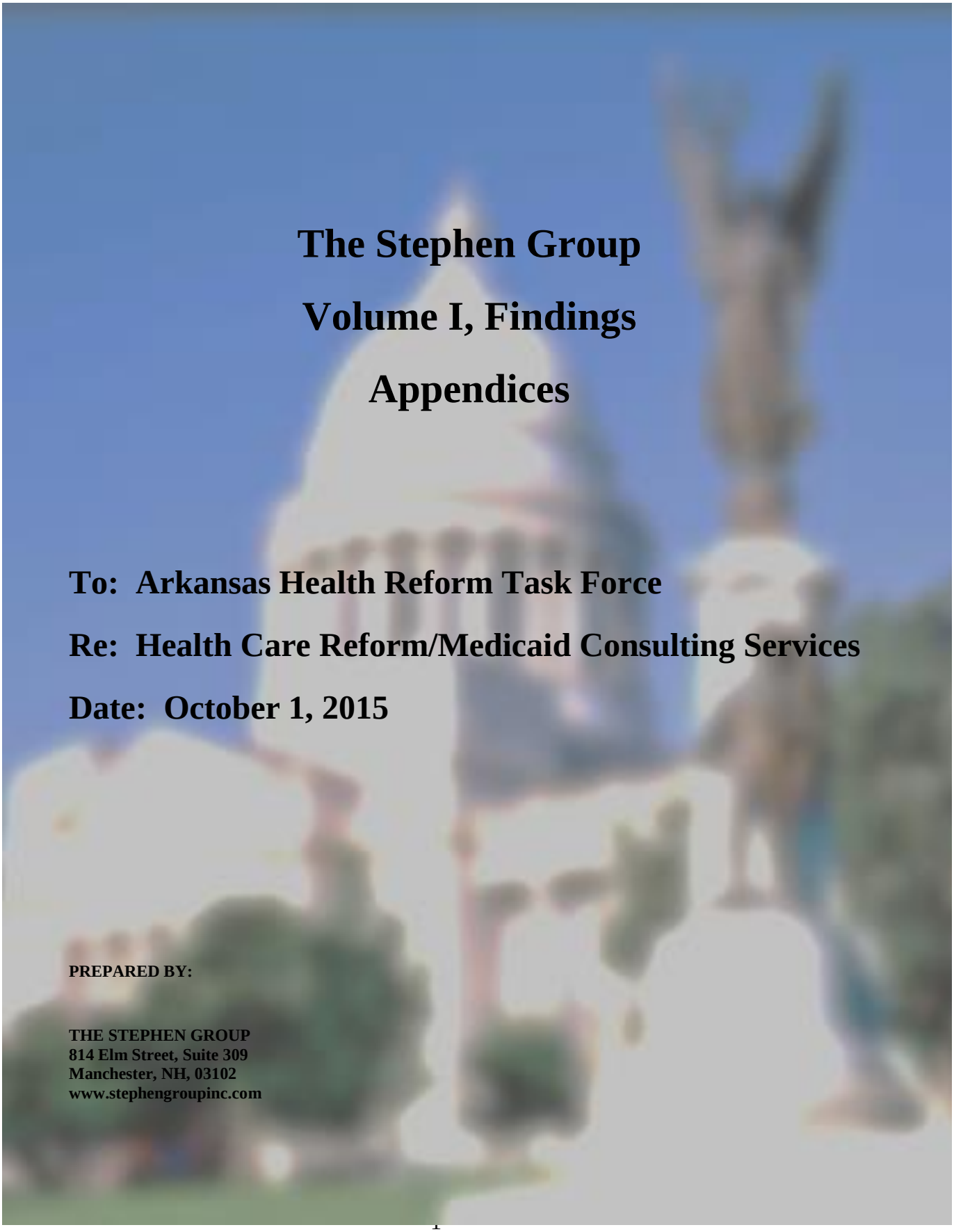

The Stephen Group

Volume I, Findings

Appendices

To: Arkansas Health Reform Task Force

Re: Health Care Reform/Medicaid Consulting Services

Date: October 1, 2015

PREPARED BY:

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APPENDIX 1. SOME EXAMPLES OF SUPPORT FROM TSG TEAM MEMBERS

- **Susan Burton – Invaluable sharing of DHS/DCO and EEF Business Process and Background.**
- **Mary Franklin – Quick reaction support to a wide array of questions.**
- **Brad Nye – Responsive and forthcoming exchange about current AAS challenges.**
- **Verna Brooks – Patient responses to many questions, deep understanding of AAS systems.**
- **Wona Chennault – Detailed review of her area graciously provided with little notice.**
- **Mark White – Quick and accurate responses to many questions.**
- **Dr. Dan Rahn's August 20th Task Force Meeting Presentation, which set the vision for improving Arkansas' Population Health Status and tied improved health status with education, employment, income opportunities, and personal health education and behaviors and a goal of being "First in the SEC."**
- **TSG's meeting with the Forrest City citizen and provider community that illustrated the importance of community based health education for people accessing health insurance for the first time in their lives through the Private Option to reduce the use of the Emergency Room by increased use of primary care.**
- **The vision of the Arkansas Nursing Home industry to look towards the future by expressing their interest in expanding their capacity for care coordination and their community capacity and always bringing Long Term Care system improvement suggestions to the public planning process.**
- **Walking through every ward of the Arkansas Health Center with Director Jay Hill. The team was struck by the interaction, professionalism, and compassion of the staff with many of the sickest and most disabled people in the state.**
- **Meeting with seven primary care physicians that serve the Pine Bluff community. The team was impressed with their commitment to the people they serve, regardless of their insurance coverage or inability to pay,how forthright they were about the overall/population health and social determinant challenges their community faces and their willingness to do something about it every day in their practices.**
- **The leadership and staff of DAAS, DDS, and DBHS have been open, supportive of the work of the Task Force, and always willing to provide context, their opinions, requested program information and data, and answer questions from the beginning of this project and throughout.**
- **Tim Lampe's willingness to talk about the tough issues was impressive. He candidly shared the challenges with managing several vendor contracts. He demonstrated a good deal of self-awareness about what DHS does well and what they struggle with.**
- **Victor Sterling and Barry Goldman helped TSG tremendously in analyzing the large contract spend. They openly shared all the supporting paperwork behind every contract and provided answers to TSG's questions. They provided additional financial details whenever asked and brainstormed with TSG about opportunities for improvement.**
- **Victor also made sure that the DHS data team put every project request at the top of the priority list.**

- **Jason Derdon, Pharm.D. at DHS. He was nothing but forthcoming in helping orient Rory to the DHS pharmacy programs. He facilitated claims data and a thorough program summary. He arranged meetings with every local vendor to the program and attended the meetings/interviews with Rory. On a subsequent trip, he met with Rory for dinner, taking away from his family time, to continue to brief Rory on the FFS pharmacy program.**
- **Mark Story tirelessly supported the project with data, analysis and explanations. He met with the team before hours, through lunch and after hours on several occasions. As he often put it, "whatever you need." The project could not have been so successful without Mark's brand new DeComp report.**
- **Bo Ryan met on many occasions with the TSG team. For the benefit of the project, AHA added to the analysis of its hospital survey of Private Option impact. He carefully guided the team through its thinking as it affected hospitals.**
- **The Arkansas Department of Insurance stepping in to lend its support to the project's need for data. They coordinated and facilitated collection of data from the Private Option carriers.**
- **The Private Option carriers have each been extremely supportive. They provided data in an unprecedented manner, then added support for interpreting it. Leadership of each met several times with the TSG team.**

APPENDIX 2. BIOGRAPHIES OF TSG ASSESSMENT PROJECT TEAM

Staff Member	Qualifications
John Stephen	**Biography: John Stephen is the founder and managing partner of The Stephen Group, a business and government consulting firm, focusing on assisting business and governments in healthcare and social services intelligence, public sector growth strategies and innovation. Prior to founding The Stephen Group, John was a partner at The Lucas Group from 2008 to 2011, where he led the firm's Government practice, and assisted the firm's private equity division in evaluating transactions impacted by government regulation, and offering strategies for value based growth. In addition to his experience consulting with business and government, John has the benefit of heading two large state agencies through a period of major change.** **Among his many accomplishments, John has successfully led large scale state agency projects in numerous aspects of Health and Human Services. John recently worked alongside TSG consultants in the MDHS 2014 Child Support Enforcement Assessment project, which resulted recommendations to improve the efficiency of CSE operations, including Medicaid IV D funding. John also was a member of the TSG team that provided similar technical expertise to MDHS in preparing for the RFP for outsourced counties.** **John has led additional successful projects in states of Texas (child welfare agency assessment and recommendations for operational improvements and implementation of child protection system, Medicaid IV E transformation project that resulted in TSG recommendations): Mississippi (child welfare, Medicaid IV D, TANF and SNAP systems redesign for the Department of Human Services) recommending systems redesign to improve the delivery of services and leverage available federal funding; Florida (Medicaid fraud and benefit recovery assessment and implementation for the Department of Children and Families) that will assist the state in enhancing fraud recoveries by over $125 million over a five year period; Illinois (Child Welfare, Medicaid and Human Services), by serving as the Governor's lead facilitator for the Taxpayer Action Board Human Services (Child Welfare) and Medicaid Reform Committees and recommending over $2 billion in program changes and savings, many of which are occurring today; Rhode Island (Medicaid) in drafting and negotiating the state's landmark Medicaid Global Section 1115 Waiver); South Carolina (Medicaid) in assessing the states long term care system and providing recommendations for modernization and re-design, many of which are occurring today.** **John also led efforts in early 2010 to assist the State of South Carolina in re-organizing the state agency responsible for putting people back to**

Staff Member	Qualifications
	work, and identifying over $1.2 billion dollars in savings for the state unemployment insurance system, while offering a plan to cut taxes for small businesses. The Chairman of South Carolina's Senate Labor, Commerce and Industry Committee, W. Greg Ryberg, applauded John's efforts and stated that "John's clear-headed and forthright analysis and advice illuminated the path for SC to fix its UI system and relieve the burden on small business." **John served from 2003 to 2007 as Commissioner of New Hampshire's largest Department, the Department of Health and Human Services, where he was in charge of a $1.8 billion dollar annual budget, and was able to contain Medicaid cost to less than a 1% growth during his four year term. As Commissioner, John led the Department through a period of major innovation, including improving the efficiency of the Child Support program and the state Medicaid operations, and in engaging families on assistance in work activities. He helped develop and implement the state's Child Support payment reform program and assure the efficient delivery of support payments; John also developed a national recognized Health Care Reform program that focused Medicaid on prevention, wellness and rebalancing long term care, as well as embracing a family centered practice for at-risk youth. His child welfare agency was recognized nationally for its permanency planning and solutions. John also initiated disease management and care coordination programs that transitioned New Hampshire Medicaid away from treating the sick to keeping people healthy. During each of the four years John was Commissioner, New Hampshire ranked first nationally in the Kids Count survey. During that same period, the enrollment of low income, uninsured children into the State's Medicaid and SCHIP program increased by 7500. John also oversaw the state's welfare program, Special Nutritional Assistance Program (SNAP) and Temporary Aid to Needy Families (TANF) program. In this role, John was able to transform welfare in New Hampshire, reducing the rolls by 20 percent and dramatically increasing work participation rates by bringing accountability to the program.** **Prior to heading the $1.8 billion annual budget at HHS, John served as Assistant Commissioner of the Department of Safety, where he was appointed as the state's first Homeland Security Coordinator.** **John was a prosecutor for 10 years, taking him from the county level to an Assistant Attorney General. John is a respected author; he has written or co-authored eight books on various legal matters.** **Educational background:John received his BA in 1984 from the Whittemore School of Business and Economics at the University of New Hampshire, and his JD in 1987 from the Detroit College of Law.**

Staff Member	Qualifications
Richard Kellogg	**Biography: Richard Kellogg is a senior consultant with TSG. Richard has served in Executive Branch health and human services positions as Commissioner, Deputy, or Director in the states of Virginia, Tennessee, New Hampshire and Washington beginning in 1994 through 2011. Richard's scope of responsibility has included medical and pharmacy services, mental health and substance abuse service systems, psychiatric hospitals and developmental residential programs, developmental/intellectual disabilities community based services and support systems, and long-term care services systems. He has extensive experience with comprehensive Medicaid budgeting, cost containment, waivers integration, IT, and managed care procurement, contracting, and oversight.** **Prior to beginning his career in state government Richard was a successful CEO of local government and private sector organizations charged with managing and delivering comprehensive mental health, substance abuse, developmental/intellectual disabilities and long term care services including community based and inpatient services on behalf of local government and non-profit organizations.** **Richard provided leadership to the successful resolution of several Department of Justice lawsuits involving CRIPA/ADA/Olmstead issues within state psychiatric hospitals and developmental residential centers, access to community services, and EPSDT litigation while serving as Commissioner of BH/DD for the Commonwealth of Virginia. He is an expert witness in matters directly related to the medical, psychiatric, recovery and protection of state psychiatric hospital patients and residents of state developmental centers including community based systems based on assessment, acuity, and outcomes.** **While Commissioner for Virginia Richard served as the Chair of the State's Executive Council of the State's Comprehensive Services Act, encompassing Foster Care/IVE, Special Education, and Juvenile Justice funding. In this role Richard was responsible for integrated services, including Medicaid policy for primary care, behavioral health, prevention and intervention, for children/adolescents at risk.** **Richard helped lead the development of a comprehensive plan addressing CMS concerns and moratorium on TennCare HCBS waivers and on-going Department of Justice litigation for Tennessee's system of care for adults with developmental/intellectual disabilities.** **While serving as Director of Community Based Services Richard was administered the Bureaus of Behavioral Health, Developmental Disabilities, and Long Term Care Services. Under the Commissioner's leadership and Richard's efforts New Hampshire was able to successfully rebalance the long term care system to a community first choice culture and option. Richard was also Acting Medicaid Business Director when**

Staff Member	Qualifications
	New Hampshire moved ahead on disease management and effective cost containment strategies (2005). **From 2006-2011 Richard served the $11 billion dollar Washington State Department of Social and Health Services as Director of Integrated Health Services and Director of Medicaid Mental Health Policy. Richard was responsible for advising the Secretary of DSHS and the Governor's Policy Office on all aspects of national health reform, organizational structure between DSHS and the Health Care Authority, and was a member of the Governor's Sub-Cabinet on Health Care Reform.** **Educational background: Richard received his BA (History, Economics, and Political Science) and his M. Ed. (Organizational Development) from the University of Vermont. He has taken advanced education at Dartmouth College: CAS: Administrative Psychiatry: 1989, and Harvard University: CAS: New World of Health Care Economics: 2001**

Staff Member	Qualifications
Dr. WillOliver	**Biography: Dr. William J. Oliver is a Senior Consultant at The Stephen Group and has over 25 years of experience leading teams and helping senior technology and operating executives improve their organizations' effectiveness. Dr. Oliver has many years of experience assisting public and private healthcare organizations. As a consultant, he has assisted MDHS in the past in the Child Support Assessment conducting much of the data analysis needed to make recommendations. He has also consulted on Health and Human Service process improvement-related projects in Indiana, Missouri, Pennsylvania, Rhode Island, South Carolina, and New York. In addition, he has assisted other aspects of benefits management in Florida and Michigan. Dr. Oliver brings extensive experience working with private sector healthcare payers and providers as well.** **Dr. Oliver is deeply experienced in managing resources and helping organizations reduce their costs and improve performance. Recently, Dr. Oliver worked alongside the TSG team in Mississippi in 2014 during the Child Support Enforcement program Assessment, conducting process mapping focus groups in the regions and also analyzing numerous data to provide the TSG team with support for its recommendations. In 2011, Dr. Oliver worked with John Stephen in furthering the vision of the Secretary of the Department of Children and Families to enhance the safety and well-being of all Florida children by strengthening the child protection and investigation process, and recognize Florida as a world class child welfare agency. Dr. Oliver's efforts as project manager for the state's Child Protection**

Staff Member	Qualifications
	Transformation initiative established the initial framework for the Department's program implementation. Dr. Oliver also has in the past led a project to assist the State of Indiana Family and Social Services Department to re-invent Medicaid eligibility processing. After considering current costs and options, Dr. Oliver helped write the RFP and manage vendor selection for the largest benefits eligibility privatization in US history. Dr. Oliver also has led a team supporting Pennsylvania Office of Income Maintenance. He worked with Agency leadership to organize many separate improvement initiatives into a comprehensive process improvement program. In the process, he led teams to document current processes and create better ones. Working with Missouri's Family Support Division, Dr. Oliver led a change program that launched a major multi-year program to improve Medicaid eligibility determination. Also, in Missouri, Dr. Oliver worked with the Governor's office to evaluate current state operations in order to develop cost savings initiatives the state is implementing to save $150 million annually. During his career, Dr. Oliver has worked with various hospitals, payers, and other players in the medical community. **Prior to joining The Stephen Group, Dr. Oliver worked as a government solutions consultant with The Lucas Group, and was part of the team that designed the Rhode Island Global Medicaid Waiver. He has also served as COO of BridgeHRO (HR outsourcing services), Vice President of 3i Venture Capital, Client Partner of Granitar Systems (web development), Director of Gemini Consulting (process improvement consulting for hospitals), senior manager of KMPG (consulting to BCBS of MA), and with Bain & Company, where he was a founding member of Bain's well known healthcare cost reduction practice.** **Educational background: Dr. Oliver holds a Doctorate in Management from Case Western Reserve University, a Masters in Management from MIT's Sloan School of Management, and a BBA in Accounting from the University of Alaska. Dr. Oliver is a CPA.**

Staff Member	Qualifications
Martha Tuthill	**Biography: Martha Tuthill is a senior consultant with The Stephen Group and has over 30 years of experience helping clients achieve their**

Staff Member	Qualifications
	business and technology goals. Her experience includes public sector clients at the federal and state level as well as private industry. She has extensive experience with helping organizations change the way they do business to achieve faster, more cost effective solutions. She has extensive procurement and contracting experience from both a vendor and a state agency perspective and resolved issues between state agencies and vendors as problems arose. She has a Bachelor's Degree in Computer Science from The College of William & Mary and has spent much of her career bridging the gap between the needs of the business and organizational leaders and the technology personnel who support them. She also is on the local board of CASA in her hometown in Maryland. She also serves on the Colonial Williamsburg Foundation's President's Council. **Prior Experience: 30 years** **Mississippi Department of Human Services (2014)** - **Assisted MDHS with an assessment of the Child Support Enforcement Operations and an insource/outsource decision on legal and child support enforcement personnel. Reviewed the call center and field operations for strengths, weakness, and opportunities. Assisted MDHS conduct a vendor information day and draft an RFP for outsourced services for 17 counties.** **Texas Department of Families and Protective Services (2014 – 2015)** - **Conducted an end-to-end assessment of the Child Protective Services organization, process, and technology. Concentrate review and assessment of contracts management, including IV E contracts, organizational design and continuous quality improvement. Developed recommendations and presented findings to leadership and to Texas Legislature.** - **Led regional teams to facilitate over 20 significant initiatives to improve field operations including reduced time to permanency, improved provisioning of services to families, improved working relationships within the Department, and accelerated closing of investigations that met criteria for administrative closure, and improved training of new hires. Overall goals of transformation to reduce turnover, decrease time to permanency, and decrease time to close investigations.** **Florida Department of Children and Families - Child Welfare Transformation (2011 – 2015)** - **Child Welfare Transformation Vision – Worked directly for Secretary Wilkins to identify issues in the Florida Abuse Hotline and the Child Protective Investigators. Worked with the central office and the regional personnel to identify people, process, and**

Staff Member	Qualifications
	technology issues and make recommendations to correct deficiencies. Working with John Stephen and Will Oliver, we created the vision that enabled the Secretary to obtain funding from the Legislature to advance the Department's transformation agenda. - **Florida Abuse Hotline – Worked with State staff to write RFP, conduct vendor negotiations, select appropriate vendor, and on-board the selected vendor to address technology challenges in the Abuse Hotline. Identified ways to reduce call volume through greater automation of web-based intakes.** - **Child Protective Investigator Transformation– Phase 1, 2, and 3 – Worked with the State staff to write the ITN for $100 million of technology work to support the Child Welfare Transformation as well as the maintenance and operations to support the SACWIS system. Coached the State team on commercial best practices for project and enhancements delivery, service level agreements, negotiation strategy, and transition from the incumbent to the new service provider. Worked with the State and the selected vendor to deliver the results from the three phases of Transformation including Created a person book and case book feature to allow investigators to get a quick overview of the alleged victim and alleged perpetrator and all the history the Department had about these families. Implemented new approaches for Unified Home Studies, support for legislatively mandated changes to Independent Living and Affordable Care Act, and a new Safety Decision Making Framework, Safety Plan, and Family Functioning Assessment. Worked with Agency leadership to resolve issues between the State and the vendor as necessary. Worked with key business leaders to resolve issues with the organization's ability to absorb the new technology and process changes.** **Florida Department of Children and Families - Information Technology Strategic Plan (2014)** - **Led the development of a long range Information Technology Strategic Plan across all areas of the Agency. The plan included the development of short, medium and long term initiatives to support the needs of the organization across Eligibility, Substance Abuse and Mental Health, Family and Community Services, Finance, HR, and Legal. The plan will enable the agency to focus on the legislative funding cycle and the continuous need to keep technology costs down while delivering more support to the business. Worked with the Agency leaders to standardize the**

Staff Member	Qualifications
	governance process across IT work across the agency. **From 2008 – 2011, Ms. Tuthill managed the delivery organization within Accenture for Health and Public Services, including delivery of consulting services to State Medicaid operations. Responsible for 10,000 professionals delivering services on 500 contracts to 150 clients across the United States. Managed the work to on-time and on-budget services in alignment with the contract terms and conditions. Worked with the most complex situations to negotiate the contracts and resolve issues. Accenture is one of the leading consulting and outsourcing companies in the world.** **From 1997 – 2008, Ms. Tuthill managed the delivery of outsourcing contracts for Communications and High Tech clients. She worked with top executives across clients like AT&T, Verizon, BellSouth and Microsoft to achieve their strategic goals through successful vendor partnerships for accounting services, call center services, and information technology services. The typical contract required a 40% improvement in the productivity and output of the existing workforce. Applied best practices in process improvements, organizational improvements and technology improvements in order to deliver these results. She rose through the organization from managing a single contract to having global responsibility for delivery of over $6B of services.** **From 1986 – 1997, Ms. Tuthill led the implementation teams serving gas and electric companies around the globe. She worked with the call center operations for over 20 utility companies to improve customer service, reduce operational costs, improve collections and reduce fraud. Applied best practice techniques and industry leading technology to deliver significant improvements. Specialized in minimizing the time it took to move the workforce from the old ways of doing work to the new processes with minimal learning curve.**

Staff Member	Qualifications
Rory Rickert	**Biography: Rory Rickert is a senior consultant with TSG and a national Medicaid Pharmacy cost containment expert. Rory is also a principal at Quarterline-HIS, where he is responsible for overall leadership, management and vision for the commercial consulting practice and national pharmacy practice and sales for the entire firm. Rory has more than 30 years progressive experience in the pharmaceutical industry. Starting as a clinical pharmacist at the Minneapolis Children's Medical**

Staff Member	Qualifications
	Center and progressing to the position of Corporate Vice President for AdvancePCS, Mr. Rickert was responsible for the oversight of corporate accounts and Government marketplace for the nation's largest independent health and wellness company, and was Corporate Director for Home Nutritional Services, a national provider of home infusion therapy. Rory is a nationally recognized speaker and industry expert in managed care, drug utilization and cost control, distribution channels and rebates, marketing, sales and delivery models in the pharmaceutical industry. Rory, has also served as a pharmacy expert witness in a number of cases, including: *Hall v. Medical Security Card, Co.,* CV 2002-010900, Superior Court of Arizona, in and for the County of Maricopa. Rickert was deposed December 6, 2004 as part of this matter. *Association Benefit Services, Inc., v. AdvancePCS, a Delaware corporation, Caremark Rx Inc. a Delaware corporation and CaremarkPCS, a Delaware corporation,* No. 04 C 3271, United States District Court for the Northern District of Illinois. State of Hawaii v. Abbott Laboratories, Inc. et al. Rory has also been retained to act as a consulting expert in other matters related to pharmacy benefits since 2004 and was a member of the team that assisted the State of Rhode Island in Medicaid cost containment solutions as part of the work on the RI Global Medicaid Waiver. **Educational background: Rory Rickert holds a Bachelor of Science in Pharmacy from the University of Minnesota**

Staff Member	Qualifications
Robert Chin	**Biography: Robert Chin is a senior consultant and subject matter expert for TSG. Bob will be responsible for reviewing and analyzing Medicaid hospital inpatient and outpatient costs, including costs associated with DRG and CPT codes. Bob is an expert in the use of cost transparency tools for the private health care consumer market and also worked with TSG in 2012 to assist the State of Pennsylvania Department of Public Welfare in assessing the difference between medical costs between hospitals and outpatient clinics in the state for the same medical procedures. Bob's analysis introduced a wide disparity of health care costs and the Secretary subsequently used the analysis to launch a health care cost transparency program in Pennsylvania Medicaid. Bob is an expert in looking at transparency of costs within the hospital inpatient and outpatient acute care network.**

Staff Member	Qualifications
	Bob is an experienced executive and entrepreneur in healthcare and technology with over 37 years of experience in health insurance, operations and information systems. He has a strong mix of skill and experience in strategy, technology, operations and analytics, particularly in the field of health care and health insurance. These capabilities have been developed and honed over decades in various roles and at various levels of management. Moreover, Bob has served as senior officer at multi-billion-dollar, public companies, as well as de novo start-ups (self-funded, government-loan-funded & equity funded). **Bob was formerly a senior partner and board member with Compass Healthcare Advisers where he assisted a number of health care clients in cost savings through the use of medical cost intelligence tools, which also allowed consumers to achieve medical savings. Bob also provided innovation and expertise for various programs as CIO at Averde Health in the introduction of game-changing products and services into the health insurance market. There Bob also developed and deployed state-of-the-art business intelligence and monitoring of performance metrics, business continuity assurance, client outcomes and service level requirements.** **In 2012, Bob was part of a veteran team of healthcare executives who organized, applied for and received approval for a Consumer Operated and Oriented Plan (a provision of the ACA) in Massachusetts, called Minuteman Health. In 2013, Minuteman was approved to expand into New Hampshire. At this writing, in total across both states, Minuteman has currently enrolled almost 15,000 members. Bob continues to provide senior entrepreneurial leadership for Minuteman Health.** **Bob also has executive management experience in several health care and technology organizations. Instrumental as CoFounder, Lead Angel and/or Key Executive for three successful M&A exits ($1.7B at Healthsource; $4.3B for Oxford; $122M for NaviNet). Numerous large consulting engagements, mostly in health care and technology.** **Educational background: Bob holds a BA in Applied Mathematics from Harvard University.**

Staff Member	Qualifications
Lindsay Littlefield	**Biography: Lindsay Littlefield is a senior consultant at The Stephen Group, where she focuses on budget and financial analysis, project**

