Allegheny County HealthChoices Program

2001 Year-In-Review

presented by

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AHCI is a contract agency for the Allegheny County Department of Human Services' HealthChoices Program

Executive Summary

The HealthChoices program is Pennsylvania's managed care program for adults and children who receive Medical Assistance. This report reviews the second full year of mandatory implementation of the behavioral health component of the HealthChoices program in Allegheny County.

HealthChoices enrollment remained steady throughout the year at an annual average of 120,000 persons, of which approximately 23,500 individuals used behavioral health services. Claim payments totaled $98.6 million for calendar year (CY) 2001. African Americans continued to access services at a lower, disproportionate level compared to enrollment. Utilization patterns by race, gender, age, and service did not change substantially during CY 2001.

In 2001 there were several positive initiatives undertaken to enhance the Allegheny County HealthChoices program. This included the following:

- Implementation of a quality review program to better monitor access to behavioral health rehabilitation services provided to children and adolescents;
- Implementation of an ambulatory follow-up and intervention plan for consumers discharged from inpatient mental health services;
- Implementation of services funded through reinvestment dollars, including community treatment teams (CTT), psychiatric rehabilitation services, outreach to special populations, enhanced community-based support services for women with substance abuse issues who have children, and additional respite services; and
- Increased training and technical assistance opportunities for providers.

The fourth year (2002) of the Allegheny County HealthChoices program will provide an opportunity for greater improvement in the choice and quality of services for HealthChoices consumers. The system will focus on:

- Increased integration between Community Care and the physical health managed care organizations to improve the coordination of medical and behavioral health services, including pharmacological treatment for mental health and substance abuse conditions;
- Continued implementation of a comprehensive community education and outreach plan for consumers with strong collaboration between Allegheny HealthChoices, Inc. (AHCI) and Community Care;
- Implementation of dual diagnosis assessments for all consumers accessing HealthChoices services; and
- Monitoring the implementation of reinvestment-funded services to assess their benefit to consumers and the continuum of care.

Introduction

AHCI has been reporting on the status of the HealthChoices Program since 1999. The purpose of this report is to highlight annual findings on enrollment and service utilization and to summarize program operations. This includes presenting information on claims processing, complaints, grievances, denials, critical incidents, education, outreach, and ombudsman activities.

Defining the Data

During calendar year (CY) 2001, the second year of full enrollment in the HealthChoices program, AHCI reported on changes related to the volume of activity, cost patterns, practice patterns, and system changes. The related terms used throughout the report are defined in *Appendix A*, *Definitions of Terms*.

In terms of data used for this report, information related to admission, readmission, and length of stay is based on authorizations for services. Other utilization information, including statistics related to diagnoses, is based on claims paid during the study period.

Additionally, since a consumer may access different levels of care concomitantly and more than one service during the study period, the consumer would be counted once (unduplicated) and each service would be counted as a unique episode. Therefore, the number or the annual percent of enrollees and consumers in this report represents an unduplicated count during each calendar year.

Report Snapshot

Enrollment and Utilization

The following summary provides a comparison of enrollment and service utilization by HealthChoices members during the CY 2000 and CY 2001:

- For both CY 2000 and CY 2001, approximately 120,000 individuals were enrolled in the HealthChoices program;
- In the CY 2000, a total of $90.6 million claims were paid. The total dollars in paid claims increased to $98.6 million for CY 2001;
- In CY 2001, the annual average cost per consumer was $4,195, a slight increase from $3,927 in CY 2000;
- The annual average number of consumers was 24,000 in CY 2001, an increase of 1,000 consumers from CY 2000.

Demographic Variables

Table 1.0 provides an annual comparison of the demographic characteristics of enrollees and consumers for CY 2001.

Table 1.0
Comparison of Annual Demographic Characteristics Between Enrollees and Consumers for 2001

	Enrollees	Consumers
Female	59%	42%
Male	41%	58%
African American	47%	36%
Caucasian	50%	62%

While females represented a higher annual percent of enrollees, males represented a higher annual percent of consumers. Caucasians represented a slightly higher annual percent of enrollees, but a much higher annual percent of total consumers.

Table 1.1 provides a comparison of the annual average cost per consumer for African American males and females, and Caucasian males and females.

Table 1.1
Comparison of the Annual Cost Per Consumer By Race and Gender for 2001

	Consumers
All Consumers	$4,195
Caucasian Male	$5,406
African American Male	$4,509
Caucasian Female	$3,221
African American Female	$3,620

The average cost per consumer for African American and Caucasian males was higher than the average cost for all consumers combined, while the average cost per consumer for African American and Caucasian females was lower than the overall average cost per consumer.

Table 1.2 depicts the comparison between the annual percent of enrollees and consumers within each age group.

