



Arkansas Health & Human Services System Market Profile



Health & Human Services System Market Profile Overview

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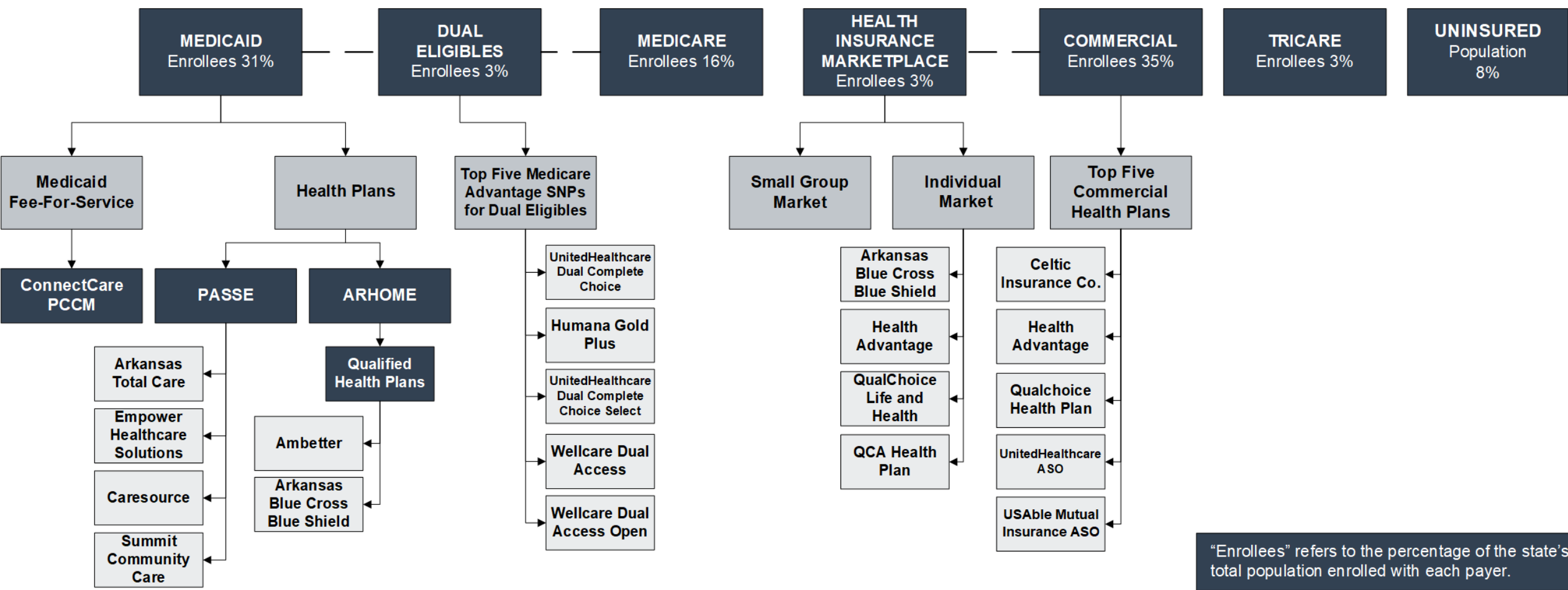
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A. Executive Summary

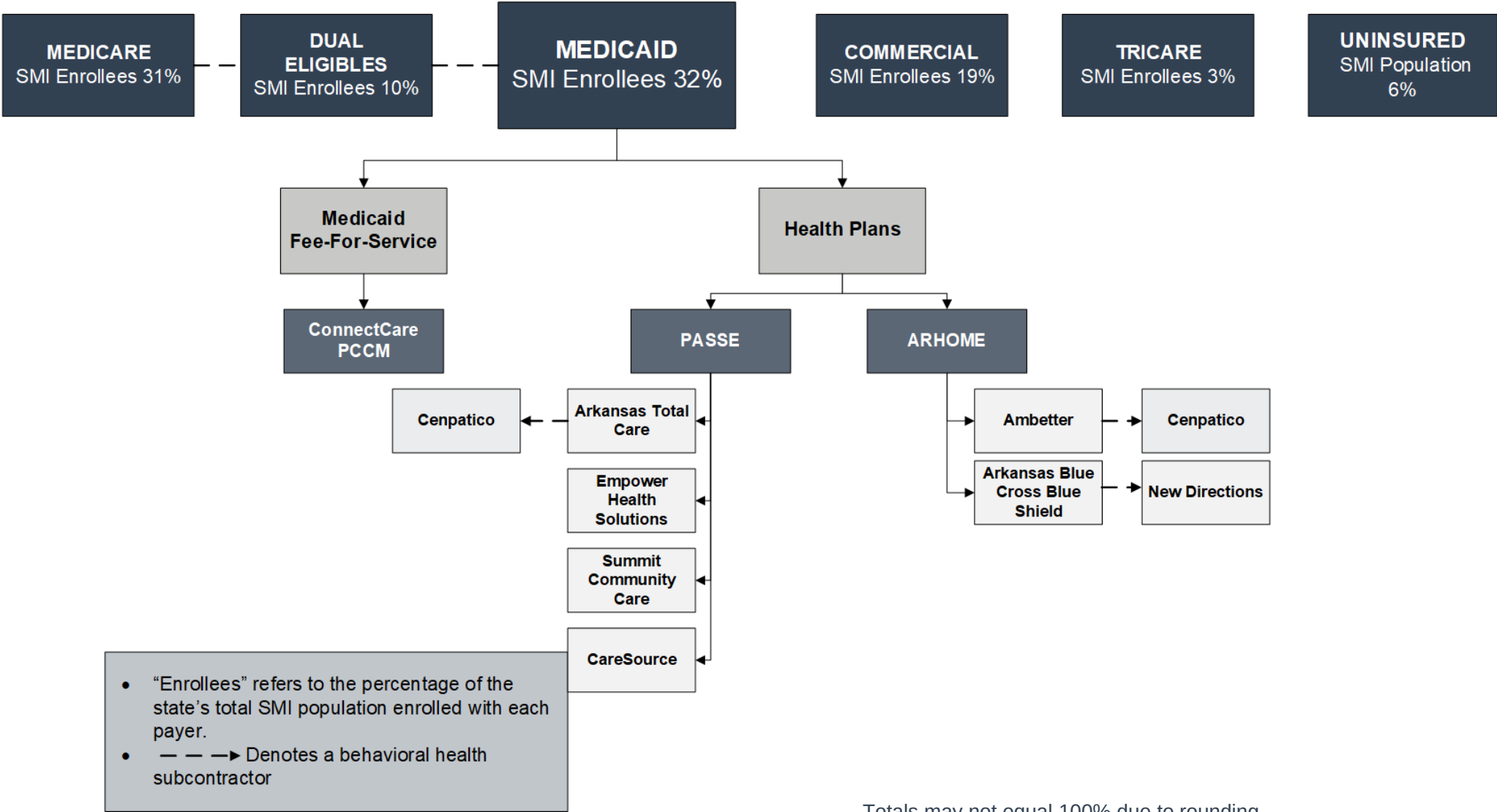
A.1. Arkansas Physical Health Care Coverage by Payer

Total Arkansas Population- 3,025,891
Estimated Serious Mental Illness (SMI) Population- 238,038



Totals may not equal 100% due to rounding

A.1. Arkansas Behavioral Health Care Coverage by Payer



Totals may not equal 100% due to rounding

A.2. Medicaid Care Coordination Initiatives

Medicaid Care Coordination Entities For Chronic Care Populations (Including SMI)		
Care Coordination Entity	Active Program	Description
Managed Care Health Plan	✓	Yes, the PASSEs are responsible for care coordination.
Primary Care Case Management (PCCM)	✓	Yes, the state has a PCCM called ConnectCare.
Accountable Care Organization (ACO) Program	✓	Yes, the state has one Medicaid ACO
Affordable Care Act (ACA) Model Health Home		None
Patient-Centered Medical Home (PCMH)	✓	Yes, the state operates a PCMH program with shared savings.
Dual Eligible Demonstration		None
Managed Long-Term Services and Supports (MLTSS)	✓	Yes, the PASSEs are responsible for LTSS for the I/DD and behavioral health population.
Certified Community Behavioral Health Clinics (CCBHC) Grant	✓	The state currently has three CCBHCs.

A.3. Health Care Safety-Net Delivery System

State Agencies Responsible For Uninsured Citizens & Delivery System Model

Physical Health Services

- The Office of Rural Health and Primary Care within the state Department of Health is responsible for providing physical health services to the safety-net population.

Mental Health Services

- The Division of Behavioral Health Services within the Department of Human Services (DHS) provides mental health services to the safety-net population by funding 12 community mental health centers.

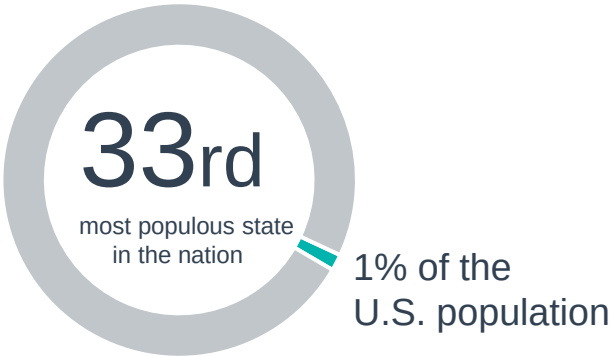
Addiction Treatment Services

- The Division of Behavioral Health Services within the Department of Human Services provides addiction disorder treatment services to the safety-net population through a network of provider organizations.

B. Arkansas Health Financing System Overview

B.1. Population Demographics

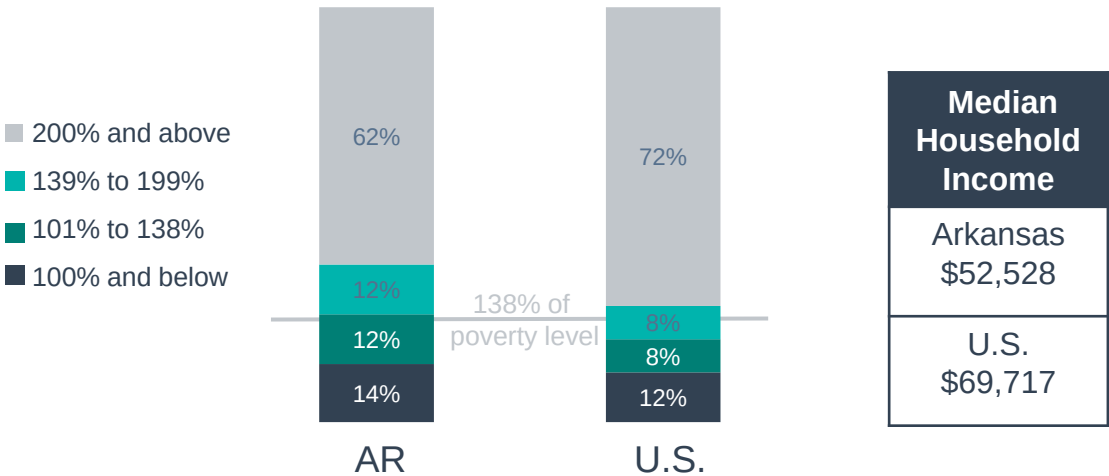
Total Arkansas Population- 3,025,891
Estimated SMI Population- 238,038



