

HEALTH CARE RESOURCES

The information in this document is intended primarily to provide people working in subsidized housing and homeless assistance systems basic information about available health care resources. It is also intended to provide context for a discussion on gaps in needed health care services and treatment. Finally, information is included to inform housing, health care, and service providers about some current health-related efforts that may benefit their clients through and to facilitate strategic discussions about ways to creatively take advantage of existing and emerging healthcare resources. The following resources are covered:

Healthcare Resources and Medicaid Coverage

- Federally Qualified Health Centers: Community Health Centers; Health Care for the Homeless
- Rural Health Resources
- Indian Health Resources
- Veteran Health Resources
- HIV/AIDS Health Resources
- Behavioral Health Resources
- Other Resources for the Uninsured
- Medicaid
- Managed Care

Healthcare Changes Underway

- State Innovation Model (SIM) Awards
- 1115 Waivers
- Accountable Care Organizations (ACOs)
- Patient-Centered Medical Homes
- Health Homes

A variety of health care resources for low-income people exist at the federal and state level. These resources can take the form of health care directly accessible by individuals or funding that flows through organizations that provide health care and related services. Accessing certain resources requires enrollment (and re-certification) based on specific, documented eligibility criteria. As with housing resources, many health care resources focus on particular populations, such as people experiencing homelessness, people living with HIV/AIDS, veterans, or people with disabilities.

HEALTH CARE RESOURCES AND MEDICAID

Federally Qualified Health Centers (FQHCs)¹

The Federal Health Center Program serves medically underserved populations or areas, works with special populations, and provides for enhanced Medicaid reimbursement. The four types of health centers are: (1) Community Health Centers; (2) Health Care for the Homeless; (3) Migrant Health Centers; and (4) Public Housing Primary Care Health Centers. Details about Community Health Centers and Health Care for the Homeless Programs are below.

¹ National Association of Community Health Centers, "So You Want to Start a Health Center...? A Practical Guide for Starting a Federally Qualified Health Center," July 2011: 1, <http://www.nachc.com/client/documents/Starting%20a%20FQHC%20Manual-September%202011.pdf>.

Community Health Centers²

Community Health Centers (CHCs) deliver comprehensive, high-quality preventative and primary health care to patients regardless of their ability to pay. They also provide oral health and behavioral health care tailored to the needs of the communities they serve. CHCs offer a sliding fee discount based on income.

Health Care for the Homeless (HCH) Programs³

HCH Programs emphasize a multi-disciplinary approach to delivering care to homeless persons, combining aggressive street outreach with integrated systems of primary care, mental health and substance abuse services, case management, and clinical advocacy. Emphasis is placed on coordinating efforts with other community health providers and social service agencies.

Rural Health Resources

Critical Access Hospitals (CAHs) and Rural Health Clinics (RHCs) are the safety net providers for rural and remote communities.

Critical Access Hospitals (CAHs)⁴

“Critical Access Hospital” is a designation given to certain rural hospitals by the Centers for Medicare and Medicaid Services (CMS). The CAH designation is designed to reduce the financial vulnerability of rural hospitals and improve access to healthcare by keeping essential services in rural communities. This is accomplished through cost-based Medicare reimbursement.

To ensure that CAHs deliver services to improve access to rural areas that need it most, restrictions exist concerning what types of hospitals are eligible for the CAH designation. The primary eligibility requirements for CAHs are:

- 25 or fewer acute care inpatient beds
- Location more than 35 miles from another hospital
- Maintained annual average length of stay of 96 hours or less for acute care patients
- 24/7 emergency care services

Rural Health Clinics (RHCs)⁵

A Rural Health Clinic is a federally qualified health clinic (but not a part of the FQHC Program) that is certified to receive special Medicare and Medicaid reimbursement. CMS provides advantageous reimbursement to increase rural Medicare and Medicaid patients' access to primary care services.

CMS reimburses RHCs differently than it does other facilities. CMS is required to pay RHCs using a prospective payment system (PPS) rather than a cost-based reimbursement system. RHCs receive an interim payment from Medicare, and at the end of the year, this payment is reconciled using the clinic's cost reporting. For services provided to Medicaid patients, states can reimburse using PPS or by an alternative payment methodology that results in a payment equal to what the RHC would receive under PPS. Regardless of whether the patient sees a mid-level provider or a physician, the RHC must receive the same amount for its services.