Table 1.2
Comparison of Annual Percent of Enrollees and Consumers Within Each Age Group for 2001

Age Group	Enrollees	Consumers
0 to 5	19%	3%
6 to 12	20%	18%
13 to 17	11%	14%
18 to 20	5%	5%
21 to 44	24%	40%
45 to 64	13%	23%
65+	8%	2%

Note: The annual percent are calculated based on the total number of enrollees and consumers, respectively.

The highest annual percent for both enrollees and consumers was people in the 21-44 age group. Three age groups, 13-17, 21-44, and 45-64 years, represented a larger annual percent of consumers than enrollees, with age group 21-44 years representing an especially large gap between the annual percent of enrollees and the annual percent of consumers.

Category of Aid

There are seven different eligible groups or aid categories to which HealthChoices members can belong. These categories of aid are defined in *Appendix B*. Category of aid is important because different categories have different capitation rates, affecting the total funds the managed care organization receives each month. Projecting the number of members and consumers in each category is crucial in the HealthChoices program's budgeting and management processes. Table 1.3 provides a comparison of the annual percent of enrollees and consumers within each category of aid. The percents listed below remained stable in both CY 2000 and CY 2001.

Table 1.3
Comparison of Annual Percent of Enrollees and Consumers Within Each Category of Aid for 200l

Category of Aid	Enrollees	Consumers
CATN	2%	9%
FGA	2%	8%
HB	17%	7%
MEDN	1%	1%
SSI	18%	40%
SSIM	15%	14%
TANF	45%	32%

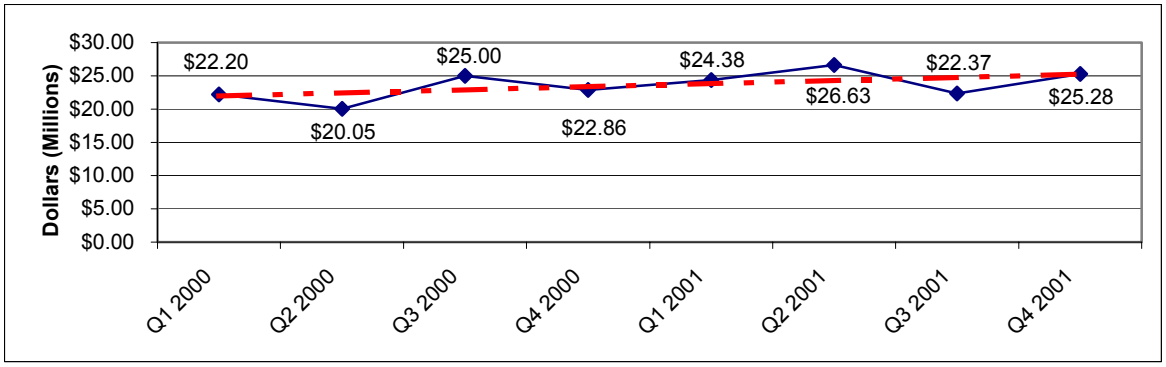
The Temporary Assistance to Needy Families (TANF) category of aid represented the highest annual percent of enrollees and the second highest percent of consumers, while the Supplemental Security Income without Medicare (SSI) category represented the highest annual percent of consumers. The Supplemental Security Income without Medicare (SSI) category of aid also represented the highest annual average cost per consumer ($5,779). The Temporary Assistance to Needy Families (TANF) category of aid represented the second highest annual average cost per consumer ($3,054).

Claims

During CY 2001, Community Care paid $98.6 million in claims, nearly nine million dollars more than during CY 2000. Of the $98.6 million, $55.5 million or 56% of claims were paid for people with a mental health diagnosis. People with a dual diagnosis represented $30.2 million or 31% of total claims and $13.0 million or 13% of claims were paid for people with a substance abuse diagnosis. Chart 1.0 depicts two years of quarterly paid claims history. As the trend line indicates, claims payments have only slightly increased over this period.

Chart 1.0

Quarterly Paid Claims Trends from January 2000 – December 2001



Note: The dashed line represents the trend over time.

Community Care's performance in claims processing has remained consistent throughout the year. Changes in CY 2001 included a shortened turnaround time between service delivery and claims payment due to improved efficiency on the part of providers. Faster claims processing on the part of Community Care's claims vendor also impacted this change. According to the monthly financial reports, Community Care adjudicated 99.96% of clean claims within 30 days during every month of the year. A "clean claim" is a claim that can be processed without obtaining additional information from the provider of the service or from a third party. Nearly all claims (clean and unclean) were adjudicated within 60 days.