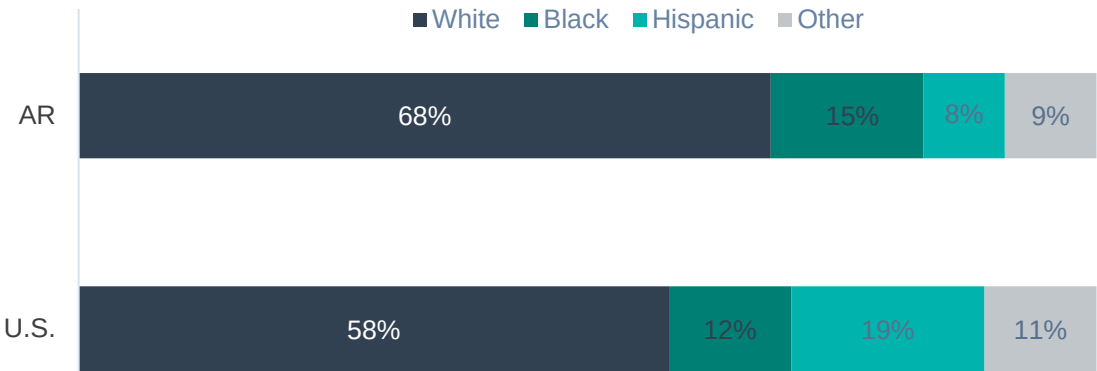
Population Distribution By Age



Population Distribution By Income To Poverty Threshold Ratio



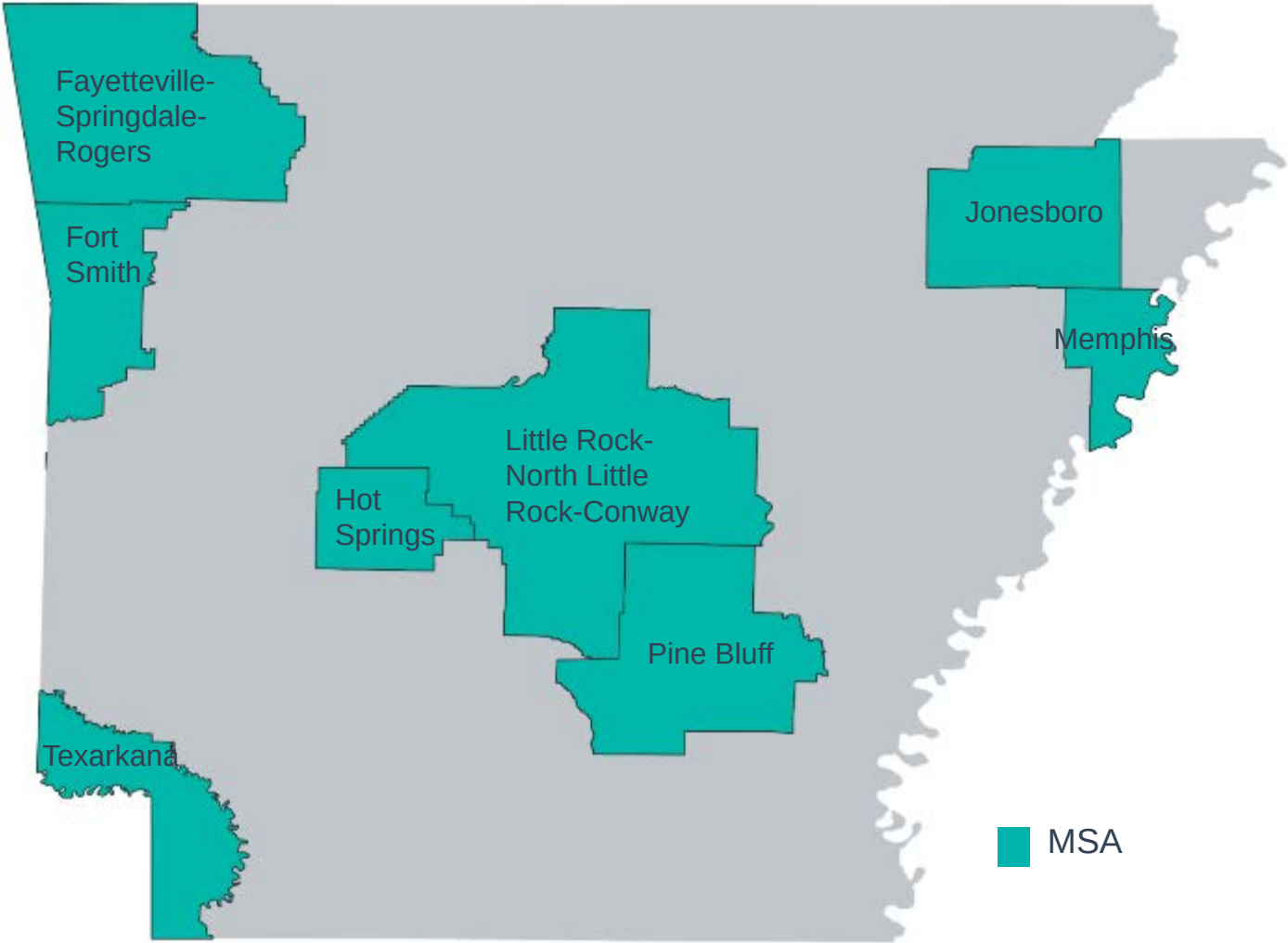
Arkansas & U.S. Racial Composition



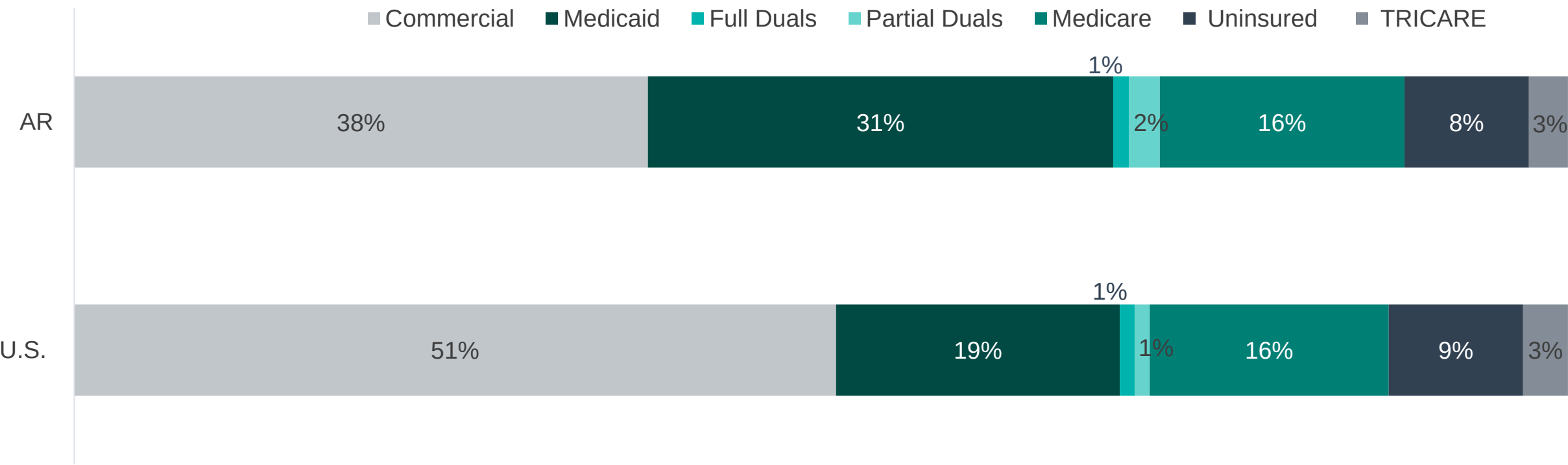
Totals may not equal 100% due to rounding

B.2. Population Centers

Metropolitan Statistical Areas (MSAs)		
MSA	Arkansas MSA Residents	Percentage of Total Population
Total MSA Population	3,308,033	N/A
Memphis, TN-MS-AR	1,332,305	44%
Little Rock-North Little Rock-Conway, AR	757,615	25%
Fayetteville-Springdale-Rogers, AR-MO	576,403	19%
Fort Smith, AR-OK	247,072	8%
Texarkana, TX-AR	146,408	5%
Jonesboro, AR	135,512	4%
Hot Springs, AR	100,089	3%
Pine Buff, AR	84,629	3%

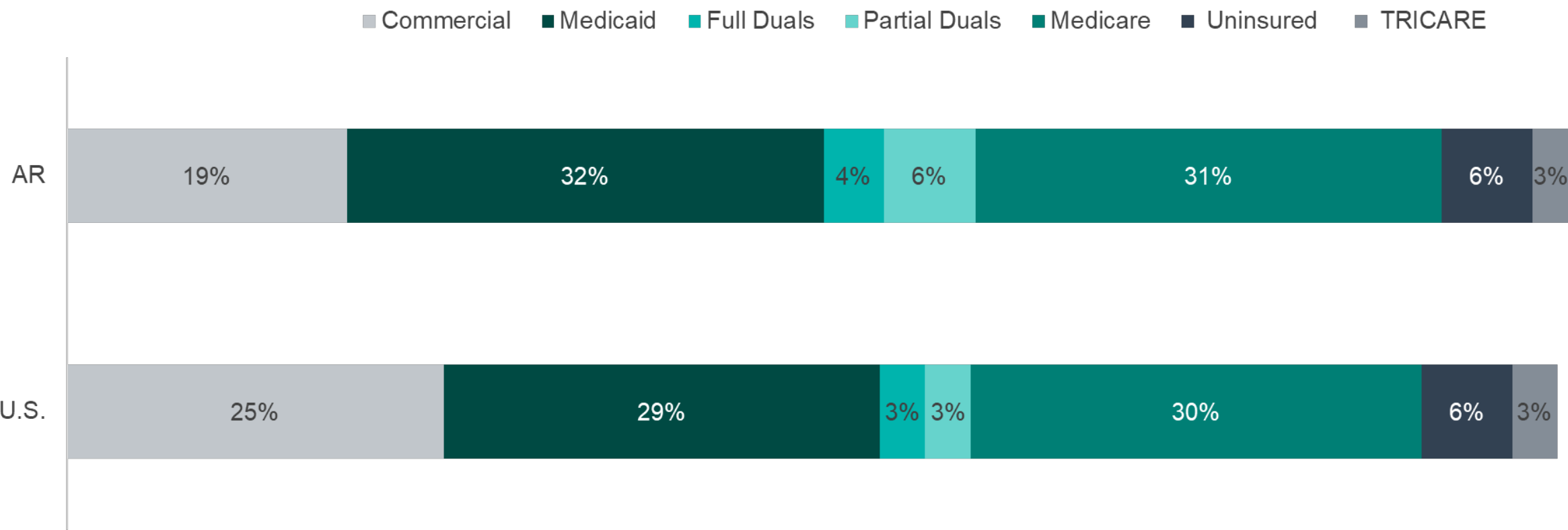


B.3. Population Distribution By Payer: National vs. State



Totals may not equal 100% due to rounding

B.3. SMI Population Distribution By Payer: National vs. State



Totals may not equal 100% due to rounding

B.4. Largest Arkansas Health Plans By Enrollment

Plan Name	Plan Type	Enrollment*
USABLE Mutual Insurance Company	Commercial administrative services organization (ASO)	1,597,409
Medicaid fee-for-service (FFS)	Medicaid	1,026,643
Medicare FFS	Medicare	318,539
UnitedHealthcare ASO	Commercial ASO	289,298
HMO Partners Inc	Commercial	154,412
Health Advantage	Commercial	131,429
Celtic Insurance Company	Commercial	87,862
TRICARE	Other public	85,400
Ambetter	Commercial	73,283
UnitedHealthcare Medicare Advantage Choice	Medicare advantage	62,639

*Medicaid enrollment as of March 2023; TRICARE as of December 2022; Commercial as of March 2023; Medicare enrollment as of March 2023

B.4. Largest Arkansas Health Plans By Estimated SMI Enrollment

Plan Name	Plan Type	Enrollment*	Estimated SMI Enrollment
Medicaid FFS	Medicaid	1,026,643	88,291
USAbile Mutual Insurance Company	Commercial ASO	1,597,409	65,494
Medicare FFS	Medicare	318,539	50,996
UnitedHealthcare ASO	Commercial ASO	289,298	11,861
UnitedHealthcare Dual Complete Choice	Medicare advantage	31,763	10,164
UnitedHealthcare Medicare Advantage Choice	Medicare advantage	62,639	10,022
TRICARE	Other public	85,400	7,088
HMO Partners Inc	Commercial	154,412	6,331
Humana Gold Plus	Medicare advantage	35,976	5,756
Health Advantage	Commercial	131,429	5,389

*Medicaid enrollment as of March 2023; TRICARE as of December 2022; Commercial as of March 2023; Medicare enrollment as of March 2023

B.5. Health Insurance Marketplace

Health Insurance Marketplace	
Health Plan Marketplace Percentage	3%
Type of Marketplace	State-based
Individual Enrollment Contact	https://www.healthcare.gov/
	1-800-318-2596
Small Business Enrollment Contact	No small group plans are available through the marketplace. Employers must purchase coverage directly from an insurance carrier or through an insurance broker.

2023 Individual Market Health Plans	
1.	QualChoice
2.	QCA Health Plan
3.	Health Advantage
4.	Arkansas Blue Cross Blue Shield

2023 Small Group Market Health Plans	
	None

B.6. Accountable Care Organizations

Medicare Shared Savings ACOs	
1.	Aledade Accountable Care 16, LLC
2.	Aledade Accountable Care 22, LLC
3.	Aledade Accountable Care 57, LLC
4.	Aledade Accountable Care 58, LLC
5.	Arkansas Health Network, LLC
6.	Arkansas Rural Health Partnership Clinically Integrated Network, LLC
7.	Baptist Health – UAMS Accountable Care Alliance
8.	Baxter Physician Partners, LLC
9.	Caravan Health ACO 17, LLC
10.	Caravan Health ACO 22, LLC
11.	Central US ACO, LLC
12.	CHRISTUS Health Quality Care Alliance, LLC
13.	CHSPSC ACO 7, LLC
14.	HealthChoice, LLC
15.	Mercy Health ACO, LLC
16.	Prime Care Managers, LLC
17.	SBMACO, LLC
18.	TP-ACO LLC
19.	White River Health System Clinically Integrated Network, LLC

