Health Care Reform:
The Nuts & Bolts of Understanding, Planning, & Thriving
Part 1

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Health Care & Housing Are Human Rights
National Goals of Health Reform

- Increase access to care
- Improve health outcomes
- Lower costs to individuals
- Reduce total spending
- Improve quality of care
The Affordable Care Act (ACA)

- P.L. 111-148 as amended by P.L. 111-152

- 8 Major Components:
  - Private insurance reforms (includes Exchanges)
  - Medicaid reforms
  - Quality improvements
  - Prevention of chronic disease/public health
  - Strengthening health care workforce
  - Improve transparency and accountability
  - Improve access to medical technologies
  - Revenue provisions
Current Status

- 20 months since legislation signed into law; major provisions not active until 2014, but there’s so much to do!

- Growing public awareness of benefits & content

- Myriad of philosophical viewpoints

- Administration: Full speed ahead

- Congress: Attempts to repeal, hinder, de-fund

- Judicial: mixed decisions to date; Headed for Supreme Court
Possible Congressional Actions

- Repeal and replace
- Repeal specific provisions
- Block regulations
- Hold hearings
- Defund implementation
  - Block appropriations and/or mandatory spending
  - No reconciliation on annual budget
Current Legal Challenges

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Legal Challenges

- 26 states part of federal lawsuits

- Three arguments:
  - Individual mandate/use of commerce clause
  - Violates states rights to establish health care policy
  - Over-reaching federal government

- Mixed rulings to date

- Final stop: Supreme Court
Priorities for HCH Grantees

- Medicaid Expansion
- Health Center Expansion
- Workforce Expansion
- Care Delivery Models

Parameters of Law; Opportunities & Challenges

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Presentation Overview

Part 1: **Policy & Potential**
- Medicaid expansion
- Health Center expansion
  - Group breakout, feedback & discussion

Part 2: **Operations & Action**
- Workforce development
- Care delivery models
  - Group breakout, feedback & discussion

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Medicaid Expansion: The Bus Pass

Bus Pass
December 2008

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Medicaid Expansion: Who Gets Covered

- Expands Medicaid to 138% FPL*
  - $~15,000/year for individual
  - $~25,500/year for family of 3
  - Does not eliminate categorical eligibility

- ~16 million newly eligible

- ~5 million newly enrolled/currently eligible

- Total enrollment: 50 million $\rightarrow$ ~70 million+

- Largest benefit in health reform law for low-income people

- Federal match to states
  - 100% in 2014 → 90% in 2020

- Cannot reduce Medicaid or CHIP eligibility, increase premiums or enrollment fees, or otherwise cut enrollment

- Penalty: Lose all federal matching funding for the entire Medicaid program until corrected

- Opportunities for making current system better:
  - More screening tools for other assistance programs
  - Ability to hold identification documents and birth certificates
  - Ability to check status of application
  - Single, streamlined application
Medicaid Expansion: Enrollment

- Simplify process and use technology; each state to match income against existing federal and state data
  - This includes matching with vital records, employment history, other assistance programs, tax records, and other data.

- Coordinate Medicaid, State Exchange and CHIP

- “No-wrong door” approach required

- Permits outreach and enrollment activities
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Medicaid Expansion: Draft Regs

- Comments were due October 31 (see Council submission)
- Moves to four Medicaid categories
- All income determined by MAGI; no more asset tests
- “No fixed address” and self-attestation sufficient to determine residency
- No need for paper documentation or in-person visits
- Real-time determinations; use of CMS data hub
- Moves to a “culture of coverage”
Medicaid Expansion: Benefits

Beginning in 2014, the benchmark coverage must include “essential health benefits,“

- Ambulatory patient services
- Emergency and hospital services
- Maternity and newborn care
- Mental health and substance abuse disorder services
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services (to include oral and vision care)
Medicaid Expansion: Let’s Get On With It!

- Early Expansion
  - Allowed to phase in expansion for newly eligible under existing reimbursement rate

- Early Implementers to Date
  - Connecticut, DC, Minnesota

- Our Recommendation: Expand early starting at the lowest income levels (e.g., 0% to 50%)

- Rationale
  - Reduces large influx at one time
  - Helps access to care for poorest individuals
  - Cost effective because people are healthier
Medicaid Expansion: Maximize Options

- Community-based, in-home services are mainstream for seniors & individuals with disabilities

- Our vision: Medicaid for services in permanent supportive housing (PSH) and medical respite care programs

- Our recommendation: States should maximize current options to achieve three goals:
  - Reduce homelessness
  - Decrease health spending
  - Improve individual and community health
Medicaid Expansion: Factors for States

- Current fiscal situation
- Current eligibility level
- Level of benefits covered
- Level of current participation
- Impact of outreach: 23 million new enrollees possible
A Word on the State Exchanges