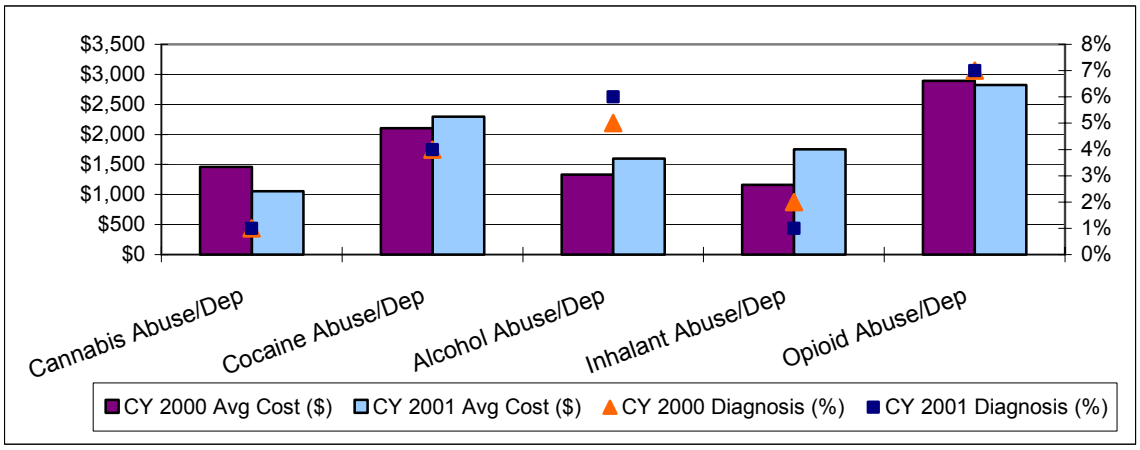
Service Utilization

Utilization by Drug and Alcohol Diagnoses

Chart 1.1 depicts the annual average cost per person and the percent of consumers with a drug and alcohol diagnosis. A consumer may have more than one diagnosis due to multiple initial diagnoses or a change in diagnosis during the course of treatment.

Chart 1.1

Comparison of the Annual Average Cost Per Consumer Based on Drug and Alcohol Diagnosis and the Percent of Consumers by Diagnosis for 2000 and 2001



Key: Dep - Dependency

The comparison of the annual percents of consumers and cost per consumer for CY 2000 and CY 2001 yielded some differences based on paid claims. While the annual percent of consumers remained relatively stable, the annual cost per consumer with a diagnosis of cannabis abuse/dependency decreased by 28% and the annual cost per consumer with a diagnosis of inhalant abuse/dependency increased by 34% from CY 2000 to CY 2001. The above graph reflects minimal changes in the annual cost per consumer with a diagnosis of cocaine abuse/dependency and in the annual cost per consumer with a diagnosis of opioid abuse/dependency.

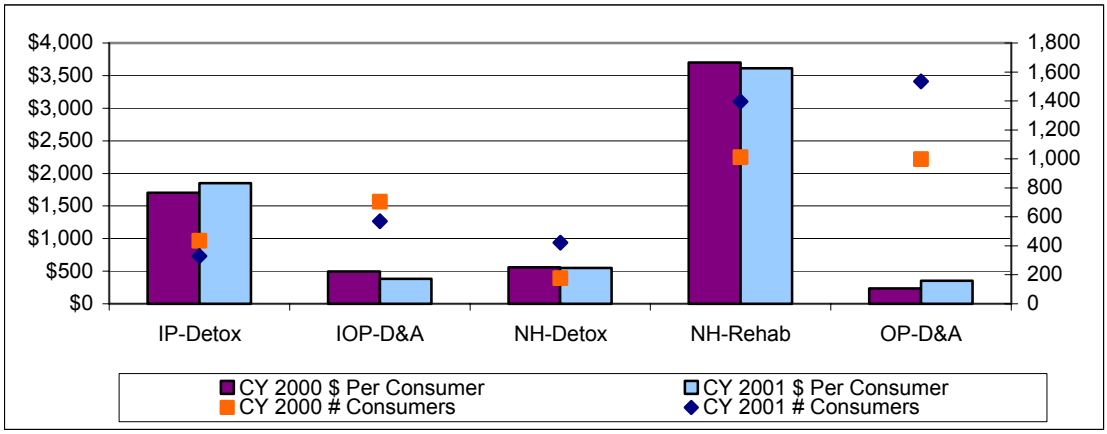
Treatment for cannabis, cocaine, and inhalant abuse/dependency involved a relatively small percent of consumers, but the average cost per consumer was high. Intensive services may be required for treatment of the long-term effects of cocaine abuse/dependency because of the severity of symptoms that may occur. In addition, the high average cost of services may be related to the existence of comorbid behavioral health issues that may not be recognized and treated. Comorbid issues may complicate treatment and delay recovery.

Utilization of Drug and Alcohol Services

Chart 1.2 depicts the annual number of consumers and average cost per consumer for drug and alcohol services, respectively.