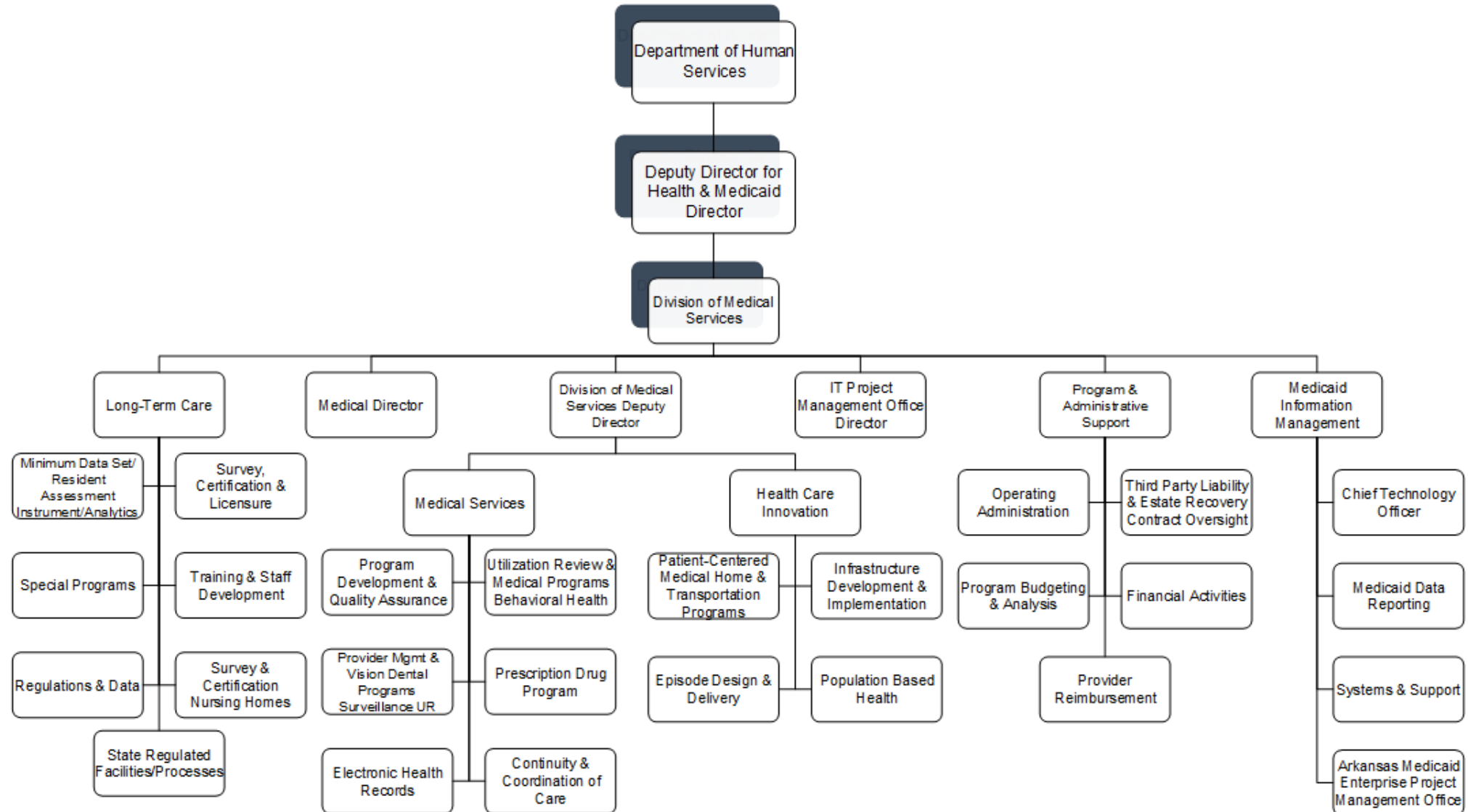
Commercial ACOs	
ACO	Commercial Insurer
Mercy Health ACO, LLC	Aetna, Cigna, Humana

Next Generation ACOs
1. Franciscan Missionaries of Our Lady Health System Clinical Network, LLC

Medicaid ACOs
1. Arkansas Total Care

C. Medicaid Administration, Governance & Operations

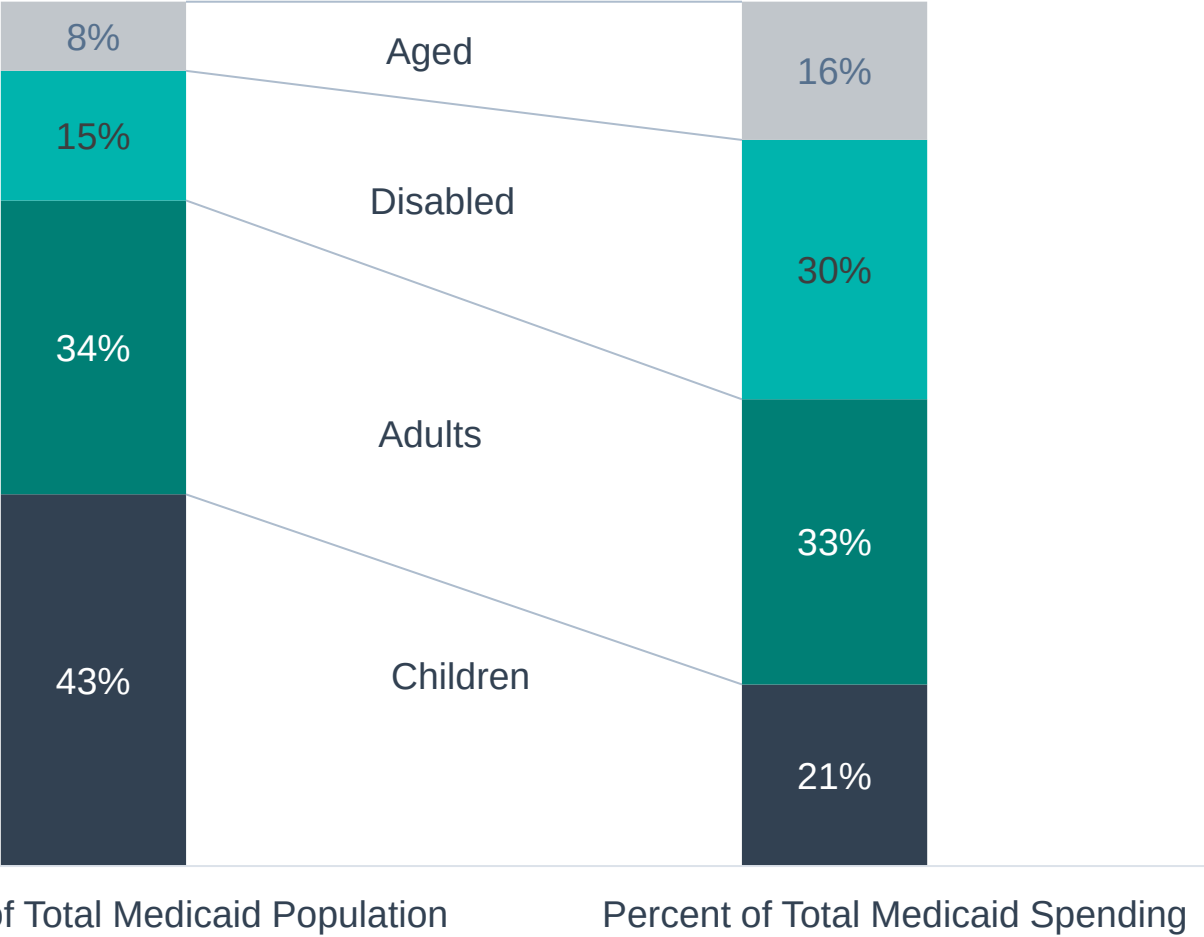
C.1. Medicaid Governance: Organization Chart



C.1. Medicaid Governance: Key Leadership

Name	Position	Department	Email
Kristi Putnam	Secretary	DHS	kristi.putnam@dhs.arkansas.gov
Dawn Stehle	Deputy Director	DHS	dawn.stehle@dhs.arkansas.gov
Janet Mann	Medicaid Director	DHS	janet.mann@dhs.arkansas.gov
Elizabeth Pitman	Director	DHS, Division of Medical Services	Elizabeth.Pitman@dhs.arkansas.gov
William Golden, M.D.	Medical Director	DHS, Division of Medical Services	william.golden@dhs.arkansas.gov
Andy Morgan	DMS Chief Financial Officer	DHS, Division of Medical Services	Not available
Jason Callan	Medicaid Chief Financial Officer	DHS, Division of Medical Services	jason.callan@dhs.arkansas.gov

C.2. Medicaid Program Spending By Eligibility Group



Medicaid Spending Per Enrollee, FY 2020		
	U.S.	AR
All populations	\$8,718	\$7,637
Children	\$3,495	\$3,809
Adults	\$5,461	\$6,097
Expansion adults	\$7,227	\$7,837
Blind and disabled	\$23,123	\$13,356
Aged	\$18,552	\$14,855

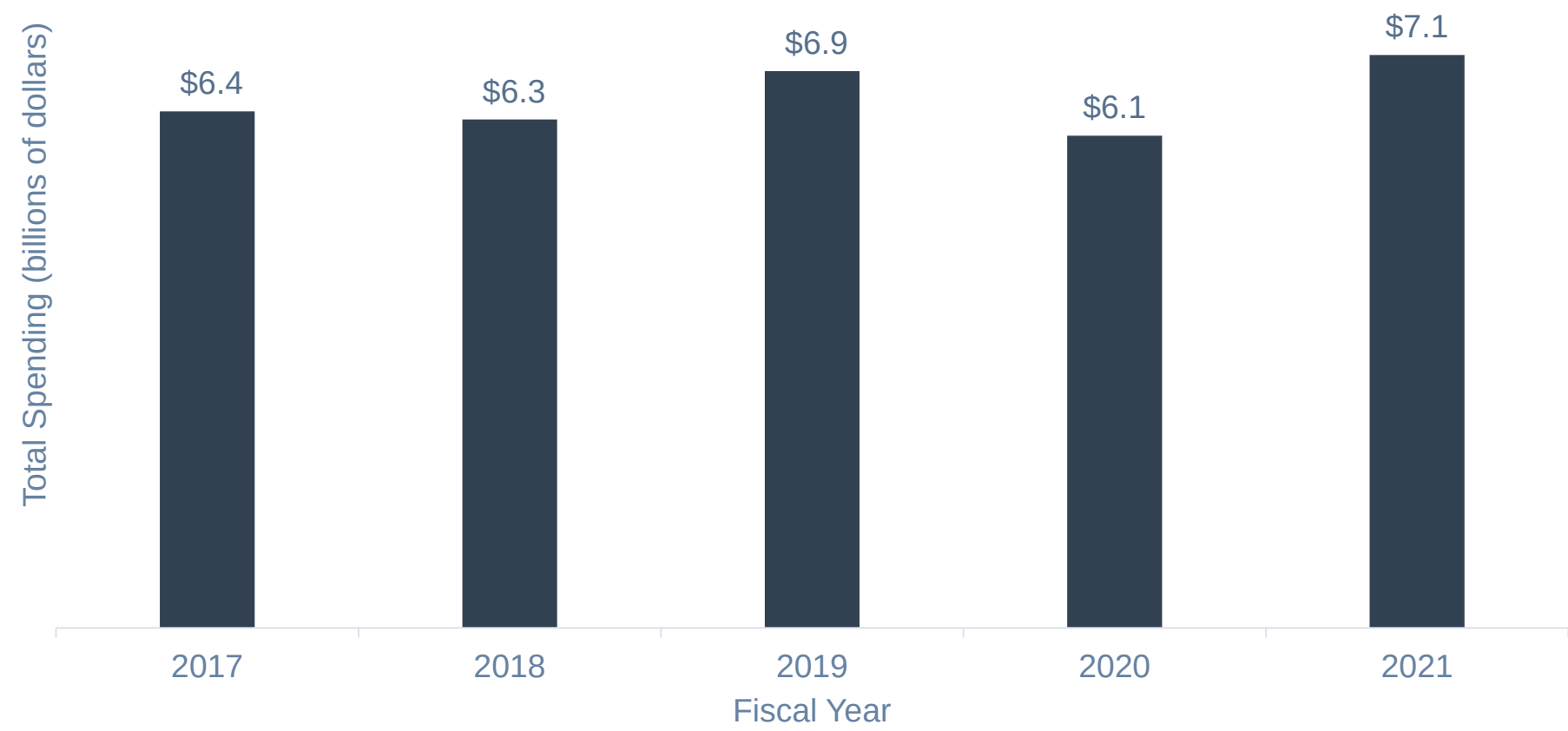
Based on FY 2020 data

C.2. Medicaid Program Spending: Budget

Budget Item	SFY 21 Spending	Percent Of Budget
Managed care and premium assistance	\$3,345,000,000	47%
Hospital	\$1,257,000,000	18%
Institutional LTSS	\$739,000,000	10%
Other acute	\$649,000,000	9%
Medicare premiums and coinsurance	\$382,000,000	5%
Home-and community-based LTSS	\$330,000,000	5%
Physician	\$328,000,000	5%
Clinic and health center	\$68,000,000	1%
Drugs	\$45,000,000	1%
Other practitioner	\$27,000,000	<1%
Dental	\$1,000,000	<1%
Budget Total: \$7,171,000,000		

Federal & County Financial Participation	
FY 2023 Federal Medical Assistance Percentage (FMAP)	77.5%
CY 2023 Newly Eligible FMAP (expansion population)	88%
Counties contribute to state Medicaid share	No

C.2. Medicaid Program Spending: Change Over Time



C.3. Medicaid Expansion Status

Medicaid Expansion	
Participating In Expansion	Yes
Date Of Expansion	January 2014
Medicaid Eligibility Income Limit For Able-Bodied Adults	133% of the Federal Poverty Level (FPL) Note: The Patient Protection and Affordable Care Act (PPACA) requires that 5% of income be disregarded with determining eligibility.
Legislation Used To Expand Medicaid	<ol style="list-style-type: none">1. Acts 1497 and 1498, collectively known as the Health Care Independence Act, passed in 2013 and authorized the state to expand Medicaid through a section 1115 demonstration waiver.2. Act 1 of the second extraordinary session of 2016, known as the Arkansas Works Act, extended the Medicaid expansion program, which needs ongoing legislative authorization to continue.
Number Of Individuals Enrolled In The Expansion Group (April 2023)	342,184
Number Of Enrollees Newly Eligible Due To Expansion	329,397
Benefits Plan For Expansion Population	<ul style="list-style-type: none">• The state's alternative benefit plan is more restrictive than the state plan benefit package.• The Medicaid expansion population, if medically frail, must be offered the full array of State Plan benefits. Medically frail individuals include adults with SMI and chronic substance use disorders.