Staff Member	Qualifications
	management and Health and Human Services subject matter expertise. Prior to joining The Stephen Group, Lindsay worked as a budget and performance analyst at the Texas Legislative Budget Board (LBB) and was a senior consultant at MAXIMUS. **At the LBB, Lindsay was the lead budget analyst for the Department of Aging and Disability Services and has a policy and budget background in Medicaid acute care and long-term services and supports. Lindsay developed a subject-matter expertise in services and supports for persons with intellectual and developmental disabilities. She managed a cross-agency project team on the state supported living center system and authored the report "Decrease the Number of State Supported Living Centers to Reduce Costs and Improve Care." In addition to institutional services, she has conducted research and written legislative reports on other topics across the continuum of long-term services and supports including Texas General Revenue-funded community services for persons with intellectual and developmental disabilities, Community First Choice program/habilitation services, and Medicaid 1915(c) waiver programs. Lindsay also has a strong policy background in Medicaid acute care budget and policy issues, having authored several legislative reports on healthcare payment and delivery reform, hospital quality, using data to drive healthcare systems improvements.** **Throughout her tenure at the LBB, Lindsay developed budget and policy recommendations to improve the efficiency and effectiveness of state government operations; monitored trends and innovations at the federal level and in other states and analyzed applicability to Texas; and briefed internal management, state legislative members, and state executive leadership and staff on areas of research, including providing frequent testimony before policy and budget committees.** **Prior to her work at the LBB, Lindsay was a senior consultant with MAXIMUS, where she was selected to participate in the Management Development Program. The program provided participants with intensive mentoring resources and afforded the opportunity to rotate throughout the firm. Lindsay worked primarily on the Texas Eligibility Support Services Project and performed a variety of communication, reporting, and change management functions in the project management office, including establishing internal policies and procedures, preparing reports, and conducting data and policy analysis.** **Lindsay also worked as an analyst in Washington DC at the National Conference of State Legislators where she tracked state and federal legislation on immigration policy and created a database of state legislation; conducted analysis and prepared reports on federal immigration reform, state legislative trends in immigration policy, the**

Staff Member	Qualifications
	Violence Against Women Act, and federal appropriations for select Health and Human Services programs. **Educational background: Lindsay has a Master's in Public Affairs at the LBJ School of Public Affairs at the University of Texas, and a B.A, in Political Science and Communications from Wake Forest University, where she graduated Summa cum laude and was a 2002 Harry S. Truman Scholar.**

Staff Member	Qualifications
Jason Melancon & Michael Walker	**Biography: Jason Melancon and Michael Walker are subject matter expert consultants for TSG. Both Jason and Michael have over 70 years' experience with information technology projects in the public and private sector. They co-founded DataMadeUseful, a Colorado Limited Liability Company. There, they build tailored, virtual project teams. Each team is chosen specifically for the job at hand.** **Jason is a seasoned executive level Organizational Development, Information Technology, and Change Management consultant. As Vice President of DMU, Jason is responsible for finalizing project specifications, and recruiting and managing the project teams.** **The core of Jason's career has revolved around Project and Program Management – particularly project assessment and the recovery of projects in trouble. He understands practical project management, from effective use of tools and methods to the interpersonal and organizational aspects that must be mastered for projects to succeed. He has been responsible for complex programs requiring the skills of more than one hundred professionals as well as many smaller projects. He has helped develop and has taught a variety of technical and managerial Project Management and Applied Systems Theory Courses.** **Jason's line and consulting responsibilities have been with a variety of service and production industries at both the wholesale and retail levels, including: Aerospace, Federal Aviation Administration, Wood Products, Food and Electronic Manufacturing, Printing, Retail Soft Goods, and Automotive Product Distribution. More recently his work has revolved around Human Service Nonprofits, from database systems in support of evaluation, operations and outcome reporting to strategic planning.** **Michael has a succeeded in wide variety of jobs and industries during his 35-year business career, often working his way up from line employee to manager. He uses his broad and deep background in business to help**

Staff Member	Qualifications
	him understand the total organization, and to inform his dealings with stakeholders both inside and outside his organization. **As President of DMU, Michael concentrates on business development and has developed an expert-level competence at building applications with QlikView. This skill enables him to translate the often vague customer requirements into a concrete roadmap, which the technical team can use to build applications that precisely meet the customer's needs.** **DMU is currently under contract to the Maine Department of Health and Human Services, building applications to assist DHHS staff in finding and prioritizing their investigations of fraud in the use of EBT cards. This work involves the analysis of SNAP eligibility and more than 50 million transactions from 200,000 EBT cards. Investigators use our tools to pinpoint the largest and most frequent possible abusers of the system. Since the start of the project in July 2014, the tools have saved the state over $500,000, and provides policymakers the solid data analysis to make systemic changes to the program in order to reduce fraud.**

APPENDIX 3. MEDICALLY FRAIL QUESTIONNAIRE

Arkansas Health Care Needs Questionnaire

First are some questions about your general health and needs:

1. **In general, compared to other people your age, how would you rate your health (select only one)?**
    a. **Excellent**
    b. **Very good**
    c. **Good**
    d. **Fair**
    e. **Poor**

2. **In general, compared to other people your age, how would you rate your mental health (select only one)?**
    a. **Excellent**
    b. **Very good**
    c. **Good**
    d. **Fair**
    e. **Poor**

3. **What is your current living situation (select only one)?**
    a. **In a private home, apartment, or rented room**
    b. **In assisted living**
    c. **In a nursing home or other institution**
    d. **In a group home for persons with physical, mental, or intellectual disability**
    e. **Currently homeless**

4. **Are you currently receiving help on a daily basis from family or friends for any of the following activities (answer each question)?**

YES	NO	
		Personal hygiene/grooming--such as brushing teeth, washing face, combing hair
		Assistance walking or if you use a wheelchair, help once seated in chair
		Help transferring from one place to another--such as moving from chair to bed, chair to toilet or bed to standing position

		Help eating -- Using a feeding tube or someone needing to feed you with a fork or spoon
		Managing medications--includes help with reminders to take medicines, opening bottles, taking the correct dosage, giving injections

5. **Are you currently receiving services on a daily basis from any agency or provider for any of the following activities (answer each question)?**

YES	NO	
		Personal hygiene/grooming--such as brushing teeth, washing face, combing hair
		Assistance walking or if you use a wheelchair, help once seated in chair
		Help Transferring from one place to another--such as moving from chair to bed, chair to toilet or bed to standing position
		Help Eating -- Using a feeding tube or someone needing to feed you with a fork or spoon
		Managing medications--includes help with reminders to take medicines, opening bottles, taking the correct dosage, giving injections

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Now we want to ask about your use of hospitals, emergency rooms, and clinics:

6. **In the last six months, how many times did you stay one or more nights in a <u>hospital</u>?**
   a. **Not been hospitalized in the last six months**
   b. **One time**
   c. **Two times**
   d. **Three or more times**

7. **If hospitalized, were any of these hospital stays related to mental health?**
   a. **Not hospitalized in last six months**
   b. **None for mental health problem**
   c. **One time for mental health problem**
   d. **Two times for mental health problem**
   e. **Three or more times for mental health problem**

8. **In the last six months, how many times have you used an <u>emergency room</u>?**
   a. **Not used emergency room in the last six months**

b. **One time**
c. **Two times**
d. **Three or more times**

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9. **In the last six months, how many times have you been seen in a clinic by a doctor or nurse practitioner or physician assistant for a health concern?**
    a. **No visits in last month**
    b. **One time**
    c. **Two times**
    d. **Three times**
    e. **Four times**
    f. **Five to nine times**
    g. **Ten or more times**

10. **In the last six months, how many times have you been seen by a mental health professional in a clinic for a mental health concern?**
    a. **No visits in last month**
    b. **One time**
    c. **Two times**
    d. **Three times**
    e. **Four times**
    f. **Five to nine times**
    g. **Ten or more times**

Finally, we have some questions about conditions and special needs to get you better care:

11. **Has a doctor, nurse, or other health professional EVER told you that you had any of the following? For each, select "Yes," "No," or you're "Not sure."**

YES	NO	Don't Know / Not Sure	
			Diabetes
			Severe joint pain
			Asthma

			Cancer
			Stroke
			Heart disease
			Emphysema
			HIV or AIDS
			Sickle Cell Disease
			Obesity
			High cholesterol
			High blood pressure
			Kidney disease
			Depression

12. **Do any of the following statements apply to you today (answer all that apply):**

YES	NO	
		I have major financial problems due to unpaid medical bills
		I am not able to work, even part time, due to a health/mental health condition
		My family/close friends feel overwhelmed by my health/mental health problems
		I consider myself "medically frail"

APPENDIX 4. UMASS CHART

Disability Evaluation Services
Commonwealth Medicine
333 South Street, Shrewsbury, MA 01545
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commed.umassmed.edu

State Differences in the Application of Medical Frailty under the Affordable Care Act

Peter Mosbach, Ph.D.
Sherry Campanelli, M.P.A.
A. E. Adams, Ph.D.

RESEARCH OBJECTIVES

The ACA expanded Medicaid to include childless adults earning below 138% of the poverty level, allowing states' expansion of coverage to be different from state plan Medicaid. This study examines how states undergoing Medicaid expansion differ in their treatment of the "medically frail" population. The medically frail are individuals who may need the extra benefits offered by traditional Medicaid.

Medical Frailty Definition:

CMS defines medical frailty as involving individuals who encompass having:

- Disabling mental disorders
- Chronic substance abuse disorders
- Serious and complex medical conditions
- Physical, intellectual, or developmental disability that impairs one or more activities of daily living
- Disability determination by Social Security criteria or state plan criteria

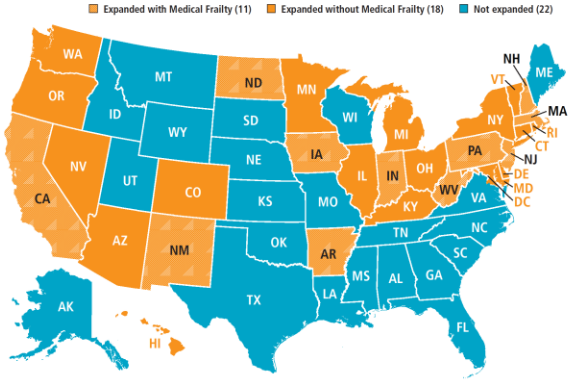
CMS does not determine how to define such categories as disabling mental disorders, chronic substance abuse disorders, and serious and complex medical conditions, and leaves it up to the states to determine the definition of these criteria.

The issue of medical frailty is salient in states that have Medicaid expansion, but do not provide traditional Medicaid to individuals in the expansion group. Individuals who considered medically frail are exempt from enrolling in alternative benefit plans. The Centers for Medicare and Medicare Services (CMS) has provided guidelines for medical frailty, but has not directed states on the specific methods used to determine if an individual meets criteria for medical frailty.

STUDY DESIGN

- Medicaid expansion states were identified (28 states and D.C.)
- Our review found 11 states which have Medicaid expansion and offer an alternative benefit plan which has lower benefits or higher costs than standard Medicaid
- These states are required by CMS rules to provide medically frail individuals the option to apply for standard Medicaid if they have special medical needs
- We examined state plan amendments, waiver materials submitted to CMS, and primary documents from states including client informational materials and policy documents in order to understand the methodology used to assess frailty in each state

Status of State Medicaid Expansion in May 2015



PRINCIPLE FINDINGS

There are substantial differences in how the 11 states assess medical frailty. Four primary methods of assessment were derived: self-report, data review, administrative and clinical (See table below). Note that several states use more than one method to determine medical frailty.

- **Self-Report**: Nine states (AR, IA, IN, MA, ND, NH, NM, PA, WV)
- **Data Review**: Three states (AR, IA, PA)
- **Administrative Review**: Five states (CA, IA, ND, NJ, PA)
- **Clinical Review**: Five states (IA, IN, ND, NJ, NM)

Methods of Assessing Medical Frailty in ACA Expansion States

State	Self-Report	Data Review	Administrative Review	Clinical Review
Arkansas	Online screening for conditions/service use predictive of exceptional needs in coming year	Claims monitoring to identify those no longer medically frail		
California			Criteria for Medicaid Long Term Services and Supports are equivalent to 'medical frailty' – no separate assessment	
Iowa	If receives Social Security Disability Insurance or asserts Activities of Daily Life limitations, individual completes "Medically Exempt Member Survey"	Survey score determines assignment to state plan Medicaid or Alternative Benefit Plan	Department of Human Services employees, mental health regional designees, or Iowa Department of Corrections employees may complete survey	Providers with current National Provider Identifier number may complete survey
Indiana	Application screens for qualifying conditions/medical frailty indicators			Managed Care Entity (MCE) verifies medically frail status using claims, lab results etc., after enrollment. MCE also verifies annually after frailty established.
Massachusetts	Self-identification as having Special Health Care Needs (facilitated by informational materials)			
New Hampshire	Self-identification as having ADL limitations or reside in medical facility or nursing home			
New Jersey			Review of eligibility criteria, and hotline assistance by Medical Assistance Customer Center staff	"Medically Exempt Attestation" form completed by providers
New Mexico	Self-identification facilitated by Managed Care Organization (MCO) counseling		Review of eligibility criteria	MCOs complete health risk assessment (in 30 days)
North Dakota	Medically frail questionnaire		Medical professional review of responses	Client must be examined and submits report by physician
Pennsylvania	Self-administered questionnaire identifies medical and behavioral health needs	Questionnaire responses and claims data analyzed to determine assignment to coverage plan		
West Virginia	Self-identification facilitated by informational materials			

(Information current as of February 2015)

CONCLUSIONS

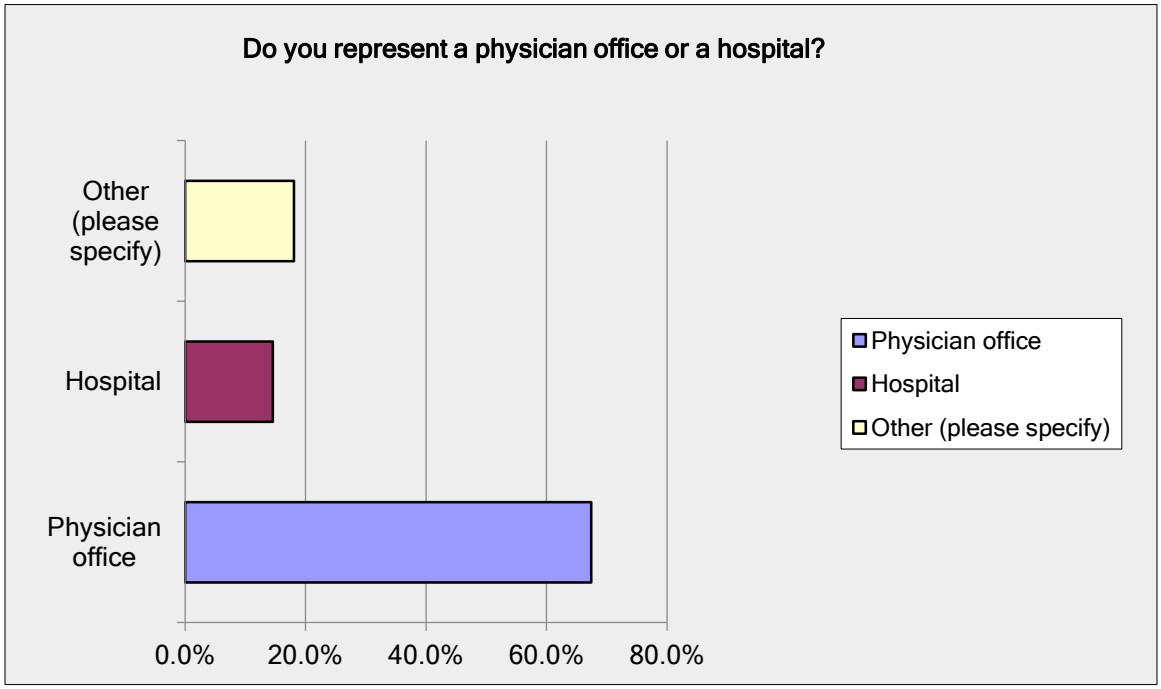
The results provide needed information to policymakers that are interested in improving access among vulnerable populations in the 23 states that have not yet implemented Medicaid expansion, but may do so in the future. While regulations provide categories that qualify for medical frailty, each state is free to use their own method of determining who meets the definition. There is a need for ongoing study to determine whether state differences in how medical frailty is addressed are associated with differences in access by persons with high medical need.

APPENDIX 5. TSG ARKANSAS PHYSICIAN SURVEY: PROVIDER SURVEY RESPONSES

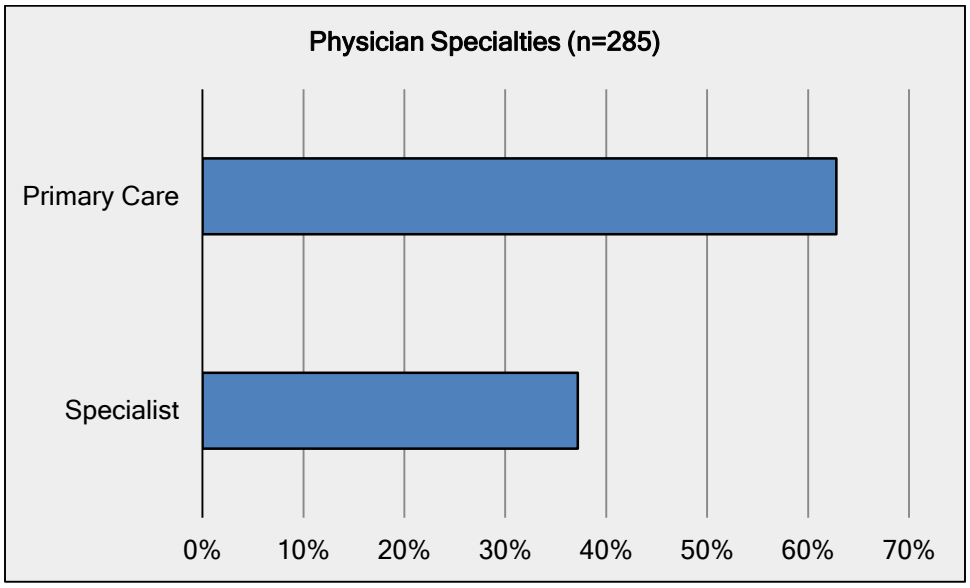
Do you represent a physician office or a hospital?

Do you represent a physician office or a hospital?		
Answer Options	**Response Percent**	**Response Count**
Physician office	**67.4%**	**287**
Hospital	**14.6%**	**62**
Other (please specify)	**18.1%**	**77**
Answered question		**426**
Skipped question		**3**

Provider survey responses: Do you represent a physician office or a hospital?



The survey included 285 responses from physicians representing physician offices. Of the physician responses, over 60% self-identified as primary care providers.

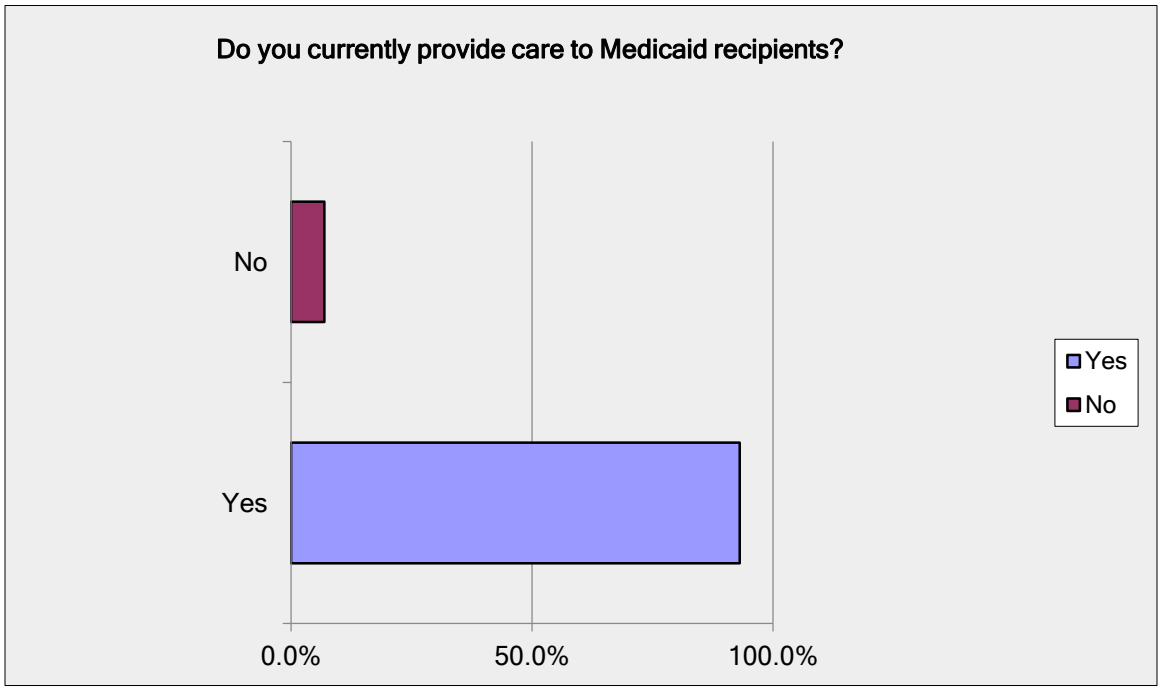


One of the underlying questions in which we were interested was whether the Private Option might have made more providers begin to accept Medicaid patients. In fact, based on the data collected through the survey, slightly fewer providers reported providing care to Medicaid recipients after the implementation of the Private Option. One possible issue with this question could be whether providers interpreted 'Medicaid recipients' to include individuals on the Private Option. If not, it could be that some providers have chosen not to provide care to traditional Medicaid recipients due to the increased opportunity of serving individuals covered by the Private Option.

Provider survey responses: Do you currently provide care to Medicaid recipients?

Do you currently provide care to Medicaid recipients?		
Answer Options	**Response Percent**	**Response Count**
Yes	**93.1%**	**390**
No	**6.9%**	**29**
Answered question		**419**
Skipped question		**10**

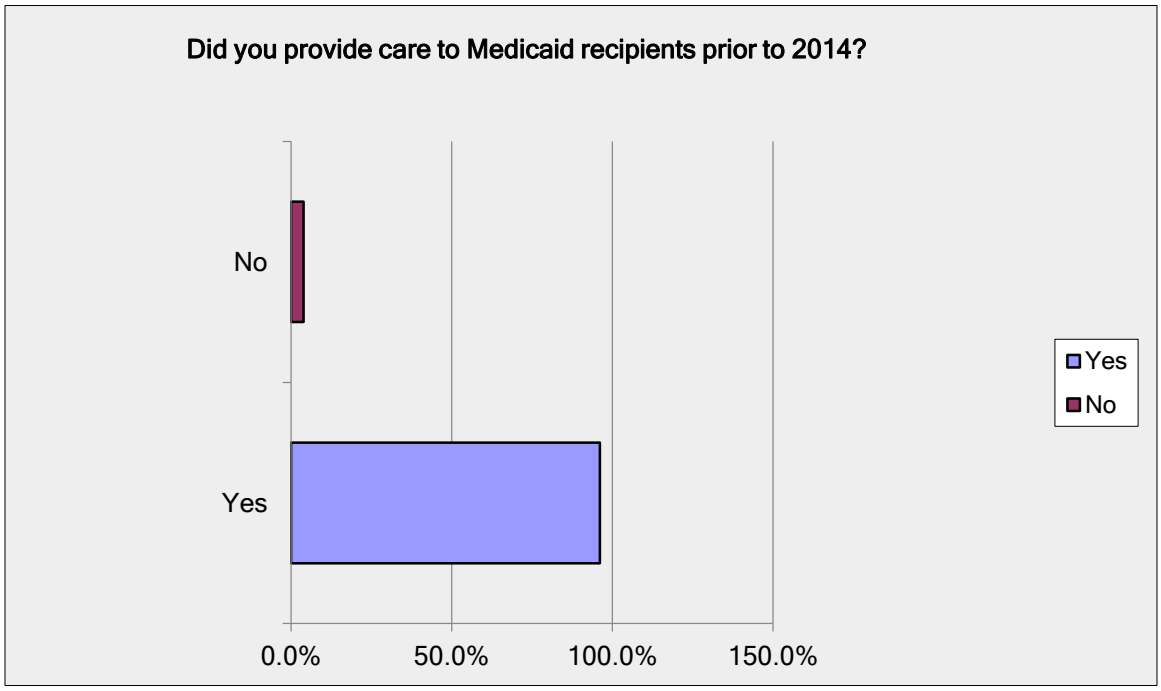
Provider survey responses: Do you currently provide care to Medicaid recipients?



Provider survey responses: Did you provide care to Medicaid recipients prior to 2014?

Did you provide care to Medicaid recipients prior to 2014?		
Answer Options	**Response Percent**	**Response Count**
Yes	**96.1%**	**398**
No	**3.9%**	**16**
Answered question		**414**
Skipped question		**15**

Provider survey responses: Did you provide care to Medicaid recipients prior to 2014?

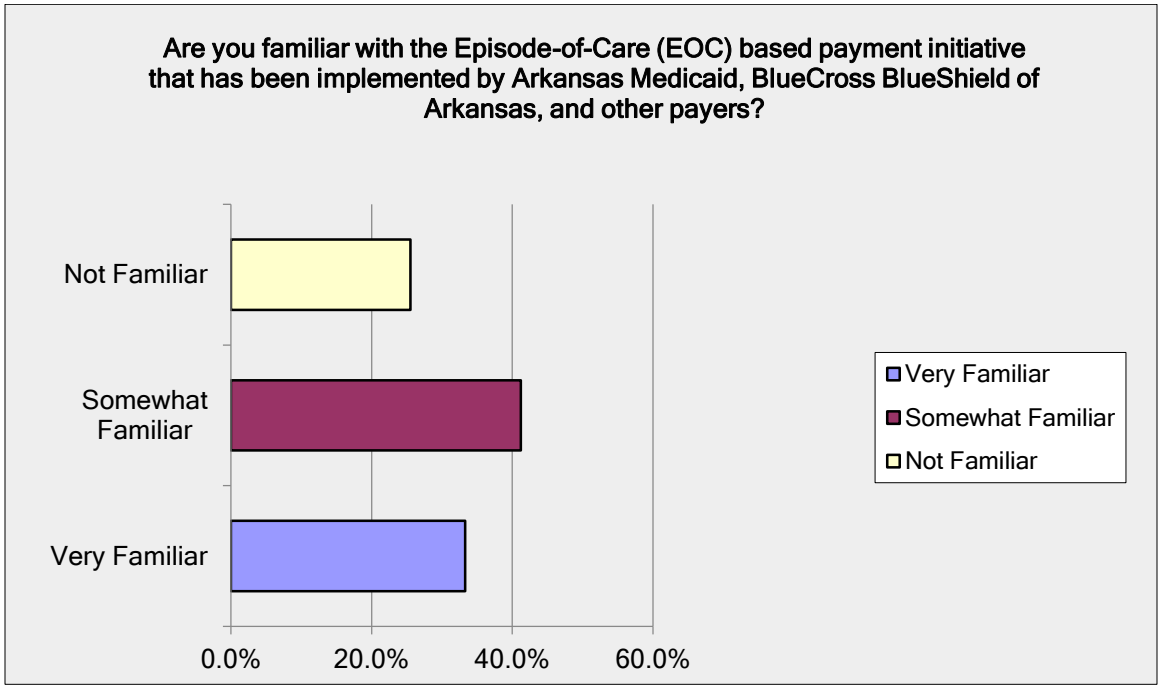


Almost three-quarters of responding providers reported being either somewhat or very familiar with the EOC initiative.