- “Shopping center” for health insurance for individuals and small employers
- Must be implemented by January 1, 2014
- Subsidies and credits, based on income 100%-400% FPL
- Focused on individual and small group markets
- Must contain insurance with “Essential Health Benefits”
- States will need to determine what additional benefits they cover (at state expense)
Medicaid Expansion: State Challenges

- Handling large influx of enrollment
- Determining newly eligible from previously eligible
- Ensuring state Exchange and Medicaid are able to integrate seamlessly
- Boosting provider availability
- Budgeting for rate increases
- Ensuring public programs can share data
- Changing the “culture of Medicaid”
Medicaid Expansion: 6 Clinical Questions

- How will client characteristics change as a result of assertive outreach?

- How can the clinical team’s connection to the outreach team & front desk team be optimized?

- How can “walk in’s” be accommodated more easily?
Medicaid Expansion: 6 Clinical Questions

- How can clinical teams train reception, security & other front-line workers to accommodate higher needs clients?

- How are clinical operations and patient needs communicated within your organization?

- How are clinical needs of those currently uninsured communicated to your State policymakers as they make decisions about enrollment, benefits, advance expansion, etc.?
Medicaid Expansion: 8 Admin Questions

- How can enrollment and care be maximized for very vulnerable individuals?
- How will new Medicaid and Exchange systems impact financing?
- How will State Medicaid plans enable meaningful outreach and enrollment?
- What other services are needed and how are these needs being communicated?
Medicaid Expansion: 8 Admin Questions

- How will a transition from block grants to managed care impact service delivery/staffing?
- What additional training needs to be provided for outreach/front desk/security?
- How is feedback from frontline/clinical teams captured and considered at your project?
- How are needs being communicated to the State level decisionmaking?
Medicaid Expansion: Readiness

- Learn Medicaid!

- Health Centers: contact your PCA for TA

- Identify/recruit dedicated billing staff who are knowledgeable of Medicaid and stay abreast of policy developments

- Use an audit firm that understands FQHCs so you can maximize Medicaid (and Medicare) rates

- Train staff on effective coding of visits
Those Outside the Law

- Law does **not** provide a “right to health care”
- In 2016: 21 million non-elderly left uninsured
  - Medicaid eligible, but un-enrolled
  - Undocumented
  - Non-participating
- “Individual Mandate” Penalty: $95 in 2014, $695 or 2.5% in 2016. Those below filing threshold are exempt from the penalty.

Sources: Congressional Budget Office (CBO), March 20, 2010. Letter to Speaker Pelosi. CBO, Payments of Penalties for Being Uninsured Under the PPACA, April 22, 2010.
Those Remaining Uninsured

- Medicaid Eligibles: 8.4 million
- 3.5 million with Affordable Unsubsidized Option
- 1.7 million (Exchange)
- 3.7 million with Affordability Exemption
- Undocumented Immigrants: 5.6 million

Unresolved Questions

- Breadth of services required under essential health benefits (awaiting guidance)
- Specifics behind enrollment procedures (draft guidance out, final decisions TBD)
- Fate of mainstream funding sources (block grants, health center funds, Ryan White, etc.)
- Impact of Congressional & judicial decisions
Health Centers: The Bus
Health Center Expansion

- $11 billion in new funding (in addition to annual funding) + creation of Trust Fund

- Funding for New Services and Locations: $9.5 billion total
  - FY2011: $1 billion
  - FY2012: $1.2 billion
  - FY2013: $1.5 billion
  - FY2014: $2.2 billion
  - FY2015: $3.6 billion

- Funding for New Buildings: $1.5 billion total

Completely depends on related Congressional decisions
What To Do With $11 Billion?

- National goal: Double the number of people served by CHCs
  - 20 million → 40 million by 2015
- Expanded services: Medical, behavioral health, enabling
- Capital projects: New buildings, expansions, renovations

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Health Center Expansion: Opportunities

- New Access Points
  - New service delivery site for the provision of comprehensive primary and preventive health care
  - New Starts
  - Satellite Applicant

- Expanded Services
  - Medical
  - Behavioral Health
  - Enabling

- Capital Grants
Health Center Funding to Date

- New Access Points: Awarded in August
  - 67 awards made (16 HCH)—286,000 new patients
  - Congressional cuts to health centers reduced impact (350 NAPs had been planned)

- Capital Development
  - $600 million for 125-150 large project awards ($500K-$5M)
  - $100 million for 250-300 small project awards (<$500K)
  - Applications were due October 12, 2011
Health Center Expansion: Readiness

- Have a clear organization-wide plan
  - What’s your long range vision?
  - How have you identified your priorities?
  - What are your strategic objectives?
  - What will your outcome measures be?
Health Center Expansion: Readiness

- How will you evaluate your programs?
- What’s your process for continuous improvement?
- What constitutes success for your organization?
- Did you take Health Care Reform into account when you developed your Strategic Plan?
NEEDS ASSESSMENT

- Understanding your target population and the presenting clinical needs
  - Who is homeless in your local area?
  - What are the most prevalent health care and social service needs?
  - Who is un-served or underserved?
  - What makes up your health & safety net?
  - What are the gaps?