C.4. Medicaid Program Benefits

Federally Mandated Services

1. Inpatient hospital services other than services in an institution for mental disease (IMD)
2. Outpatient hospital services
3. Rural Health Clinic services
4. Federally Qualified Health Center (FQHC) services
5. Laboratory and x-ray services
6. Nursing facilities for individuals 21 and over
7. Early and Periodic Screening and Diagnosis and Treatment (EPSDT)
8. Family planning services and supplies
9. Free standing birth centers
10. Pregnancy-related and postpartum services
11. Nurse midwife services
12. Tobacco cessation programs for pregnant women
13. Physician services
14. Medical and surgical services of a dentist
15. Home health services
16. Nurse practitioner services
17. Non-emergency transportation to medical care

Arkansas's Optional Services

1. Podiatrist services
2. Optometrist services and eyeglasses
3. Chiropractic services
4. Private duty nursing
5. Clinic services
6. Dental services
7. Physical and occupational therapy
8. Services for individuals with speech, language, and hearing disorders
9. Prescribed drugs
10. Dentures and prosthetic devices
11. Rehabilitative services
12. Services in an intermediate care facility for individuals with I/DD
13. Inpatient psychiatric services for individuals under age 22
14. Case management services
15. Hospice services
16. Respiratory care services

D. Medicaid Financing & Service Delivery System

D.1. Medicaid Financing & Service Delivery System

- As of 2022, Arkansas is the only state still utilizing a private option approach (i.e., with Medicaid expansion enrollees covered under state-purchased QHPs in the exchange, instead of fee-for-service or managed care Medicaid coverage).

Medicaid System Characteristics		
Characteristics	Medicaid Fee-For-Service (FFS)	ARHOME
Enrollment (March 2023)	1,026,643	342,495
SMI Enrollment	<ul style="list-style-type: none">Arkansas requires individuals with behavioral health needs to enroll in the PASSEs.100% of SMI population is enrolled in the PASSE programs.	
Management	DHS	DHS
Payment Model	FFS	N/A
Geographic Service Area	Statewide	Statewide

Total Medicaid: 1,369,138 | Total Medicaid With SMI: 117,745

D.1. Medicaid System Overview

Medicaid Financial Delivery System Enrollment	
Total Medicaid population distribution	As of March 2023: 75%% in FFS, and 25% in ARHOME.
SMI population inclusion in managed care	<ul style="list-style-type: none">Arkansas requires individuals with behavioral health needs to enroll in the Provider-Led Arkansas Shared Savings Entities (PASSEs).100% of population in a PASSE program.
Dual eligible population inclusion in managed care	<ul style="list-style-type: none">The state does not consider their programs to be traditional managed care, therefore 100% of the dual eligible population is in the fee-for-service program

Medicaid Financing & Risk Arrangements: Behavioral Health		
Service Type	FFS Population	Managed Care Population
Traditional behavioral health	Covered FFS by the state	<ul style="list-style-type: none">PASSE: Included in the health plan's capitation rateARHOME: Included in the health plan's capitation rate
Specialty behavioral health	Covered FFS by the state	<ul style="list-style-type: none">PASSE: Included in the health plan's capitation rateARHOME: Included in the health plan's capitation rate
Pharmaceuticals	Covered FFS by the state	<ul style="list-style-type: none">PASSE: Included in the health plan's capitation rateARHOME: Included in the health plan's capitation rate
Long-term services and supports (LTSS)	Covered FFS by the state	Waiver services for individuals with I/DD are included in the PASSE's capitation rate. All other LTSS will be covered FFS by the state.

D.1. Medicaid Care Coordination Initiatives

Medicaid Care Coordination Entities For Chronic Care Populations (Including SMI)		
Care Coordination Entity	Active Program	Description
Managed Care Health Plan	✓	Yes, the PASSEs are responsible for care coordination.
Primary Care Case Management (PCCM)	✓	Yes, the state has a PCCM called ConnectCare.
Accountable Care Organization (ACO) Program	✓	Yes, the state has one Medicaid ACO
Affordable Care Act (ACA) Model Health Home		None
Patient-Centered Medical Home (PCMH)	✓	Yes, the state operates a PCMH program with shared savings.
Dual Eligible Demonstration		None
Managed Long-Term Services and Supports (MLTSS)	✓	Yes, the PASSEs are responsible for LTSS for the I/DD and behavioral health population.
Certified Community Behavioral Health Clinics (CCBHC) Grant	✓	The state currently has one CCBHC.

D.1. Medicaid Service Delivery System Enrollment By Eligibility Group

- As of 2022, Arkansas is the only state still utilizing a private option approach (i.e., with Medicaid expansion enrollees covered under state-purchased QHPs in the exchange, instead of fee-for-service or managed care Medicaid coverage).
- Arkansas offers two Medicaid programs: AR Health and Opportunity for ME (ARHOME) and PASSE. The PASSE program does not enroll individuals based on eligibility category, but instead based on service need.
 - ARHOME enrolls the Medicaid expansion population (adults with income up to 138% of the FPL).
 - The PASSE program enrolls individuals with behavioral health conditions and individuals with I/DD.
 - All other qualifying individuals are enrolled in FFS.

Eligibility Criteria For PASSE	Groups Excluded From PASSE
<ul style="list-style-type: none">• Behavioral Health: Individuals that have a behavioral health diagnosis and have received an independent assessment that determines they need services in Tiers 2 or 3.• I/DD: Individuals qualify for an institutional level of care either receive services and supports in the community or reside in an institutional setting.	<ul style="list-style-type: none">• Residing in a Human Development Center, skilled nursing home, or assisted living• Eligible for spenddown• Enrolled in the ARChoices or Arkansas Independent Choices program, and Autism Waiver

D.2. Medicaid FFS Program: Overview

- FFS enrollment as of April 2022 was 1,026,643.
- The state's PCCM is called ConnectCare and enrolls over 450,000 individuals.
 - The ConnectCare program includes children, parent and caretaker relatives, and disabled adults.
 - ConnectCare excludes individuals who are eligible for Medicare, reside in a nursing home or intermediate care facility, are eligible under medical spenddown, or are enrolled in a home- and community-based service (HCBS) waiver.
 - Under ConnectCare, individuals enroll with a primary care provider (PCP) who acts as a gatekeeper to accessing additional services.
 - PCPs are responsible for health education, coordination of services, and 24/7 live voice telephone access.
 - PCPs receive a per member per month (PMPM) care management fee.
 - PCPs can also participate in patient-centered medical homes (PCMHs).

D.2. Medicaid FFS Program: Behavioral Health Overview

- In July 2018, Arkansas launched a new outpatient behavioral health program that provides three tiers of services.
 - The new program eliminates the Rehabilitative Services for Person with Mental Illness, Licensed Mental Health Practitioner program, and the Substance Abuse Treatment Services program.
- The three tiers of services include:
 - Counseling – Time-limited behavioral health services in an outpatient-based setting for the purpose of assessing and treating mental health and/or addiction conditions.
 - Rehabilitative – Home- and community-based behavioral health services with care coordination for the purpose of treating mental health and/or addiction conditions. Services shall be rendered and coordinated through a team-based approach.
 - Intensive – The most intensive behavioral health services for the purpose of treating mental health and/or addiction disorder conditions. Services shall be rendered and coordinated through a team-based approach.
- Rehabilitative and intensive level services require an independent assessment.
 - Individuals who qualify for these levels of service must enroll in the PASSE Medicaid program.
- All behavioral health services and pharmacy for the FFS population are delivered FFS.

D.2. Medicaid FFS Program: Behavioral Health Benefits

All enrollees, regardless of tier, have access to inpatient psychiatric, crisis, and acute detoxification services.

Counseling Services	Rehabilitative Services	Intensive Services
<div><div>1.</div><div>Individual, group, and marital/family behavioral health counseling</div></div> <div><div>2.</div><div>Psychoeducation</div></div> <div><div>3.</div><div>Mental health diagnosis</div></div> <div><div>4.</div><div>Substance abuse assessment</div></div> <div><div>5.</div><div>Psychological evaluation</div></div> <div><div>6.</div><div>Pharmacologic management</div></div> <div><div>7.</div><div>Psychiatric assessment</div></div>	<div><div>1.</div><div>Treatment plan</div></div> <div><div>2.</div><div>Partial hospitalization</div></div> <div><div>3.</div><div>Adult rehabilitative day services</div></div> <div><div>4.</div><div>Supportive housing</div></div> <div><div>5.</div><div>Supportive employment</div></div> <div><div>6.</div><div>Adult life skills development</div></div> <div><div>7.</div><div>Peer support</div></div> <div><div>8.</div><div>Aftercare recovery services</div></div> <div><div>9.</div><div>Intensive outpatient substance abuse treatment</div></div> <div><div>10.</div><div>Pharmacologic counseling</div></div> <div><div>Children only:</div></div> <div><div>1.</div><div>Behavioral assistance</div></div> <div><div>2.</div><div>Family support partners</div></div>	<div><div>1.</div><div>Therapeutic communities</div></div> <div><div>2.</div><div>Residential community reintegration program</div></div>

D.2. Medicaid FFS Program: SMI Population

- Arkansas requires individuals with behavioral health needs to enroll in the PASSE programs.
- As of March 2023, 100% of the SMI population was enrolled in one of the PASSE programs.

D.2. Medicaid FFS Program: Pharmacy Benefit

Arkansas FFS Program Pharmacy Benefit & Utilization Restrictions	
State Uses Pharmacy Benefit Manager	Yes, Magellan Medicaid Administration
Responsible For Financing General Pharmacy Benefit	Medicaid FFS
Responsible For Financing Mental Health Pharmacy Benefit	Medicaid FFS
State Uses A Preferred Drug List (PDL) For General Pharmacy	Yes
State Uses A PDL For Mental Health Drugs	Yes, antipsychotics, antidepressants, and anxiolytics are included on the PDL.
State Uses A PDL For Addiction Treatment Drugs	Yes, drugs for opioid dependence are included on the PDL.
Coverage Of Antipsychotic Injectable Medications	Antipsychotic injectable medications are included on the PDL; but may also be billed as a medical benefit.
Utilization Restrictions For Mental Health Or Addiction Treatment Drugs	Non-preferred drugs require prior authorization. Preferred drugs may be subject to review for quantity limits, dosage limits, and therapeutic duplication.
State Has A Pharmacy Lock-In Program Or Other Restriction Program	Yes, the state has a beneficiary lock-in program which identifies individuals who are using non-medically necessary services by using an algorithm and clinical review process. Individuals are locked-in to one pharmacy.

D.3. Medicaid Managed Care Program: Overview

- As of 2022, Arkansas is the only state still utilizing a private option approach (i.e., with Medicaid expansion enrollees covered under state-purchased QHPs in the exchange, instead of fee-for-service or managed care Medicaid coverage).
- Arkansas has two managed care programs that serve different populations:
 - PASSE – Provides care to individuals with I/DD and individuals with behavioral health conditions. Beginning in March 2019, the PASSEs receive a capitated rate.
 - ARHOME– The state's non-traditional Medicaid expansion program that provides premium assistance to purchase insurance on the health insurance marketplace. It includes cost-sharing and work requirements.

D.3. Medicaid Managed Care Program: PASSE

- PASSEs, which began operating in October 2017, are provider-led organizations that partner with an organization experienced in an insurance and/or administrative function.
 - The state did not issue a competitive procurement request, instead choosing to license willing PASSEs that met the licensing requirements. The state certified three statewide PASSEs.
- The PASSEs are responsible for providing care to individuals with I/DD and behavioral health conditions, specifically:
 - Individuals with I/DD who qualify for an institutional level of care
 - Individuals that have a behavioral health diagnosis and have received an independent assessment that determines they need services in Tiers 2 (Rehabilitative) or 3 (Intensive).
 - In the future, the state plans to allow individuals who qualify for Tier 1 services to enroll in the PASSEs voluntarily.
- For the first phase of implementation, the PASSEs received a PMPM care coordination fee, while services were reimbursed FFS. In March 2019, the PASSEs began receiving a global capitation rate for all services provided to enrollees.
 - Services provided under the PASSE include behavioral health services, physical health services, and home- and community-based waiver services.
- All individuals participating in a PASSE receive an annual reassessment, a care coordinator, and a person-centered care plan.

D.3. Medicaid Managed Care Program: Arkansas Health and Opportunity for Me (ARHOME)

- The Arkansas Works waiver was valid through the end of 2021. As of 2022, the state switched to the Arkansas Health and Opportunity for Me (ARHOME) waiver demonstration. The 1115 waiver was approved by the federal government in December 2021 and allows the state to continue to provide private coverage (obtained via the Arkansas health insurance marketplace) to more than 300,000 people who are enrolled in the Arkansas Medicaid expansion program.
- However, the waiver approval notes that after the end of 2022, Arkansas will no longer be allowed to charge premiums to enrollees with income above the poverty level. Medicaid expansion covers adults with income up to 138% of the poverty level, and the Arkansas Works waiver, approved by the Obama administration, included a provision that allows the state to charge premiums (2% of income) for Medicaid expansion enrollees with income between 100% and 138% of the poverty level.
- There are currently four health plans participating in the ARHOME marketplace:
 - Arkansas Health & Wellness (Ambetter)
 - Arkansas Blue Cross Blue Shield
 - QCA
 - QualChoice
- Individuals with income above 100% of the FPL are required to pay premiums of up to 2% of household income and are responsible for cost-sharing as defined in the Medicaid state plan.
 - There is a two-month grace period for late payments. Unpaid premiums will be considered a debt to the state; but will not result in disenrollment.
 - Cost-sharing and premiums cannot exceed 5% of an individual's household income.
 - Individuals with income under 100% of the FPL are not subject to cost-sharing or premiums.