Provider survey responses: Are you familiar with the Episode-of-Care (EOC)?

Are you familiar with the Episode-of-Care (EOC) based payment initiative that has been implemented by Arkansas Medicaid, BlueCross BlueShield of Arkansas, and other payers?		
Answer Options	**Response Percent**	**Response Count**
Very Familiar	**33.3%**	**110**
Somewhat Familiar	**41.2%**	**136**
Not Familiar	**25.5%**	**84**
Answered question		**330**
Skipped question		**99**

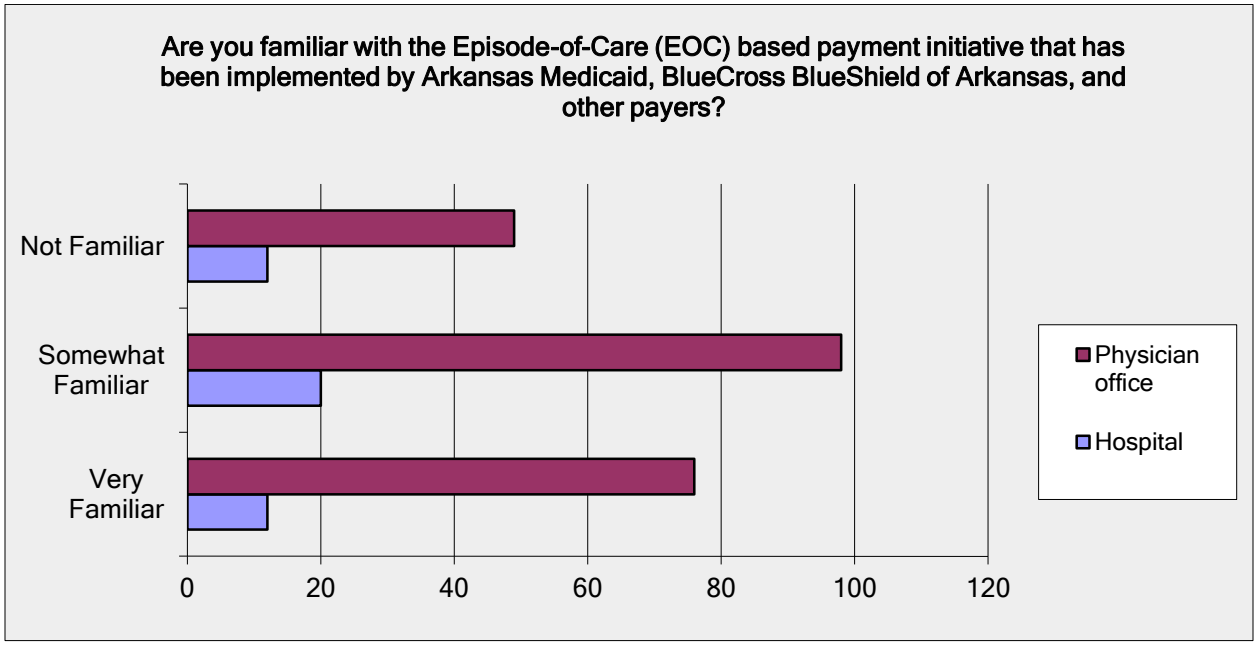
Provider survey responses: Are you familiar with the Episode-of-Care (EOC)?



Provider survey responses: Are you familiar with the Episode-of-Care (EOC) based payment initiative?

Are you familiar with the Episode-of-Care (EOC) based payment initiative that has been implemented by Arkansas Medicaid, BlueCross BlueShield of Arkansas, and other payers?				
	Do you represent a physician office or a hospital?			
Answer Options	**Physician office**	**Hospital**	**Response Percent**	**Response Count**
Very Familiar	**76**	**12**	**33.0%**	**88**
Somewhat Familiar	**98**	**20**	**44.2%**	**118**
Not Familiar	**49**	**12**	**22.8%**	**61**
Answered question				**267**
Skipped question				**82**

Provider survey responses: Familiarity, by type of physician office

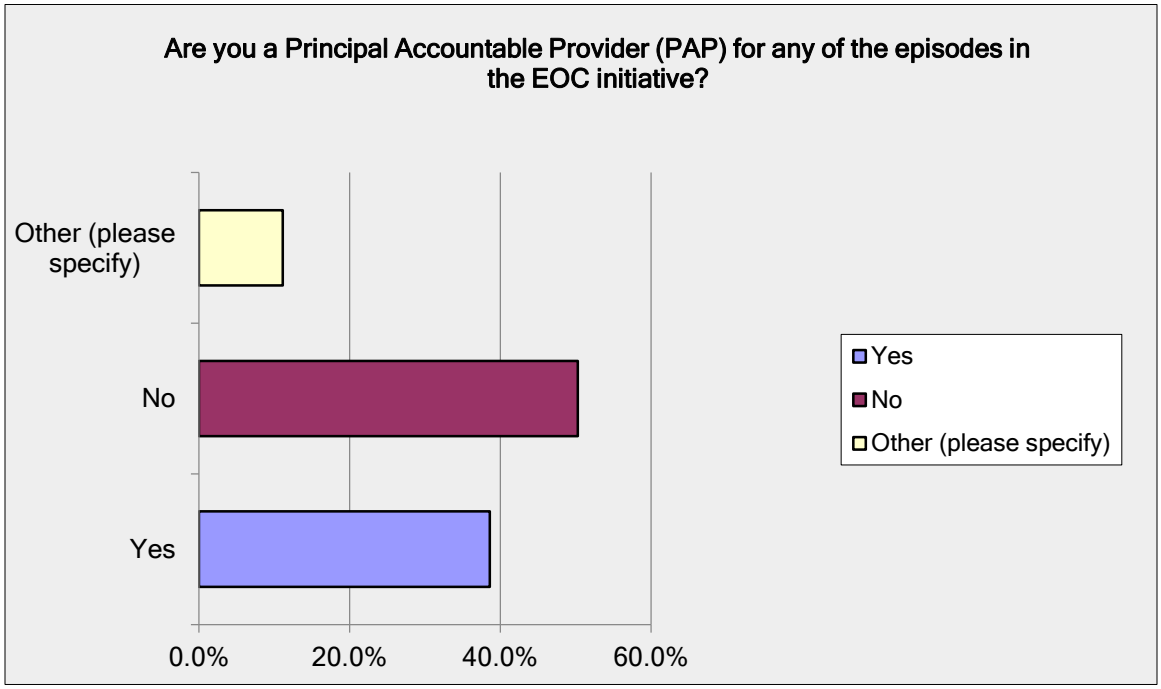


About 40% of providers reported being Principal Accountable Providers for the EOC initiative.

Provider survey responses: Are you a Principal Accountable Provider (PAP)?

Are you a Principal Accountable Provider (PAP) for any of the episodes in the EOC initiative?		
Answer Options	**Response Percent**	**Response Count**
Yes	**38.6%**	**125**
No	**50.3%**	**163**
Other (please specify)	**11.1%**	**36**
Answered question		**324**
Skipped question		**105**

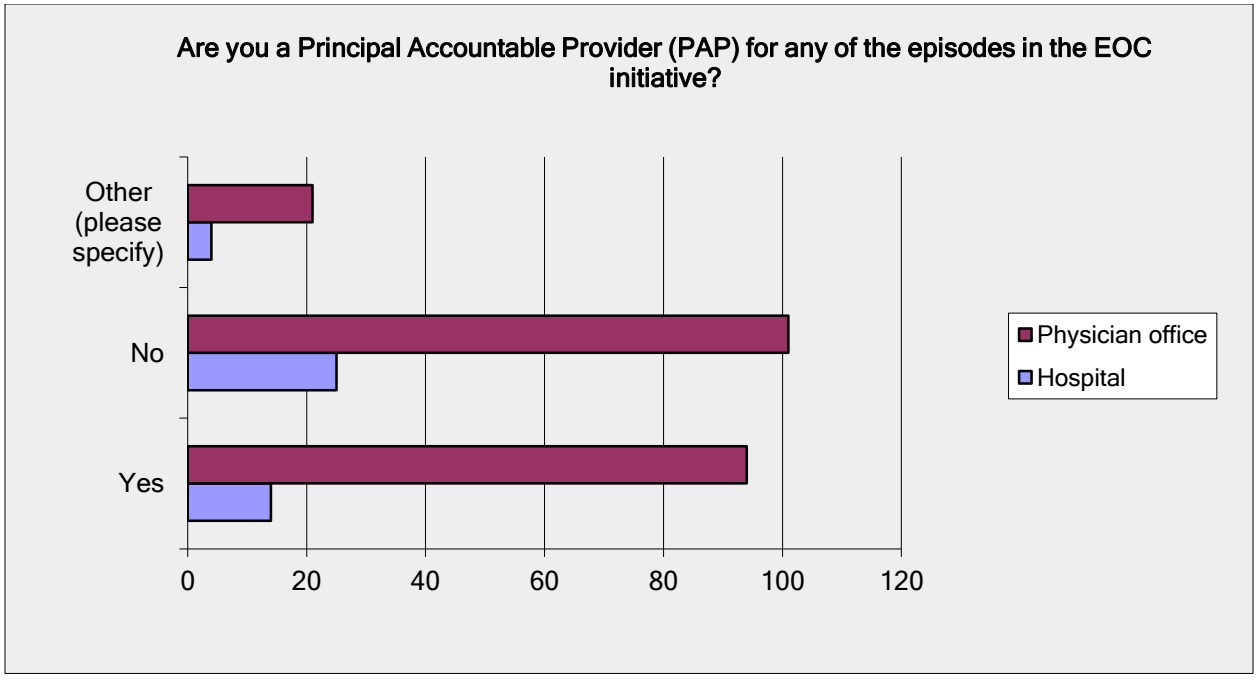
Provider survey responses: Are you a Principal Accountable Provider (PAP)?



Provider survey responses: Are you a PAP for any of the episodes?

Are you a Principal Accountable Provider (PAP) for any of the episodes in the EOC initiative?				
	Do you represent a physician office or a hospital?			
Answer Options	**Physician office**	**Hospital**	**Response Percent**	**Response Count**
Yes	**94**	**14**	**41.7%**	**108**
No	**101**	**25**	**48.6%**	**126**
Other (please specify)	**21**	**4**	**9.7%**	**25**
Answered question				**259**
Skipped question				**90**

Provider survey responses: Are you a PAP for any of the episodes?

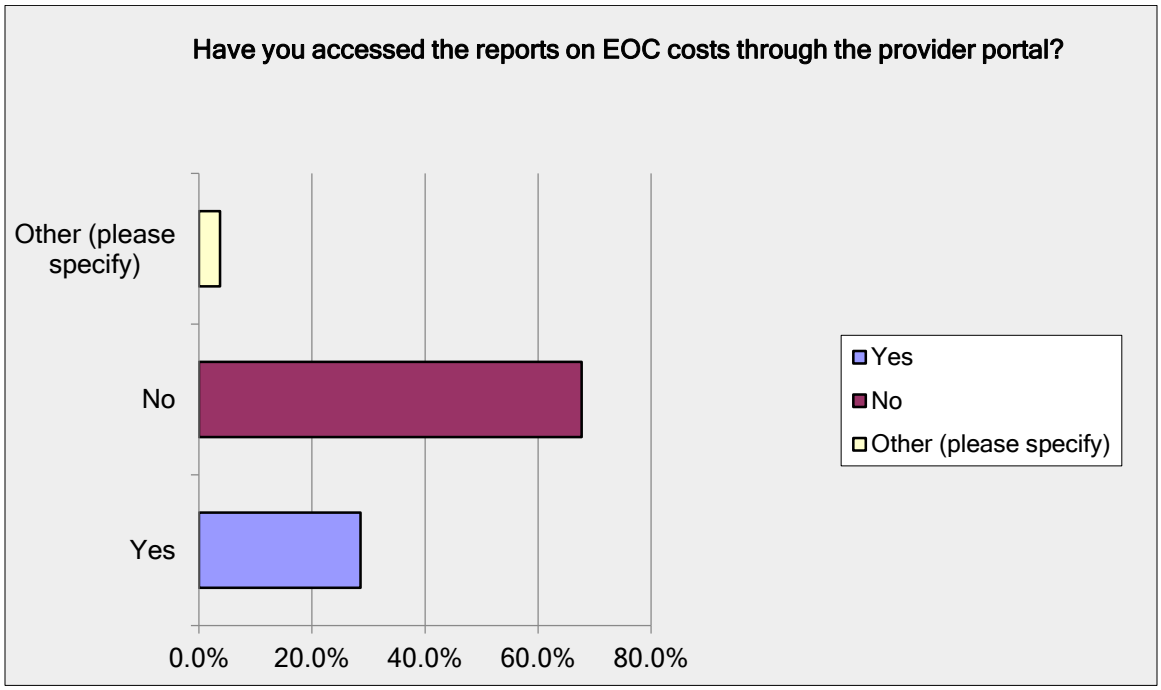


Although about 40% of providers reported being PAPs under the EOC initiative, fewer than 30% of providers had accessed the EOC reports through the provider portal, suggesting that there is an opportunity for DHS to promote the use of the provider portal more aggressively.

Provider survey responses: Have you accessed reports on the provider portal?

Have you accessed the reports on EOC costs through the provider portal?		
Answer Options	**Response Percent**	**Response Count**
Yes	**28.6%**	**93**
No	**67.7%**	**220**
Other (please specify)	**3.7%**	**12**
Answered question		**325**
Skipped question		**104**

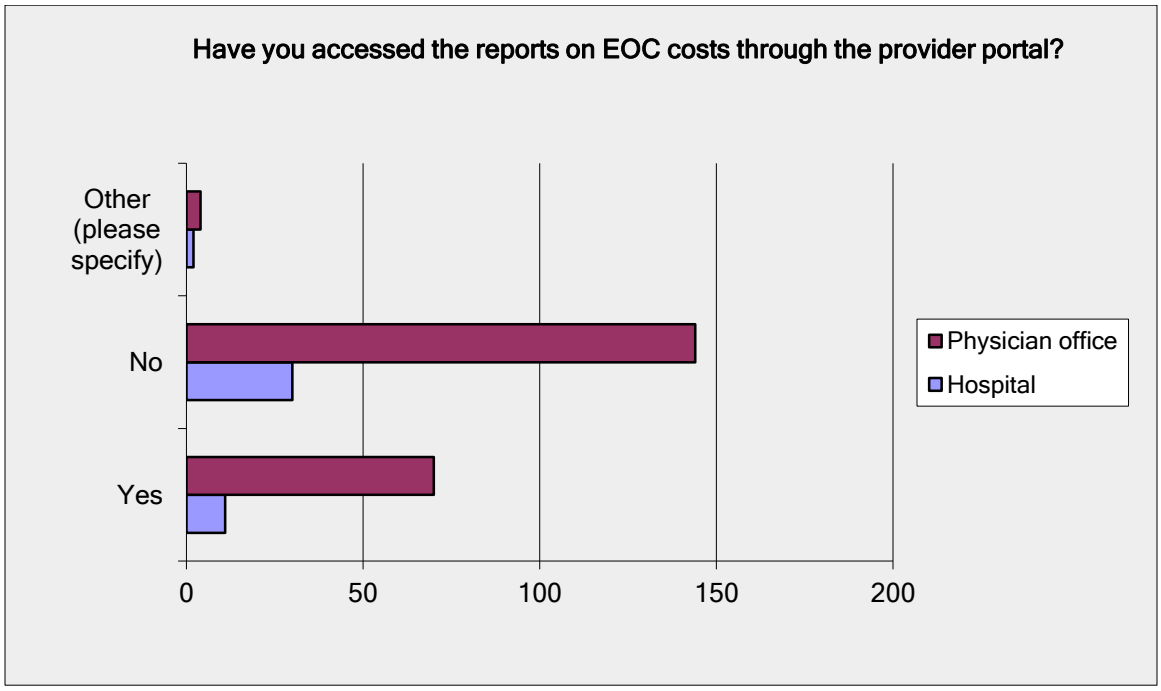
Provider survey responses:

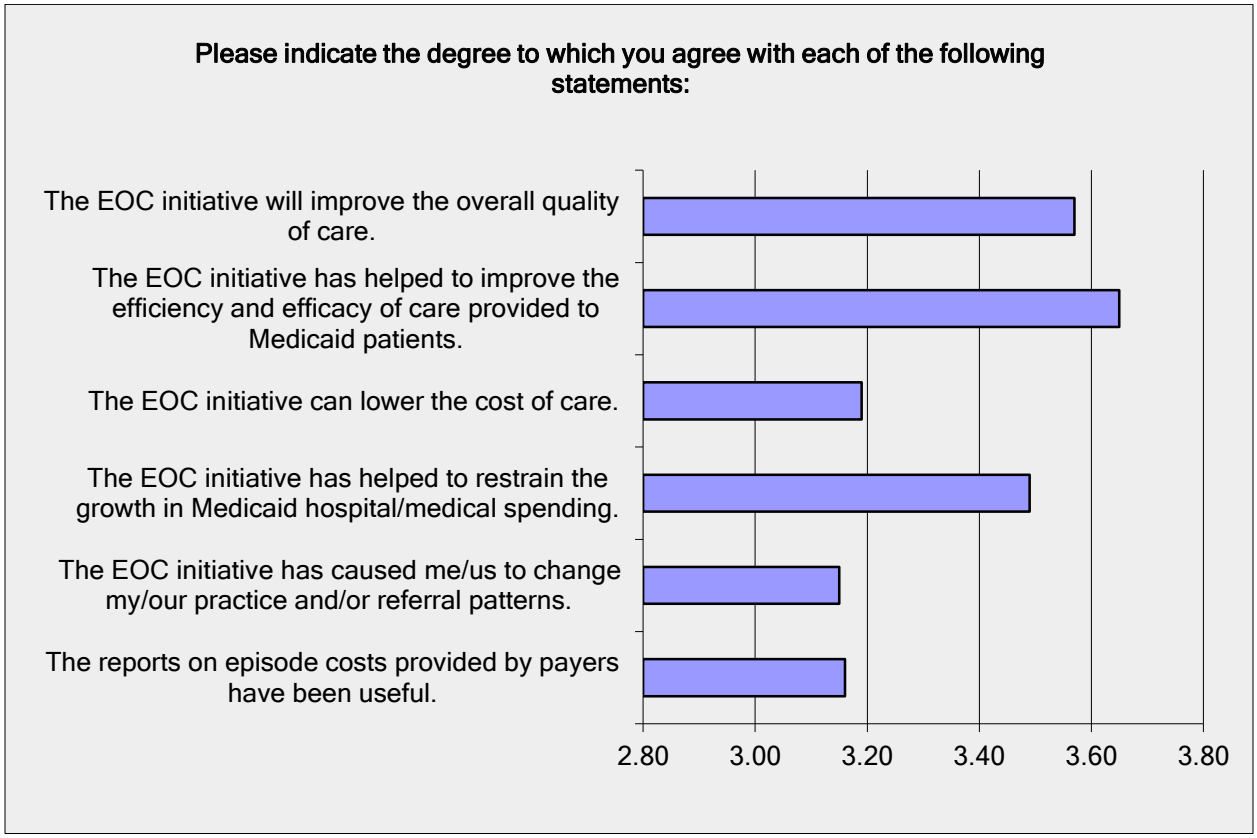


Provider survey responses: Have you accessed reports on the provider portal?

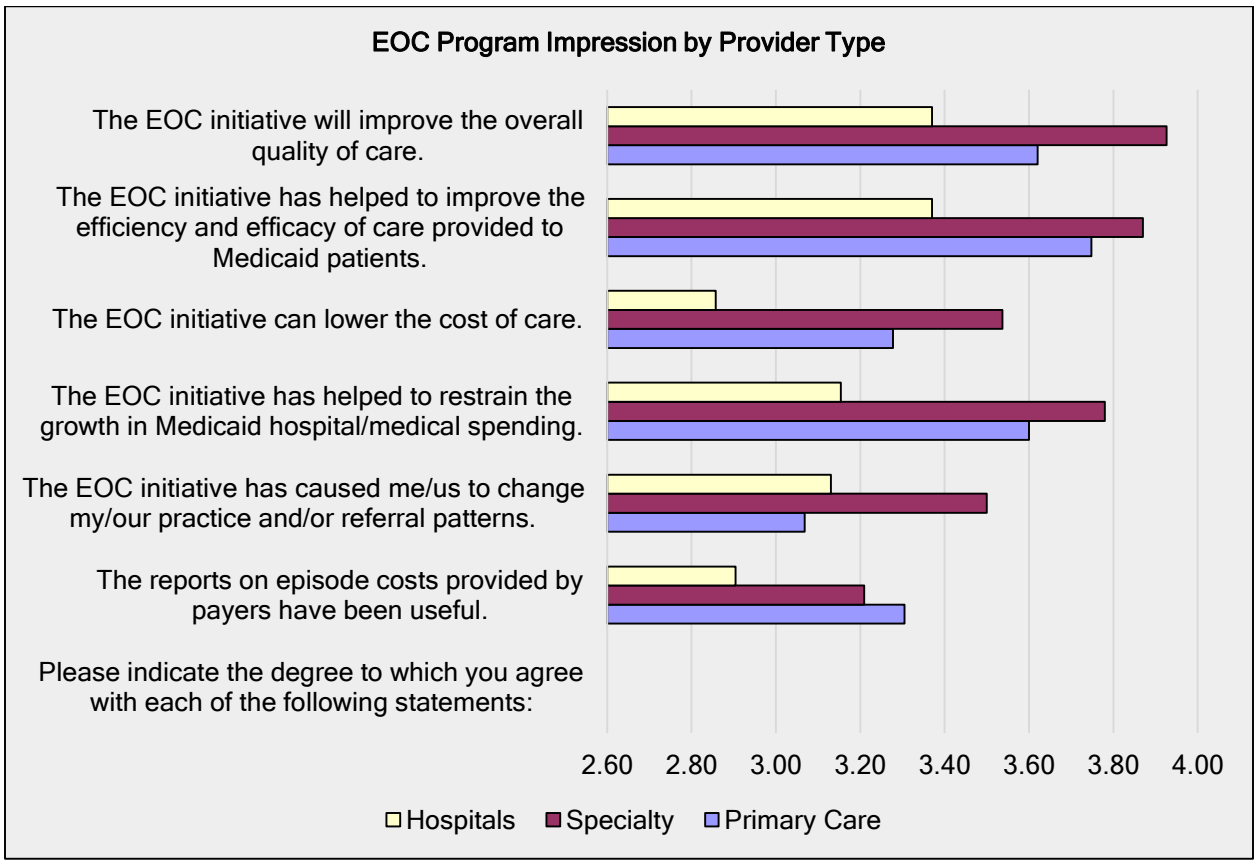
Have you accessed the reports on EOC costs through the provider portal?				
	Do you represent a physician office or a hospital?			
Answer Options	**Physician office**	**Hospital**	**Response Percent**	**Response Count**
Yes	**70**	**11**	**31.0%**	**81**
No	**144**	**30**	**66.7%**	**174**
Other (please specify)	**4**	**2**	**2.3%**	**6**
Answered question				**261**
Skipped question				**88**

Provider survey responses:




Please indicate the degree to which you agree with each of the following statements:
The EOC initiative will improve the overall quality of care.
The EOC initiative has helped to improve the efficiency and efficacy of care provided to Medicaid patients.
The EOC initiative can lower the cost of care.
The EOC initiative has helped to restrain the growth in Medicaid hospital/medical spending.
The EOC initiative has caused me/us to change my/our practice and/or referral patterns.
The reports on episode costs provided by payers have been useful.
2.80
3.00
3.20
3.40
3.60
3.80

The following table shows the breakdown in responses by provider type to the questions about impressions regarding the EOC initiative. As above, Strongly Agree is coded as 1 and Strongly Disagree is coded as 5, so any averages above 3 indicate greater disagreement than agreement. Respondents representing hospitals generally agreed with the statements more often than physicians. Among physician respondents, both primary care physicians and specialists disagreed with the statements more than they agreed with them, on average, with specialists generally disagreeing more strongly.

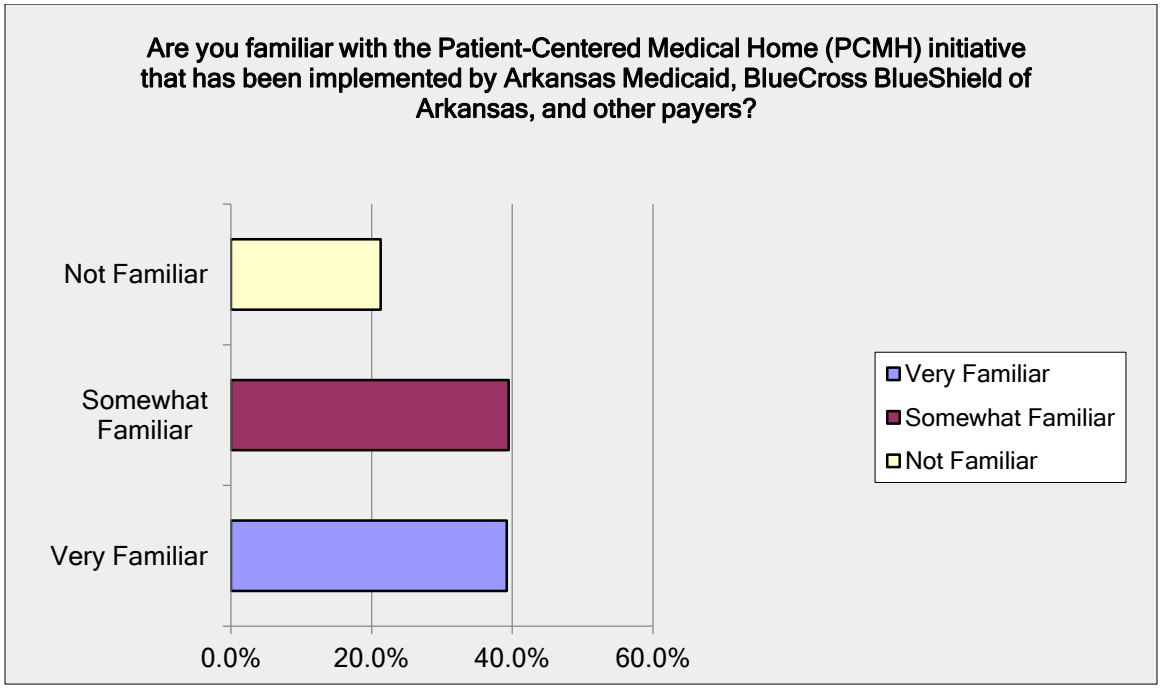


Almost 80% of responding providers indicated that they were either somewhat or very familiar with the PCMH initiative.

Provider survey responses: Are you familiar with PCMH?