² Idaho Primary Care Association, “What is a Community Health Center?”, 2015, <http://www.idahopca.org/community-health-centers#what-are-community-health-centers>.

³ National Association of Community Health Centers, “Health Care for the Homeless,” <http://www.nachc.com/homeless-healthcare.cfm>.

⁴ Rural Health Information Hub, “Critical Access Hospitals (CAHs),” <https://www.ruralhealthinfo.org/topics/critical-access-hospitals>.

⁵ U.S. Department of Health and Human Services Health Resources and Services Administration, “What are Rural Health Clinics (RHCs)?”, 2015, <http://www.hrsa.gov/healthit/toolbox/RuralHealthITToolbox/Introduction/ruralclinics.html>.

Indian Health Services⁶

The Indian Health Service (IHS), an agency within the Department of Health and Human Services, is responsible for providing federal health services to American Indians and Alaska Natives. The provision of health services to members of federally-recognized tribes grew out of the special government-to-government relationship between the federal government and Indian tribes. The IHS is the principal federal health care provider and health advocate for Indian people, and its goal is to raise their health status to the highest possible level. The IHS provides a comprehensive health service delivery system for approximately 1.9 million American Indians and Alaska Natives who belong to 567 federally recognized tribes in 35 states.

Veteran Health Resources

Veterans Health Administration⁷

The Veterans Health Administration is the largest integrated health care system in the United States, providing care at 1,233 health care facilities, including 168 VA Medical Centers and 1,053 outpatient sites of care of varying complexity (VHA outpatient clinics), serving more than 8.9 million Veterans each year.

The following programs may be offered at VA medical facilities, including community-based outpatient clinics, to provide healthcare to homeless Veterans.

Health Care for Homeless Veterans (HCHV) Program

The HCHV program serves as the hub for a myriad of housing and other services which provide the VA a way to outreach and assist homeless Veterans by offering them entry to VA care. The central goal is to reduce homelessness among veterans by conducting outreach to those who are the most vulnerable and are not currently receiving services and engaging them in treatment and rehabilitative programs. HCHV's Contract Residential Treatment Program ensures that Veterans with serious mental health diagnoses can be placed in community-based programs that provide quality housing and services.

Homeless Patient Aligned Care Teams (H-PACTs) Program

The Homeless Patient Aligned Care Teams (H-PACTs) Program implements a coordinated homeless primary care model that focuses on improving access, care coordination, and quality of treatment for alcohol and other substance use for veterans experiencing or at risk of homelessness. H-PACTs provide a coordinated "medical home" specifically tailored to the needs of homeless Veterans, integrating clinical care with the delivery of social services.

Health Care for Re-Entry Veterans Program

The Health Care for Re-Entry Veterans Program helps incarcerated Veterans successfully rejoin the community through supports including those addressing mental health and substance use problems.

Homeless Veterans Dental Initiative

The Homeless Veterans Dental Initiative provides dental treatment for eligible Veterans in a number of programs: Domiciliary Residential Rehabilitation Treatment, VA Grant and Per Diem, Compensated

⁶ Indian Health Services, "About IHS," <https://www.ihs.gov/aboutihs/>

⁷ U.S. Department of Veterans Affairs, "Veterans Health Administration," www.va.gov/health/aboutVHA.asp and U.S. Department of Veterans Affairs, "Homeless Veterans – Health Care," http://www.va.gov/homeless/health_care.asp

Work Therapy/Transitional Residence, Healthcare for Homeless Veterans (contract bed), and Community Residential Care.

HIV/AIDS Health Resources

Ryan White HIV/AIDS Program⁸

The Ryan White HIV/AIDS Program provides a comprehensive system of care that includes primary medical care and essential support services for people living with HIV who are uninsured or underinsured. The Program works with cities, states and local community-based organizations to provide HIV care and treatment services to more than 512,000 clients in the U.S. each year.

Part A

Part A provides assistance to Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs) that are most severely impacted by the HIV epidemic.

Part B

Part B provides grants to State departments of health or other State and U.S. Territories which administer public health programs and services. Part B grants include a base grant, the AIDS Drug Assistance Program (ADAP) award, ADAP supplemental grants, grants to State for Emerging Communities and an award for Minority AIDS initiative activities.