Chart 1.2

Comparison of the Annual Number of Consumers and Average Cost Per Consumer by Service Who Utilized Drug and Alcohol Services for 2000 and 2001



Key:

IP-Detox Inpatient detoxification
IOP-D&A Intensive outpatient drug and alcohol
NH-Detox Non-hospital detoxification
OP-D&A Outpatient drug and alcohol
NH-Rehab Non-hospital rehabilitation

The annual average cost per consumer remained relatively stable from CY 2000 to CY 2001 while increases occurred in the annual number of consumers who utilized non-hospital detoxification (42% increase), non-hospital rehabilitation (27% increase), and outpatient drug and alcohol services (35% increase). Conversely, the annual number of consumers who utilized intensive outpatient drug and alcohol services decreased by 19% from CY 2000 to CY 2001.

The annual average cost per consumer for inpatient detoxification increased from CY 2000 ($1,705) to CY 2001 ($1,850) while the total dollars in paid claims for this service decreased (from $740,073 to $608,504). The total dollars and the average cost per consumer for outpatient drug and alcohol services ($673,408 and $398/person) and intensive outpatient drug and alcohol services ($532,158 and $354/person) decreased from CY 2000 to CY 2001. The total number of people accessing inpatient detoxification was significantly less than the total number accessing intensive outpatient and outpatient drug and alcohol services as illustrated in Chart 1.2.

Inpatient rehabilitation was not graphed because of the low number of consumers who utilized these services (annual average of 44 consumers for CY 2000 and 34 consumers for CY 2001, with an average cost per consumer of $2,391 in CY 2000 and $1,324 in CY 2001).

Admission and Readmission Rates and Average Length of Stay for Drug and Alcohol Services

A total of 2,544 drug and alcohol admissions occurred in CY 2001. Charts 1.3, 1.4, and 1.5 depict admission and readmission rates for drug and alcohol services presented as a rate per 1,000 members, and the average length of stay (ALOS).

Chart 1.3

Admission Rates for Drug and Alcohol Services in 2001

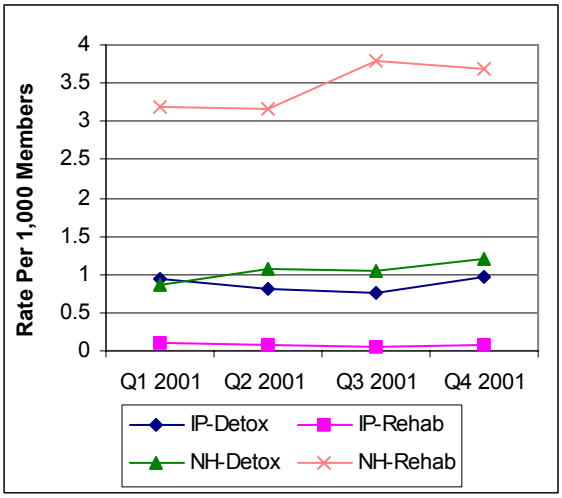
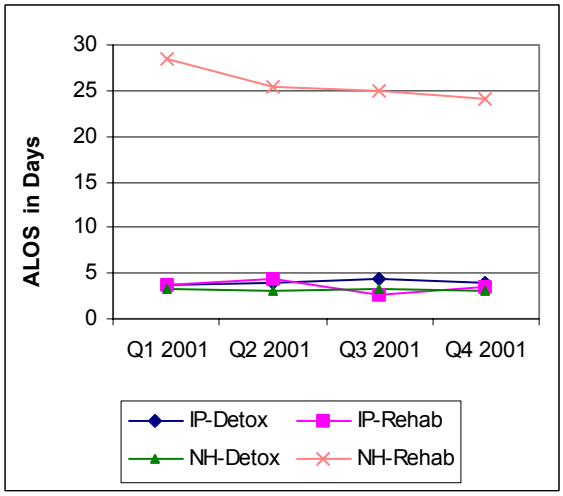


Chart 1.4

Average Length of Stay for Drug and Alcohol Services in 2001

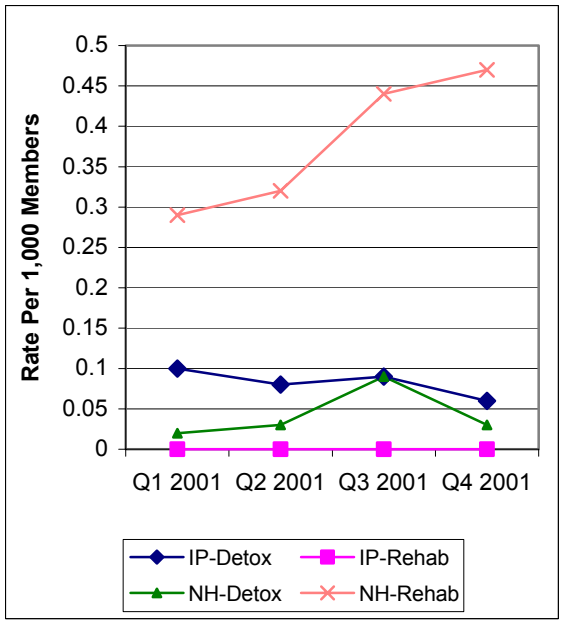


The graphs depicting admission rates, ALOS, and readmission rates within 30 days of discharge for drug and alcohol services show relatively little variation in inpatient detoxification and inpatient rehabilitation services (there were no readmissions for inpatient rehabilitation services). Admission and readmission rates for non-hospital rehabilitation show a general upward trend, while ALOS shows a downward trend.