Are you familiar with the Patient-Centered Medical Home (PCMH) initiative that has been implemented by Arkansas Medicaid, BlueCross BlueShield of Arkansas, and other payers?		
Answer Options	**Response Percent**	**Response Count**
Very Familiar	**39.2%**	**116**
Somewhat Familiar	**39.5%**	**117**
Not Familiar	**21.3%**	**63**
Answered question		**296**
Skipped question		**133**

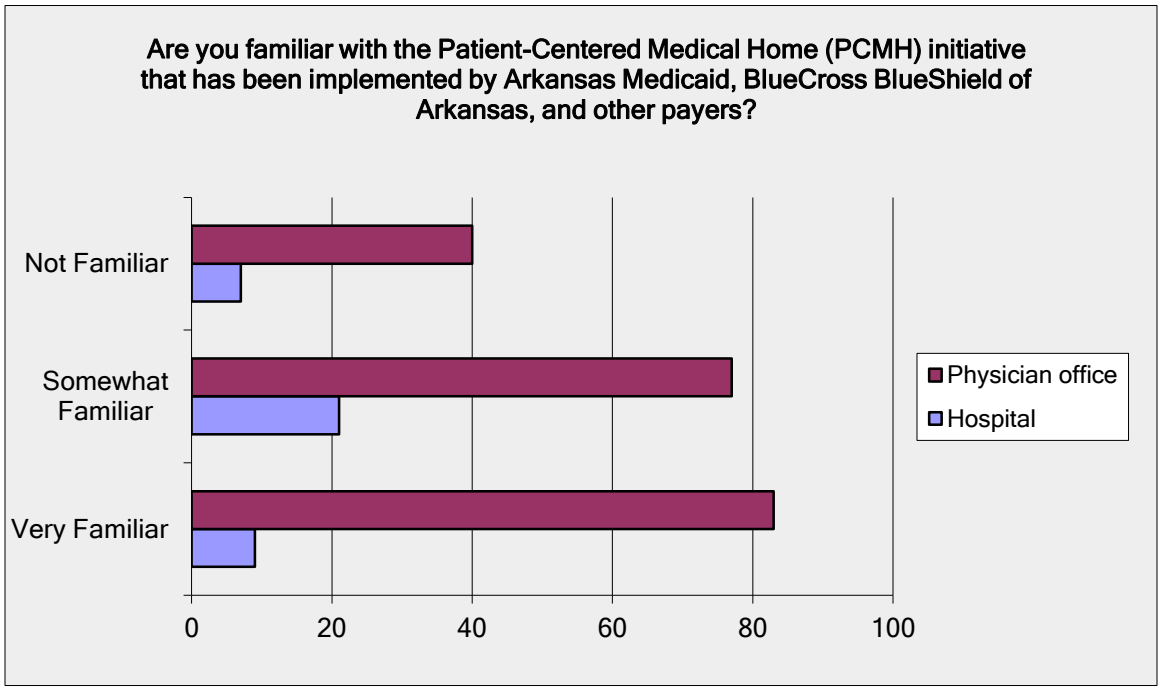
Provider survey responses: Are you familiar with PCMH?



Provider survey responses: PCMH familiarity by office type

Are you familiar with the Patient-Centered Medical Home (PCMH) initiative that has been implemented by Arkansas Medicaid, BlueCross BlueShield of Arkansas, and other payers?				
	Do you represent a physician office or a hospital?			
Answer Options	**Physician office**	**Hospital**	**Response Percent**	**Response Count**
Very Familiar	**83**	**9**	**38.8%**	**92**
Somewhat Familiar	**77**	**21**	**41.4%**	**98**
Not Familiar	**40**	**7**	**19.8%**	**47**
Answered question				**237**
Skipped question				**112**

Provider survey responses: PCMH familiarity by office type

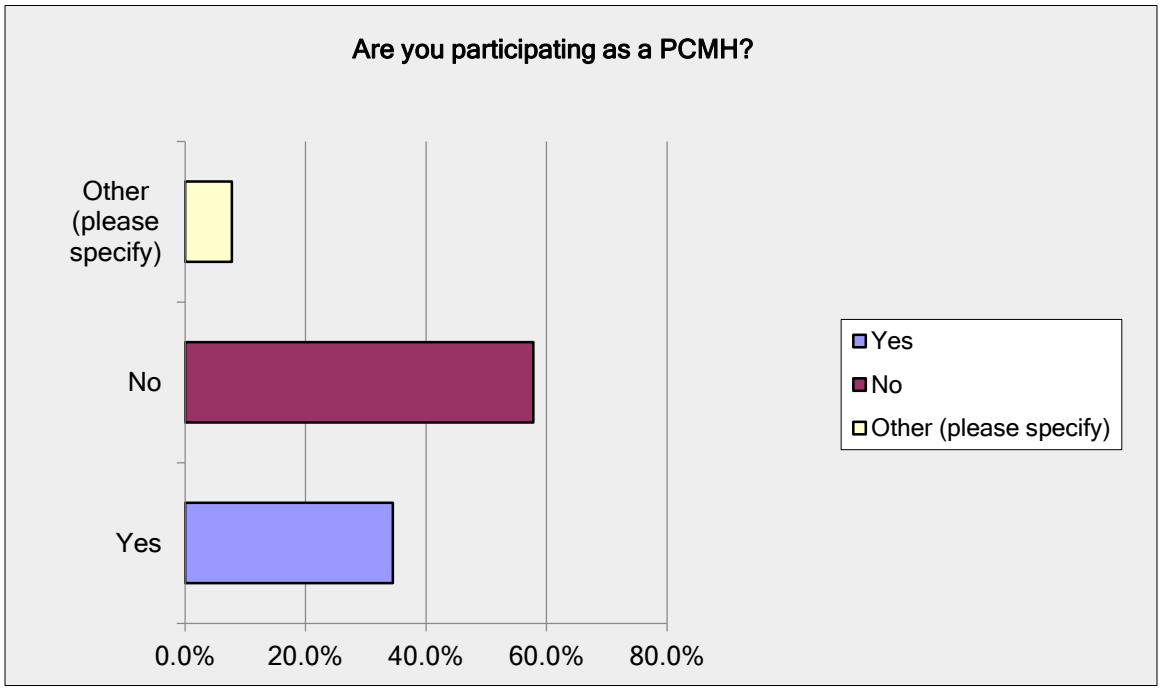


Although about 80% of providers reported being familiar with the PCMH program, only about 35% reported participating as a PCMH.

Provider survey responses: Are you participating as a PCMH?

Are you participating as a PCMH?		
Answer Options	**Response Percent**	**Response Count**
Yes	**34.5%**	**102**
No	**57.8%**	**171**
Other (please specify)	**7.8%**	**23**
Answered question		**296**
Skipped question		**133**

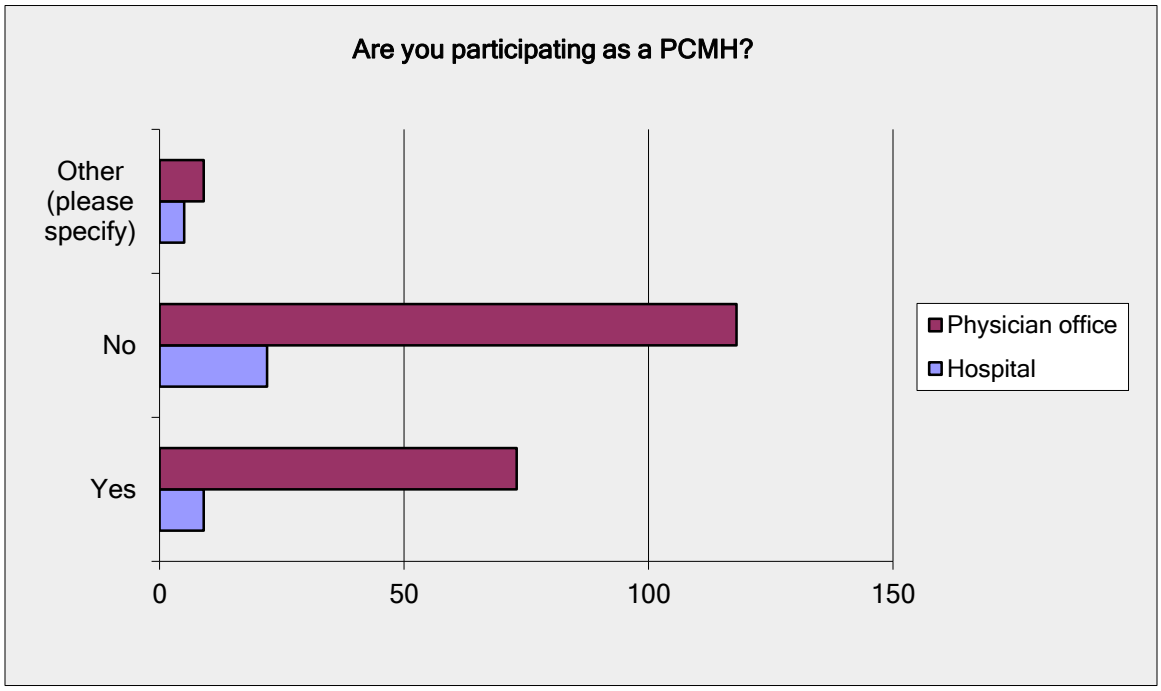
Provider survey responses: Are you participating as a PCMH?



Provider survey responses: Are you participating as a PCMH, by office type?

Are you participating as a PCMH?				
	Do you represent a physician office or a hospital?			
Answer Options	**Physician office**	**Hospital**	**Response Percent**	**Response Count**
Yes	**73**	**9**	**34.7%**	**82**
No	**118**	**22**	**59.3%**	**140**
Other (please specify)	**9**	**5**	**5.9%**	**14**
Answered question				**236**
Skipped question				**113**

Provider survey responses: Are you participating as a PCMH, by office type?



The following table reports on the degree of agreement or disagreement from providers regarding different aspects of the PCMH program. As noted above, for the purpose of calculating the rating average, the scoring runs from 'Strongly Agree' = 1 to 'Strongly Disagree' = 5, so anything above a 3 indicates a larger degree of disagreement than agreement and anything below a 3 indicates a higher agree of agreement than disagreement.

While the corresponding questions regarding the EOC initiative demonstrated rating averages that consistently showed greater disagreement than agreement, the sentiments captured below regarding the PCMH initiative are somewhat more positive, with three of the five questions showing slightly more agreement than disagreement, but all of the rating averages are relatively close to neutral (3).

APPENDIX 6. HIGH UTILIZER REVIEW ANALYSIS

TSG reviewed an Agency report requested by the Legislature that helped unpack the medical experience for those Medicaid beneficiaries with the highest claims experience. TSG would like to thank Optimus for its assistance in addressing specific TSG questions related to high utilizers and providing the data used in this section. TSG reviewed two reports: 1,000 highest traditional Medicaid experience and 1,000 highest experience by those in the category of Medically Frail. The 1,000 highest overall users of traditional Medicaid account for $322 million in claims between 2/1/2014 and 6/30/2015. In contrast the highest users in the Medically Frail category account for only $55 million.

1.1. High Users by Amount of Total Claims

The average total claims amount for the top 1,000 traditional Medicaid beneficiaries is $322,742. Figure 1 shows that this average fails to show a very skewed population. The largest total claims amount for a single traditional Medicaid beneficiary in the period was $6.0 million. For Medically Frail, the average total claim for the top 1,000 was $67,776. This, too hides a "long tail" of claims amounts with the largest being $546,000.

Figure 1—Size of total claims amount for high users of traditional Medicaid

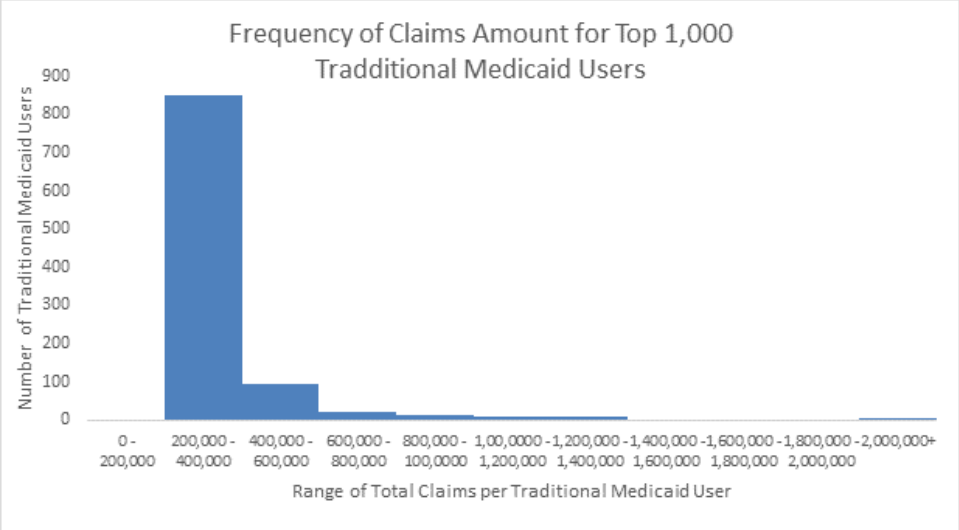
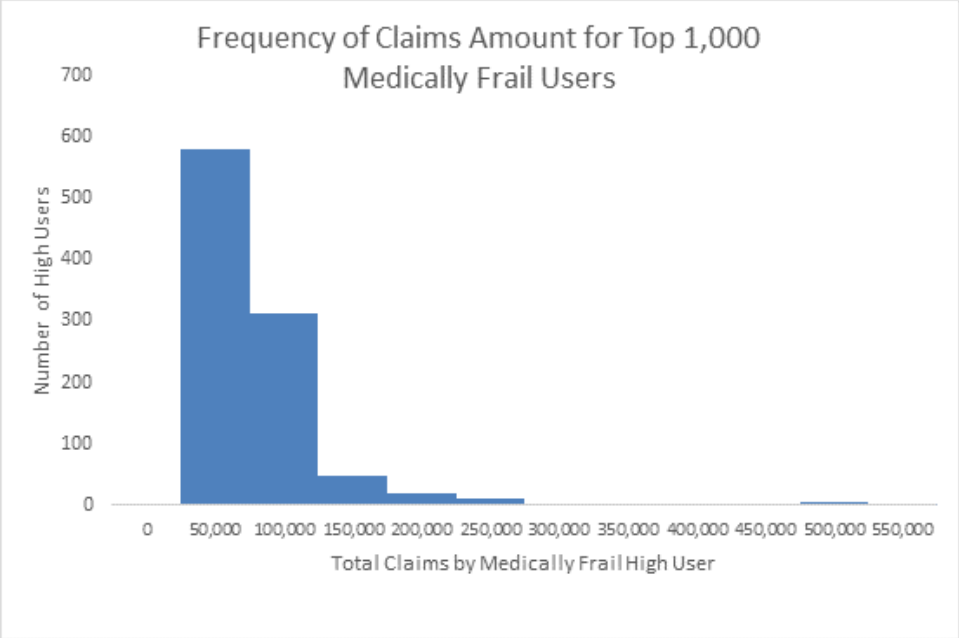


Figure 2—Size of total claims amount for high Medically Frail users

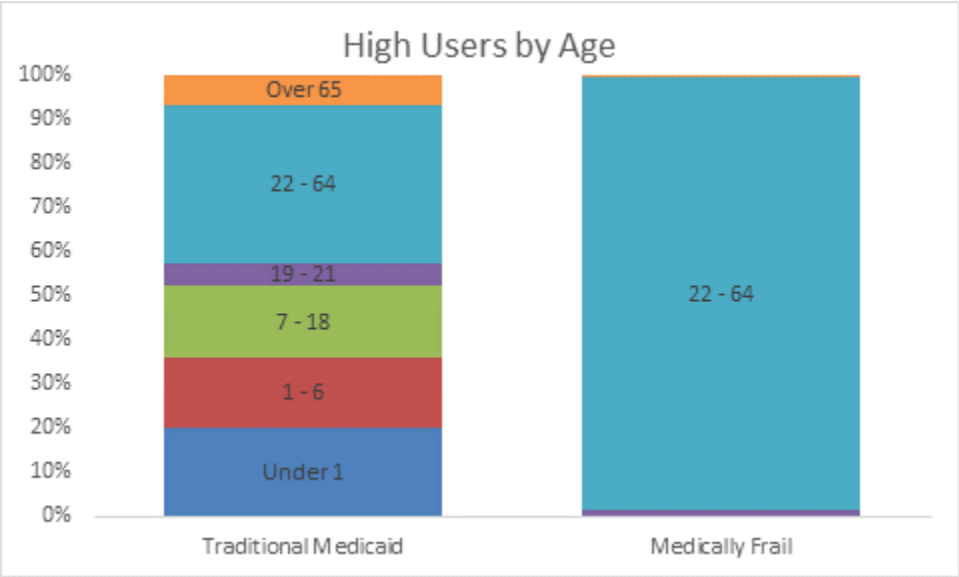


1.2. High Utilizers by Age

Figure 3 shows as expected that approximately 56% of the high utilizers are under age 19. Surprisingly, only 7% of the claimants were over 65, although 218 were dually eligible with Medicare.

The highest users in the Medically Frail category are nearly all between 22 and 64.

Figure 3—Highest traditional recipients by age



1.3. High Utilizers by Diagnosis

Traditional Medicaid and Medically Frail high users have entirely different diagnoses. Table 1 shows the highest cost diagnoses for traditional Medicaid. Table 2 shows the top diagnoses for the Medically Frail.

Table 1— High use traditional Medicaid recipients by diagnosis

Diagnosis	Count	Amount
3182 - PROFOUND INTELLECTUAL DISABILITIES	131	26,391,189
769 - RESPIRATORY DISTRESS SYNDROME IN NEWBORN	140	15,404,729
3181 - SEVERE INTELLECTUAL DISABILITIES	82	15,383,153
77989 - OTHER SPECIFIED CONDITIONS ORIGINATING I	50	13,530,601
51881 - ACUTE RESPIRATORY FAILURE	214	11,587,528
3180 - MODERATE INTELLECTUAL DISABILITIES	69	9,740,359
317 - MILD INTELLECTUAL DISABILITIES	57	6,444,908
77084 - RESPIRATORY FAILURE OF NEWBORN	55	5,646,889
2860 - CONGENITAL FACTOR VIII DISORDER	22	5,026,328
2948 - OTHER PERSISTENT MENTAL DISORDERS CONDI	22	4,073,032
4280 - CONGESTIVE HEART FAILURE UNSPECIFIED	60	4,039,825
51883 - CHRONIC RESPIRATORY FAILURE	108	3,939,207
3439 - INFANTILE CEREBRAL PALSY, UNSPECIFIED	85	3,916,980
76503 - EXTREME IMMATURITY	35	3,898,001
V5811 - ENCOUNTER FOR ANTINEOPLASTIC CHEMOTHERAP	49	3,653,077
29570 - SCHIZO-AFFECTIVE TYPE SCHIZOPHRENIA, UNS	34	3,525,812
76502 - EXTREME IMMATURITY	35	3,175,809
V3001 - SINGLE LIVEBORN BY CESAREAN SECTION	79	3,035,244

Table 2 — High use Medically Frail recipients by diagnosis

Diagnosis	Count	Amount
1749 - MALIGNANT NEOPLASM OF BREAST (FEMALE), U	62	1,368,928
V5811 - ENCOUNTER FOR ANTINEOPLASTIC CHEMOTHERAP	118	985,740
0389 - UNSPECIFIED SEPTICEMIA	104	688,271
1539 - MALIGNANT NEOPLASM OF COLON, UNSPECIFIED	49	676,178
1541 - MALIGNANT NEOPLASM OF RECTUM	24	561,819
1629 - MALIGNANT NEOPLASM OF BRONCHUS AND LUNG,	57	544,380
V5789 - CARE INVOLVING OTHER SPECIFIED REHABILIT	57	495,145
20300 - MULTIPLE MYELOMA WITHOUT MENTION OF REMI	17	444,604
2989 - UNSPECIFIED PSYCHIATRICOSIS	89	440,003
1744 - MALIGNANT NEOPLASM OF UPPER-OUTER QUADRA	20	437,189
1623 - MALIGNANT NEOPLASM OF UPPER LOBE, BRONCH	18	405,271
311 - DEPRESSIVE DISORDER, NOT ELSEWHERE CLASS	140	346,304

1.4. High Utilizers by Aid Category

The high users of traditional Medicaid are largely disabled and many involve children. Figure 4 shows number of recipients with claims in various Aid Categories. Note that three of the largest four categories are for disabled services categories. Figure 5 combines the aid categories to show that 70% of the high users of traditional Medicaid had charges related to services for developmental disabilities.

Figure 4-- Highest traditional Medicaid recipients by aid category

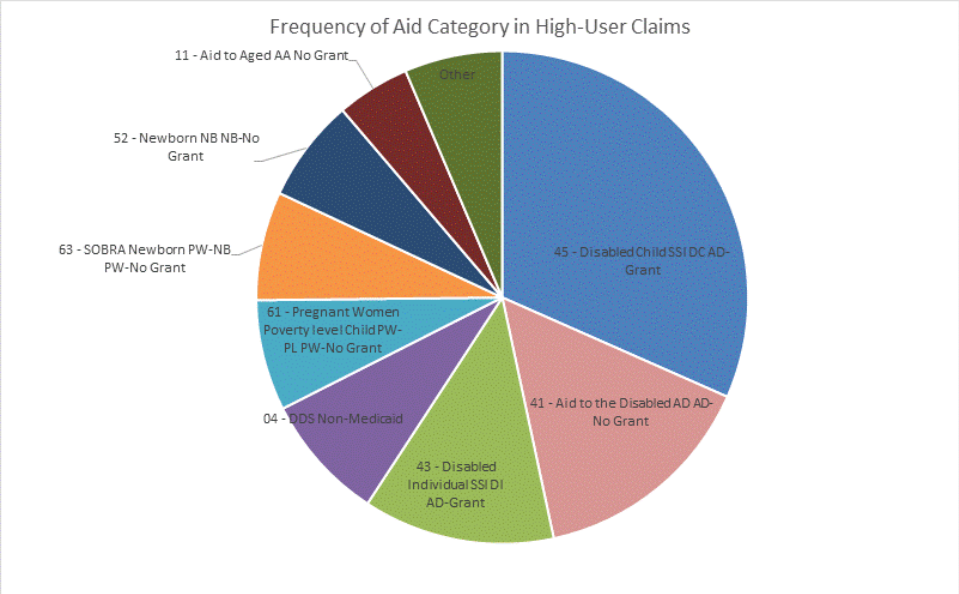
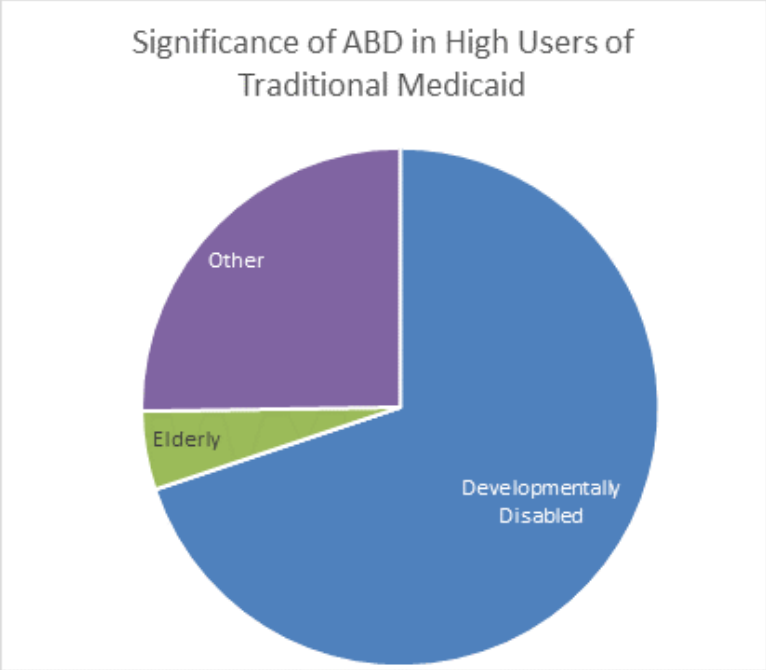


Figure 5— Highest traditional Medicaid recipients by Aid Category Grouping

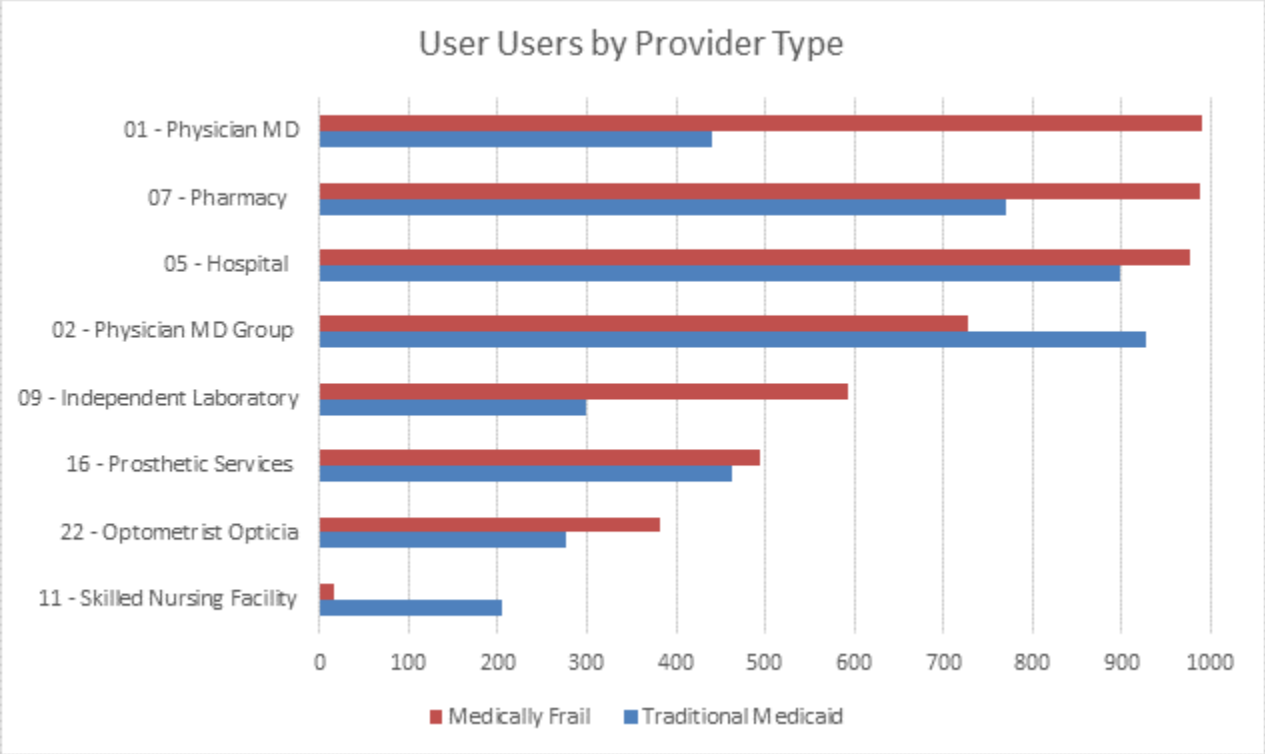


1.5. High Users by Provider Type

The highest users of traditional Medicaid have claims from a wide variety of providers. Please note that the figure shows number of recipients that had claims for a provider type, not claims amount. Thus, as many high users had claims including physicians as had claims that included hospitals—this does not say that physicians claimed as much by dollar amount. Interestingly, high users of traditional Medicaid tended to visit physician group practices, while the Medically Frail visited individual doctors more frequently. Also, the Medically Frail tended to use transportation services and pharmaceuticals more frequently.