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Target Population: Needs

- Presenting Needs
  - Primary Care
  - Oral Health
  - Behavioral Health
  - Housing
  - Vocational
  - Transportation
  - Etc., Etc.

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Resources to Meet Needs

- Who provides the services in each area of identified need?

- How will Health Care Reform, including Medicaid expansion, impact any of these service providers?

- How will the state of the current economy impact any of these service providers?
Resources to Meet Needs (cont’d)

- What are the greatest gaps between Needs and Resources?
- Are you in a position to address any of these gaps?
- Could Health Care Reform help you to address any of these gaps either directly or in partnership with others?
Key Relationships
You Need Them and They Need You

- Examine your current partnerships
  - Local hospital
  - Discharge planning sources
  - Referral sources
  - Emergency responders – police & fire
  - Political leaders
  - Business community
  - Continuum of Care
    - Don’t be afraid to “step out of the box”!

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Meeting the Needs

- How do you engage new populations?
- What are the health and service gaps to be filled?
- How can existing partnerships be strengthened?
- How can new partnerships lead to new programs and services?
Readiness: Finances

- Financial Management
  - Policies and procedures
  - Billing and collection systems
  - Systems for collecting, organizing and tracking key financial performance data
Readiness: Finances

- What is the financial “health” of the organization?
- Do you have a diverse funding stream?
- Do you have a philanthropic base?
- How prepared are you to take on new start up expenses?
Readiness: Governance

- Is your Board 330 compliant?
- Does your Board understand the impacts of Health Care Reform?
- How well does your Board function?
Readiness: Consumer Input

- Do you have a consumer as a member of your board of directors?
- Do you have a Consumer Advisory Board?
- Do you utilize Focus Groups to gain consumer input?
- Do you conduct Consumer Satisfaction Surveys?
Group Discussion & Feedback

- Medicaid Expansion + Health Center Expansion

- What questions remain?

- What issues concern you most?

- What are the primary challenges your project/organization is facing in the areas of Medicaid Expansion and Health Center Expansion?

- How do you think you can help to address the issues and challenges?
Next Session

- Part 2: **Operations & Action**
  - Workforce development
  - Care delivery models
  - Group breakout, feedback & discussion
Health Care Reform:
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Part 2

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Health Care & Housing Are Human Rights
Presentation Overview: Part 2

- **Operations & Action**
  - Workforce development
  - Care delivery models

- Group breakout, feedback & discussion
Workforce: The Bus Driver

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Workforce Development

- $1.5 billion for National Health Service Corps
- Health Center-based residency programs
- Scholarships, loan repayments (primary care physicians, family nurse practitioners, certified nurse midwives, physician assistants, dentists, dental hygienists, and certain mental health clinicians)
- School-based health centers
- Increases to provider payments
Workforce Provisions and Planning

- 20 million new patients to be seen at CHCs
- On top of already expanding patient volume & existing state efforts to address shortages
- Economy pushing more people into unstable housing and living situations
- How do we prepare for meeting patient needs?
Workforce Provisions and Planning

- Where are the gaps in your existing staffing pattern?
- What staff will you need for service expansion?
- What is your staff retention rate?
- What strategies do you use to retain existing staff?
- What’s the “health” of your team?
Workforce Provisions and Planning

- Are you a learning environment?

- How do you train for Evidence Based Practices?

- How can self-care training and integration be a key part of recruitment and retention strategies?
Workforce Provisions and Planning

- What “feeder schools” are in your project area (2 and 4 year programs, as well as certificate programs)

- Do the curricula in these schools address the needs of underserved populations?

- How are job opportunities at your project marketed at these schools? Could these be maximized?

- Are there lecture series, class presentations, or other opportunities to highlight underserved/homeless patient care as an area of service for current or upcoming graduates?
Workforce Provisions and Planning

- Do you have an opportunity to partner with a school of medicine?