D.3. Medicaid Managed Care Program: ARHOME Community Engagement Requirements

- The Biden administration officially withdrew the state's Medicaid work requirement waiver approval in March 2021, although it had not been in effect for two years prior to that. The state's new ARHOME waiver, which was approved in December 2021 to continue to state's approach to Medicaid expansion, did not include a proposal for a work requirement, as the Biden administration had made it clear that such proposals would not be approved.
- Arkansas is no longer removing people from the Medicaid program for failure to comply with the work requirement or reporting requirement, and the people who had already lost their coverage under the work requirement rules were able to re-apply for Medicaid — although many may not be aware that their access to Medicaid has been reinstated (albeit not automatically, as they do still need to re-apply for coverage).
- As of June 2021, there were more than 921,000 people enrolled in Arkansas Medicaid and CHIP, which was higher than it had been in the months following implementation of the work requirement, but still lower than it had been in 2018, in spite of the fact that the COVID pandemic had been ongoing for over a year.

D.3. Medicaid Managed Care Program: PASSE Characteristics

Arkansas Total Care	Summit Community Care
<div><div>1. Provider Participants:<ul style="list-style-type: none">Mercy HealthLifeShare Management Group, LLC</div><div>2. Insurer participant: Arkansas Health & Wellness (Centene)</div><div>3. Behavioral health subcontractor: Cenpatico</div><div>4. Pharmacy benefit manager: Envolve Pharmacy Solutions</div><div>5. Enrollment share: 29%</div></div>	<div><div>1. Provider Participant: Arkansas Provider Coalition</div><div>2. Insurer participant: Anthem</div><div>3. Behavioral health subcontractor: None</div><div>4. Pharmacy benefit manager: IngenioRx</div><div>5. Enrollment share: 33%</div></div>
Empower Healthcare Solutions	CareSourcePASSE
<div><div>1. Provider Participants:<ul style="list-style-type: none">Woodruff Health Group, LLCThe Arkansas Healthcare Alliance, LLCArkansas Community Health NetworkStatera, LLCIndependent Case Management, Inc.</div><div>2. Insurer participant: Beacon Health Options</div><div>3. Behavioral health subcontractor: None</div><div>4. Pharmacy benefit manager: CVS Caremark</div><div>5. Enrollment share: 40%</div></div>	<div><div>1. Provider Participant:<ul style="list-style-type: none">AcadiaAshley County Medical CenterCareSourceChenal Family TherapyDr James E Zini, DORehab Net</div><div>2. Insurer participant: CareSource</div><div>3. Behavioral health subcontractor: None</div><div>4. Pharmacy benefit manager: CareSource RxInnovatons</div><div>5. Enrollment share: 1%</div></div>

D.3. Medicaid Managed Care Program: Behavioral Health Overview

- Under the ARHOME program, individuals receive commercial behavioral health and pharmacy benefits through qualified health plans on the Marketplace.
 - These health plans must include addiction disorder inpatient and outpatient services as required by the state's alternative benefit plan for the Medicaid expansion population.
- The PASSEs are at-risk for all behavioral health services, including pharmacy benefits.

D.3. Medicaid Managed Care Program: PASSE Behavioral Health Benefits

Counseling Services	Rehabilitative Services	Intensive Services
<div><div>1.</div><div>Individual, group, and marital/family behavioral health counseling</div></div> <div><div>2.</div><div>Psychoeducation</div></div> <div><div>3.</div><div>Mental health diagnosis</div></div> <div><div>4.</div><div>Substance abuse assessment</div></div> <div><div>5.</div><div>Psychological evaluation</div></div> <div><div>6.</div><div>Pharmacologic management</div></div> <div><div>7.</div><div>Psychiatric assessment</div></div>	<div><div>1.</div><div>Treatment plan</div></div> <div><div>2.</div><div>Partial hospitalization</div></div> <div><div>3.</div><div>Adult rehabilitative day services</div></div> <div><div>4.</div><div>Supportive housing</div></div> <div><div>5.</div><div>Supportive employment</div></div> <div><div>6.</div><div>Adult life skills development</div></div> <div><div>7.</div><div>Peer support</div></div> <div><div>8.</div><div>Aftercare recovery services</div></div> <div><div>9.</div><div>Intensive outpatient substance abuse treatment</div></div> <div><div>10.</div><div>Pharmacologic counseling</div></div> <div><div>Children only:</div></div> <div><div>1.</div><div>Behavioral assistance</div></div> <div><div>2.</div><div>Family support partners</div></div>	<div><div>1.</div><div>Therapeutic communities</div></div> <div><div>2.</div><div>Residential community reintegration program</div></div>

D.3. Medicaid Managed Care Program: SMI Population

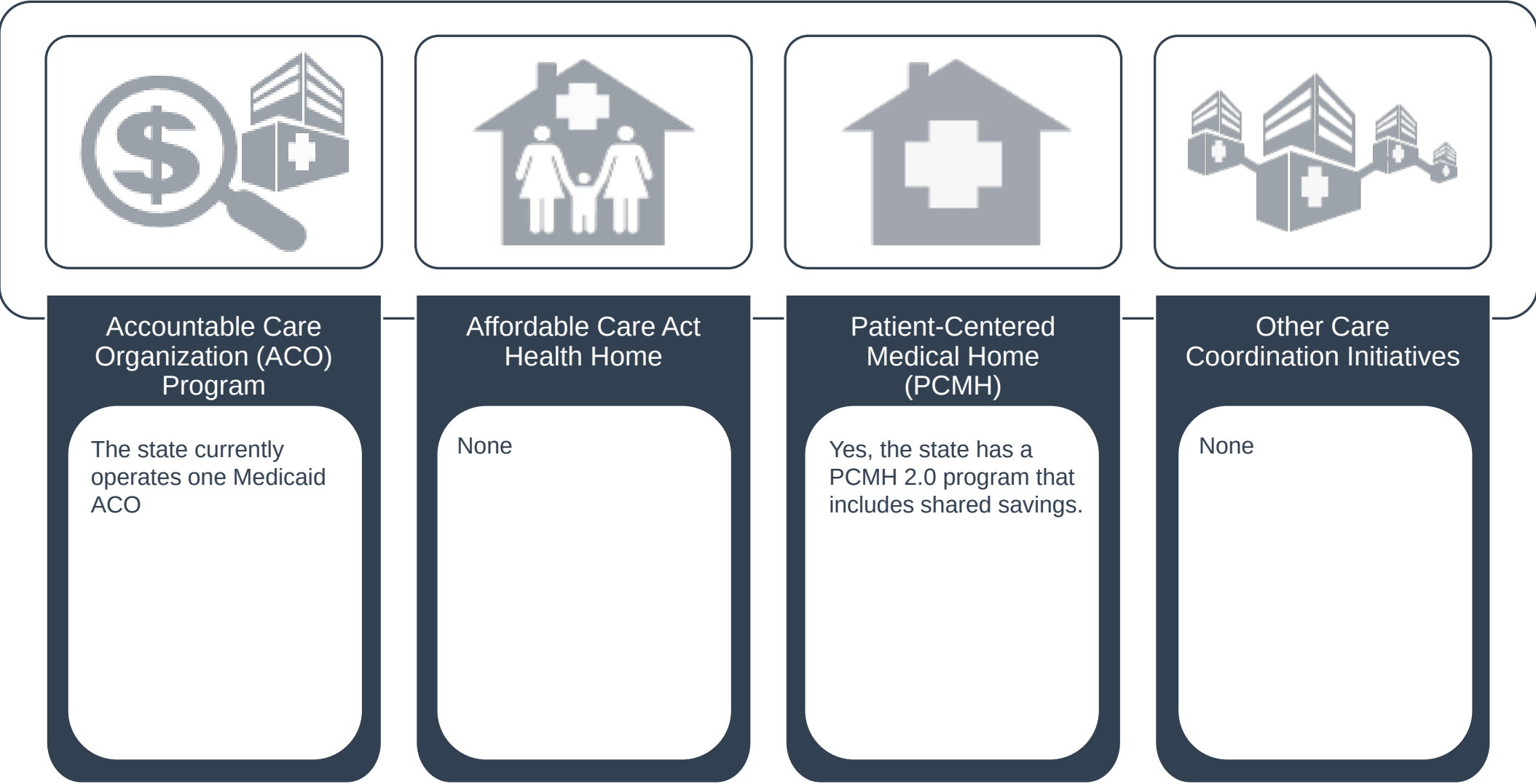
- Arkansas requires individuals with behavioral health needs to enroll in a PASSE program.
- The Medicaid expansion population, if medically frail, must be offered the full array of State Plan benefits. Medically frail individuals include adults with SMI and chronic addiction disorders.

D.3. Medicaid Managed Care Program: Pharmacy Benefit

- Pharmacy for the AR Works population is covered through the marketplace plans; each plan is able to set their own PDL and prior authorization criteria.

Arkansas PASSE Pharmacy Benefit	
Responsible For Financing General Pharmacy Benefit	PASSEs
Responsible For Financing Mental Health Pharmacy Benefit	PASSEs
Health Plan Uses A Preferred Drug List (PDL) For General Pharmacy	Yes, the PASSEs must follow the state FFS PDL for all drug classes. Mental health drug classes and drugs for opioid dependence are included on the PDL.
Health Plan Uses A PDL For Mental Health Drugs	
Health Plan Uses A PDL For Addiction Treatment Drugs	
Health Plan Use Of Utilization Restrictions For Mental Health & Addiction Treatment Drugs	<ul style="list-style-type: none">• Drugs on the PDL must be covered without prior authorization except for clinical and utilization edits.• Non-preferred drug prior authorization requirements cannot be more restrictive than those used on the state FFS PDL.
Health Plan Allowed To Implement Pharmacy Lock-In Program	The PASSE contract agreement does not include language about implementing a lock-in program.

D.4. Medicaid Program: Care Coordination Initiatives



D.4. Medicaid Program: Patient-Centered Medical Home

PCMH 2.0 Characteristics

Target Population	<ul style="list-style-type: none">Individuals eligible to enroll in ConnectCare, the state's PCCM
Geographic Service Area	Statewide
Care Delivery Model	<ul style="list-style-type: none">Primary care practices participating in ConnectCare with at least 150 beneficiariesProvider organizations must have 1,000 members attributed for the shared savings component of the program. Provider organizations can reach 1,000 participants in multiple ways:<ul style="list-style-type: none">Independently – Individual practices are responsible for performance-based incentive payments (PBIP) and quality metrics.Participation in the voluntary pool for practices with 150-299 participants – Practice performance is aggregated for PBIP and quality metrics.Participation in the default pool – Practice performance is aggregated for PBIP, but not for quality metrics.Practices with less than 300 beneficiaries who do not wish to participate in the voluntary pool may participate in the Petite pool. Practice performance is aggregated for PBIP and quality metricsMust provide same-day appointments, 24/7 access to care, identify top 10% of high priority enrollees, ability to receive consumer feedback, care plan creation for high priority enrollees, 10-day follow-up after acute inpatient hospital stay, etc.
Payment Model	<ul style="list-style-type: none">Per member per month payment based on the individual's resource utilization band score. Payments range from \$1 to \$30.Performance-Based Incentive Payments – PCMH incentive payments based on performance on three measures, incentive amount is multiplied by member months. In order to receive payment, the PCMH must meet at least two-thirds of quality measures assessed.<ul style="list-style-type: none">PCMHs in the top 10th percentile receive 100% of incentive payment.PCMHs in the 35th percentile receive 50% of incentive payment.
Practice Performance & Improvement	<ul style="list-style-type: none">PCMHs can receive payment for practice transformation activities.See next slide for the list of quality measures.

D.4. Medicaid Program: Patient-Centered Medical Home Quality Metrics

Performance-Based Incentive Payments Metrics		
Metric	Practices In 10 th Percentile	Top 11 th – 35 th Percentile
Inpatient rate	\$12, times the number of attributed member months	\$6, times the number of attributed member months
Emergency department rate	\$8, times the number of attributed member months	\$4, times the number of attributed member months
Focus metric-adolescent wellness (see below for detail)	\$5, times the number of attributed member months	\$2.50, times the number of attributed member months

Quality Metrics That Must Be Met To Receive PBIP Payment		
Metric Name	Description	2023 Target
Infant wellness	Percentage of beneficiaries who turned 15 months old during the performance period who receive at least five wellness visits in their first 15 months (0-15 months)	75%
Child wellness	Percentage of beneficiaries 3-6 years of age who had one or more well-child visits during the measurement year	70%
Adolescent wellness	Percentage of beneficiaries 12-21 years of age who had one or more well-care visits during the measurement year	50%
URI	Percentage of beneficiaries, age one year and older, events with a diagnosis of non-specified URI that had appropriate treatment during the measurement period	82%
Controlling BP	Percentage of consumers, 18-85 years of age, who had a diagnosis of hypertension and whose blood pressure was adequately controlled (All payer source)	68%
HbA1c poor control	Percentage of consumers, 18-75 years of age, with diabetes who had hemoglobin A1c > 9.0% during the measurement period (All payer source)	28%

D.4. Medicaid Program: Patient-Centered Medical Home Quality Metrics (cont.)