The Medically Frail use a very different set of providers, with the largest being Physicians and physician groups, then hospitals and transportation. The Medically Frail make far less use of Skilled Nursing Facilities (SNF).

Figure 6— Highest traditional Medicaid recipients by provider type



Of those providers, two hospitals accounted for $118 million (36%) of the high user traditional Medicaid claims, as shown in Table 3. For Medically Frail, the two big hospitals accounted for only $7.6 million.

Table 3— Highest traditional Medicaid recipients by two top hospitals

	Traditional Medicaid		Medically Frail	
Billing Provider Name	Recipient ID Count	Total Paid Amount	Recipient ID Count	Total Paid Amount
ARKANSAS CHILDRENS HOSPITAL	492	$109,716,477	11	$311,832
UNIV HOSPITALOF ARKANSAS	187	$8,051,344	389	$7,390,493

High users mostly claimed for inpatient care (41%) and nursing homes (31%). Table 4 shows the breakdown of claims by type of claim. For the Medically Frail claims included a larger share of other medical and pharmacy.

Table 4— Highest traditional Medicaid recipients by type of claim

	Traditional Medicaid		Medically Frail	
	Total Paid Amount	Percent	Total Paid Amount	Percent
S - Inpatient and inpatient adjustment	132,613,692	41%	15,744,479	29%
T - Nursing home and nursing home adjustment	100,091,132	31%	104,450	
J - Medical and medical adjustment	47,725,125	15%	17,145,907	31%
D - Drug and drug adjustment	36,484,218	11%	14,096,857	26%
M - Outpatient and outpatient adjustment	5,283,812	2%	7,495,048	14%
E - Professional crossover and professional crossover adjustment	207,963		86,384	
W - Outpatient crossover and outpatient crossover adjustment	118,918		70,709	
V - Inpatient crossover and inpatient crossover adjustment	108,873		39,520	
K - Dental and dental adjustment; screening and screening adjustment	63,259		222,631	
B - Early and Periodic Screening, Diagnostic, and Treatment	33,680		59	
X - Nursing home crossover and nursing home crossover adjustment	11,553		25,727	
Total	322,742,223	100%	55,031,771	100

These Medicaid high users were heavily represented by nursing homes, the State Skilled Nursing Facility (SNF) and Human Development Centers and special care venues, as shown in Table 5. In contrast, the Medically Frail tended to make claims through provider Type 26, "Rehabilitation Center, Specialty R6 - Rehabilitative Services for Persons w/ Mental Illness".

One point of interest is that transplants were involved in only 35 of the 1,000 highest users of traditional Medicaid, and 9 of the Medically Frail.

Table 5— Highest users by number in institutions

	Traditional Medicaid	Medically Frail
Nursing facilities	205	14
Human Development Centers	254	0
AR State Psychiatric	32	2
AR State SNF	205	1
Clinics, Specialty V3 – DDTC	85	1
Rehabilitative Center for Persons w/ Mental Illness	95	278
	876	296

1.6. Summary of the Highest Users

The average claim of the top 1,000 "high users" of traditional Medicaid in the 18-month period studied was $320,000, with the most expensive single beneficiary claiming $6.0 million. High users of traditional Medicaid are typically between 22-65 years of age. High Medicaid users are evenly spread around the state. High users are heavily in the Developmentally Disabled category. They claim mostly for hospitals, physicians and pharmaceuticals. Only a few involve transplants. Fully 33% of the claims for the high users of traditional Medicaid were paid to UAMS, and that is before accounting for settlements. Non-claims payments to UAMS would increase their amount from $110MM to $160MM, or 43% of the cost of supporting the top 1,000 users of traditional Medicaid. Behind hospitals, nursing homes account for the next largest share of the claims for high users of traditional Medicaid.

Costs of care for the Medically Frail are very different from those of the high user in traditional Medicaid. Average claims for the Medically Frail high users were only $68,000 in the 18 months studied. Like traditional Medicaid, there was a "long tail", with the largest claims amount for a single Medically Frail beneficiary being $546,000. Medically Frail high users are typically 22-64. A surprising finding about the Medically Frail high users is that they tend to be heavily concentrated in counties with small populations. While traditional Medicaid is heavily DD, Medically Frail high users tend to have claims for neoplasm (cancer). Medically Frail high users tend to be responsible for claims from physicians and physician groups, inpatient hospitals and for pharmaceuticals. Neither UAMS nor Children's Hospital account for much of the spending on Medically Frail high users. The Medically Frail are typically not generating claims for institutional care including nursing homes.

APPENDIX 7. CASE MANAGEMENT TRACKING ACROSS SOCIAL SERVICES PROGRAMS

1.7. Medicaid Case Management Services

TSG conducted an examination of case management tracking for beneficiaries across social services programs include state comparison. Medicaid reimbursable case management services became an allowable category of medical assistance in 1986. Congressional action at the time included case management services as an allowable expense when included as a service under a 1915 waiver program, thus the connection with home and community based care systems and what is now known as "Long Term Services and Supports/LTSS" by the Center for Medicaid Services.

The history of the definition of case management services in the federal Medicaid program has been a somewhat confusing policy road for states to follow. The question of whether Targeted Case Management (TCM) services are a medical or administrative activity has a history back to 1981 when Congress permitted case management services to be Medicaid reimbursable when provided through "primary care case management services."[1]

The Deficit Reduction Act of 2005 clarified the definition of Medicaid case management and targeted case management (TCM) based on concerns from many states and CMS over federal policy confusion, state concerns about duplication, redundancy and innovative options, and consumer and advocacy concern about person centered planning and access. Concern about appropriate use of Medicaid case management services had been growing for several years prior to the DRA of 2005 based on OIG state audits of appropriate state use, clearly non-reimbursable services and cost shifting across state agencies (summarized in FY 2007 Top Management and Performance Challenges DHHS OIG report, III-2), and state concerns about appropriate use, perceived CMS policy confusion, and state paybacks.

The DRA (440.169) defined Case Management services to assist eligible individuals "who reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, educational, and other services." The section defined Targeted Case Management (TCM) services as not being subject to CMS requirements for state wideness and comparability thereby permitting states to provide case management services in defined locations of the state for specific ("Targeted") populations based on the standard definition of case management services. Case management services for transitions from institutional settings (with IMD and inmate exceptions) were also identified as allowable

[1] "The CMS Medicaid Targeted Case Management Rule: Implications for Special Needs Service Providers and Programs". Center for Health Care Strategies, Inc. p. 1-2 (4/2008)

costs for up to 60 days for a 180 day institutional stay or longer and up to 14 days for an institutional stay less than 180 days.

CMS identified the comprehensive components of reimbursable case management services to minimally include an assessment of any eligible person, development of a plan of care, referral to services, and monitoring and support of the delivery of the identified plan of care. Medicaid paid case management services were denied as not being reimbursable when the case management services were an "integral" service of another covered service. This clarification has taken on an important meaning since the DRA was passed as CMS has invested in innovative approaches to health homes, the integration of primary care and behavioral health services and states have pursued modernization efforts to integrate care, improve quality, and control costs through payment reform models such as PCMH, population specific health homes, and integrated value based managed care, ACO, and bundled payments strategies. CMS also identified case management services that are a "direct delivery" of "medical, educational, social, or other services" the person has been referred to, such as child welfare/child protective services, foster care programs, public guardianship, and special education services, as not eligible for Medicaid reimbursement.

CMS provided several clarifications that are important policy and system design considerations for Arkansas that addresses an eligible individual's freedom of choice of case manager and systems design. The DRA specifically permits a state to limit provider participation for case management services to "specific persons or entities" for a target group of individuals with developmental disabilities and chronic mental illness. A state would need to establish "qualifying criteria" to design a delivery model for this exception. Individuals are eligible for Medicaid reimbursable case management services from a "single" case manager and cannot receive this service from multiple providers or multiple TCM programs. Persons (and their legal representatives) must make a choice of one reimbursable case management service if they are programmatically eligible for two. Further the DRA of 2005 and promulgated Rules of 2007 clarified the medical case management characteristics of managed care plans as not as extending to services associated with home and community based services.[2]

Medicaid reimbursable case management services cannot include services such as determination of medical necessity and prior authorization and related Medicaid administrative services. These services are reimbursable as Medicaid administrative services. Disease Management services defined as disease education, medical monitoring, and health self-management services were excluded by the DRA from being reimbursable through Medicaid case management services. It is important for state Medicaid policy planning initiatives to include a clear separation of services related to PCMH, health

[2] Ibid. p. 4

homes, and disease management models from case management services in their delivery system and payment design considerations.

1.8. State Best Practice: Case Management and Care Coordination

In 2011, the Little Hoover Commission of the state of California issued the ground breaking report on "A Long-Term Strategy for Long-Term Care". The Little Hoover Commission was created by the state Legislature in 1962 as a bipartisan independent state oversight agency. Members of the Commission are appointed by the Governor and the Legislature.

While California and Arkansas are fundamentally different in population, size and California's reliance on a unique state-county government partnership in the California Medicaid program, several of the Commissions' insights and recommendations are relevant to the Arkansas long-term care system today. These points include: 1) a "decades" long delay in developing a "cohesive system" to manage long-term care services at the state level; 2) acknowledgement of the abundance of "good ideas, long term programs, and examples of innovative local approaches or dedicated caregivers"; and 3) the need for the state to develop and implement "a vision for long-term care in California, one that anticipates the changes ahead to create a continuum of care from the most independent setting to the most supportive".[3]

The Report called for sweeping reforms based on consolidation of all long-term Medicaid services at the state level, reform of the system based on the client at the center of all reforms, and focus on Care Coordination as the "key linchpin" to the coordination of all aspects of the long-term system: Federal, state, local, community, and individual resources.

The Commission identified care coordination as "a mechanism to ensure that a senior or person with disabilities receives the right care in the right setting at the right time – which, given the preferences of clients and the Olmstead imperative, tends to keep people in their homes and communities and out of costly institutions".[4] The importance of case management in the Commission's vision of a state-wide long-term care system targeting comprehensive Care Coordination was identified by the "Essential Tools" of care coordination that include: 1) single point of entry; 2) uniform assessment; 3) case

[3] "A Long-Term Strategy for Long-Term Services". The Little Hoover Commission, State of California, April, 2011, Cover Letter from the Commission's Chairman
[4] Ibid., p. 48.

management; 4) data collection; and, 5) management of technology that can bridge siloed programs.[5]

The Commission's LTC report identified Washington and Oregon as best practice long-term care services state models from which to learn. It is important to note that, in FY 2013, Oregon ranked first in the country of percent of LTC recipients living in the community, Washington ranked fifth, and California ranked 6th.[6]

The Washington model utilizes an integrated software platform that includes the CARES (Comprehensive Adult Resources Evaluation System) preadmission assessment of strengths and needs of individuals at risk for institutional settings, plan of care, expanded case management capabilities, individual case records, individual and groups of individuals data reports on provider utilization, caseloads, and costs, and query capability.

The integration of case specific information provides the case manager with a broader array of client specific information than the LTC specific information with on-line linkages to chronic care management dual eligible models currently in demonstration projects on a voluntary enrollment basis developed since the Little Hoover Commission report.

The Oregon model utilizes a case management model that integrates several LTC functions that are provided by separate entities in most other states. Oregon defines a case manager as the designated individual "responsible for service eligibility, assessment of need, offering service choices to eligible individuals, service planning, service authorization and implementation, and evaluation of the effectiveness of Medicaid home and community based services."[7] Additional case manager services include: diversion activities from nursing home admission, other programs coordination engagement, crisis response and intervention, and assistance with resolution of service provision issues.[8]

The Department of Health and Office of Mental Health of New York state have implemented an innovative modernization of both Medicaid health homes and mental health Targeted Case Management. The transformative design incentivizes traditional TCM providers to become a program element of DOH/Medicaid program health homes.

Additionally, the program design incentivizes Assertive Community Teams (ACT) to also become a program element of DOH/Medicaid program health homes.[9] The ACT program

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[5] Ibid. p. 70.
[6] Truven Health Analytics/Mathematica/CMS: 6/30/15)

[7] Oregon Administrative Rules, Chapter 411, Division 28, 411. 028-0010
[8] Ibid. 411-028-0020
[9] "ACT Programs and Health Homes". NY DOH, 2014

is an evidence based team approach on the streets 24/7 designed for high need people with serious and persistent mental illness and has proven successful in reducing hospitalization use in numerous studies.

The DOH/OMH partnership is basing the transformed health home model of service delivery by expanding the traditional medical home model through linkages to other community and social supports, and to enhance coordination of medical and behavioral health care, with the main focus on the needs of persons with multiple chronic illnesses. The objectives of this transformation is to increase community stability for a high risk high cost population, avoid unnecessary hospitalizations and use of ERs, improve population health for a multiple chronic care condition population, and contain costs.

The University of Minnesota, through the affiliated Research and Training Center on Community Living (RTC), conducted and examination of the case management practices of twenty states, including AZ, CO, KS, OR, WI, and WA, serving people with developmental/intellectual disabilities, Traumatic Brain Injury, and adults under 65 with physical disabilities and/or chronic medical conditions. The study was triggered by a Legislative mandate for the Department of Human Services to study and make recommendations on redesigning case management practices in the state's Medicaid and related programs. From the outset of the study the RTC identified the following "challenges" [10]related to Medicaid case management:

- **Increased choices creating a demand on resources**
- **Tensions created by limits on services**
- **Duplication and redundancy**
- **Overlapping eligibility for programs**
- **Variation of rules, standards and reimbursement from program to program**
- **Inequities from group to group**
- **Multiple assessment processes**
- **Variation in quality from across a state and from case manager to case manager**

The Deficit Reduction Act of 2005, the CMS Quality Framework for Medicaid Home and Community Based Services, and the choice of a case manager by an individual were cited as key points of Federal influence over Medicaid reimbursed case management services. Additionally, the recent CMS Final Rule on Home and Community Based Services (CMS 2249-F and CMS 2296-F, 1/16/14) has further clarified Federal expectations of states regarding choice, independent assessment, and independent case management. The study also identified the Governance Structure of a state human services enterprise as a factor in

[10] "Innovative Models and Best Practices for Case Management and Support Services" (University of Minnesota, Research and Training Center on Community Living, 2008), p. 2

the delivery and variability of case management services primarily based on the differences between state-county based partnerships and state only administration models.

Case management is often a confusing term given the complexity of its use in state Medicaid programs across disparate populations. The RTC defined the definition of case management[11] as follows:

"Definition of Case Management: Case management has two key features: (1) providing an interface or connection between individuals with disabilities and the system of publicly-funded and generic services and supports; and (2) assuring that these services meet reasonable standards of quality and lead to important life outcomes for individuals."

Five roles or functions for case management were identified:

- **Administrative**
- **Crisis management**
- **Consumer empowerment**
- **Individual advocacy**
- **Systems advocacy**

These roles could be seen as additive, going from the most basic and required functions to roles that are desirable but beyond the required minimum. A fundamental question in the design of a case management model is who should fulfill the various roles. As case management has evolved, different terms such as "service coordination," "support coordination" and "resource management" have been used.

As self-directed services and consumer control have increased, the role of supports brokering – assisting individuals to self-direct their services – has also emerged. In some states the role of the case manager has shifted to that of "service broker," especially for people receiving support due to physical disabilities or mental illnesses. Programs for individuals with developmental disabilities often define service brokering as a key role of case management. Service brokering involves assisting people to access needed services, coordinating payment for those services, and empowering the consumer to manage them. Attempts to determine the outcomes and effectiveness of different case management models was identified as meeting with "mixed results regarding costs, satisfaction, and life outcomes."[12]

The study did identify state innovations in managing case management resources in Pennsylvania, Oregon, and Washington by each state's development of a standardized data based management information system that tracks case management performance on

[11] Ibid. p. 4
[12] Ibid. p. 5

meeting process deadlines and required client contacts and follow-up as well as state specific software innovations as mentioned above in the state of Washington. Providing adequate support structures for self-determination, a key requirement for consumer choice of services, promoting a consumer's choice of case manager, and streamlining processes were identified as key design features of state case management models supporting consumer control over the services they are eligible to receive.

The Case Management Society of America (CMSA) is a non-profit organization founded in 1990 with 30,000 members nationwide and 75 chapters. The By-Laws of the organization are well developed and governance represents nursing, social work, business, and related disciplines. CSA supports its membership through leadership forums, educational forums, and discipline related tools that address practical definitions and models of case management in the regulatory environment of health services while focused on avoiding unnecessary costs throughout the health care system.

As a national organization, the CMSA has a vital perspective on case management practice across the states with recognition that Medicaid, Medicare, and commercial and employer insurance are the primary sources of case management services reimbursement, impact on the profession, and corresponding need for the profession represented through CMSA to integrate expectations and requirements of this relationship.

With this in mind, the CMSA identifies case management services as[13]:

- **Assessment is the process of identification of the condition/needs, abilities and preferences of the individual, which leads to the development of a plan of care.**
- **Care planning, which is a kind of health care map, including goals and preferences. The care plan defines strategies and next steps towards achieving the desired outcomes. The ultimate goal is to help individuals take control of their care and be actively involved in evaluating the experience.**
- **Alignment, which means case managers work to align all the moving parts and puts the plan into action with the individual.**
- **Evaluation/Outcomes Measurement, which tells the individual and case manager what's working, what's not working and what needs to be modified (plan, goals, etc.). Finally, it identifies what progress is being/has been made toward individual goals.**

[13] This is explained at: http://solutions.cmsa.org/acton/fs/blocks/showLandingPage/a/10442/p/p-0005/t/page/fm/0/r/%7B%7BEnv.RecId%7D%7D/s/%7B%7BEnv.SrcId%7D%7D?utm_medium=landing+page&utm_source=Act-On+Software&utm_content=landing+page&utm_campaign=&utm_term=Default&cm_mmc=Act-On%20Software-_-email-_--_-Default

- **Promotes Client Self-Determination, which means the individual learns the skills necessary to take control of their care with confidence. In other words, they know what's wrong with them, what they need to do about it, and the value of doing so.**

Equally important the CMSA identifies the following services as not being a function of core case management functions (not reimbursable as a case management function): benefit determination, utilization management, precertification, administrative tasks, direct patient care not related to case management assessment and intervention, quality management, risk management, and claims adjustment.

APPENDIX 8. SUMMARY OF MCO ANSERS TO TASK FORCE QUESTIONS

Summary of Managed Care Organization Answers to Task Force Questions

The Task Force was informed that most Medicaid MCOs have extensive state experience ranging from a high of 23 current state Medicaid contracts, most in the range of 12 to 20, and one MCO with 2 as an outlier. All MCOs have extensive Medicaid population experience (TANF, CHIP, ABD/LTSS, Dual Eligibles, and Child Welfare) and full scope of core Medicaid services including medical, pharmacy, ancillary services, and HCBS waivers and targeted state plan amendments. This broad coverage and scope reflects the policy trend of many states over the past several years to construct fully integrated high cost care coordination at risk contracted Medicaid health system.

All MCOs reported innovative approaches and models in response to the question on how they improved access to quality of services for populations served that are worth noting. Integrated care management and the use of data analytics connected to paying for value measured by outcomes is a theme across the responses. Several reported innovative provider engagement and "rewarding" providers for high quality care that address health disparities. The importance of outreach to beneficiaries was mentioned as well as the use of Community Health Workers designed to improve access to services. Disease management, telemedicine, clinical outcomes designed to improve health status, and the PCMH model were also mentioned as ways to improve access and quality of services provided by MCOs.

All MCOs (with one non-response to the question) reported significant impact on state budget savings although not in a comparable way. One MCO noted $2.7 billion in savings over 5 years in the state of Pennsylvania. Several MCOs noted the $3.8 billion in managed care savings within the Texas Star Plus managed care model documented by a recent Milliman study cited in another section of this Report. It is important to note that the reported Texas Star Health Plan reported savings was achieved by several MCOs, not just one. One MCO reported savings as a result of increased use of HCBS services and a reduction in institutional care for the LTSS population.

Primary care is a priority consideration for all respondent MCOs. All noted a priority to align PCP incentives, reimbursement, data analytic support, and care coordination as key considerations in achieving reductions of unnecessary hospitalizations and ED usage that produces cost savings. Four mentioned direct experience supporting and working with the PCMH model.

As reflected by the dramatic increase in states instituting Managed Long Term Services and Support integrated at risk care models for the ABD populations over the past several years, all MCOs responded affirmatively to the question on experience with the population

and reducing reliance on institutional care. Three MCOs reported that together they served 1.75 million individual ABD and LTC beneficiaries in several states. All reported decreased reliance on institutional care for the ABD population through the implementation of Integrated Care Management for chronic care conditions, mobile and crisis response teams, transitions of care, intensive intervention programs, reduced residential care for behavioral health, and population health program models.

The question "Experience with PMPM over the past five years" yielded responses that indicate all MCOs have significant experience with PMPM in a number of states and, for the most part, PMPM increases have beat the national increase in overall Medicaid expenditures. The range of state PMPM increases over the past five years by all respondents indicate a range of -.09% to +4% over base, although this survey did not adjust for individual state managed care covered populations or new mandated drugs. Shared Health (TN) noted that their TennCare PMPM rates have been steady over the past 5 years and fourth lowest in the nation.

In response to the question of "what are the critical success factors for Arkansas to consider with Managed Care," five of the MCOs specifically recommended the importance of stakeholder collaboration in the development of the state model/contract and implementation. Many stated that carving in all benefits, realistic timelines for implementation, care in least restrictive setting, flexibility for MCOs to develop value based reimbursement and care models, focus on quality, and transparent rate setting process were important factors for Arkansas to consider in order to be successful.

There was virtually universal agreement among the MCOs for Arkansas to Not develop a fragmented approach through carve outs, limiting program participation, allowing population opt outs or allowing voluntary enrollment. There was considerable agreement that Arkansas should not regionalize the managed care model the state chooses to implement, require rates that are not actuarially sound, mandate unreasonable savings, or mandate detailed operational requirements.

In response to the presentations made by the MCOs at the 8/20/15 Task Force meeting, several follow-up questions were of concern to members resulting in MCOs being asked to respond to these four additional questions:

- **Describe any prior or current litigation, which includes any fines or penalties to the state, related to state managed care contracts in any state you have participated.**
- **Response: Six MCOs responded they were not involved in litigation. One MCO responded they were involved in "non-material" litigation. Two MCO's did not respond to the four questions.**
- **There is concern about the impact of administration fees on the Arkansas Medicaid Program, if the state were to adopt a managed care strategy. In any of the states that you described a history of savings within the Medicaid program, did those**

savings include the cost of your administrative fees or were they excluded from the savings? Please describe.

- **Response: Six MCOs responded that savings they obtained in other states included their administrative fees. One MCO reported that in most cases their cost savings surpassed the administrative cost in the first year.**
- **In any of the states that you described savings due to managed care, did those savings actually reduce costs below the previous year or did they reduce costs below a trend? Please provide financial analysis for your answers, and a contact person from that state government that we could speak with.**
- **Response: The seven responding MCOs reported their savings were below trend. One MCO reported that KanCare had cash savings over prior year in the first year of managed care.**
- **Can you please describe any impact on provider reimbursement rates in any of the states that you are currently involved in operating a managed care Medicaid program? Were there any rate reductions from the provider fee-for-service rates during the contract period for any providers that were in your network?**
- **Response: five MCOs reported that provider rates were based on FFS Medicaid rate schedules. One MCO responded that physician rates went from 60% of Medicare rates in 1994 to 80% of Medicare rates today. LTSS provider rates are defined by the state and based on historical FFS rates.**

APPENDIX 9. PRIVATE OPTION ELIGIBILITY DOCUMENTATION WHEN INCONSISTENCIES

U.S. CITIZENSHIP

- **U.S. passport**
- **Certificate of Naturalization (N-550/N-570)**
- **Certificate of Citizenship (N-560/N-561)**
- **State-issued enhanced driver's license (available in Michigan, New York, Vermont, and Washington)**
- **Document from federally recognized Indian tribe that includes your name and the name of the federally recognized Indian tribe that issued the document, and shows your membership, enrollment, or affiliation with the tribe. Documents you can provide include:**
    - **A Tribal enrollment card**
    - **A Certificate of Degree of Indian Blood**
    - **A Tribal census document**
    - **Documents on Tribal letterhead signed by a Tribal official**

If you don't have any of the documents above, you can provide 2 documents – one from each list below.

