law, all exchanges must be fully certified and operational by January 1, 2014.

Home and Community Based Services (HCBS): States can offer a variety of services under a State Plan Home and Community-Based Services (HCBS) benefit. People must meet State-defined criteria based on need and typically receive a combination of acute-care medical services (like dental services, skilled nursing services) and long-term services (like respite, case management, supported employment and environmental modifications).

HRSA: Health Resources and Services Administration (HRSA) is part of the U.S. Department of Health and Human Services and their mission is to improve access to health care services for people who are uninsured, isolated, or medically vulnerable. Community health centers, including Health Care for the Homeless Clinics and other Federally Qualified Health Centers (FQHCs), are overseen by this agency.

Mandatory and Optional Medicaid Benefits: The federal legislation that created the Medicaid program detailed specific mandatory benefits that all Medicaid beneficiaries must receive. These benefits include: Inpatient hospital services, outpatient hospital services, family planning, FQHC services, midwife services, physician care, and Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services for children.

States also have the ability to provide optional benefits to all or specific Medicaid populations. These benefits include: prescribed drugs, rehabilitative, clinic services, dentistry, physical therapy, and primary care case management. In addition, services available through specific Medicaid waivers or state plan amendments are also considered optional services and the state can discontinue these additional benefits as they see fit.

Managed care network/organization: Any arrangement for health care in which an organization, such as an HMO, another type of doctor-hospital network, or an insurance company, acts as intermediate between the person seeking care and the physician.

Medical respite: Medical respite care is acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets or at home alone, but who are not ill enough to be in a hospital. Increasingly, the medical respite model is being used for those living in permanent supportive housing who are chronically ill and need to recover from inpatient hospital care before returning to their apartment.

Unlike “respite” for caregivers, “medical respite” is short-term residential care that allows homeless individuals or those living in permanent supportive housing the opportunity to rest in a safe environment while accessing medical care and other supportive services. Medical respite care is offered in a variety of settings including freestanding facilities, homeless shelters, nursing homes, and transitional housing. Once recovered, those with supportive housing apartments return home.

MFP: The “Money Follows the Person” Rebalancing Demonstration Program (MFP) helps States rebalance their long-term care systems to transition people with Medicaid from institutions to the community. Forty-three States and the District of Columbia have implemented MFP Programs. From spring 2008 through December 2010, nearly 12,000 people have transitioned back into the community through MFP Programs. The Affordable Care Act of 2010 strengthens and expands the “Money Follows the Person” Program to more States. Goals of MFP are to: increase the use of home and community-based services (HCBS) and reduce the use of institutionally-based services; eliminate barriers in State law, State Medicaid plans, and State budgets that restrict the use of Medicaid funds to let people get long-term care in the settings of their choice; strengthen the ability of Medicaid programs to provide HCBS to people who choose to transition out of institutions; and put procedures in place to provide quality assurance and improvement of HCBS.

NAHC: National AIDS Housing Coalition is the only national organization which focuses exclusively on the housing needs of people living with HIV/AIDS.

NACHC: National Association of Community Health Centers works with a network of state health center and primary care organizations to serve health centers in a variety of ways: provide research-based advocacy for health centers and their clients, educate the public about the mission and value of health centers, train and provide technical assistance to health center staff and boards, and develop alliances with private partners and key stakeholders to foster the delivery of primary health care services to communities in need.

Olmstead v. LC: On June 22, 1999, the United States Supreme Court issued its decision in *Olmstead v. L.C.* – a landmark disability rights case. The lawsuit, brought against the State of Georgia, questioned the state’s continued institutionalization of two disabled individuals after physicians had determined that they were ready to return to the community. The Supreme Court described Georgia’s action as “unjustified isolation,” and determined that the state had violated these individuals’ rights under the Americans with Disabilities Act (ADA). The Court explained that unjustified isolation was a form of discrimination. It reflected two judgments:

- First, institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life ...
- Second, confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and

cultural enrichment.