Metric Name	Description	2023 Target
Asthma Compliance	Percentage of consumers who are compliant with prescribed asthma controller Medicaid.	55%
Diabetic Nephropathy	Percentage of consumers aged 18-75 with diabetes that had an annual screening of nephropathy.	85%
Diabetes RX	Percentage of consumers over the age of 18 who met the threshold for the correct proportion of days of medication use.	50%
Low Back Imaging	Percentage of consumers with low back pain who did not get imaging.	75%
Adult Bronchitis	Percentage of consumers between the ages of 18-64 who have a diagnosis of acute bronchitis who did not receive an antibiotic.	55%
Breast Cancer Screening	Percentage of female consumers between the ages of 52-74 who receive a mammogram.	65%
Colorectal Cancer Screening	Percentage of consumers between the ages of 50-75 who had appropriate screening for colon cancer.	52%
Diabetes Retinopathy	Percentage of diabetic consumers between the ages of 18-75 who had an eye exam performed.	50%
Cervical Cancer Screening	Percentage of female consumers between the ages of 21-64 who had an appropriate screening for cervical cancer.	60%
Antidepressant Medication Management	Percentage of consumers who start an antidepressant medication that remained on the treatment for at least 12 weeks.	60%

D.5. Medicaid Program: Demonstration & Care Management Waivers

Waiver Title	Waiver Description	Waiver Type	Enrollment Cap	Effective Date	Expiration Date
Arkansas Health and Opportunity for Me (ARHOME)*	Authorizes Arkansas's non-traditional Medicaid expansion program, which utilizes commercial benefit health plans available on the health insurance marketplace. The state's community engagement requirements are currently on hold due to a legal challenge.	1115	None	01/01/2022	12/31/2026
Arkansas' Tax Equity and Fiscal Responsibility Act (TEFRA-like)*	Provides Medicaid services to disabled children who are eligible for institutional placement. If the family has income above 150% of the FPL, premiums are charged on a sliding scale basis.	1115	None	01/01/2003	12/31/2022
Care Coordination (AR-07)	Authorizes the state to enroll individuals with developmental disabilities and behavioral health conditions in the PASSEs for care coordination services.	1915 (b)	None	04/01/2022	12/31/2026

*Waiver still considered pending through CMS.

D.5. Medicaid Program: Section 1915 (c) HCBS Waivers

Waiver Title	Target Population	2023 Enrollment Cap	Operating Unit	Concurrent Management Authority
AR Choices in Homecare (0195.R06.00)	Individuals ages 21-64 with a physical disability and individuals over the age of 65.	11,500	Division of Aging, Adult, and Behavioral Health Services and Division of Provider Services and Quality Assurance	Yes, 1915 (j) state plan amendment
AR Community and Employment Support (0188.R06.00)	Individuals with autism, developmental disabilities, and intellectual disabilities of any age.	5,483	Division of Developmental Disabilities Services	Yes, 1915 (b) PASSE waiver
AR Living Choices Assisted Living	Individuals ages 21-64 with a physical disability and individuals over the age of 65.	1,200	Division of Aging, Adult, and Behavioral Health Services and Division of Provider Services and Quality Assurance	No

D.6. Medicaid Program New Initiatives

- Arkansas does not have any major new initiatives at this time.

E. Dual Eligible Financing & Service Delivery System

E.1. Dual Eligible Medicaid Financing & Service Delivery System

Dual Eligible* Medicaid System Characteristics			
Characteristics	Medicaid Fee-For-Service (FFS)	Managed Care-PASSE	PACE
Enrollment (March 2023)	83,312		304
Estimated SMI Enrollment	26,659		97
Management	Department of Human Services	Four provider-led health plans	Two organizations
Payment Model	FFS	Capitated rate	Blended capitated rate
Geographic Service Area	Statewide	Statewide	Certain ZIP codes

Total Dual Eligible Enrollment: 83,616 | Total Dual Eligible Enrollment With SMI: 26,757

*Unless otherwise noted, the term *dual eligibles* in this section refers to Medicare enrollees with full Medicaid benefits.

E.2. Largest Dual Eligible Health Plans By Estimated SMI Enrollment

Health Plans	Parent Company	Plan Type	May 2023 Enrollment	Estimated SMI Enrollment
UnitedHealthcare Dual Complete Choice	UnitedHealthcare, Inc	Medicare Advantage D-SNP	31,763	10,164
Humana Gold Plus	Humana, Inc	Medicare Advantage D-SNP	10,312	3,300
UnitedHealthcare Dual Complete Choice Select	UnitedHealthcare, Inc	Medicare Advantage D-SNP	7,039	2,252
Wellcare Dual Access	Wellcare Health Plans, Inc	Medicare Advantage D-SNP	3,510	1,123
Wellcare Dual Access Openn	Wellcare Health Plans, Inc	Medicare Advantage D-SNP	3,510	1,123
Wellcare Dual Liberty	Wellcare Health Plans, Inc	Medicare Advantage D-SNP	3,510	1,123
HumanaChoice	Humana, Inc	Medicare Advantage D-SNP	1,697	543
Aetna Medicare Assure	Aetna/CVS Health	Medicare Advantage D-SNP	1,553	497
Wellcare Dual Liberty	Wellcare Health Plans, Inc	Medicare Advantage D-SNP	1,537	492
WellCare Access	Wellcare Health Plans, Inc	Medicare Advantage D-SNP	812	260

E.3. Dual Eligible Medicaid Financing & Delivery System: Overview

- Dual eligible enrollment as of March 2023 was 83,616.
- Medicare covers most acute services (which may include psychiatric care), while Medicaid, the payer of last resort, covers LTSS and non-physician behavioral health services.
- For Medicaid services, dual eligibles who meet the criteria for enrollment will be assigned to a PASSE. All other dual eligibles are enrolled in FFS for Medicaid services.
- D-SNP enrollment as of May 2023 was 66,146. SMI enrollment for D-SNP plans was 21,167.

E.4. Dual Eligible Medicaid Financing & Delivery System: New Initiatives

- The state does not have any new initiatives related to dual eligibles at this time.

F. Long-Term Services & Supports Financing & Service Delivery System

F.1. LTSS Financing & Service Delivery System

- Arkansas delivers MLTSS services through the Provider-led Arkansas Share Savings Entity (PASSE) program. The PASSE is a new model of organized care that addresses the needs of Medicaid beneficiaries with complex health care issues.

LTSS* Medicaid System Characteristics	
Characteristics	Medicaid Managed Care
Enrollment (July 2023)	56,814
Estimated SMI Enrollment	18,180
Management	Four health plans
Payment Model	Capitated
Geographic Service Area	Statewide

Total LTSS Enrollment: 56,814 | Total LTSS Enrollment With SMI: 18,180

F.1. LTSS Financing & Service Delivery System

- Arkansas delivers MLTSS services through the Provider-led Arkansas Share Savings Entity (PASSE) program. The PASSE is a new model of organized care that addresses the needs of Medicaid beneficiaries with complex health care issues.

LTSS* Medicaid System Characteristics	
Characteristics	Medicaid Managed Care
Enrollment (July 2023)	56,814
Estimated SMI Enrollment	18,180
Management	Four health plans
Payment Model	Capitated
Geographic Service Area	Statewide

Total LTSS Enrollment: 56,814 | Total LTSS Enrollment With SMI: 18,180

F.1. Medicaid LTSS Service Delivery System Enrollment By Eligibility Group

- The PASSE program does not enroll individuals based on eligibility category, but instead based on service need.
 - The PASSE program enrolls individuals with behavioral health conditions and individuals with I/DD.
 - All other qualifying individuals are enrolled in FFS.

Eligibility Criteria For PASSE	Groups Excluded From PASSE
<ul style="list-style-type: none">• Behavioral Health: Individuals that have a behavioral health diagnosis and have received an independent assessment that determines they need services in Tiers 2 or 3.• I/DD: Individuals qualify for an institutional level of care either receive services and supports in the community or reside in an institutional setting.	<ul style="list-style-type: none">• Residing in a Human Development Center, skilled nursing home, or assisted living• Eligible for spenddown• Enrolled in the ARChoices or Arkansas Independent Choices program, and Autism Waiver

F.2. LTSS Medicaid Financing & Delivery System: Overview

- PASSEs, which began operating in October 2017, are provider-led organizations that partner with an organization experienced in an insurance and/or administrative function.
 - The state did not issue a competitive procurement request, instead choosing to license willing PASSEs that met the licensing requirements. The state certified four statewide PASSEs.
- The PASSEs are responsible for providing care to individuals with I/DD and behavioral health conditions, specifically:
 - Individuals with I/DD who qualify for an institutional level of care
 - Individuals that have a behavioral health diagnosis and have received an independent assessment that determines they need services in Tiers 2 (Rehabilitative) or 3 (Intensive). In the future, the state plans to allow individuals who qualify for Tier 1 services to enroll in the PASSEs voluntarily.
- For the first phase of implementation, the PASSEs received a PMPM care coordination fee, while services were reimbursed FFS. In March 2019, the PASSEs began receiving a global capitation rate for all services provided to enrollees.
 - Services provided under the PASSE include behavioral health services, physical health services, and home- and community-based waiver services.
- All individuals participating in a PASSE receive an annual reassessment, a care coordinator, and a person-centered care plan.

F.3. Medicaid LTSS Program: Health Plan Characteristics

Arkansas Total Care
<div><div>1. Provider Participants:</div><div><div>Mercy Health</div><div>LifeShare Management Group, LLC</div></div></div> <div>2. Insurer participant: Arkansas Health & Wellness (Centene)</div> <div>3. Behavioral health subcontractor: Cenpatico</div> <div>4. Pharmacy benefit manager: Envolve Pharmacy Solutions</div> <div>5. Enrollment share: 29%</div>
Empower Healthcare Solutions
<div><div>1. Provider Participants:</div><div><div>Woodruff Health Group, LLC</div><div>The Arkansas Healthcare Alliance, LLC</div><div>Arkansas Community Health Network</div><div>Statera, LLC</div><div>Independent Case Management, Inc.</div></div></div> <div>2. Insurer participant: Beacon Health Options</div> <div>3. Behavioral health subcontractor: None</div> <div>4. Pharmacy benefit manager: CVS Caremark</div> <div>5. Enrollment share: 38%</div>

Summit Community Care
<div><div>1. Provider Participant: Arkansas Provider Coalition</div></div> <div>2. Insurer participant: Anthem</div> <div>3. Behavioral health subcontractor: None</div> <div>4. Pharmacy benefit manager: IngenioRx</div> <div>5. Enrollment share: 33%</div>
CareSourcePASSE
<div><div>1. Provider Participant:</div><div><div>Acadia</div><div>Ashley County Medical Center</div><div>CareSource</div><div>Chenal Family Therapy</div><div>Dr James E Zini, DO</div><div>Rehab Net</div></div></div> <div>2. Insurer participant: CareSource</div> <div>3. Behavioral health subcontractor: None</div> <div>4. Pharmacy benefit manager: CareSource RxInnovatons</div> <div>5. Enrollment share: 1%</div>

F.4. Medicaid LTSS Program: Health Benefits

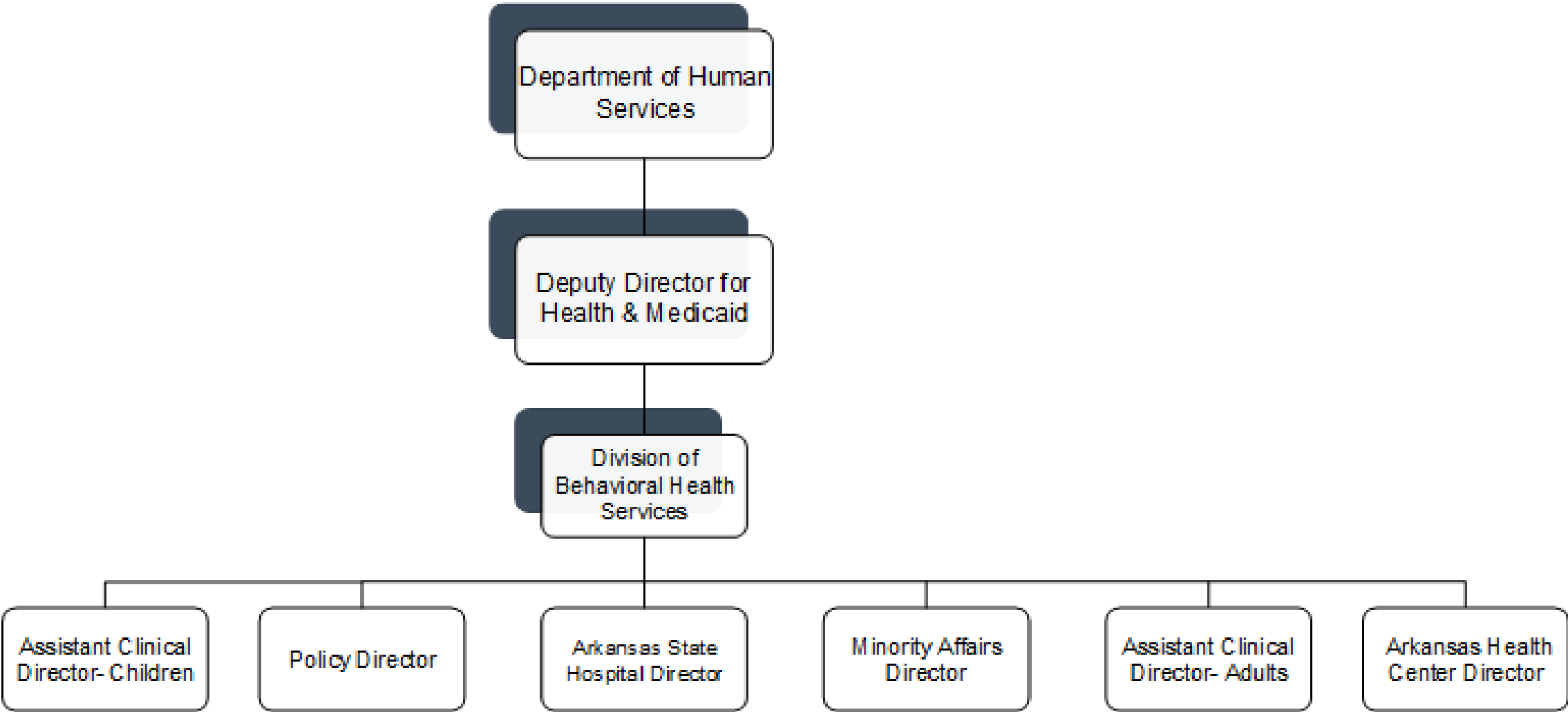
Counseling Services	Rehabilitative Services	Intensive Services
<div><div>1.</div><div>Individual, group, and marital/family behavioral health counseling</div></div> <div><div>2.</div><div>Psychoeducation</div></div> <div><div>3.</div><div>Mental health diagnosis</div></div> <div><div>4.</div><div>Substance abuse assessment</div></div> <div><div>5.</div><div>Psychological evaluation</div></div> <div><div>6.</div><div>Pharmacologic management</div></div> <div><div>7.</div><div>Psychiatric assessment</div></div>	<div><div>1.</div><div>Treatment plan</div></div> <div><div>2.</div><div>Partial hospitalization</div></div> <div><div>3.</div><div>Adult rehabilitative day services</div></div> <div><div>4.</div><div>Supportive housing</div></div> <div><div>5.</div><div>Supportive employment</div></div> <div><div>6.</div><div>Adult life skills development</div></div> <div><div>7.</div><div>Peer support</div></div> <div><div>8.</div><div>Aftercare recovery services</div></div> <div><div>9.</div><div>Intensive outpatient substance abuse treatment</div></div> <div><div>10.</div><div>Pharmacologic counseling</div></div> <div><div>Children only:</div></div> <div><div>1.</div><div>Behavioral assistance</div></div> <div><div>2.</div><div>Family support partners</div></div>	<div><div>1.</div><div>Therapeutic communities</div></div> <div><div>2.</div><div>Residential community reintegration program</div></div>