You can provide one of these documents:

- **U.S. public birth certificate**
- **Consular Report of Birth Abroad (FS-240, CRBA)**
- **Certification of Report of Birth (DS-1350)**
- **Certification of Birth Abroad (FS-545)**
- **U.S. Citizen Identification Card (I-197 or the prior version I-179)**
- **Northern Mariana Card (I-873)**
- **Final adoption decree showing the person's name and U.S. place of birth**
- **U.S. Civil Service Employment Record showing employment before June 1, 1976**
- **Military record showing a U.S. place of birth**
- **U.S. medical record from a clinic, hospital, physician, midwife or institution showing a U.S. place of birth**
- **U.S. life, health or other insurance record showing U.S. place of birth**
- **Religious record showing U.S. place of birth recorded in the U.S.**
- **School record showing the child's name and U.S. place of birth**
- **Federal or State census record showing U.S. citizenship or U.S. place of birth**
- **Documentation of a foreign-born adopted child who received automatic U.S. citizenship (IR3 or IH3)**

AND one of these documents (that has a photograph or other information, like your name, age, race, height, weight, eye color, or address):

- **Driver's license issued by a State or Territory or ID card issued by the Federal, state, or local government**
- **School identification card**
- **U.S. military card or draft record or Military dependent's identification card**
- **U.S. Coast Guard Merchant Mariner card**
- **Voter Registration Card**
- **A clinic, doctor, hospital, or school record, including preschool or day care records (for children under 19 years old)**
- **2 documents containing consistent information that proves your identity, like employer IDs, high school and college diplomas, marriage certificates, divorce decrees, property deeds, or titles**

IMMIGRATION STATUS

- **Reentry Permit (I-327)**
- **Permanent Resident Card, "Green Card" (I-551)**
- **Refugee Travel Document (I-571)**
- **Machine Readable Immigrant Visa (with temporary I-551 language)**
- **Temporary I-551 Stamp (on Passport or I-94/I-94A)**
- **Foreign passport**
- **Arrival/Departure Record (I-94/I-94A)**
- **Arrival/Departure Record in foreign passport (I-94)**
- **Certificate of Eligibility for Nonimmigrant Student Status (I-20)**
- **Certificate of Eligibility for Exchange Visitor Status (DS-2019)**
- **Employment Authorization Card (I-766)**
- **Notice of Action (I-797)**
- **Certification from U.S. Department of Health and Human Services (HHS) Office of Refugee Resettlement (ORR)**
- **Document indicating withholding of removal (or withholding of deportation)**
- **Administrative order staying removal issued by the Department of Homeland Security**
- **Document indicating a member of a federally-recognized Indian tribe or American Indian born in Canada**
- **Office of Refugee Resettlement (ORR) eligibility letter (if under 18)**
- **Resident of American Samoa Card**

VETERAN STATUS

- **Veteran's discharge certificate showing "Honorable" discharge**
- **Current orders showing active duty in the Army, Navy, Air Force, Marine Corps, or Coast Guard**

RESIDENCY

- **Driver's license**
- **State ID**
- **Mortgage payment receipt**

- **Mortgage deed showing primary residency**
- **Lease agreement**
- **School enrollment documentation**
- **Utility bill**
- **Government mail (SSA statement, DMV notice, etc.)**

SOCIAL SECURITY NUMBER (SSN)

- **Social Security card**
- **Tax form(s)**
- **Benefit or income statement from Social Security containing your SSN**
- **Pending application for an SSN**
- **Letter from Social Security stating that you're not eligible for an SSN or are only eligible for a non-work SSN**
- **Letter stating that you refuse to obtain an SSN for established religious objections**

IDENTITY

- **Driver's license issued by state or territory**
- **School identification card**
- **Voter registration card**
- **U.S. military draft card or draft record**
- **Identification card issued by the federal, state, or local government**
- **U.S. passport or U.S. passport card**
- **Certificate of Naturalization (Form N-550 or N-570) or Certificate of U.S. Citizenship (Form N-560 or N-561)**
- **Permanent Resident Card or Alien Registration Receipt Card (Form I-551)**
- **Employment Authorization Document that contains a photograph (Form I-766)**
- **Military dependent's identification card**
- **Native American tribal document**
- **U.S. Coast Guard Merchant Mariner card**
- **Foreign passport, or identification card issued by a foreign embassy or consulate that contains a photograph**

IF YOU CAN'T PROVIDE A COPY OF ONE OF THE DOCUMENTS ABOVE, YOU CAN SUBMIT COPIES OF 2 OF THESE DOCUMENTS:

- **Birth certificate**
- **Social Security card**
- **Marriage certificate**
- **Divorce decree**
- **Employer identification card**
- **High school or college diploma (including high school equivalency diplomas)**
- **Property deed or title**

Federal Portal income qualification when inconsistences

INCOME

- **1040 Tax return (can be Federal or state). Note: It must contain your first and last name, income amount, and tax year.**
- **Wages and tax statement (W-2 and/ or 1099, including 1099 MISC, 1099G, 1099R, 1099SSA, 1099DIV, 1099SS, 1099INT). Note: It must contain your first and last name, income amount, year, and employer name (if applicable).**
- **Pay stub. Note: It must contain your first and last name, income amount, pay period or frequency of pay with the date of payment. If a pay stub includes overtime, please indicate average overtime amount per paycheck.**
- **Self-employment ledger documentation (can be a Schedule C, the most recent quarterly or year-to-date profit and loss statement, or a self-employment ledger). Note: It must contain your first and last name, company name, and income amount. If you're submitting a self-employment ledger, include the dates covered by the ledger, and the net income from profit/ loss.**
- **Social Security Administration Statements (Social Security Benefits Letter). Note: It must contain first and last name, benefit amount, and frequency of pay.**
- **Unemployment Benefits Letter. Note: It must contain your first and last name, source/ agency, benefits amount, and duration (start and end date, if applicable).**

SELF-EMPLOYMENT

- **1040 SE with Schedule C, F, or SE (for self-employment income)**
- **1065 Schedule K1 with Schedule E**
- **Tax return**
- **Bookkeeping records Receipts for ALL allowable expenses**
- **Bank Statements (personal & business) and cancelled checks**
- **Signed time sheets and receipt of payroll, if you have employees**
- **Most recent quarterly or year-to-date profit and loss statement**

UNEARNED INCOME

- **Annuity statement**
- **Statement of pension distribution from any government or private source**
- **Worker's compensation letter**
- **Prizes, settlements, and awards, including court-ordered awards letter**
- **Proof of gifts and contributions**
- **Proof of inheritances in cash or property**
- **Proof of strike pay and other benefits from unions**
- **Sales receipts or other proof of money received from the sale, exchange or replacement of things you own**
- **Interests and dividends income statement**
- **Loan statement showing loan proceeds**
- **Royalty income statement or 1099-MISC**

- **Proof of bonus/incentive payments (like a letter of bank statement showing deposit)**
- **Proof of severance pay**
- **Pay stub indicating sick pay**
- **Letter, deposit, or other proof of deferred compensation payments**
- **Pay stub indicating substitute/assistant pay**
- **Pay stub indicating vacation pay**
- **Proof of residuals**
- **Letter, deposit, or other proof of travel/business reimbursement pay**

APPENDIX 10 PHARMACY PLAN

Pharmacy Query Plan:

Cost Analysis:
Goal: Create a list of drugs that are comparable between DHS and POs. Complete cost and claim analysis that removes bias due to variation in drug mix.

1. **Use claims for POs and DHS, same reporting period (2014)**
2. **Remove specialty pharmacy claims (See list of HICS)**
    a. **Save the Specialty pharmacy claims in a separate table for future analysis (*Name it: Quarterline Specialty Claims)***
    b. **Save the remaining claims in a separate table (*name it: Quarterline Comparable Claims)***
        i. **Create a list of top drugs by cost for DDS and POs**
        ii. **Create a list of top drug class by cost for DDS and POs**
        iii. **Analyze differences in the top 10 top drugs and top 10 classes (if see alignment 80% or better, consider the lists comparable)**
3. **Once we determine the lists are comparable (80% or more alignment), use all claims in the Quarterline Comparable Claims file, and create Quarterline comparable claims buckets (a,b,c below) and name the files as such for DDS and POs**
    a. QL comparable MAC generics (MAC= maximum allowable cost)
    b. QL comparable non-MAC generics
    c. QL comparable Brands
4. **Complete Cost Analysis by claim buckets above**
        a. **For DDS and POs, complete calculations below for Brand and Generic drugs**
        b. ~~**For POs only, complete calculations by each brand /generic code 1-4**~~ **(due to limitations with the data drilled down to brand and generic categories only)**
    c. **Sum Totals and calculate averages by claim or % of claims for the following attributes**
        . **Paid amount (sum and average per claim)**
        i. **Claims (Sum and % claims by bucket)**
        ii. **Dispensing fee (Sum and average per claim)**
        iii. **Day supply (Sum and average per claim)**
        d. **Calculate average AGE for DHS and for each POs**
        e. **Add total number of eligible members to the output table (all members who are eligible for the pharmacy benefit and not just members who have claims history for a medication)**

DHS Claim Limit:

Goal: Analyze utilization patterns for DHS, looking at claims per member per month, to assess how the claims limit of 3 - 6 claims per month impacts utilization patterns. Use all claims for this analysis (not a subset of claims as was done in the cost analysis)

1. **Use 2014 claims**
2. **Limit claims to members who are 18 year and older (DHS does not have a claims limit for members < 18 years of age)**
3. **<u>Complete the following analysis for DHS and for POs separately so we can compare and summarize key findings from the data</u>**
4. **<u>Annual Picture</u>: Sum total number of claims by unique member over a 1 year period**
   a. **Count number of unique members who received the maximum 6 claims per month over the year, 72 claims**
   b. **Consider summarize the data in a table to show number of unique members by claim bands**
      i. **>72 claims**
         We shouldn't see DHS members above this limit
      ii. **=72 claims**
         The members in this bucket, worked with their pharmacist to hit the limit-they succeeded at maximizing their medication benefit; their pharmacists likely helped them pick the most necessary medications to fill; some medically necessary medications did not get filled.
      iii. **>60 < 72 claims**
         These members are close to hitting the limit; some members in this bucket would hit the limit of 72 if they filled all of their prescriptions written to treat their chronic conditions; their utilization patterns look like a member who is not adhering to their drug therapy, looks like members dropped off of their therapy
   c. **For members who are in the following "buckets" above, "=72 claims" and "61-71", determine their medical/pharmacy utilization patterns compared to the total population**

      . **Number of hospitalizations**
      i. **Number of office visits**
      ii. **Number of ER visits**
      iii. **Average total medical spend**
      iv. **Average Age**
      v. **Number of pharmacies visited**
      vi. **Rx claims by HIC, Top HIC Class**
      vii. **Tina, claims by maintenance HICs????not sure how to get at this**
      viii. **ICD9s and descriptions (Diagnosis); Top diagnosis**
      ix. **Number of providers visited**

Top Drugs with Abusive Potential:

Drugs: Narcotics, antianxiety, amphetamines, methylphenidates, muscle relaxants, some antipsychotic drugs
Goal: Assess the DHS membership compared to POs for utilization patterns
Use the Specific HICs (see HIC list, column D "Opioid and other drug Analysis") (on 8/6/15 added HIC H3W to the HIC list, see updated HIC list)

Appendix 1. Pull claims for both DHS and POs
Appendix 2. Use 2014 claims
Appendix 3. Sum totals, calculate averages by DHS and POs Plans

a. **Sum or Count total -Dollars, claims, number of unique IDs, quantity, day supply**
b. **Calculate Averages- cost/claim; Drugs with Abusive Potential claims/total claims, unique utilizers of Drugs with Abusive Potential /total # of unique utilizers**
c. **Top drugs by utilization (number of claims) by DHS and POs Plans; average quantity/claim; average day supply per claim**
d. **Add total eligible number of members to the spreadsheets (output)**

Appendix 4. Sub-analysis narcotics only- (HIC codes- H3U and H3A)

a. **Identify unique members with a total day supply > 90 days and pull the following information**
    1. **Average age**
    2. **Top Diagnosis codes and descriptions (Michael: in interest of time, lets determine how many of these unique members have diagnosis for cancer or in hospice care**
    3. **From pharmacy claims, average unique number of prescribers (doctors)**
    4. **From pharmacy claims, average unique number of pharmacies**

Future refinement of the analysis:

Opioids:

- **Complete assessment QualChoice**
- **Identify members who are taking triple cocktail- oxycodone (generic or OxyContin), carisoprodol (Soma) alprazolam (Xanax)**
- **Co-morbid conditions, percentage of use with other substances that treat mental health disorders**

Cost Analysis:

- **Show a cost comparison between the plans for a single brand drug and generic drug. These two drugs should be common (in top 10 drug class), ideally the fill date is same across all Plans, same quantity**
- **Claim Limits**
    - **Further evaluation of comorbidities**
    - **Identify nursing home residents**

APPENDIX 11. EXCERPTS FROM RHODE ISLAND WAIVER

The Rhode Island Global Waiver Flexibility. Approved by CMS January 16, 2009

Excerpts from the Waiver:

Rhode Island has flexibility to make changes to its demonstration based on how the changes align with the categories defined below and the corresponding process in this Section paragraph 18 Process for
Changes to the Demonstration. The category of changes described below are for changes to the program as described in the STCs. Initiatives described in the STCs are approved upon approval of the demonstration.

Categories of Changes and General Requirements for Each Category. When making changes, the State must characterize the change in one of the three following categories. CMS has 15 calendar days after receiving notification of the change (either informally for Category I or formally for Categories II and III) to notify the State of an incorrect characterization of a programmatic change. To the extent the State and CMS are unable to reach mutual agreement on the characterization of the programmatic change, the CMS characterization shall be binding and non-appealable as to the procedure to be followed.

a) Category I Change: Is a change which is administrative in nature for which the State has current authority under the State plan or demonstration, and which does not affect beneficiary eligibility, benefits, overall healthcare delivery systems, payment methodologies or cost sharing. The State must notify CMS of such changes either in writing or orally in the periodic review calls and update reports as
specified in the General Reporting Section paragraphs 71 through 73. Implementation of these changes
does not require approval by CMS.

Examples of Category I changes include, but are not limited to:

- **Changes to the instruments used to determine the level of care**
- **Changes to the Assessment and Coordination Organization Structure**
- **Changes to general operating procedures**
- **Changes to provider network methodologies (provider enrollment procedures, but not delivery**
- **system changes)**
- **Changes to prior authorization procedures**
- **Adding any HCBS service that has a core definition in the 1915(c) Instructions/Technical**
- **Guidance if the State intends to use the core definition.**
- **Modifying an HCBS service definition to adopt the core definition.**

b) Category II Change: Is a change that could be made as a State Plan Amendment or through authority in sections 1915(b), 1915(c), 1915(i) or 1915(j) without any change in either the STCs, or the

section 1115 waiver and expenditure authorities. These changes may affect benefit packages, overall healthcare delivery systems, cost sharing levels, and post-eligibility contributions to the cost of care. Such changes do not, however, include changes that affect beneficiary eligibility (including changes to the level of spenddown eligibility). The State must comply with its existing State Plan Amendment public notice process prior to implementation. The State must also notify CMS in writing of Category II changes prior to implementation, and must furnish CMS with appropriate assurances and justification, that include but are not limited to the following:

i) That the change is consistent with the protections to health and welfare as appropriate to title XIX of the Act, including justification;
ii) That the change results in appropriate efficient and effective operation of the program, including justification and response to funding questions;
iii) That the changes would be permissible as a State Plan or section 1915 waiver amendment; and that the change is otherwise consistent with sections 1902, 1903, 1905, and 1906, current Federal regulations, and CMS policy; and
iv) Assessment of the cost of the change.

CMS will not provide Federal matching funds for activities affected by unapproved but implemented Category II changes.

Examples of Category II changes include, but are not limited to:

- **Changes to the ICF/MR, hospital or nursing home level of care criteria that are applied prospectively (not to existing long term care or HCBS recipients);**
- **Adding any HCBS service for which the State intends to use a definition other than the core definition. (The service definition must be included with the assurances.);**
- **Modifying any HCBS service definition unless it is to adopt the core definition;**
- **Adding an "other" HCBS service that does not have a core definition. (The service definition must be included with the assurances.);**
- **Removing any HCBS service that is at that time being used by any participants;**
- **Change/modify or end RIte Share premium assistance options for otherwise eligible individuals;**
- **Changes to payment methodologies for Medicaid covered services including, but not limited to DRG payments to hospitals or acuity based payments to nursing homes;**
- **Healthy Choice Accounts Initiatives;**
- **Addition or elimination of optional State plan benefits;**
- **Changes in the amount, duration and scope of State plan benefits that do not affect the overall sufficiency of the benefit;**
- **Benefit changes in accordance with the DRA Benchmark flexibility; and**
- **Cost-Sharing Changes up to the DRA limits unless otherwise defined in the STCs or currently waived.**

c) Category III Change: Is a change requiring modifications to the current waiver or expenditure authorities including descriptive language within those authorities and the STCs, and any other change that is not clearly described within Categories I and II. In addition, a programmatic change may be categorized as a Category III change by the State to obtain reconsideration after unsuccessfully pursuing approval of the change under Category II. The State must comply with the section 1115

demonstration public notice process as described in paragraph 14 of these STCs. The State must notify CMS in writing of Category III changes, and submit an amendment to the demonstration as described in paragraph 18: Process for Changes to the Demonstration. Category III changes shall not be implemented until after approval of the amendment by CMS.

Examples of Category III changes:

- **All Eligibility Changes**
- **Changes in EPSDT**
- **Spend down level changes**
- **Aggregate cost-sharing changes that are not consistent with DRA cost sharing flexibility (would exceed 5 percent of family income unless, otherwise specified in these STCs);**
- **Benefit changes are not in accordance with DRA benchmark flexibility;**
- **Post-eligibility treatment of income; and**
- **Amendments requesting changes to the budget neutrality cap.**

Process for Changes to the Demonstration. The State must submit the corresponding notification to CMS for any changes it makes to the demonstration as characterized in the Category I, II or III definitions section depending on the level of change. CMS will inform the State within 15 calendar days of any correction to the State's characterization of a change, which shall be binding and non-appealable as to the procedure for the change. The State must also have a public notice process as described below for Category II and III changes to the demonstration.

a) Process for Category I Changes: The State must notify CMS of any changes to the demonstration defined as a Category I change 30 calendar days before implementing the change. The State must also report these changes in the quarterly and annual reports for purposes of monitoring the demonstration. The State does not need CMS approval for changes to the demonstration that are Category I changes.

i) If CMS determines at any time subsequent to State implementation of a Category I change that it is not consistent with State assurances, or is contrary to Federal statutes, regulations or CMS policy then CMS reserves the right to take action to request prompt State corrective action as a condition of continued operation of the demonstration. If the State does not take appropriate action CMS reserves the right to end the demonstration per Paragraph 10 of these STCs.

b) Process for Category II Changes: The State will notify CMS of any changes to the demonstration defined as a Category II change. This notification will include assurances that the change is consistent with Federal statutes, regulations and CMS policy. No federal funding shall be available for unapproved demonstration activities affected by a Category II change.

The State must submit the notification and assurances 45 calendar days prior to the date set by the State for implementing the change. CMS will not provide Federal matching funds for unapproved Category II changes. After receipt of the State's written notification, CMS will notify the State:

i) within 45 calendar days of receipt if the assurances supporting the change are approved; or
ii) within 45 calendar days of receipt if the assurances do not establish that the change is consistent with Federal statutes, regulations and CMS policy. As part of the notification CMS will describe the

missing information, necessary corrective actions and/or additional assurances the State must pursue to make the change consistent.
iii) During days 46 and beyond CMS will be available to work with the State. During this time period the State can provide to CMS additional justification or assurance in order to clarify the appropriateness of the change.
iv) During days 46 through 75 the State upon taking appropriate action, must submit a written statement to CMS indicating how the State has addressed CMS concerns on the assurances. Within 15 calendar days of the date of the additional submission CMS will notify the State if the assurances are approved.
v) By day 90 if the assurances have not been approved by CMS, then the State may obtain reconsideration by pursuing the change again as a revised Category II change if the State has additional
information or as a Category III change.
vi) If CMS determines at any time subsequent to State implementation of an approved Category II change that the assurances are no longer valid, CMS shall request prompt State corrective action as a condition of continued operation of the demonstration.
vii)After implementation FFP is available for approved changes.

c) Process for Category III Changes. The State must submit an amendment to the demonstration as defined in the paragraphs below.

i) All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The State must not implement changes to these elements without prior approval by CMS. Amendments to the Demonstration are not retroactive and FFP will not be available for changes to the Demonstration that have not been approved through the amendment process set forth in paragraph c) ii) below. The State will notify CMS of proposed Demonstration changes at the monthly monitoring call, as well as in the written quarterly report, to determine if a formal amendment is necessary.
ii) Requests to amend the Demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. Amendment requests must be reviewed by the Federal Review Team and must include, but are not limited to, the following:

(1) An explanation of the public process used by the State consistent with the requirements of paragraph 14 to reach a decision regarding the requested amendment;
(2) A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality expenditure cap. Such analysis must include current "with waiver" and "without waiver" status on both a summary and detailed level through the current extension approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment which isolates (by Eligibility Group) the impact of the amendment;
(3) An up-to-date SCHIP Allotment Neutrality worksheet;
(4) A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation including a conforming title XIX and/or title XXI State plan amendment if necessary; and
(5) If applicable, a description of how the evaluation design must be modified to incorporate the amendment provisions.

GLOSSARY

The following provides a look-up of the key terms used in this report, and in the discussions that have taken place during the TSG assessment project.

AARP	**American Association of Retired Persons**
ABD	**Aged, Blind and Disabled programs and beneficiaries**
ACA (or PPACA)	**Patient Protection and Affordable Care Act of 2010**
ACEP	**American College of Emergency Physicians**
ACHE	**American College of Healthcare Executives (ACHE) an international professional society of 30,000 healthcare executives who lead our nation's hospitals, healthcare systems, and other healthcare organizations**
ACO	**Accountable Care Organization**
Actuarially Sound	**The federal statutory standard to which capitation payments made by state Medicaid programs under risk contracts to managed care organizations (MCOs) are held. See Capitation Payment, MCO, Risk Contract.**
ADA	**American Dental Association (ADA) is a professional association of dentists committed to the public's oral health, ethics, science and professional advancement.**
ADA	**The Americans with Disabilities Act (ADA) is a wide-ranging civil rights law that prohibits discrimination based on disability. It is similar to the Civil Rights Act of 1964, which makes it illegal to discriminate because of race, sex, religion, national origin and other characteristics.**
ADC	**Adult Day Care (ADC) provides daily structured programs in a community setting, with activities plus health-related and rehabilitation services for older adults who are physically or emotionally disabled and need a protective environment. Care is provided during daytime hours and the individual returns to his or her home for the night. Adult day care is offered at a special facility or as a service of another type of care facility, such as a nursing home or assisted living residence.**
ADHD	**Attention Deficit Hyperactivity Disorder**
ADRC	**Aging and Disability Resource Centers**
ADS	**Alternate Delivery System (ADS) health services that are more cost-effective than inpatient, acute-care hospitals, such as skilled and intermediary nursing facilities, hospice programs and in-home services.**
AFDC	**Aid to Families with Dependent Children (AFDC) is a program administered and funded by Federal and State governments to provide financial assistance to needy families. In an average state, more than half (55 percent) of the total cost of AFDC payments are funded by the Federal government. The States provide the balance of these payments, manage the program and determine who receives benefits and how much they get.**
AFMC	**Arkansas Foundation for Medical Care**
AHCPII	**Arkansas Health Care Payment Improvement Initiative**
AHRQ	**Agency for Healthcare Research and Quality**
AIPP	**Arkansas Innovative Performance Program**
AL	**Assisted Living Waiver**

ALOS	**Average Length of Stay (ALOS) in hospitals it is calculated by dividing the sum of inpatient days by the number of patients within the diagnosis-related group category. Inpatient days are calculated by subtracting day of admission from day of discharge, so persons entering and leaving a hospital on the same day have a length of stay of zero.**
AMA	**The American Medical Association (**
AMP	**Average Manufacturer Price. The average price paid to a drug manufacturer in the U.S. by wholesalers for drugs distributed to retail pharmacies. Used in calculating the amount of the rebate participating manufacturers are required to pay on covered outpatient drugs purchased by state Medicaid programs.**
APCs	**Ambulatory Payment Classifications**
APDU	**Advanced Planning Directive**
APHSA	**American Public Health Services Association. The National Collaboration leadership and membership including state and local government health and human services leaders**
APR-DRG	**All Patient Refined - Diagnosis Related Groups. Has a much more rigorous and refined severity adjustment compared to DRG**
AR	**Accounts Receivable (AR) is the area that funds are paid to reimburse Medicaid.**
ARRA	**American Recovery and Reinvestment Act**
ARS	**Automated Response System**
ASC	**An Ambulatory Surgical Center (ASC) is a licensed facility that is used mainly for performing outpatient surgery, has a staff of physicians, has continuous physician and nursing care by registered nurses and does not provide for overnight stays.**
ASH	**Arkansas State Hospital**
AWP	**Any Willing Provider**
BBA	**The Balanced Budget Act (BBA) signed into law by the President on Aug. 5, 1997 contains the largest reductions in federal Medicaid spending in Medicaid since 1981. The legislation is projected to achieve gross federal Medicaid savings of $17 billion over the next five years and $61.4 billion over the next ten years.**
BCBS	**Blue Cross Blue Shield of Arkansas**
Beneficiary	**An individual who is eligible for and enrolled in the Medicaid program in the state in which he or she resides. Millions of individuals are eligible for Medicaid but not enrolled and are therefore not program beneficiaries.**
Best Price	**The lowest price on a prescription drug available from a manufacturer to any wholesaler, retail pharmacy, provider, or managed care organization, subject to certain exceptions. Used in calculating the amount of the rebate participating manufacturers are required to pay on covered outpatient drugs (other than generic drugs) purchased by state Medicaid programs.**
BIP	**Balancing Initiatives Program**
BKD	**CPA firm that provides audit tax and consulting services in Little Rock**
BLR	**Arkansas' Bureau of Legislative Research**
Boren Amendment	**The requirement in federal Medicaid law from 1980 until 1997 that states pay for inpatient hospital and nursing facility services using rates that are "reasonable and adequate" to meet the costs that must be incurred by efficiently and**

	economically operated facilities in order to provide care and services in conformity with federal and state quality and safety standards.
BPM	**Business Process Management**
BPR	**Business process reengineering**
CABG	**Coronary artery bypass graft. A form of bypass surgery**
CAH	**Critical Access Hospital (CAH) a rural limited medical services hospital that provides short-term inpatient and emergency hospital services.**
CAI	**Computer Aid Inc. Independent Verification and Validation Vendor**
Caid/Care	**Caid-Care, Inc. Specializes in assisting families with placement into Managed Home Care Services facilities**
CANS	**Child and Adolescent Needs and Strengths Assessment instrument. Developed by J. Lyons. MD; open domain; copyright held by Buddin Praed Foundation**
CAP	**Corrective Action Plan (CAP) documentation for implementing activities structured to remedy a problem, and what will happen if the problem is not resolved. Includes a specific time frame for the remedy to be implemented.**
Capitation Payment	**A payment made by a state Medicaid agency under a risk contract, generally to a managed care organization (MCO). The payment is made on a monthly basis at a fixed amount on behalf of each Medicaid beneficiary enrolled in the MCO. In exchange for the capitation payment, the MCO agrees to provide (or arrange for the provision of) services covered under the contract with the state Medicaid agency to enrolled Medicaid beneficiaries. See fee-for-service, MCO, Risk Contract.**
CARES	**Comprehensive Adult Resources Evaluation System. Preadmission assessment of strengths and needs of individuals at risk for institutional settings, plan of care, expanded case management capabilities**
Carve Out	**The term used to describe the exclusion of certain services to which Medicaid beneficiaries are entitled from a risk contract between a state Medicaid agency and an MCO**
Categorical Eligibility	**A phrase describing Medicaid's policy of restricting eligibility to individuals in certain groups or categories, such as children, the aged, or individuals with disabilities. Certain categories of individuals**
Categorically Needy	**A phrase describing certain groups of Medicaid beneficiaries who qualify for the basic mandatory package of Medicaid benefits. For example, Arkansas Medicaid is required to cover pregnant women and infants with incomes at or below 133 percent of the Federal Poverty Level (FPL)**
CBO	**Community Based Organizations for services such as training, finding and accessing members in need, home visits and traditional waiver services**
CCD	**Continuity of Care Document (CCD) is a spreadsheet-based document containing the encoding, structure and semantics of a patient's clinical summary document for exchange.**
CCM	**Certified Case Manager**
CCNC	**Community Care North Carolina**
CCO	**Coordinated Care Organizations**
CDC	**US Centers for Disease Control and Prevention**