It is important to note that African American consumers received non-hospital rehabilitation services for an average of 10 days more than Caucasian consumers. The average readmission rate for African American consumers (0.22) was also slightly higher than the readmission rate for Caucasian consumers (0.15).

Chart 1.5

Readmission Rates for Drug and Alcohol Services in 2001



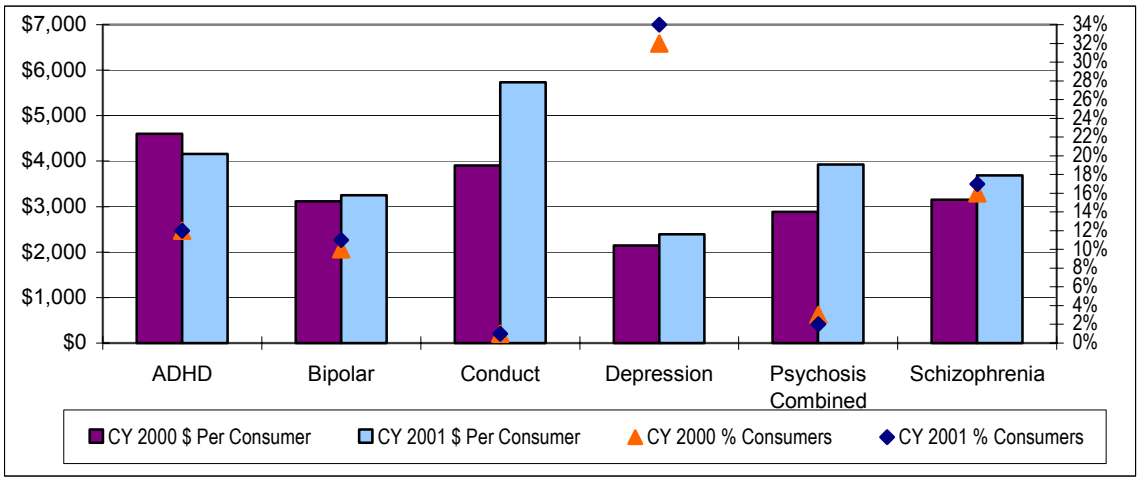
A literature review indicated that increases in admission and readmission rates could be a result of the September 11th terrorist attacks. Preliminary national data from the Drug Evaluation Network System showed that treatment admissions have increased 10 to 12% nationally[1]. However, a monthly analysis of admission and readmission rates for HealthChoices consumers did not reveal increases that correlated to this date/event.

Utilization by Mental Health Diagnoses

Chart 1.6 depicts the annual average cost per person and the percent of consumers with a mental health diagnosis. While the annual percent of consumers remained relatively stable from CY 2000 and CY 2001, the annual cost per consumer with a diagnosis of conduct disorder increased by 32% and the annual cost per consumer with a diagnosis of psychosis combined (psychosis and unspecified psychosis, including autism) increased by 27%.

Chart 1.6

Comparison of the Annual Average Cost Per Consumer Based on Mental Health Diagnosis and the Percent of Consumers by Diagnosis for 2000 and 2001



The increase in the average cost to treat persons with a conduct disorder or a psychosis disorder may be explained by the need for more than the average number of days in a high/intensive level of care. Some individuals with these diagnoses may not be compliant with after care and require recurrent treatment.

The total dollars and the average cost per person for behavioral health rehabilitation services increased by 10% and 9% respectively from CY 2000 to CY 2001. This may explain the increase observed in the cost to treat people with a conduct disorder or a psychosis disorder. Likewise, the total cost for residential treatment facilities increased by 6% and family-based services increased by 19% from CY 2000 to CY 2001. Some children/adolescents with a diagnosis of conduct disorder or psychosis may require periodic inpatient hospitalization. The total dollars paid increased by 2% and the average cost per person increased by 10% from CY 2000 to CY 2001.

[1]From the website: www.health.org/newsroom/releases/2001/dec01/3.htm

In CY 2001, the percent of consumers (37%) diagnosed with autism represented the largest diagnostic subcategory of psychosis. All diagnostic codes for autism were included in the annual average cost per consumer. The annual average cost per consumer with a diagnosis of autism was $14,811. The observations included in the previous paragraph may have contributed to the average cost per person.