The AIDS Drug Assistance Program (ADAP) provides free medications for the treatment of HIV/AIDS and opportunistic infections. The drugs provided through ADAP can help people with HIV/AIDS to live longer and treat the symptoms of HIV infection. ADAP can help people with partial insurance and those who have a Medicaid spend down requirement.

Part C

The Part C Early Intervention Services (EIS) component funds comprehensive primary health care in outpatient settings for people living with HIV disease.

Part D

Ryan White HIV/AIDS Program Part D grant recipients provide outpatient ambulatory family-centered primary and specialty medical care and support services for women, infants, children, and youth living with HIV.

Behavioral Health Resources

Projects for Assistance in Transition from Homelessness (PATH)⁹

The Substance Abuse and Mental Health Services administration (SAMHSA) operates the grant program Projects for Assistance in Transition from Homelessness (PATH), which provides assistance to individuals who are homeless and have serious mental illnesses. PATH funds are distributed to states, which then contract with local public or non-profit organizations to fund services for homeless individuals.

⁸ U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), HIV/AIDS Program, "Ryan White HIV/AIDS Program Parts," <http://hab.hrsa.gov/abouthab/partd.html>

⁹ Benefit.gov, "Projects for Assistance in Transition from Homelessness (PATH)", <https://www.benefits.gov/benefits/benefit-details/728>

Among the services eligible for funding under PATH are outreach services, screening and diagnostic treatment services, habilitation and rehabilitation services, community mental health services, alcohol and drug treatment services staff training, case management services, supportive and supervisory services in residential settings, referrals for primary health services, job training, educational services, and relevant housing services.

Other Health Resources for Uninsured Residents

Free Clinics¹⁰

Free health and medical clinics offer services free of cost or for a nominal fee to persons who have limited income, no health insurance, or do not qualify for Medicaid or Medicare.

Medicaid

State Medicaid Plan¹¹

Overview: Historically, Medicaid eligibility was restricted to specific categories of low-income individuals, such as children, their parents, pregnant women, the elderly, or individuals with disabilities. In most states, adults without dependent children were ineligible for Medicaid, regardless of their income, and income limits for parents were very low. The Affordable Care Act (ACA) extended Medicaid to nearly all nonelderly adults with incomes at or below 138% of poverty (about \$32,500 for a family of four in 2013). All states previously expanded eligibility for children to higher levels than adults through Medicaid and the Children's Health Insurance Program (CHIP).

Home and Community Based Services Waiver Programs¹²

The 1915(c) 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.

Managed Care¹³

Managed Care is a health care delivery system organized to manage cost, utilization, and quality. Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a set per member per month (capitation) payment for these services.

By contracting with various types of MCOs to deliver Medicaid program health care services to their beneficiaries, states can reduce Medicaid program costs and better manage utilization of health

¹⁰ Mental Health America, "Paying for Care," <http://www.mentalhealthamerica.net/paying-care>

¹¹ The Henry J. Kaiser Family Foundation, "How Will the Uninsured Fare Under the Affordable Care Act?", April 7, 2014, <http://kff.org/health-reform/fact-sheet/how-will-the-uninsured-fare-under-the-affordable-care-act/>.

¹² Medicaid.gov, "1915(c) Home & Community-Based Waivers," <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Home-and-Community-Based-1915-c-Waivers.html>

¹³ Medicaid.gov, "Managed Care," <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html>

services. Improvement in health plan performance, health care quality, and outcomes are key objectives of Medicaid managed care.

Some states are implementing a range of initiatives to coordinate and integrate care beyond traditional managed care. These initiatives are focused on improving care for populations with chronic and complex conditions, aligning payment incentives with performance goals, and building in accountability for high quality care.

HEALTH CARE CHANGES UNDERWAY

*State Innovation Models*¹⁴

Background

The State Innovation Models (SIM) Initiative is providing financial and technical support to states for the development and testing of state-led, multi-payer health care payment and service delivery models that will improve health system performance, increase quality of care, and decrease costs for Medicare, Medicaid and Children's Health Insurance Program (CHIP) beneficiaries—and for all residents of participating states. The Center for Medicare and Medicaid Innovation (CMMI) periodically issues RFPs for demonstration projects: innovative health care delivery approaches that may achieve better health outcomes and cost efficiencies.