CDT	**The Current Dental Terminology (CDT) is a publication copyrighted by the American Dental Association (ADA) that lists codes for billing for dental procedures and supplies. The CDT is included in HCPCS level II.**
Center for Medicaid and State Operations (CMSO)	**The agency within the Centers for Medicare and Medicaid Services (CMS) with responsibility for administering Medicaid and the Children's Health Insurance Program (SCHIP).**
Centers for Medicare and Medicaid Services (CMS)	**The agency in the Department of Health and Human Services with responsibility for administering the Medicaid, Medicare, and State Children's Health Insurance programs at the federal level. Formerly known as the Health Care Financing Administration (HCFA).**
CFCO	**Community First Choice Option is a Medicaid-funded program that could provide a broad range of home and community-based services and supports for elders**
CFO	**Chief Financial Office**
CFR	**Code of Federal Regulations**
CG	**Class Group Code required on the Medicaid claim form.**
CHAMPUS	**Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) a federally funded health program that provides beneficiaries with medical care supplemental to that available in military and Public Health Service (PHS) facilities.**
Children's Health Insurance Program (SCHIP)	**Enacted in the 1997 Balanced Budget Act as Title XXI of the Social Security Act, SCHIP is a federal-state matching program of health care coverage for uninsured low-income children. In contrast to Medicaid, SCHIP is a block grant to the states; eligible low-income children have no individual entitlement to a minimum package of health care benefits**
CHIP	**The Children's Health Insurance Program (CHIP) is a joint federal and state program that provides health insurance coverage to low-income uninsured children.**
CHIRPA	**Comprehensive Health Insurance Risk Pool Association**
CIM	**Carrier Information Module (CIM) data on insurance companies with whom Medicaid beneficiaries have medical coverage.**
CISR	**MIT's Center for Information Systems Research**
Civil Money Penalty (CMP)	**An intermediate sanction (i.e., less drastic than exclusion from participation in the program) applied to participating providers and managed care plans that are found to have engaged in program fraud or have violated certain program requirements.**
CLIA	**Clinical Laboratory Improvement Congress passed the Clinical Laboratory Improvement Amendments (CLIA) in 1988 establishing quality standards for all laboratory testing to ensure the accuracy, reliability and timeliness of patient test results regardless of where the test was performed. Centers for Medicare & Medicaid Services (CMS) assumes primary responsibility for financial management operations of the CLIA program.**
CMHC	**Community Mental Health Center (CMHC) a comprehensive mental health center which provides outpatient therapy and emergency mental health services.**
CMMI	**Center for Medicare and Medicaid Innovation, part of CMS**

CMN	**Certificate of Medical Necessity (CMN) a form required by Medicare authorizing the use of certain medical services and equipment prescribed by a physician.**
CMS	**Center for Medicare and Medicaid Services is the federal agency which administers the Medicare program and works in partnership with the States to administer Medicaid, the State Children's Health Insurance Program (SCHIP), and health insurance portability standards. In addition to these programs, CMS has other responsibilities, including the administrative simplification standards for the Health Insurance Portability and Accountability Act of 1996 (HIPPA), quality standards in health care facilities through its survey and certification activity, and clinical laboratory quality standards.**
CMS 1500	**Form prescribed by CMS for the Medicare program for claims from physicians and suppliers, except for ambulance services**
CMSA	**Case Management Society of America**
CNP or NP	**Certified Nurse Practitioner (CNP) is a registered nurse (RN) who has completed an advanced training program in a medical specialty such as pediatrics or internal medicine**
COB	**Coordination of Benefits (COB) a common provision in most benefit plans. It applies when a member has more than one health coverage plan in effect at the time services are rendered.**
COBRA	**Consolidated Omnibus Budget Reconciliation Act of 1985 a federal law, enforced by the US Department of Labor, Pension and Welfare Benefits Administration, which provides continuation of group health coverage that otherwise might be terminated. The law contains provisions giving certain former employees, retirees, spouses and dependent children the right to temporary continuation of health coverage at group rates.**
Comparability	**A rule of Medicaid benefits design that requires a state to offer services in the same amount, duration, and scope to one group of categorically needy individuals (e.g., poverty-related children) as it offers to another group of categorically needy individuals (e.g., elderly SSI recipients). See Amount, Duration, and Scope; Categorically Needy.**
Continuous Eligibility	**An option available to states under federal Medicaid law whereby children enrolled in Medicaid may remain eligible for a continuous period of 12 months, regardless of intervening changes in family income or status.**
Copayment	**A fixed dollar amount paid by a Medicaid beneficiary at the time of receiving a covered service from a participating provider. Copayments, like other forms of beneficiary cost-sharing (e.g., deductibles, coinsurance), may be imposed by state Medicaid programs only upon certain groups of beneficiaries, only with respect to certain services, and only in nominal amounts as specified in federal regulation.**
COPD	**Chronic Obstructive Pulmonary Disease**
COS	**Category of Service (COS) code required on the Medicaid claim form.**
CPS	**Child Protective Services**
CPT	**Current Procedural Terminology (CPT) book contains codes approved for use by medical providers to request payment for a particular medical service.**
CQM	**Clinical Quality Measures**
CR	**Carrier Term (CT) applied to a medical insurance company with who a Medicaid beneficiary has coverage.**

CRBA	**Consular Report of Birth Abroad**
CRH	**Center for Rural Health**
CRNA	**Certified Registered Nurse Anesthetist an advanced practice nurse who administers anesthesia.**
CRRN	**Certified Rehabilitation Registered Nurse**
CSA	**See CMSA**
CSR	**Computer System Request (CSR) the means by which requests from authorized Medicaid staff for enhancements and modifications to the MMIS are submitted to the Fiscal Agent.**
CSR	**Cost-Sharing Reduction: advance payments made by Private Option members (akin to co-pay)**
DAAS	**Division of Aging and Adult Services**
DAC	**Disabled Adult Child**
DBHS	**Arkansas Division of Behavioral Health Services**
DCLH	**Disabled Child Living at Home (DCLH), better known as the Katie Beckett Program, the Disabled Child Living at Home is a special program where children who do not meet eligibility for other Medicaid programs due to their parents' high income or assets can qualify for Medicaid if the child meets certain defined criteria.**
DD	**Developmentally Disabled**
DDS	**Developmentally Disabled Services**
DDTC	**Developmental Day Treatment Clinic**
DDTCS	**Developmental Day Treatment Clinic Services**
De-Linking	**The informal term used to refer to breaking the historic link between eligibility for cash assistance under Aid to Families with Dependent Children (AFDC) and eligibility for Medicaid. The process of de-linking began in the mid-1980s with the enactment of optional eligibility groups of poverty-related pregnant women and children and continued with the repeal of the AFDC program in 1996 and the enactment of a new section 1931 eligibility group. See Poverty-Related, Section 1931.**
Departmental Appeals Board (DAB)	**The agency within the Department of Health and Human Services that adjudicates disputes between CMS and state Medicaid agencies regarding disallowances of federal matching payments and hears appeals of CMS or OIG decisions to impose civil money penalties or exclusions on providers.**
DERP	**Drug Effectiveness Review Project**
DHA	**Delta Health Alliance**
DHB	**North Carolina Division of Health Benefits**
DHCF	**Department of Health Care Finance (DHCF), formerly the Medical Assistance Administration under the Department of Health, is the District of Columbia's state Medicaid agency**
DHH	**Department of Health & Hospitals, State of Louisiana**
DHHS	**U.S. Department of Health and Human Services**
DHS	**Arkansas Department of Human Services**
DHS/DBHDS	**Virginia Behavioral Health and Development Services**

Disallowance	**A determination by CMS not to provide federal Medicaid matching payments to a state in connection with an expenditure made by the state's Medicaid program because the expenditure does not meet federal requirements for matching payments. States may appeal CMS disallowances to the Departmental Appeals Board (DAB) and to federal court. See Departmental Appeals Board. Disregards**
Disproportionate Share Hospital (DSH) Payments	**Payments made by a state's Medicaid program to hospitals that the state designates as serving a "disproportionate share" of low-income or uninsured patients. These payments are in addition to the regular payments such hospitals receive for providing inpatient care to Medicaid beneficiaries. States have some discretion in determining which hospitals qualify for DSH payments and how much they receive. The amount of federal matching funds that a state can use to make payments to DSH hospitals in any given year is capped at an amount specified in the federal Medicaid statute.**
DME	**Durable Medical Equipment (DME) is equipment that can be used over and over again; is ordinarily used for medical purposes; and is generally not useful to a person who isn't sick, injured or disabled.**
DMH	**Department of Mental Health**
DMS	**Arkansas Division of Medicaid Services, Office of Long Term Care**
DMS/OLTC	**Arkansas Division of Medicaid Services**
DMV	**Arkansas Department of Motor Vehicles**
DO	**Doctor of Osteopathy is a doctor with a degree in osteopathy which is therapy based on the assumption that restoring health is best accomplished by manipulating the skeleton and muscles.**
DOB	**Date of Birth**
DOD	**Date of Death, the date upon which a person's death occurs.**
DOE	**Date of Eligibility**
DOH	**Arkansas Department of Health**
DOI	**Department of Insurance responsible for admitting, licensing, and regulating insurance companies as well as regulating the various kinds of insurance sold in the state, in addition to the companies and agents selling it.**
DOS	**Date of Service, is the date a beneficiary received a medical service.**
DRA	**Deficit Reduction Act of 2005**
DRG	**Diagnosis Related Groups, is a system of classification of diagnoses and procedures based on the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM).**
Drug Use Review (DUR)	**The program of prospective and retrospective review of prescriptions paid for by a state Medicaid program that each state is required to conduct in order to ensure that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical outcomes.**
DSH	**See Disproportionate Share Hospital Payments**
DSRIP	**Delivery System Reform Incentive Payment**
DSS	**Decision Support System**
Dual Eligibles	**A term used to describe an individual who is eligible both for Medicare and for full Medicaid coverage, including nursing home services and prescription drugs, as well as for payment of Medicare premiums, deductibles, and co-insurance. Some**

	Medicare beneficiaries are eligible for Medicaid payments for some or all of their Medicare premiums, deductibles, and co-insurance requirements, but not for Medicaid nursing home or prescription drug benefits.
DUR	**Drug Utilization Review Board a quality assurance body which seeks to assure appropriate drug therapy to include optimal patient outcomes and appropriate education for physicians, pharmacists, and the patient**
E&D	**Elderly and Disabled**
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services	**One of the services that states are required to include in their basic benefits package for all Medicaid-eligible children under age 21. EPSDT services include periodic screenings to identify physical and mental conditions as well as vision, hearing, and dental problems. EPSDT services also include follow-up diagnostic and treatment services to correct conditions identified during a screening, without regard to whether the state Medicaid plan covers those services with respect to adult beneficiaries.**
ED	**Emergency Department, Emergency Room**
EDI	**Electronic Data Interchange is the electronic transmission of structured data between organizations.**
EEF	**Arkansas Eligibility & Enrollment Framework, a project to develop a new eligibility processing system**
EFT	**Electronic Funds Transfer is the transfer of money initiated through electronic terminal, automated teller machine, computer, telephone or magnetic tape.**
EHR	**Electronic Health Records**
EMR	**Electronic Medical Records**
Enrollment Broker	**The term used to describe an organization, usually a private entity, that contracts with a state Medicaid agency to inform Medicaid beneficiaries about, enroll them in, and disenroll them from MCOs and PCCMs participating in the state's Medicaid program.**
Entitlement	**A program that imposes a legal obligation on the federal government to any person, business, or unit of government that meets the criteria set in law.**
EOB	**Explanation of Benefits (EOB) statement of the action taken on claims filed by medical providers for services rendered for the treatment of a patient.**
EOC	**Episodes of Care**
EOMB	**Explanation of Medicaid Benefits (EOMB) statement sent to a Medicaid beneficiary detailing services submitted/action taken on claims filed by Medicaid providers for services rendered to a Medicaid beneficiary.**
EPO	**Exclusive Provider Organization (EPO) limited healthcare provision: a health insurance plan that will reimburse the insured only for care received from particular providers.**
ePrescribing	**Electronic Prescribing, entails the process of electronically transmitting an error-free prescription from a prescriber to a pharmacy for fulfillment.**
EPSDT	**See Early and Periodic Screening, Diagnosis and Treatment**
EQRO	**See External Quality Review Organization**
ER	**Emergency Room (ER), is a room in a hospital or clinic staffed and equipped to provide emergency care to persons requiring immediate medical treatment.**
Error Rates	**Refers to the percentage of Medicaid payments made by a state on the basis of erroneous Medicaid eligibility determinations. For this purpose, an error occurs**

	when an individual who is not in fact eligible is incorrectly enrolled in the program and a payment is made on that individual's behalf to a provider or plan. States are subject to the loss of federal Medicaid matching funds if their "error rate"
ESC	**Electronic Submission Claims a claim that is submitted via electronic media.**
ESDPT	**mandated child health component of Medicaid**
Estate Recovery	**The requirement that state Medicaid programs seek to collect from the estate of a deceased Medicaid beneficiary the amounts paid on the individual's behalf for nursing facility services, home and community-based services, and related hospital and prescription drug services.**
Exclusion	**A sanction imposed upon providers or managed care plans for certain fraudulent conduct, usually by the Office of Inspector General (OIG) or a state Medicaid fraud control unit (MFCU). An excluded provider or plan may not receive Medicaid reimbursement during the period of exclusion, which varies with the nature and severity of the offense. See MFCU, OIG.**
External Quality Review Organization (EQRO)	**A private entity that conducts the required annual, external independent reviews of the quality and accessibility of services for which state Medicaid agencies have entered into risk contracts with Medicaid MCOs. See MCO, Risk Contract.**
F&A	**Fraud and Abuse**
FA	**Fiscal Agent**
Fair Hearing	**Because Medicaid is an entitlement, individuals have a statutory right to appeal denials or terminations of Medicaid benefits to an independent arbiter. The fair hearing is the administrative procedure that provides this independent review with respect to individuals who apply for Medicaid and are denied enrollment, individuals enrolled in Medicaid whose enrollment is terminated, and Medicaid beneficiaries who are denied a covered benefit or service.**
FDA	**The Food and Drug Administration (FDA) agency of the Public Health Service division of the U.S. Department of Health and Human Services is charged with protecting public health by ensuring that foods are safe and pure, cosmetics and other chemical substances harmless and products safe, effective and honestly labeled.**
Federal Financial Participation (FFP)	**The technical term for federal Medicaid matching funds paid to states for allowable expenditures for Medicaid services or administrative costs. States receive FFP for expenditures for services at different rates, or FMAPs, depending on their per capita incomes. FFP for administrative expenditures also varies in its rate, depending upon the type of administrative cost. See FMAP.**
Federal Medical Assistance Percentage (FMAP)	**The statutory term for the federal Medicaid matching rate**
Federal Poverty Level (FPL)	**The federal government's working definition of poverty that is used as the reference point for the income standard for Medicaid eligibility for certain categories of beneficiaries. Adjusted annually for inflation and published by the Department of Health and Human Services in the form of Poverty Guidelines.**

Federally Qualified Health Center (FQHC)	**Primary care and other ambulatory care services provided by community health centers and migrant health centers funded under section 330 of the Public Health Service Act, as well as by "look alike" clinics that meet the requirements for federal funding but do not actually receive federal grant funds. FQHC status also applies to health programs operated by Indian tribes and tribal organizations or by urban Indian organizations.States are required to include services provided by FQHCs in their basic Medicaid benefits package.**
Fee-For-Service	**A traditional method of paying for medical services under which doctors and hospitals are paid for each service they provide. Bills are either paid by the patient who then submits them to the insurance company or are submitted by the provider to the patient's insurance carrier for reimbursement.**
FFM	**Federally-Facilitated Marketplace (FFM). Implementation of ACA in states that have chosen not to build their own Marketplace**
FFP	**Federal Financial Participation. The federal government pays states for a specified percentage of program expenditures, called the Federal Medical Assistance Percentage (FMAP).**
FFS	**Fee for Service (FFS) pertaining to the charging of fees for specific services rendered in health care, as distinguished from participating in a prepaid medical practice.**
FHA	**Federal Health Architecture (FHA), an E-Government Line of Business initiative managed by the Office of the National Coordinator for Health IT. FHA was formed to coordinate health IT activities among the more than 20 Federal Agencies that provide health and healthcare services to citizens.**
Financial Eligibility	**In order to qualify for Medicaid, an individual must meet both categorical and financial eligibility requirements. Financial eligibility requirements vary from state to state and from category to category, but they generally include limits on the amount of income and the amount of resources an individual is allowed to have in order to qualify for coverage.**
FMAP	**Federal Medical Assistance Percentage. The percentage rates used to determine the matching funds rate allocated annually to certain medical and social service programs**
FNP	**Family Nurse Practitioner**
Formulary	**States that elect to cover prescription drugs in their Medicaid programs may limit the drug products covered through the use of a formulary, a listing of the specific drugs for which a state will make payment without prior authorization. States may exclude from their formularies specific drugs of manufacturers participating in the Medicaid rebate programs only if certain criteria are met and only if the excluded drug is made available through a prior authorization program.**
FPL	**Federal Poverty Level**
FPW	**Family Planning Waiver (FPW) a Medicaid program for women 15-44 years of age that covers selected family planning services and supplies.**
FQHC	**Federally Qualified Health Clinic (FQHC) is a center that provides health care to a medically under-served populations.**
FTE	**Full Time Equivalent. Measure of staffing**
FY	**Fiscal Year**
GDIT	**General Dynamics Information Technology**

GF	**General Fund**
GINA	**Genetic Information Nondiscrimination Act of 2008**
GMLOS	**Geometric Mean Length of Stay**
GUI	**Graphical User Interface**
H/HS	**Health and Human Services**
HBE	**Health Benefit Exchange**
HCBC	**Home and Community Based Care**
HCBS	**Home and Community Based Services provides individualized assistance with daily living activities to people with disabilities through Medicaid's optional personal care services program.**
HCIA	**Health Care Improvement Act**
HCIP	**Health Communications Internship Program**
HCPCS	**The Healthcare Common Procedure Coding System (HCPCS) is the required code set for substances, equipment, supplies and other items used in health care.**
HCPII	**Arkansas Health Care Payment Improvement Initiative**
HDS	**Health Data System**
Health Insurance Portability and Accountability Act of 1996 (HIPAA)	**The Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, which requires each state's Medicaid management information system (MMIS) to have the capacity to exchange data with the Medicare program and contains "Administrative Simplification" provisions that require state Medicaid programs to use standard, national codes for electronic transactions relating to the processing of health claims.**
HEDIS	**Healthcare Effectiveness Data and Information Set. A tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service**
HEIDIS	**Health Plan Employer Data and Information Set**
HH	**Home Health (HH) services cover a broad range of services including: high tech pharmacy services, skilled professional and paraprofessional services, custodial care, and medical equipment provided or delivered to the home.**
HHA	**A Home Health Agency (HHA) is a public or private agency that provides skilled nursing care, physical therapy, speech therapy and other therapeutic services in the patient's home.**
HHS	**The Department of Health and Human Services (HHS) is the United States department that administers all federal programs dealing with health and welfare.**
HHSC	**Health and Human Services Hierarchical Condition Categories risk adjustment model**
HIC	**Hierarchical Ingredient Code ("HIC") was created by First Data Bank. The HIC is a 6-character code that identifies the drug**
HIPAA	**The Health Insurance Portability and Accountability Act of 1996**
HIT	**Health Information Technology**
HITECH	**The Health Information Technology for Economic and Clinical Health Act, enacted as part of the American Recovery and Reinvestment Act of 2009**
HMA	**Health Management Associates**

HMO	**A Health Management Organization (HMO) is group insurance that entitles members to services of participating hospitals and clinics and physicians.**
Home- and Community-Based Services (HCBS) Waiver	**Also known as the "1915(c) waiver" after the enabling section in the Social Security Act, this waiver authorizes by CMS in order to ensure that the facilities meet quality requirements and that the surveys of these facilities conducted by state survey agencies are adequate.**
HRSA	**The Health Resources Services Administration (HRSA) is a research grant to collect and analyze data that describe the characteristics of the uninsured.**
HSP	**Hospice (HSP) used in terminology associated with beneficiary's lock in segment for Home and Community Based Services.**
IAPD	**Implementation Advance Planning Document**
ICD	**International Classification of Diseases**
ICD-10	**International Classification of Diseases, tenth revision**
ICD-9-CM	**International Classification of Diseases Ninth Edition Clinical Modification**
ICF	**An Intermediate Care Facility is a health care facility that provides care and services to individuals who do not need skilled nursing care, but whose mental or physical condition requires more than custodial care and services in an institutional setting.**
ICF/ID	**Institutional Care Facilities for Intermediate care**
ICF/MR	**Intermediate Care Facilities for the Mentally Retarded or related conditions provides twenty-four hour supervision and training, and is regulated through requirements established by Medicaid.**
ICN	**An Internal Control Number (CN) is a unique identifier for a claim line assigned by the MMIS.**
ICU	**An Intensive Care Unit (ICU) is a hospital unit staffed and equipped to provide intensive care.**
ID/DD	**Intellectual Disabilities/ Developmental Disabilities Waiver**
IDEA	**Individuals with Disabilities Education Act (IDEA) is the federal law which safeguards a child with a disability's right to a free and appropriate public education.**
IEP	**An Individualized Education Plan (IEP) is a written document that outlines a child's education. As the name implies, the educational program should be tailored to the individual student to provide maximum educational benefit.**
IFSP	**Individualized Family Service Plan see EI/TCM**
IHE	**Integration the Healthcare Enterprise (IHE) is an initiative by healthcare professionals and industry to improve the way computer systems in healthcare share information. IHE promotes the coordinated use of established standards such as DICOIM and HL7 to address specific clinical needs in support of optimal patient care.**
IHS	**Indian Health Services**
IP	**Inpatient is a term for patients who receives lodging and food, as well as treatment, in a hospital or an infirmary.**
IT	**Information Technology**
IV&V	**Independent Verification and Validation**
IV-E	**Federal foster care program**

IWG	**Interagency Working Group**
JCHO	**The Joint Commission on Accreditation of Healthcare Organizations (JCHO) is the predominant health care standards-setting and accrediting organization in the U.S. Their mission is to continually improve the safety and quality of patient care by providing accreditation, education and consultation services.**
LBO	**Legislative Budget Office**
LCSW	**Licensed Certified Social Worker (LCSW) individuals having an education that includes a Masters degree in social work (M.S.W.) and post M.S.W. supervised experience in clinical social work.**
LOCUS	**Level of Care Utilization System Assessment instrument: American Association of Community Psychiatrists**
LOS	**Length of Stay (LOS) is calculated by dividing the sum of inpatient days by the number of patients within the DRG category.**
LPN	**Licensed Practical Nurse**
LTC	**Long Term Care (LTC) includes any chronic or disabling condition which requires nursing care or constant supervision.**
LTSS	**Medicaid Managed Long Term Services and Supports**
MAGI	**Modified Adjusted Gross Income**
Managed Care Entity (MCE)	**The federal statutory term for a managed care plan participating in Medicaid. There are two types of MCEs: managed care organizations (MCOs) and primary care case managers (PCCMs). MCEs may be public or private.**
Managed Care Organization (MCO)	**An MCO is an entity that has entered into a risk contract with a state Medicaid agency to provide a specified package of benefits to Medicaid enrollees in exchange for an actuarially sound monthly capitation payment on behalf of each enrollee. See Actuarially Sound, Capitation Payment and Risk Contract.**
Mandatory	**State participation in the Medicaid program is voluntary. However, if a state elects to participate, as all do, the state must at a minimum offer coverage for certain services to certain populations. These eligibility groups and services are referred to as "mandatory" in order to distinguish them from the eligibility groups and services that a state may, at its option, cover with federal Medicaid matching funds. See Optional.**
MAO	**Medical Assistance Only (MAO) is medical assistance for Aged or Disabled Medicaid beneficiaries residing in nursing facilities who pay part of the cost of their care with Medicaid paying the remaining amount.**
MARS	**Management and Administrative Reporting Subsystem**
MCO	**See Managed Care Organization**
MD	**A physician, medical doctor**
Means Testing	**The policy of basing eligibility for benefits upon an individual's lack of means, as measured by his or her income or resources. Means testing by definition requires the disclosure of personal financial information by an applicant as a condition of eligibility.**
Medicaid Fraud Control Unit (MFCU)	**A state agency independent of the state Medicaid agency responsible for investigating and prosecuting fraud and patient neglect and abuse under state law.**
Medicaid Management	**A state's computer systems for tracking Medicaid enrollment, claims processing, and payment information.**

Information System (MMIS)	
Medical Assistance	**The term used in the federal Medicaid statute (Title XIX of the Social Security Act) to refer to payment for items and services covered under a state's Medicaid program on behalf of individuals eligible for benefits.**
Medically Needy	**A term used to describe an optional Medicaid eligibility group made up of individuals who qualify for coverage because of high medical expenses, commonly hospital or nursing home care. These individuals meet Medicaid's categorical requirements**
Medicare Buy-in	**The informal term referring to the payment of Medicare Part B premiums on behalf of low income Medicare beneficiaries who qualify for full Medicaid coverage (dual eligibles) or just for assistance with Medicare premiums and cost-sharing (Qualified Medicare Beneficiary, Specified Low-Income Beneficiaries, and Qualifying Individual).**
MEDS/MEDSX	**Medicaid Eligibility Determination System Expansion**
MEDX	**Medical Electronic Data Exchange**
MEHRS/eScript	**Medicaid Electronic Health Records System and ePrescribing System**
MES	**Medicaid Enterprise Solution**
Methodology	**The rules that a state uses in counting an individual's income or resources in determining whether he or she meets its Medicaid eligibility standards. For certain eligibility categories, states have the flexibility to disregard some or all of an individual's income and resources in determining whether the individual qualifies for Medicaid. See Disregards, Standard.**
MFCU	**The Medicaid Fraud Control Unit (MFCU) is the law enforcement agency under the State Attorney General staffed by attorneys, auditors, and investigators trained in the complex subject of health care fraud. The Unit shares pertinent information with other state and federal agencies so that appropriate administrative sanctions can be implemented against health care providers who abuse the Medicaid program or residents of health care facilities.**
MFP	**Money Follows the Person. The Money Follows the Person (MFP) Rebalancing Demonstration Grant helps states rebalance their Medicaid long-term care systems**
MID	**Medicaid Id Number**
MITA	**Medicaid Information Technology Architecture (MITA) initiative is a national framework designed to support improved systems development and healthcare management for the Medicaid enterprise.**
MLR	**Medical Loss Ratio. Method the Affordable Care Act uses to restrict administrative costs of insurance carriers**
MLTSS	**Managed Long Term Services and Supports, see LTSS**
MMA	**The Medicare Modernization Act (MMA) calls for Medicare to pay for two drugs in each therapeutic class.**
MMIS	**The Medicaid Management Information Systems (MMIS) is the data files, computer systems and computer subsystems which handle the electronic administration processes of the Medicaid program.**
MN	**Medical Necessity (MN) or Medically Necessary Analysis determines appropriateness of services rendered to ensure quality of care.**