F.5. LTSS Medicaid Financing & Delivery System: New Initiatives

- Arkansas has no pending initiatives that will influence the finance or delivery systems of the LTSS population.

G. State Behavioral Health Administration & Finance System

G.1. Division Of Behavioral Health Services: Organization Chart



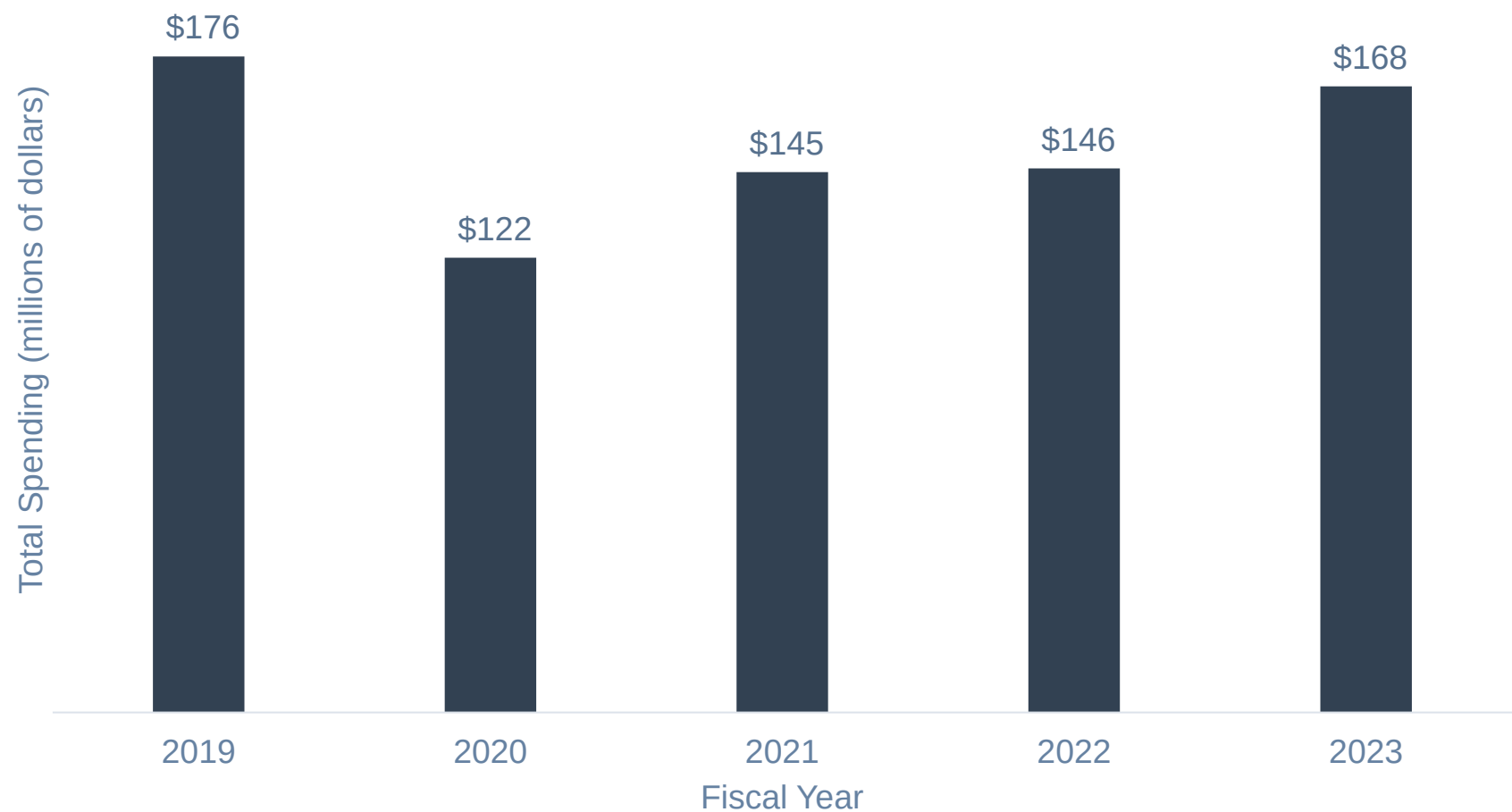
G.1. Division Of Behavioral Health Services: Key Leadership

Name	Position	Department	Email
Kristi Putnam	Secretary	Department of Human Services (DHS)	kristi.putnam@dhs.arkansas.gov
Jay Hill	Director	DHS, Division of Aging, Adult, and Behavioral Health Services	jay.hill@dhs.arkansas.gov
Tammy Alexander	Assistant Director	DHS, Division of Aging, Adult, and Behavioral Health Services	tammy.alexander@dhs.arkansas.gov
Kirk Lane	State Drug Director	DHS, Division of Aging, Adult, and Behavioral Health Services	kirk.lane@dhs.arkansas.gov

G.2. Division Of Behavioral Health Services: Spending

Budget Item	FY 2023 Request	Percent Of Budget
Division of Aging, Adult, & Behavioral Health Services	\$127,104,051	76%
Alcohol & Drug abuse prevention	\$40,513,788	24%
Total Spending: \$167,617,839		

G.2. Division Of Behavioral Health: Spending Over Time



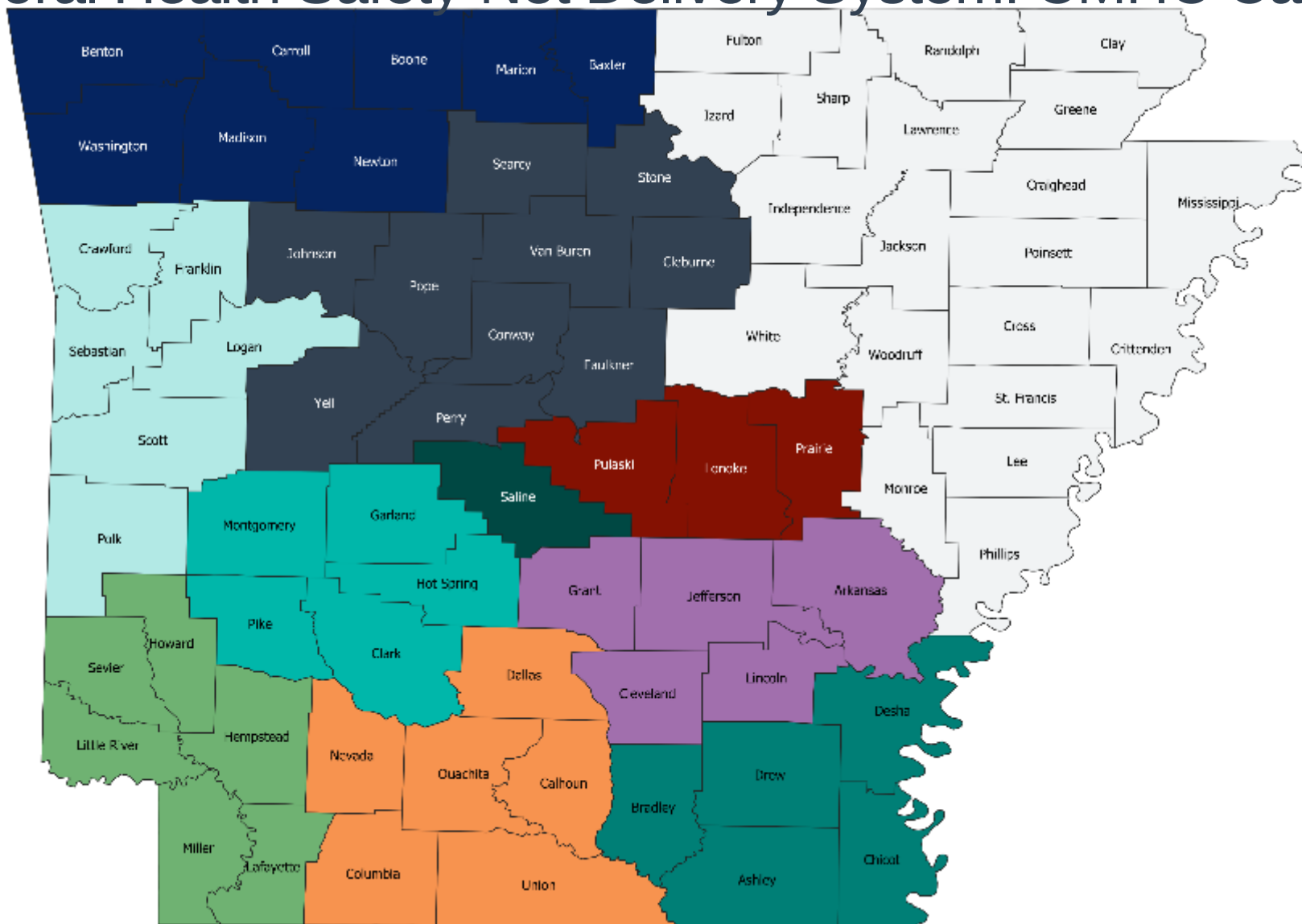
G.3. State Psychiatric Institutions

State Psychiatric Institutions		
Institution	Location	Beds
Arkansas Health Center	Benton	310
Arkansas State Hospital	Little Rock	222
Total		532

G.4. Behavioral Health Safety-Net Delivery System

- The Division of Behavioral Health Services (DBHS) contracts with 12 community mental health centers (CMHCs) to provide mental health services to the safety-net population.
- Each CMHC serves as the single point of entry into the public mental health system for adults in its catchment area.
 - During the first half of 2019, the state competitively bid the CMHCs.
- CMHCs provide services to the Medicaid population along with the uninsured population.
- DBHS also delivers addiction disorder treatment services to the underinsured population by contracting with local provider organizations throughout the state. Services include — but are not limited to — counseling and residential treatment services.
- In August 2020, the state was awarded a \$21 million grant to expand access to medication-assisted treatment for opioid and stimulant abuse, and to decrease deaths caused by opioids and stimulants over the next two years.