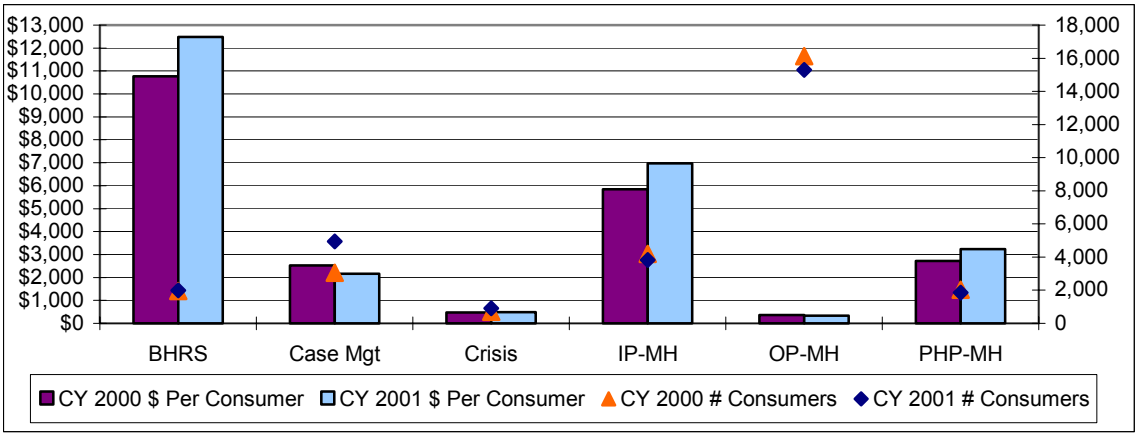
While there was a high percent of consumers treated for depression (major depression and depressive disorder), the annual average cost per consumer was relatively low for this diagnosis in both CY 2000 and CY 2001.

Utilization of Mental Health Services

Chart 1.7 depicts the annual number of consumers and average cost per consumer for mental health services that were highly utilized or represented a significant proportion of paid claims in CY 2000 and CY 2001.

Chart 1.7

Comparison of the Annual Number of Consumers and Average Cost Per Consumer by Service Who Utilized Mental Health Services in 2000 and 2001



Key:

BHRS Behavioral health rehabilitation services
Case Mgt Case management
IP-MH Inpatient mental health
Med Check Medication check
OP-MH Outpatient mental health
PHP-MH Partial hospital mental health

The comparison of the annual number of consumers and cost per consumer for CY 2000 and CY 2001 yielded some differences based on paid claims:

- The annual average cost per consumer for behavioral health rehabilitation services rose by 14%;
- The annual average cost per consumer for case management services decreased by 14% while the annual number of consumers increased by 38%;
- The annual number of consumers who utilized crisis services increased by 24%;
- The annual average cost per consumer for inpatient mental health services increased by 16% while the annual number of consumers decreased by 9%; and

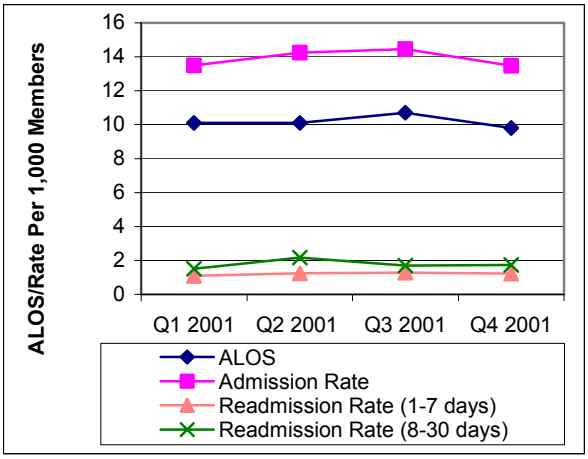
- The annual average cost per consumer for partial hospital mental health services increased by 16%.

Medication check services were not graphed because of the relative low annual average cost per consumer ($106 in CY 2000 and $114 in CY 2001) for a high annual number of consumers (9,418 in CY 2000 and 10,311 in CY 2001).

Admission and Readmission Rates and Average Length of Stay for Mental Health Services

There were a total of 6,550 admissions for inpatient mental health services in CY 2001. Chart 1.8 illustrates that admission rates, readmission rates, and ALOS for mental health services remained relatively stable during CY 2001. Readmission rates are delineated by the number of days between the initial admission and the subsequent admission to the same level of service. This delineation indicated that readmissions occurred at a slightly higher rate 8-30 days after discharge, than 1-7 days after discharge.

Chart 1.8
Admission and Readmission Rates and ALOS for Inpatient Mental Health Services



Children's Services

The utilization of behavioral health rehabilitation services and residential treatment facilities was examined to delineate the special types of care received by children in the HealthChoices program. The trend continues regarding the gap between African American children and Caucasian children who utilized behavioral health rehabilitation services in CY 2001:

- An annual, unduplicated total of 1,307 Caucasian children (67%) and 586 African American children (30%) utilized BHRS.
    - In comparison, 58% of Caucasian children and 42% of African American children were enrolled in the HealthChoices program.
- The annual average cost per child was $12,233. However, the average cost per consumer was $4,169 higher for Caucasian children than African American children.
- Caucasian children utilized 75% of the unduplicated total of BHRS units while African American children utilized 21% of the unduplicated total of BHRS units.