MNR	**Medical Necessity Referral (MNR) is a nurse who has enough training to be licensed by a state to provide routine care for the sick.**
MR/DD	**Mental Retardation and/or Developmental Disabilities (MR/DD) legislation granted the Secretary of the United States Department of Health and Human Services (DHHS) authority to waive federal regulations that previously limited Medicaid reimbursement to institutional long-term care settings. No other change in federal law to date surpasses this legislation in terms of its significance for reforming the delivery of long-term care services.**
MS	**Medical Supply (MS) are goods and equipment utilized for the treatment and care of persons with an illness, disease or disability.**
MS-DRG	**Medicare's MS-DRG Version 31**
MTM	**Medical Transportation Management**
NAAC	**Net Average Allowable Costs**
NAMI	**National Alliance for the Mentally Ill (NAMI) is a nonprofit, grassroots, self-help, support and advocacy organization of consumers, families and friends of people with severe mental illnesses**
NASMD	**National Association of State Medicaid Directors (NASMD) is a bipartisan, professional, nonprofit organization of representatives of state Medicaid agencies**
NASUAD	**National Association of States United for Aging and Disabilities**
NDC	**The National Drug Code (NDC) system was originally established as an essential part of an out-of-hospital drug reimbursement program under Medicare. The NDC serves as a universal product identifier for human drugs.**
NEMT	**Non-Emergency Medical Transportation**
NET	**Non-Emergency Transportation is prearranged transportation provided for medical appointments.**
NF	**A Nursing Facility (NF) is a nursing home which provides nursing and/or rehabilitation services to patients who need medical care that cannot be provided in the patient's home.**
NHQR	**National Healthcare Quality & Disparities Reports**
NIST	**National Institute of Standards Technology**
NP	**A Nurse Practitioner (NP) is a registered nurse who has received special training and can perform many of the duties of a physician.**
NPI	**National Provider Identifier**
NPS	**National Prevention Strategy, a CMS program**
NQS	**National Quality Strategy, a CMS program**
NSAIDs	**Nonsteroidal anti-inflammatory drugs (NSAIDs) drugs used to treat inflammation**
NWI	**National Workgroup on Integration, American Public Human Services Association**
O&P	**Orthotics and Prosthetics (O&P) is the surgical or dental specialty concerned with the design, construction and fitting of an artificial device to replace a missing part of the body or to support or brace weak or ineffective joints or muscles.**
OBRA	**On Nov. 5, 1990 the President signed into law the Omnibus Budget Reconciliation Act of 1990 (OBRA 90), P.L. 101-508.**
ODD	**Oppositional Defiant Disorder, one of the Episodes of Care**
Office for Civil Rights (OCR)	**The agency within the Department of Health and Human Services with responsibility for monitoring and enforcing compliance with federal anti-**

	discrimination laws by providers and managed care entities participating in Medicaid as well as state Medicaid agencies and their contractors.
Office of Inspector General (OIG)	**The agency within the Department of Health and Human Services with responsibility for monitoring and enforcing compliance with federal fraud and abuse laws by providers and managed care entities participating in Medicaid.**
OIG	**The Office of the Inspector General is the investigative arm of the Federal Trade Commission.**
OLTC	**Arkansas Office of Long Term Care**
OMIG	**Arkansas Medicaid Inspector General's Office**
ONC	**The Office of the National Coordinator of Health Information Technology (ONC) is an office under the U.S. Department of Health and Human Services established as part of the HITECH Act of 2009 to support the adoption of health information technology to improve healthcare.**
OP	**A hospital Out Patient (OP) is a patient who receives treatment, in a hospital or an infirmary but no lodging and food.**
Optional	**The term used to describe Medicaid eligibility groups or service categories that states may cover if they so choose and for which they may receive federal Medicaid matching payments at their regular matching rate, or FMAP. About two thirds of all federal Medicaid funds are used to match the cost of optional services for mandatory or optional groups and all services for optional populations.**
OSHA	**Occupational Safety and Health Act is a government agency in the Department of Labor to maintain a safe and healthy work environment.**
OSP	**Arkansas Office of State Procurement**
P&T	**The Pharmacy & Therapeutics (P&T) Committee conducts in-depth evaluations of available drugs and recommend appropriate drugs for preferred status and makes recommendations to the Medicaid Executive Director regarding prior authorization criteria for these drugs and classes.**
PA	**Physician's Assistant**
PA	**Prior Authorization (PA) is certification for drugs and medical services which exceed the benefit limits afforded under the Medicaid program.**
PAC	**Pricing Action Code (PAC) is a code required on the Medicaid claim form.**
PACE	**See Program for All-Inclusive Care for the Elderly**
PAM	**Payment Accuracy Measurement (PAM) Project/Grant is a method to estimate improper payments for the Medicaid program in response to the Government Performance and Results Act of 1993 (GPRA), Public Law No. 103-62, (1993). The PAM model uses a claims-based sample and review methodology and has been designed to estimate a State-specific payment error rate that is within +/-3 percent of the true population error rate with 95 percent confidence. Moreover, through weighted aggregation, the State-specific estimates can be used to make national level improper payment estimates for the Medicaid and CHIP programs.**
PAP	**Principal Accountable Provider**
PAPD	**Planning Advanced Planning Document**
PBM	**Pharmacy Benefits Management (PBM) is the procurement of prescription drugs at a negotiated rate for dispensation within a state to covered individuals, the administration or management of prescription drug benefits provided by a**

	covered entity for the benefit of covered individuals, or any services provided with regard to the administration of pharmacy benefits.
PCCM	**Primary Care Case Management (PCCM) is a Medicaid managed care program that provides case management through a client's primary care provider (PCP).**
PCMH	**Patient Centered Medical Home**
PCP	**A Primary Care Physician or Primary Care Provider (PCP) is a physician who provides primary care. The primary care physician acts as a gatekeeper to the medical system.**
PDCS	**Prescription Drug Card System**
PDL	**Preferred Drug List. A list of effective prescription drugs within therapeutic drug classes**
PDN	**Private Duty Nurse/Nursing (PND) is a nurse who is not a member of a hospital staff, but is hired by the client or his/her family on a fee-for-service basis to care for the client. A nurse who specializes in the care of patients with diseases of a particular class.**
Peer Review Organization (PRO)	**An entity that, under contract with a state Medicaid agency, reviews the utilization or quality of services provided to Medicaid beneficiaries either by fee-for-service providers or managed care entities. PROs must meet federal performance standards. CMS recently renamed PROs "Quality Improvement Organizations." Personal Needs Allowance (PNA)**
PET scans	**Positron Emission Tomography scan. A type of imaging test**
PHI	**Protected Health Information**
PHP	**Prepaid Health Plan**
PHR	**Personal Health Record**
PHRM/ISS	**Perinatal High Risk Management/Infant Services System (PHRM/ISS) is a multidisciplinary case management program established to help improve access to health care and to provide enhanced services to certain Medicaid-eligible pregnant/postpartum women and infants. The enhanced services for this target population include case management, psychosocial and nutritional counseling/assessments, home visits and health education.**
PI	**Program Integrity (PI) is a DOM bureau which identities and stops fraud and abuse in the Medicaid program by beneficiaries and providers.**
PLEs	**Provider Led Entities**
PMO	**Project Management Office**
PMP	**Project Management Professional Certification**
PMPM	**Per Member Per Month (PMPM) is the relative measure (the ratio) by which most expense and revenue, and many utilization comparisons are made.**
PO	**Private Option, under HCIA**
POC	**A Plan of Care (POC) is a written plan that directs what type of services and treatment are received.**
Poverty-Level Groups	**The popular term for eligibility groups, both mandatory and optional, for whom Medicaid income eligibility is determined on the basis of a percentage of the federal poverty level (FPL) (e.g., pregnant women and infants with family incomes at or below 133 percent of the FPL). See De-Linking, Federal Poverty Level.**
PPACA	**See ACA**

PPACA (or ACA)	**Patient Protection and Affordable Care Act of 2010**
PPI	**Public Policy Institute (PPI) of AARP**
PPO	**Preferred Provider Organization (PPO) is a network of medical providers.**
PPS	**Prospective Payment System**
PQRI	**The Physician Quality Reporting Initiative (PQRI) is a voluntary program that provides a financial incentive to physicians and other eligible professionals who successfully report quality data related to services provided under the Medicare Physician Fee Schedule (MPFS).**
Preadmission Screening and Annual Resident Review (PASARR)	**The federal requirement that states must screen all individuals with mental illness or mental retardation prior to admission to a Medicaid nursing facility and review at least annually all residents with mental illness or mental retardation in such facilities, to determine whether the individual or resident requires the level of care provided by the facility.**
Presumptive Eligibility	**The option available to states to extend limited Medicaid coverage (with federal matching payments) to certain groups of individuals from the point a qualified provider determines that the individual's income does not exceed the eligibility threshold until a formal determination of eligibility is made by the state Medicaid agency. The groups to whom states may offer Medicaid coverage during a presumptive eligibility period are pregnant women, children, and women diagnosed with breast or cervical cancer.**
Primary Care Case Manager (PCCM)	**PCCMs are physicians, physician groups, or entities having arrangements with physicians that contract with state Medicaid agencies to coordinate and monitor the use of covered primary care services by enrolled beneficiaries.**
Prior Authorization	**A mechanism that state Medicaid agencies may at their option use to control use of covered items (such as durable medical equipment or prescription drugs) or services (such as inpatient hospital care). When an item or service is subject to prior authorization, the state Medicaid agency will not pay unless approval for the item or service is obtained in advance by the beneficiary's treating provider, either from state agency personnel or from a state fiscal agent or other contractor.**
Program of All-Inclusive Care for the Elderly (PACE)	**A benefit that states may at their option offer to Medicaid beneficiaries age 55 or older who have been determined to require the level of care provided by a nursing facility.**
Provider Tax	**A tax, fee, assessment, or other mandatory payment required of health care providers by a state.**
PRTF	**A Psychiatric Residential Treatment Facility (PRTF) is a facility which provides psychiatric treatment for children under age 21 with mental/emotional/behavioral problems who do not require emergency or acute psychiatric care but who's symptoms are severe enough to require supervision/intervention on a 24 hour basis.**
PT	**Physical Therapy (PT) is therapy that uses physical agents: exercise and massage and other modalities.**
PTOS	**Procedure Type of Service**
QA	**Quality Assurance (QA) is an ongoing process that ensures the delivery of agreed standards.**

QCA	**QualChoice Holdings, Inc., is the parent company of QCA Health Plan, Inc., and QualChoice Life and Health Insurance Company, Inc., (collectively 'QualChoice').**
QHP	**Qualified Health Plan, Private Option carriers are QHPs**
QI	**Qualified Individuals**
QIO	**A Quality Improvement Organization (QIO) ensures quality assurance methods that emphasize the organization and systems: focuses on "process" rather than the individual; recognizes both internal and external "customers"; promotes the need for objective data to analyze and improve processes.**
QMB	**Qualified Medicare Beneficiaries (QMB) is a category of eligibility which pays Medicare premiums, deductibles and coinsurance for eligible individuals. To be eligible, a person must be eligible for Medicare, Part A (Hospital Insurance) and have a total monthly income that does not exceed the allowed maximum.**
Qualified Medicare Beneficiary (QMB)	**A Medicare beneficiary with income or assets too high to qualify for full coverage under the Medicaid program as a dual eligible, but whose income is at or below 100 percent of the federal poverty line (FPL) and whose countable resources do not exceed $4000. QMBs are eligible to have Medicaid pay all of their Medicare cost-sharing requirements, including monthly premiums for Part B coverage, and all required deductibles and coinsurance (up to Medicaid payment amounts).**
Qualifying Individual (QI)	**Between January 1998 and December 2002, States are required to pay all or a portion of Medicare premiums on behalf of a limited number of Medicare beneficiaries known as "Qualifying Individuals," or QIs**
Quality Control (QC)	**Also known as Medicaid Eligibility Quality Control (MEQC), quality control is the term applied to CMS's statutory duty to monitor state and local Medicaid eligibility determinations**
Quality Improvement System for Managed Care (QISMC)	**Standards and guidelines issued by CMS that direct managed care organizations to operate internal programs of quality assessment and performance improvement and collect and report data reflecting its performance. QISMC standards and guidelines are mandatory for Medicare+Choice plans but are optional for state Medicaid agencies to use in measuring and improving quality of Medicaid MCOs.**
QWDI	**Qualified Working Disabled Individual**
RA	**Remittance Advise (RA) formats for explaining the payments of health care claims.**
RAC	**Recovery Audit Contractor**
RBMC/MCO	**Risk-Based Managed Care/Managed Care Organization**
Rebate	**The amounts paid by manufacturers to state Medicaid programs for outpatient prescription drugs purchased by the programs on behalf of eligible beneficiaries on a fee-for-service basis. Rebates are calculated on the basis of the average manufacturer price (AMP) for each drug and, in the case of brand name drugs, on the basis of the manufacturer's best price. A manufacturer must agree to pay rebates in order for federal Medicaid matching funds to be paid to states for the costs of the manufacturer's drug products. See Average Manufacturer Price, Best Price, Formulary.**
Resources	**Sometimes referred to as assets, resources are items of economic value that are not income. Resources include financial instruments such as savings accounts and**

	certificates of deposit, personal property such as an automobile (above a specified value), and real estate (other than an individual's home)
RFI	**A Request for information (RFI) is a formal request distributed to potential bidders and/or professional experts for information regarding a specific system, program, process or service.**
RFP	**A Request for Proposal (RFP) is a solicitation inviting proposals from vendors who believe they can provide products to satisfy an agency's needs.**
RHC	**A Rural Health Clinic (RHC) is an outpatient facility that is primarily engaged in furnishing physicians' and other medical and health services that also meets other requirements designated to ensure the health and safety of individuals served by the clinic. The clinic must be located in a medically under-served area that is not urbanized as defined by the U.S. Bureau of Census.**
Risk Contract	**A contract between a state Medicaid agency and an MCO or other managed care entity (MCE) under which the entity agrees to provide, or arrange for the provision of, a specified set of services to enrolled beneficiaries in exchange for a fixed monthly capitation payment on behalf of each enrollee. By entering into such a contract, the MCO is assuming the financial risk of providing covered health services to the enrolled population.**
RN	**A Registered Nurse is a graduate nurse who has passed examinations for registration.**
ROI	**Return on Investment**
RR	**A Responsible Relative (RR) is a relative of a Medicaid beneficiary who assumes responsibility for conducting business on behalf of the beneficiary.**
RR	**Retro-Recovery (RR) is recovery of Medicaid funds from some third party after Medicaid has paid for medical services received by a Medicaid beneficiary.**
RSPMI	**Rehabilitative Services for Persons with Mental Illness**
R-squared	**Statistical measure of how close the data are to the fitted regression line**
RTC	**University of Minnesota, through the affiliated Research and Training Center on Community Living**
RTF	**A Resident Trust Fund (RTF) may belong to residents of Long Term Care facilities who may elect to allow a facility to manage a portion of their personal funds. These funds are audited by DOM on a regular basis to ensure facilities properly account for their funds in accordance with federal regulations.**
Rural Health Clinic (RHC)	**States are required to include services provided by RHCs in their basic Medicaid benefits package. RHC services are ambulatory care services (including physicians' services and physician assistant and nurse practitioner services) furnished by an entity that is certified as a rural health clinic for Medicare purposes. An RHC must either be located in a rural area that is a federally-designated shortage area or be determined to be essential to the delivery of primary care services in the geographic area it serves.**
RX or Rx	**Pharmaceutical**
SACWIS	**Medicaid Eligibility Determination System**
SAMHSA	**Substance Abuse and Mental Health Services Administration**
Section 1115 Waiver	**Under section 1115 of the Social Security Act, the Secretary of HHS is authorized to waive compliance with many of the requirements of the Medicaid statute to enable states to demonstrate different approaches to "promoting the objectives**

	of" the Medicaid program while continuing to receive federal Medicaid matching funds. In 2001, 19 states were operating Medicaid section 1115 waivers affecting some or all of their eligible populations and involving $27 billion in federal matching funds, or one fifth of all federal Medicaid spending that year. The waivers, which are granted (or renewed) for 5-year periods, are administered by CMS. See also Health Insurance Flexibility and Accountability Waivers.
Section 1902(r)(2) "Less Restrictive" Methodologies	**Under section 1902(r)(2) of the Social Security Act, states have flexibility, in determining an individual's Medicaid eligibility, to use methodologies for counting income and resources that are less restrictive than those used in the cash assistance programs for families (TANF) or the elderly and disabled (SSI). Using these less restrictive methodologies, states may disregard some or all of an individual's income or resources in determining whether the individual meets the applicable eligibility standard (e.g., 100 percent of the federal poverty level). As a result, a state can under section 1902(r)(2) expand the numbers of individuals eligible for Medicaid without changing the eligibility standards.**
Section 1915(b) Waiver	**Under section 1915(b) of the Social Security Act, the Secretary of HHS is authorized to waive compliance with the "freedom of choice" and "statewideness" requirements of federal Medicaid law in order to allow states to operate mandatory managed care programs in all or portions of the state while continuing to receive federal Medicaid matching funds. The waivers, which are granted (or renewed) for 2-year periods, are administered by CMS.**
Section 1931 Eligibility	**Under section 1931 of the Social Security Act, states must extend Medicaid eligibility to parents (and older children) in families who meet the eligibility requirements that were in effect under their state's Aid to Families with Dependent Children (AFDC) program as of July 16, 1996. States have the option under section 1931 to raise the eligibility levels for these parents through the use of "less restrictive" income and resource methodologies (see de-linking).**
Section 1932 State Plan Option	**Under section 1932 of the Social Security Act, states may require Medicaid beneficiaries to enroll in managed care entities (MCEs) by submitting an approvable state plan amendment (SPA) to CMS. Unlike section 1915(b) or 1115 waivers, section 1932 SPAs need not be periodically renewed by CMS.**
SED	**Serious Emotional Disturbance**
SFTP	**Secure File Transfer Protocol**
SFY	**State Fiscal Year (Arkansas' ends June30)**
SHRS	**The School Health Related Services (SHRS) Program was designed to identify children who have a learning problem because of a medical problem which requires special services. Once the child is identified an IEP (Individual Education Plan) listing services they need is then completed by the school. The schools have employed people with special training to assist children with special needs.**
SMI	**Serious Mental Illness**
Single State Agency	**The agency within state government designated as responsible for administration of the state Medicaid plan. The single state agency is not required to administer the entire Medicaid program; it may delegate most administrative functions to other state (or local) agencies or private contractors (or both).**
SIR	**System Information Request (SIR) is a request submitted to the Medicaid for electronic solutions and data analysis.**

SIS	**Supports Intensity Scale: American Association on Intellectual and Developmental Disabilities**
SLMB	**A Specified Low Income Medicare Beneficiary (SLMB) is a Medicaid category of eligibility which pays Medicare, Part B premium for qualified individuals. To be eligible, individuals must be age 65 or over or disabled, have income and resources below the maximum limits.**
SLR	**State Level Repository**
SMB	**Specified Low-Income Medicare Beneficiary**
SME	**Subject Matter Expert**
SMHP	**State Medicaid Health Information Technology Plan**
SNAP	**Supplemental Nutrition Assistance Program**
SNF	**A Skilled Nursing Facility (SNF) is a nursing home which provides skilled nursing and/or skilled rehabilitation services to patients who need skilled medical care that cannot be provided in a custodial level nursing home or in the patient's home.**
SOBRA	**Sixth Omnibus Budget Reconciliation Act--coverage for pregnant women under Medicaid**
SOP	**Standard Operating Procedures (SOP) are a set of fixed instructions or steps for carrying out usually routine operations.**
SOW	**Statement of Work**
SPA	**A State Plan Amendment (SPA) is an alteration in the provisions under the State Plan.**
SPAs	**State Plan Amendments. Sent to the Centers for Medicare and Medicaid Services (CMS) for review and approval**
Specified Low Income Medicare Beneficiary (SLMB)	**A Medicare beneficiary with income or assets too high to qualify for full coverage under the Medicaid program as a dual eligible, but whose income is above 100 percent and not in excess of 120 percent of the federal poverty line (FPL) and whose countable resources do not exceed $4000. SLMBs, like QMBs are eligible to have Medicaid pay their Medicare monthly premiums, but unlike QMBs are not eligible for Medicaid payment for their Medicare cost-sharing obligations. See also Dual Eligible, Federal Poverty Level, and Qualified Medicare Beneficiary.**
Spend-Down	**For most Medicaid eligibility categories, having countable income above a specified amount will disqualify an individual from Medicaid. However, in some eligibility categories**
Spousal Impoverishment	**The term used to describe the set of eligibility rules that states are required to apply in the case where a Medicaid beneficiary resides in a nursing facility and his or her spouse remains in the community. The rules, which specify minimum amounts of income and resources each spouse is allowed to retain without jeopardizing the institutionalized spouse's eligibility for Medicaid benefits, are designed to prevent the impoverishment of the community spouse.**
SPR	**Summary Profile Report (SPR) is a statistical report of a Medicaid provider's or a Medicaid beneficiary's actions for a specific period of time which compares their behavior to the norm established for that period of time.**
SSA	**Social Security Administration (SSA) is the federal agency which administers payment of Social Security benefits and Supplemental Security Income (SSI).**

SSDI	**Social Security Disability Insurance program. It is tied to the Social Security retirement program, but is for workers who become disabled before retirement age.**
SSI	**Supplemental Security Income (SSI) is income provided by the U.S. government to needy aged, blind and disabled persons and administered by the Social Security Administration.**
SSN	**Social Security Number**
Standard	**As used in the context of Medicaid eligibility determinations, the dollar amount of income or resources that an individual is allowed to have and qualify for Medicaid. For example, states must cover all pregnant women with family incomes at or below 133 percent of the federal poverty level (FPL), or $14,630 ($1,219 per month) for a family of 3 in 2001. In determining whether a pregnant woman meets this income standard, a state must count her income; the methodology that the state applies will determine what types of income are counted and what income (if any) is disregarded.**
State Medicaid Plan	**Under Title XIX of the Social Security Act, no federal Medicaid funds are available to a state unless it has submitted to the Secretary of HHS, and the Secretary has approved, its state Medicaid plan (and all amendments to the state plan). The state Medicaid plan must meet 64 federal statutory requirements.**
State Plan Amendment (SPA)	**A state that wishes to change its Medicaid eligibility criteria or its covered benefits or its provider reimbursement rates must amend its state Medicaid plan to reflect the proposed change.**
Statewideness	**The requirement that states electing to participate in Medicaid must operate their programs throughout the state and may not exclude individuals residing in, or providers operating in, particular counties or municipalities. This requirement may be waived under section 1115, 1915(b), and 1915(c) waivers.**
Supplemental Security Income (SSI)	**A federal entitlement program that provides cash assistance to lowincome aged, blind, and disabled individuals.**
SURS	**Surveillance and Utilization Review Subsystem (SURS) of the MMIS**
Survey and Certification	**The term for the process of surveying nursing facilities to determine whether they meet the requirements for participation in Medicaid (and Medicare). The process involves state survey agencies conducting inspections and CMS surveyors conducting "look behind" inspections. Facilities that do not meet the requirements are subject to various administrative sanctions, including civil money penalties; in extreme cases, a facility's participation in Medicaid may be terminated.**
TANF	**Temporary Assistance to Needy Families (TANF) is an assistance program for families.**
TBI/SCI	**Traumatic Brain Injury/Spinal Cord Injury is an acquired injury to the brain or spinal column caused by an external physical force, resulting in total or partial functional disability or psychosocial impairment, or both, that adversely affects educational performance. The term applies to open and closed head injuries resulting in impairments in one or more areas, such as cognition; language; memory; attention; reasoning; abstract thinking; judgment; problem-solving; sensory, perceptual, and motor abilities; psychosocial behavior; physical functions; information processing; and speech. The term does not apply to brain**

	injuries that are congenital or degenerative, or brain injuries induced by birth trauma.
TCM	**Targeted Case Management**
TCN	**A Transaction Control Number (TCN) is a unique identifier for a claim line assigned by the MMIS.**
TCP/IP	**Transmission Control Protocol and Internet Protocol (TCP/IP) is commonly known together as the Internet Protocol Suite.**
TEA/TANF	**TANF is the federal Temporary Assistance to Needy Families project. TEA is a federally funded Arkansas program and provides time-limited cash assistance to needy families with (or expecting) children**
Temporary Assistance for Needy Families (TANF)	**A block grant program that makes federal matching funds available to states for cash and other assistance to low income families with children. TANF was established by the 1996 welfare law that repealed its predecessor, the Aid to Families with Dependent Children (AFDC) program. Prior to this repeal, states were required to extend Medicaid coverage to all families with children receiving AFDC benefits. States may but are not required to extend Medicaid coverage to all families receiving TANF benefits; states must, however, extend Medicaid to families with children who meet the eligibility criteria that states had in effect under their AFDC programs as of July 16, 1996.**
Third Party Liability (TPL)	**The term used by the Medicaid program to refer to another source of payment for covered services provided to a Medicaid beneficiary.**
TIN	**Taxpayer Identification Number**
Title XIX	**Title XIX of the Social Security Act, 42 U.S.C. 1396 et seq., is the federal statute that authorizes the Medicaid program. Related titles of the Social Security Act are Title IV-A (TANF), Title IV-E (Foster Care and Adoption Assistance), Title V (MCH block grant), Title XVI (SSI), Title XVIII (Medicare), and Title XXI (SCHIP).**
TJR	**Total Joint Replacement, one of the Episodes of Care**
TMA	**Transitional Medical Assistance**
TOS	**Type of Service (TOS) is a code required on the Medicaid claim form.**
TPL	**Third Party Liability (TPL) insurance coverage a Medicaid beneficiary has which the provider must file before submitting the claim to Medicaid as the payer of last resort.**
Transfer of Assets	**Refers to the practice of disposing of countable resources such as savings, stocks, bonds, and other real or personal property for less than fair market value in order to qualify for Medicaid coverage. When such transfers occur, it is usually in connection with the anticipated or actual need for long-term nursing home care. Federal law limits (but does not entirely prohibit) such transfers.**
Transitional Medical Assistance (TMA)	**Refers to Medicaid coverage for families with children leaving welfare to become self-supporting through work. States are required to continue Medicaid benefits to families who lose their cash assistance due to an increase in earnings. The transitional coverage extends for up to 12 months as long as the family continues to report earnings.**
TSG	**The Stephen Group, author of this report**
UAMS	**University of Arkansas Medical System**
UAT	**User Acceptance Testing**
UM/QIO	**Utilization Management and Quality Improvement Organization**

UPL	**Upper Payment Limit: The Upper Payment Limit (UPL) is a federal limit placed on fee-for-service reimbursement of Medicaid**
Upper Payment Limit (UPL)	**Limits set forth in CMS regulations on the amount of Medicaid payments a state may make to hospitals, nursing facilities, and other classes of providers and plans. Payments in excess of the UPLs do not qualify for federal Medicaid matching funds.**
UR	**Utilization Review (UR) is the process by which a plan determines whether a specific medical or surgical service is appropriate and/or medically necessary.**
VA	**Veteran's Affairs**
Vaccines for Children (VFC) Program	**A program under which the federal government, through the Centers for Disease Control and Prevention, purchases and distributes pediatric vaccines to states at no charge and the state in turn arranges for the immunization of Medicaid-eligible and uninsured children through public or private physicians, clinics, and other authorized providers.**
VBP	**Value Based Purchasing factor**
VFC	**Vaccines for Children is a federally funded and state-operated program that began October 1994. The program provides vaccines free of charge to VFC eligible children through public and private providers. Providers are reimbursed by Medicaid for shot administration only.**
WAIS	**Wechsler's Adult Intelligence Scale**
Waivers	**Various statutory authorities under which the Secretary of HHS may, upon the request of a state, allow the state to receive federal Medicaid matching funds for its expenditures even though it is no longer in compliance with certain requirements or limitations of the federal Medicaid statute. In the case of program waivers such as the 1915(c) waiver for home- and community-based services, states may receive federal matching funds for services for which federal matching funds are not otherwise available. In the case of demonstration waivers such as the section 1115 waivers, states may receive federal matching funds for covering certain categories of individuals for which federal matching funds are not otherwise available. Under Section 1915(b) waivers, states may restrict the choice of providers that Medicaid beneficiaries would otherwise have.**
WIC	**The Women, Infants, Children (WIC) nutrition program provides free food and nutrition information to help keep pregnant women, infants and children under the age of five, healthy and strong**
YTD	**Year To Date. Current year and ending today. Can refer to SFY or calendar year**