- How can volunteer clinicians be recruited to help fill gaps and further make connections in the community?
Care Delivery Models: Bus Maintenance
Care Delivery Models

- Ultimate Goals of health reform:
  - Improve access
  - Increase quality
  - Decrease cost

- Emphasis on collecting data, eliminating disparities, improving systems, creating efficiencies

- Focus on TEAM: includes both clinical and non-clinical members

- Data sharing, electronic health records are key

- Models will influence finance and staffing

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Care Delivery Models

- Renewed focus on coordination and integration of services
  - Integrated care
  - Patient-Centered Medical Homes
  - Health Homes
  - Accountable Care Organizations

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Integration of Care: Access

- Minimal Collaboration: Two front doors; consumers go to separate sites and organizations for services
- Basic Collaboration: Two front doors; cross system conversations with signed releases
- Partial Integration: One reception area; co-located services; separate records
- Full Integration: One reception area/point of entry; one health record

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Integration of Care: Services

- Minimal Collaboration: Separate and distinct service plans

- Basic Collaboration: Separate and distinct services with occasional sharing of treatment plans

- Full Integration: One treatment plan with all consumers; one site for all services; ongoing consultation among team members; one health record

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Integration of Care: Funding

- Minimal Collaboration: Separate systems and funding sources; no sharing of resources

- Basic Collaboration: Separate funding systems; both may contribute to one project

- Full Integration: Integrated funding with resources shared across needs; maximization of billing and support staff

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Integration of Care: Evidence Based Practices

- **Minimal Collaboration:** Individual EBPs implemented in each system

- **Partial Collaboration:** Sharing of EBPs across systems; joint monitoring of health conditions

- **Full Integration:** Same EBPs adopted across all disciplines; all staff trained
Integration of Care: Data

- **Minimal Collaboration:** Separate systems, often paper-based; little if any sharing of data

- **Partial Integration:** Separate data sets, some collaboration around some individual cases

- **Full Integration:** Fully integrated electronic health record with information available to all practitioners on need to know basis; data available on all individuals as well as organization
Care Delivery Models: Patient Centered Medical Home

- NCQA Definition: The Patient Centered Medical Home is a health care setting that facilitates partnerships between individual patients and their personal physicians, and when appropriate, the patient’s family. Care is facilitated by registries, information technology, health information exchange and other means to ensure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.
Care Delivery Models: Patient Centered Medical Home

Six Standards (27 elements)

- **Access and Continuity**: Provide team-based care with access and advice during and after hours and patient/family information about medical home

- **Identify and Manage Patient Populations**: Acquire and use data for care of the practice’s population

- **Plan and Manage Care**: Use evidence-based guidelines for preventive, acute and chronic care management for chronic, frequent and behavior-based conditions, including medication management
Care Delivery Models: Patient Centered Medical Home (cont’d)

Six Standards (27 elements)

- **Self-Care:** Support patient and family in self-care with information, tools and community resources

- **Track and Coordinate Care:** Track and coordinate tests, referrals and transitions of care

- **Performance Measurement and Quality Improvement:** Use performance and patient experience data for continuous quality improvement

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Care Delivery Models: Patient Centered Medical Home (cont’d)

Some Questions to Ask

- Is your project planning to become an accredited medical home? What does this mean in the context of a 330(h) only program?

- What does your quality improvement program look like? Could it be strengthened?

- How is EHR implementation progressing and how can this be a stronger tool for increasing quality?
The HCH Model as a Health Care Home

- What is the “value added” of a HCH model of care?
- What is the alignment between PCMH and a Health Care Home?
- Are there policy or advocacy issues inherent in these questions?
Key Elements of Integrated Care

- National Health Care for the Homeless Council project
- Documentation of Key Elements of HCH model
- Field Review
- Resources
- Policy Development and Advocacy

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Action Steps: What to do NOW

- Write/call
  - Your state’s Medicaid director
  - Your PCO/PCA
  - Your state and local health officer & local DSS director
- Conduct tours
- Attend health reform stakeholder meetings
- Ensure strong strategic plan/needs assessment is in place
- Form PCMH workgroup internally
- Examine readiness for meaningful use
- Partner with your fellow service providers (shelters, behavioral health care, others)

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Keeping an Eye on the Ultimate Goals

- Greater access to Medicaid hopefully translates into **better health**

- Growth of health center services/locations = **increased number of places to serve patients**

- Increased number of providers = **easier access to care**

- Greater use of EHR and team models hopefully translates into **better services**

- Better health + more resources = **preventing and ending homelessness**
Group Discussion & Feedback

- Workforce Development + Care Delivery Models

- What questions remain?

- What issues concern you most?

- What are the primary challenges your project/organization is facing in the areas of Workforce Development and Care Delivery Models?

- How do you think you can help to address the issues and challenges?
More Information

- The National Health Care for the Homeless Council is a membership organization for those who work to improve the health of homeless people and who seek housing, health care, and adequate incomes for everyone. www.nhchc.org

- Additional health reform materials at: http://www.nhchc.org/healthcarereform.html

- NHCHC offers free individual memberships at: http://www.nhchc.org/council.html#membership

- Technical assistance available