Supportive Housing Leadership Forum
Managing Costs and Improving Outcomes
Through Integrated Housing and Health Innovations
Glossary of Terms
June 2012

Affordable Care Act (ACA): Whereas Medicaid previously covered only a portion of supportive housing tenants, nearly all of homeless chronically ill adults who need supportive housing will be Medicaid-eligible beginning in 2014. The ACA addresses the *Health Homes* concept and gives explicit priority to coordinating care for beneficiaries with mental illnesses, substance use disorders, and other chronic conditions that affect tenants of supportive housing.

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 with asymmetric or symmetric shared savings, 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, and the like.

Bundled Payment: Medicare currently makes separate payments to providers for the services they furnish to beneficiaries for a single illness or course of treatment, leading to fragmented care with minimal coordination across providers and health care settings. Payment is based on how much a provider does, not how well the provider does in treating the patient.

Research has shown that bundled payments can align incentives for providers – hospitals, post acute care providers, doctors, and other practitioners– to partner closely across all specialties and settings that a patient may encounter to improve the patient's experience of care during a hospital stay in an acute care hospital, and during post-discharge recovery.

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 seeks care, per period of time.

Care coordination: 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: Medicaid eligibility is based on defined indicators of financial need by families with children and pregnant women, and to persons who are aged, blind, or disabled. Persons not falling into these categories cannot qualify, no matter how low their income. The Medicaid statute defines over 50 distinct population groups as potentially eligible, including those for which coverage is mandatory in all states and those that may be covered at a state's option. The scope of covered services that states must provide to the categorically needy is much broader

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than the minimum scope of services for other groups receiving Medicaid benefits. States generally have broad discretion in determining which groups their Medicaid programs will cover and the financial criteria for Medicaid eligibility. To be eligible for Federal funds, however, States are *required* to provide Medicaid coverage for certain individuals who receive Federally assisted income-maintenance payments, as well as for related groups not receiving cash payments. In addition to the Medicaid program, most States have additional "State-only" programs to provide medical assistance for specified poor persons who do not qualify for Medicaid. Federal funds are *not* provided for State-only programs.

CMS: Centers for Medicare and Medicaid Services is an agency of the U.S. Department of Health and Human Services: formerly called the Health Care Financing Administration.

CMMI: The Center for Medicare and Medicaid Innovations presents the Centers for Medicare and Medicaid Services (CMS) and the country with an opportunity to improve our healthcare system for Medicare, Medicaid and Children's Health Insurance Program (CHIP) beneficiaries — and in doing so improve the healthcare system for the entire nation. Congress created the Innovation Center under the Affordable Care Act, giving the Center the authority and direction 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.

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, co-occurring disorders (MH/SA, MH/DD, MH/Medical), financial, social and other treatment support needs of the recipient. 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 are individuals who are in receipt of medical coverage from both Medicare and Medicaid.

FMAP: Federal Medical Assistance Percentages or Federal Financial Participation in State Assistance Expenditures are used in determining the amount of Federal matching funds for State expenditures for assistance payments for certain social services, and State medical and medical insurance expenditures.

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. These relationships offer patients comfort, convenience, and optimal health throughout their lifetimes

Health home: 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 health home model of service delivery expands on the traditional medical home models that many states have developed in their Medicaid programs, by building additional linkages and enhancing coordination and integration of medical and behavioral health care to better meet the needs of people with multiple chronic illnesses. The model aims to 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. It targets consumers with chronic conditions and has been established as a new state Medicaid option for service delivery specifically for enrollees with chronic conditions.

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 Exchange is a set of state-regulated and standardized health care plans in the United States, from which individuals may purchase health insurance eligible for federal subsidies. All exchanges must be fully certified and operational by January 1, 2014 under federal law.

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 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).

HRSA: Health Resources and Services Administration is the primary Federal agency for improving access to health care services for people who are uninsured, isolated, or medically vulnerable.

HUD: Department of Housing and Urban Development is the United States federal department that administers federal programs dealing with better housing and urban renewal.

Managed care network: 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.

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 and other vulnerable people in our society.

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.

Although the *Olmstead* decision confirmed the ADA's community integration mandate, the words "housing" or "supportive housing" do not appear in the decision. Instead, the Supreme Court used terms such as "community placements" and "less restrictive settings." Nonetheless, the *Olmstead* decision could have a profound impact on future state policies and approaches to provide community-based housing and support services for people with significant disabilities. As a result of the *Olmstead* decision, thousands of people currently living in "more restrictive settings" such as public institutions and nursing homes must be offered housing and community-based supports that are consistent with the integration mandate of the ADA.

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. Incentive based, one-sided risk model.

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

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: In 2007, the President reintroduced a plan to place new restrictions on the types of services allowable under the Medicaid rehabilitation services option (called the rehab option) to yield federal budget savings of $2.29 billion over the next five years. Currently, 47 states plus the District of Columbia provide at least some type of mental health, substance abuse, and physical health services under the rehab option.

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.

Safe haven: A form of supportive housing that serves hard-to-reach homeless persons with severe mental illness and other debilitating behavioral conditions who are on the street and have been unable or unwilling to participate in housing or supportive services. A Safe Haven project that has the characteristics of permanent supportive housing and requires clients to sign a lease may also be classified as permanent housing when applying for HUD funds.

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 options: 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. 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. 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 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 (see one-sided risk) or the savings and losses (see two-sided risk).

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).