G.4. Behavioral Health Safety-Net Delivery System: CMHC Catchment Areas



G.4. Behavioral Health Safety-Net Delivery System: CMHC Catchment Areas

Map Color	Community Mental Health Center	Counties Served
	Ouachita Behavioral Health and Wellness	Clark, Garland, Hot Springs, Montgomery, Pike
	Counseling Associates, Inc.	Cleburne, Conway, Faulkner, Johnson, Perry, Pope, Searcy, Stone, Van Buren, Yell
	Counseling Clinic, Inc.	Saline
	Delta Counseling Associates	Ashley, Bradley, Chicot, Desha, Drew
	Western Arkansas Counseling and Guidance	Crawford, Franklin, Logan, Polk, Scott, Sebastian
	Centers for Youth and Families	Pulaski
	Mid-South Health Systems, Inc.	Clay, Craighead, Crittenden, Cross Greene, Independence, Izard, Lawrence, Lee, Mississippi, Monroe, Philips, Poinsett, Randolph, Sharp, St. Francis, White
	Ozark Guidance Center, Inc.	Baxter, Benton, Boone, Carroll, Madison, Marion, Newton, Washington
	Professional Counseling Associates	Lonoke, Prairie, Pulaski
	South Arkansas Regional Health Centre	Calhoun, Columbia, Dallas, Nevada, Ouachita, Union,
	Southeast Arkansas Behavioral Healthcare	Arkansas, Cleveland, Grant, Jefferson, Lincoln
	Southwest Arkansas Counseling and Mental Health	Hempstead, Howard, Lafayette, Little River, Miller, Sevier

H. Appendices

H.1. OPEN MINDS Estimates For Share Of SMI Consumers Per Payer/Plan

Enrollment Category	Serious Mental Illness (SMI) Prevalence Estimate	Source
Commercial	4.1% of the commercially insured population over age 18	Substance Abuse and Mental Health Services Administration. (2022, January). Results from the 2020 National Survey on Drug Use and Health: Mental Health Detailed Tables. Retrieved October December 2022 from https://www.samhsa.gov/data/sites/default/files/reports/rpt35323/NSDUHDetailedTabs2020v25/NSDUHDetailedTabs2020v25/2020NSDUHDetTabs01112022.zip
Medicaid	38.2% of adults age 18 to 64, not dually eligible for Medicare, who qualify for Medicaid based on a disability	Medicaid and CHIP Payment and Access Commission. (2022, June). Report to Congress on Medicaid and Chip. Retrieved December 2022 from https://www.macpac.gov/publication/june-2022-report-to-congress-on-medicaid-and-chip/
	8.1% of persons in the Medicaid expansion population	Substance Abuse and Mental Health Services Administration. (2022, January). Results from the 2020 National Survey on Drug Use and Health: Mental Health Detailed Tables. Retrieved December 2022 from https://www.samhsa.gov/data/sites/default/files/reports/rpt35323/NSDUHDetailedTabs2020v25/NSDUHDetailedTabs2020v25/2020NSDUHDetTabs01112022.zip
Medicare	16% of persons in the Medicare population, not dually eligible for Medicaid	Centers for Medicare and Medicaid Services. (2021). Medicare-Medicaid Coordination Office Report to Congress. Retrieved December 2022 from https://www.cms.gov/files/document/reporttocongressmmco.pdf

H.1. OPEN MINDS Estimates For Share Of SMI Consumers Per Payer/Plan

Enrollment Category	Serious Mental Illness (SMI) Prevalence Estimate	Source
Medicare-Medicaid Dual Eligibility	25% of persons in the Medicare population dually eligible for partial Medicaid benefits	Congressional Budget Office. (2013, June). Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spends, and Evolving Policies. Retrieved December 2022 from https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/44308_DualEligibles2.pdf
	32% of persons in the Medicare population dually eligible for full Medicaid benefits	U.S. Department of Health and Human Services. (2019, May 9). Analysis of Pathways to Dual Eligible Status: Final Report. Retrieved December 2022 from https://aspe.hhs.gov/basic-report/analysis-pathways-dual-eligible-status-final-report
Other Public	8.3% of persons served by the Veterans Administration health care system or the TRICARE military health system	Military Health Systems. (2020, August 7). Examination of Mental Health Accession Screening: Predictive Value of Current Measures and Report Processes. Retrieved December 2022 from https://www.health.mil/Reference-Center/Presentations/2019/11/04/Examination-of-Mental-Health-Accession-Screening-Update
No Health Care Insurance	6.2% of uninsured persons over age 18	Substance Abuse and Mental Health Services Administration. (2019, August). Results from the 2018 National Survey on Drug Use and Health: Mental Health Detailed Tables. Retrieved December 2022 from https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHDetailedTabs2018R2/NSDUHDetailedTabs2018.pdf

H.2. Glossary Of Terms

Word	Abbreviation	Definition
Alternative Benefit Plan	ABP	State designed benefit package for the Medicaid expansion population (childless adults with income below 138% of the FPL). The benefit package must include the ten essential benefits as laid out in the PPACA. The Medicaid expansion population deemed medically frail (including those with SMI) are exempt from receiving benefits through the ABP.
Accountable Care Organizations	ACO	ACOs are groups of provider organizations—such as physicians and hospital systems—that form an agreement to coordinate care for a set group of individuals. If the ACO delivers high quality care—measured through performance metrics—and lowers the cost of providing care against a baseline, then the organization receives a portion of the savings generated. ACOs can exist alongside all payment structures (fee-for-service and managed care delivery systems) and payers (Medicare, Medicaid, commercial).
Administrative Services Organization	ASO	An arrangement in which an organization hires a third party to deliver administrative services to the organization, such as claims processing and billing. The ASO is not at-risk.
Capitation		A set amount of money paid per enrollee per month to a health care entity to cover the cost of health care services. Capitation can cover the cost of all health care services or subset of services, such as care coordination or home- and community-based services.
Carve-out		A carve-out is a Medicaid managed care financing model where some portion of Medicaid benefits—dental services, pharmacy services, behavioral health services, etc.—are separately managed and/or financed. Carve-out services can be financed on an at-risk basis by another organization or retained by the state Medicaid agency on a fee-for-service basis.
Certified Community Behavioral Health Clinic	CCBHC	Behavioral health clinics specially certified in a demonstration established by section 223 of the Protecting Access to Medicare Act of 2014. The clinics are designed to provide community-based mental health and addiction treatment services, to advance the integration of behavioral health with physical health care, and to provide care coordination across the full spectrum of health services.

H.2. Glossary Of Terms

Word	Abbreviation	Definition
Community Mental Health Center	CMHC	An organization that can demonstrate that it is actively providing all services in section 1913(c)(I) of the Public Health Services Act, including a.) Outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically mentally ill, and residents of the CMHC's mental health service area who have been discharged from inpatient treatment at a mental health facility; b.) 24 hour-a-day emergency care services; c.) Day treatment, or other partial hospitalization services, or psychosocial rehabilitation services; and d.) Screening for patients being considered for admission to state mental health facilities to determine the appropriateness of such admission. Additionally, the organization must meet the specifications for the state where it provides services.
Dual Eligible		An individual who is eligible for Medicare (Part A and B) and Medicaid. Medicare serves as the individual's primary insurance, and Medicaid acts as a supplement. Dual eligibles are sometimes referred to as Medicare-Medicaid enrollees (MMEs).
Federal Poverty Level	FPL	The U.S. Department of Health and Human Services sets a standard level of income that is used to determine eligibility for services and benefits, including Medicaid. In 2023, the FPL is \$13,590 for an individual and \$27,750 for a family of four.
Fee-For-Service	FFS	A system where the payer, in this case Medicaid, contracts directly with provider organizations and pays for providing care on a unit by unit basis. Health plans may also reimburse provider organizations on a FFS basis meaning they pay for each unit of care or test.
Health Home		A "whole person" care coordination model that specifically targets populations with chronic conditions including those with SMI. Health homes provide six essential functions: 1.) Comprehensive care management; 2.) Care coordination and health promotion; 3.) Comprehensive transitional care from inpatient to other settings, including appropriate follow-up; 4.) Individual and family support; 5.) Referral to community and social support services; 6.) Use of health information technology to link services. Health homes were originally developed as a Medicaid program, but have been adopted by other payers. For a state to have an official health home program they must have an approved state plan amendment.

H.2. Glossary Of Terms

Word	Abbreviation	Definition
Health Insurance Marketplace	HIM	Created by the PPACA, the health insurance marketplace is an online platform where individuals and small businesses can purchase health insurance. The federal government subsidizes coverage purchased on the marketplace through premium tax credits for individuals with income up to 400% of the FPL.
Home- & Community-Based Services	HCBS	Long-term services and supports provided in the home or community in order to avoid institutionalization. Traditionally provided through 1915(c) waivers, HCBS services are usually limited to specific populations and a specific number of people. HCBS services include skilled nursing care, personnel care services, assistance with activities of daily living, and custodial care.
Institutions For Mental Disease	IMD	A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including addiction. Federal financial participation is available for Medicaid IMD services for individuals under the age of 21 and age 65 and over. In recent years, CMS has relaxed the rules prohibiting payments in IMDs for individuals ages 21-64. Medicaid health plans may provide up to 15 days of IMD services per month in lieu of state plan services if medically appropriate, cost effective, and consented to by the individual. Additionally, states may be granted a 1115 waiver authority to allow individuals to receive addiction and mental health treatment in IMDs.
Long-Term Services & Supports	LTSS	Services provided in the home, community, or institutional setting to those who experience difficulty living independently and completing activities of daily living as a result of cognitive disabilities, physical impairments, disabling chronic conditions, and/or age.
Managed Care		A health care delivery and financing system designed to manage cost, utilization, and quality. In Medicaid, states generally implement managed care through contracts with health plans, which provide a limited set of benefits to enrollees through a capitated or per person per month (PMPM) rate. The health plans generally assumes full-risk for the cost of treatment, and therefore contracts with a network of provider organizations to provide care at the most efficient rate possible while still maintaining member health.

H.2. Glossary Of Terms

Word	Abbreviation	Definition
Medicaid		Medicaid is a joint federal-state program that provides health coverage to economically disadvantaged populations, such as low-income adults, children, and aged, blind, and disabled (ABD) individuals. States establish their own eligibility standards, benefit packages, provider payment policies, and administrative structures under broad federal guidelines. Financing is a shared responsibility of the federal government and the states.
Medicaid Waiver		Granted by CMS, waivers allow states to make temporary changes to their Medicaid program in order to test out new ways to deliver health coverage.
Medicaid Waiver Section 1115	1115 waiver	Known as research and demonstration waivers, states can apply for program flexibility to test new or existing approaches to financing and delivering Medicaid and CHIP.
Medicaid Waiver Section 1915(b)	1915(b) waiver	States can apply for waivers to provide services through managed care delivery systems, or otherwise limit an individual's choice of health plan or provider organization.
Medicaid Waiver Section 1915(c)	1915(c) waiver	States can apply for waivers to provide long-term care services in home- and community-based settings, rather than institutional settings.
Medical Home		A medical home is not a physical place, but a model for care coordination. Medical homes provide primary care services, care coordination, enhanced access to care, and care that is culturally and linguistically appropriate. Medical homes exist across multiple payers.
Medicare		Federal health insurance for individuals over the age of 65, individuals with certain disabilities, and individuals with end stage renal disease. Medicare covers most acute care services (which may include psychiatric care), but does not cover LTSS or non-physician behavioral health services.
Medicare Advantage	MA	Medicare Part C - also known as Medicare Advantage - is a program which allows individuals who are eligible for Medicare Parts A and B to elect a private health plan to provide their Medicare coverage. The federal government pays the plan's premiums up to a set level, and individuals are responsible for the difference.

H.2. Glossary Of Terms

Word	Abbreviation	Definition
Medicare Advantage Special Needs Plan	SNP	A special type of Medicare Advantage plan that is designed to provide targeted coordinated care to individuals who are a) institutionalized; b) dual eligible; and/or c) meet the severe chronic disabled conditions set forth by CMS. Plans emphasize improved care primarily through continuity of care and care coordination.
Medicare Part A		Hospital Insurance: Covers hospital, skilled nursing care, hospice, and home health care for most eligible individuals at no cost. Financed through payroll tax and deductibles, copayments are only charged if a stay becomes long-term.
Medicare Part B		Supplementary Medical Insurance: Covers most outpatient services, and consumers pay a premium based on income level.
Medicare Part C		Medicare Part C - also known as Medicare Advantage - is a program which allows individuals who are eligible for Medicare Parts A and B to elect a private health plan to provide their Medicare coverage. The federal government pays the plan's premiums up to a set level, and individuals are responsible for the difference.
Medicare Part D		Outpatient Prescription Drug Benefit: Private plans contract with Medicare to provide coverage for prescription drugs. Most consumers pay premiums based on their income.
Metropolitan Statistical Area	MSA	An urbanized area with a population of at least 50,000 plus adjacent territory that has a high degree of social and economic integration as measured by commuting ties.
Patient-Centered Medical Home	PCMH	See Medical Home.
Patient Protection & Affordable Care Act	PPACA or ACA	U.S. health care reform signed into law in 2010. The legislation regulates certain aspects of private and public health insurance programs and authorizes an individual mandate to secure essential health coverage, premium tax credits for the purchase of private health insurance, and increased insurance coverage of preexisting conditions. In 2012 the Supreme Court ruled that state participation is optional for provisions of the law expanding Medicaid coverage to adults ages 18 to 64 with incomes under 138% of the FPL. In 2017, Congress repealed the tax penalties associated with the individual mandate essentially ending the mandate.

H.2. Glossary Of Terms

Word	Abbreviation	Definition
Primary Care Case Management	PCCM	A health care delivery system model with limited utilization and cost control. Under the PCCM model, Medicaid enrollees choose a primary care physician who acts as a gatekeeper for more intensive services. The primary care physician generally receives a per person per month (PMPM) fee for care coordination, and is reimbursed fee-for-service for all medical services provided.
Program Of All Inclusive Care For The Elderly	PACE	PACE serves populations over the age of 55 who are eligible for skilled nursing home care by utilizing a comprehensive delivery system of social, medical, and long-term care services to keep enrollees in the community for as long as possible. PACE is an optional state Medicaid program, and may only be available in certain states, or regions within states.
Serious Mental Illness	SMI	A mental, behavioral, or emotional disorder that lasts for a sufficient duration of time and causes impairment of major life activities. Serious mental illnesses include major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), panic disorder, post traumatic stress disorder (PTSD), and borderline personality disorder.
Supported Employment		Provides services and supports to help individuals with disabilities become employed in an integrated or competitive work environment, and retain that employment.
Supported Housing		Housing provided for as long as needed at little or no cost to individuals with mental illness, or other vulnerable populations who are homeless or at-risk for homelessness. Mental health and social services are offered to participants, but are not a condition for participation in the program. The goal is to allow individuals to live as self-sufficient, independent lives as possible.
Value-Based Reimbursement	VBR	Reimbursement model in which payers financially reward or penalize health care provider organizations for performance on quality and cost of care. VBR payment mechanisms include P4P; capitation; shared savings models; shared risk models; and payments based on clinically-defined episodes, called episodes of care or bundled payments.

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