Health Care Innovation Awards: to organizations implementing the most compelling new ideas to deliver better health, improved care and lower costs to people enrolled in Medicare, Medicaid and Children's Health Insurance Program (CHIP), particularly those with the highest health care needs.

Health Care Innovation Awards Round Two: to applicants testing new payment and service delivery models that will deliver better care and lower costs for Medicare, Medicaid, and/or CHIP enrollees.

*1115 Waivers*¹⁵

Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs. The purpose of these demonstrations, which give states additional flexibility to design and improve their programs, is to demonstrate and evaluate policy approaches such as:

- Expanding eligibility to individuals who are not otherwise Medicaid or CHIP eligible;
- Providing services not typically covered by Medicaid; or
- Using innovative service delivery systems that improve care, increase efficiency, and reduce costs.

*Accountable Care Organizations (ACO)*¹⁶

- Typically include 3 key elements:
 - (1) Provider-run organization at base

¹⁴ Centers for Medicare & Medicaid Services, "State Innovation Models Initiative: General Information," <https://innovation.cms.gov/initiatives/state-innovations>

¹⁵ Medicaid.gov, "Section 1115 Demonstrations," <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/section-1115-demonstrations.html>

¹⁶ The Henry J. Kaiser Family Foundation, "Medicaid Delivery System and Payment Reform: A Guide to Key Terms and Concepts," June 22, 2015, <http://kff.org/medicaid/fact-sheet/medicaid-delivery-system-and-payment-reform-a-guide-to-key-terms-and-concepts/>.

- (2) Accountability for shared outcomes
- (3) Potential for shared savings
- Provider-run organizations that consist of a network of health care providers and organizations like hospitals, managed health care plans, and doctors, which come together voluntarily to give coordinated care to their patients.
- Relatively new payment model for delivering health care that coordinates all the different health care services a patient receives, breaking down traditional health care silos. Focuses on containing the overall cost of overall care.
- Participating providers are collectively responsible for the care of an enrolled population and may share in any savings associated with improvements in the quality and efficiency of the care they provide. Medicaid ACOs must meet quality of care standards, and receive a share of any savings achieved when they deliver health care at lower costs than budgeted for per-member payments. These payments create a strong incentive for ACOs to invest in preventative care for their patients.
- Patient-centered care management and coordination directed by providers:
 - Targeted and intensive complex care management, tailored to high-need/high-cost patients with cross-functional care teams
 - Data infrastructure and analytics
 - Motivated and mission-driven leadership and providers empowered to transform care delivery, build cross-functional teams/structure for meaningful patient and community partnerships
 - Capacity to address social needs

ACOs have incentives to reduce costs. Housing providers would make excellent members of care teams and can partner with ACO provider groups. If affordable housing providers can demonstrate ability to support the health of patients, ACOs may provide funding to housing providers to deliver non-medical services such as health education and hospital discharge planning. Housing providers can also help ACOs conduct outreach to inform low-income households about their eligibility to enroll in ACOs, since outreach to Medicaid enrollees is often a major challenge for ACOs.

However, ACOs come with the following challenges:

- Require substantial initial investments in capacity-building and infrastructure development.
- States or purchasers/providers must negotiate payment models aligning financial incentives to serve patients with greatest needs and risks.
- Existing risk-adjustment methodologies do not capture factors associated with social determinants of health.

Patient-Centered Medical Homes¹⁷

A patient-centered medical home (PCMH) is a coordinated care model focused on acute care for all populations. They are typically defined as physician-led primary care practices, which bring together a team of medical professionals (including nurses, nurse care managers, medical assistants, office support staff, and often pharmacists and social workers) to coordinate and personalize medical care.

¹⁷ U.S. Department of Health & Human Services, Agency for Healthcare Research and Quality (AHRQ), "Defining the PCMH," <https://pcmh.ahrq.gov/page/defining-pcmh>

Health Homes¹⁸

A health home offers coordinated care to individuals with multiple chronic health conditions, including mental health and substance use disorders. The health home is a team-based clinical approach that includes the consumer, his or her providers, and family members, when appropriate. The health home builds linkages to community supports and resources as well as enhances coordination and integration of primary and behavioral health care to better meet the needs of people with multiple chronic illnesses.

¹⁸ SAMHSA-HRSA Center for Integrated Health Solutions, "Health Homes and Medical Homes," <http://www.integration.samhsa.gov/integrated-care-models/health-homes>