The Supreme Court was careful to say that the responsibility of states to provide health care in the community was “not boundless.” States were not required to close institutions nor were they to use homeless shelters as community placements. The Department of Justice and others continue to bring lawsuits against states in order to ensure that people who can live in the community are allowed to live in the community. States are required to have Olmstead plans and work to move people, as appropriate, out of institutions and into housing of their choice.

Pay-for-performance: Providers under this arrangement are rewarded for meeting pre-established targets for delivery of healthcare services. This payment model rewards healthcare providers for meeting certain performance measures for quality and efficiency.

PMPM: Per Member Per Month is the usual unit of measure for capitation payments that payers provide to providers, both hospitals and physicians.

PHO: Physician Hospital Organization is a management service organization in which the partners are physicians and hospitals. The PHO organization contracts for physician and hospital services

Rehab Option: The Medicaid Rehabilitation State Plan Option (Rehab Option or MRO) is one of the categories of Medicaid services and covers rehabilitative, community-based services to persons with either a physical health need (such as recovering from a sports injury or car accident) or a mental health diagnosis. Increasingly states are using MRO for mental health services. MRO services can be delivered in the client’s home as well as in a clinic or doctor’s office. They focus specifically on assisting clients with gaining skills and resources that allow them to live and function as independently as possible.

Risk adjustment: A corrective tool used to level the playing field regarding the reporting of patient outcomes, adjusting for the differences in risk among specific patients. Risk adjustment also makes it possible to compare performance fairly. Comparing unadjusted event rates for different hospitals would unfairly penalize those performing operations on higher risk patients.

Section 1115 Medicaid Demonstration Waiver: Section 1115 waivers provide states flexibility to test approaches in Medicaid that differ from federal program rules. While recent waivers and waiver proposals vary in their specifics, key themes are emerging, including using the waiver authority to get a jump start on the 2014 Medicaid expansion and to restructure delivery and payment systems, particularly for high-need individuals.

The 1915(c) waivers and 1915i State plan option: These Medicaid authorities allow states to offer Home and Community Based Services (HCBS) benefits to various populations.

1915c waivers - These waivers are one of many options available to states to allow the provision of long term care services in home and community based settings under the Medicaid Program. Beneficiaries must be able to meet the requirements for institutional care but have the ability to live in the community. States can offer a variety of services under an HCBS Waiver program. Programs can provide a combination of standard medical services and non-medical services. Standard services include but are not limited to: case management (i.e. supports and service coordination), homemaker, home health aide, personal care, adult day health services, habilitation (both day and residential), and respite care. States can also propose “other” types of services that may assist in diverting and/or transitioning individuals from institutional settings into their homes and community.

1915i State Plan Option - States can also offer a variety of services under a State Plan Home and Community-Based Services (HCBS) benefit (1915i). This option was modified under the ACA to be a more

flexible resource for states. Eligible persons must meet State-defined criteria based on need and typically get a combination of acute-care medical services (like dental services, skilled nursing services) and long-term services (like respite, case management, supported employment and environmental modifications).

Shared savings model: An HHS program that would allow for groups to become ACO's who are unable to engage in risk. The payment model will be based on a fee-for-service taxonomy, but would provide bonuses for good outcomes (HHS will reward ACO's that lower growth in health care costs while meeting performance standards on quality of care and putting patients first). Both Medicaid and the ACO would share in the savings.

Targeted Case Management: Targeted Case Management (TCM) refers to case management that is restricted to specific beneficiary groups. Targeted beneficiary groups can be defined by disease or medical condition, or by geographic regions, such as a county or a city within a state. Targeted, for example, may include individuals with HIV/AIDS, tuberculosis, chronic physical or mental illness, developmental disabilities, receiving foster care, or other groups identified by a state and approved by the Centers for Medicare and Medicaid (CMS). TCM and case management are optional services that states may elect to cover, but which must be approved by CMS through state plan amendment (SPAs).