Community Care identified satisfaction problems with children's services via the annual satisfaction survey and through the Consumer Action and Response Team (CART) process. These problems substantiate the racial disparities contained in the previous bullet points. Through reinvestment funds, Community Care has implemented outreach efforts to African American children and adolescents who reside in certain geographic locations throughout Allegheny County. CART has also implemented outreach efforts to obtain feedback from parents of African American children regarding services.

The annual ALOS, number of units, and the average cost per consumer for residential treatment facility services (RTF) to serve 6-12 year old consumers were 279 days, 7,894 units, and $33,986, respectively. Comparatively, the annual ALOS, number of units and the average cost for adolescents 13-17 years old were 254 days, 16,683 units, and $33,911, respectively. The ALOS may be skewed because Caucasian males ages 6-12 years tend to have a longer length of stay; however, a larger number of consumers ages 13-17 years access RTF services.

Supplemental Services

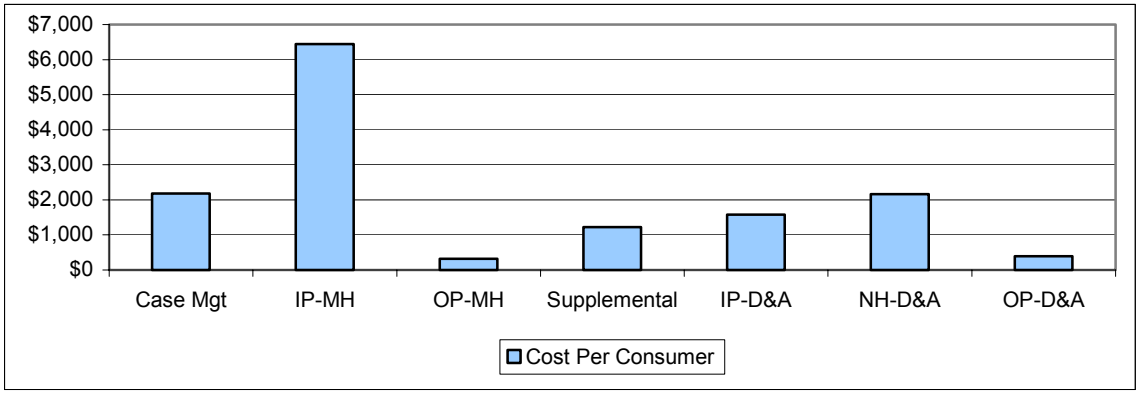
Supplemental services represented 2% of the annual total paid claims and were used by 7% of the total consumers in CY 2001. This compares to 2% of the annual total paid claims that were used by 6% of the total consumers in CY 2000. Consumers utilized the following supplemental services: drug and alcohol intensive outpatient services, community residential support, and mental health outpatient services.

Dual Diagnosis

Twenty-four percent (or 5,710) of unduplicated consumers had a dual diagnosis of mental health and substance abuse/dependency in CY 2001. Recent literature indicated that the percent of consumers with a dual diagnosis is often underreported. Chart 1.9 depicts the annual average cost per consumer by service for consumers with a dual diagnosis. The total cost to treat persons with a dual diagnosis was approximately $30.2 million; representing 31% of the total HealthChoices program dollars for CY 2001.

Chart 1.9

Annual Average Cost Per Consumer (Dual Diagnosis) by Service for 2001



Key: Case Mgt Case management IP- MH Inpatient mental health
IP-D&A Inpatient detoxification and rehabilitation OP- MH Outpatient mental health
OP-D&A Outpatient drug and alcohol NH-D&A Non-hospital detoxification and rehabilitation

Medication checks were also utilized by consumers with a dual diagnosis, but are not graphed because of the low annual average cost per consumer of $99.

Involuntary Admissions

The number of involuntary admissions represented 19% of all inpatient mental health admissions. People who were admitted at a 302 level represented 57% of all involuntary commitments, and those whose admission progressed to a 303 and a 304 represented 30% and 13%, respectively.

Complaints, Denials, and Grievances

Member Complaints

A total of 290 member complaints were filed during CY 2001. This represents a 25% decrease from the number of complaints filed in CY 2000. Several complaints were related to provider relations/provider contract issues with a specific network provider. Members/family dissatisfaction with the treatment and members/family being billed by a provider represented the two most common complaints at 26% and 24%, respectively. The majority of complaints were resolved during the first level process, with 3% continuing on to a second level review meeting.

Medical Necessity Denial and Member Grievances

Community Care issued 229 medical necessity denials during 2001. This compares to 121 (47% increase) medical necessity denials issued in CY 2000. Of the 229 denials, 97 (42%) were grieved at the first level and 25 (11%) were presented at a second level review meeting. The annual percent of denials overturned at any level was 24% (54 cases). One case was managed through the external review process and one grievance was taken to a fair hearing meeting for resolution.

Provider Complaints

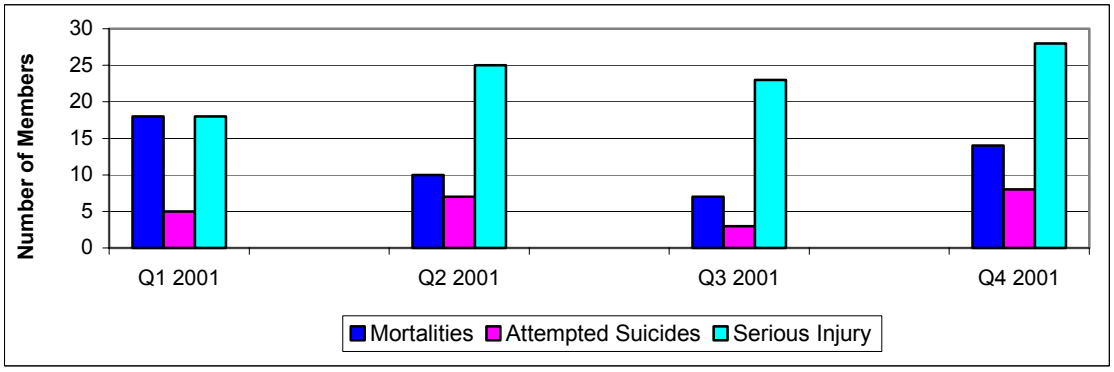
During CY 2001, individual providers or facilities filed 58 complaints. This compares to 36 (38% increase) provider-initiated complaints for the CY 2000. The most frequent complaints were regarding claims processing (53% of complaints) and managing the authorization process (14% of complaints). Although Community Care's claims processing has improved in CY 2001, some providers still experience difficulties for a variety of reasons, such as coding, formatting, and other processing issues. Community Care offered core training sessions, individual assistance, and ongoing follow-up with providers who experienced problems.

Critical Incidents

During CY 2001, 164 critical incidents related to mortalities, attempted suicide, and/or serious injury occurred. An increase in critical incidents identified as serious injury was observed between the first and fourth quarters of 2001, as illustrated in Chart 2.0 on the next page. The majority of consumers in the category of serious injury were male, Caucasian, and between 13-17 years old. Residential treatment facilities continue to be the most prevalent level of care for consumers in this category for both CY 2000 and CY 2001.

Chart 2.0

Critical Incidents 2001



Critical incidents classified as mortalities are subdivided into four types. During CY 2001 there were 49 mortalities in Allegheny County. These mortalities were categorized as follows:

- Natural causes – 21;
- Apparent accidents – 2;
- Apparent suicides – 7; and
- Unclear cause – 19.

Natural cause was the primary type of member deaths for both CY 2000 and CY 2001. Of this category, the largest percent of people were Caucasian, female, and ages 45-64 years old. This represents the same pattern as observed in CY 2000 for this category.

The second highest mortality category for CY 2001 was unclear cause. In this category, many of the critical incidents are awaiting the results of the Allegheny County Coroner's report before a final designation is made identifying the category of death. AHCI receives the Coroner's determination from Community Care, accounting for each individual's death in the appropriate category.

Education, Outreach, and Ombudsman Activity

Training and Education Efforts
During CY 2001, AHCI provided a series of four successful provider Training and Technical Assistance Institutes. Sessions were conducted by Mr. David Lloyd, President of MTM Services and Consultant for the National Council for Community Behavioral Healthcare, and were directed at enabling providers to increase their service capacity through effective development and use of internal performance measurement systems. AHCI arranged for interested providers to have access to follow-up consultation with Mr. Lloyd at affordable discounted rates. In addition to these efforts, AHCI established a voluntary paperwork reduction initiative for behavioral health providers led by Mr. Lloyd, in collaboration with the County Department of Human Services, Office of Behavioral Health and Community Care.

Community Outreach
AHCI continues its collaboration with Community Care in the provision of face to face, community based education and outreach for HealthChoices members, families, providers, and other stakeholders. During CY 2001, AHCI's efforts focused on the following areas:

- Educating consumers, family members, and providers about consumer rights in the HealthChoices program;
- Empowering consumers and family members to exercise their rights; and
- Promoting the philosophy and principles of recovery among all HealthChoices stakeholders.

Activities of note for CY 2001 included:

- Face to face Ombudsman outreach to City and County Housing Project tenant councils and community groups, City of Pittsburgh Senior Citizen Centers, drop-in centers, and homeless shelters;
- Consumer rights training sessions for County Assistance Office managers and supervisors, City of Pittsburgh Senior Interests program staffs, behavioral health provider agencies, family advocate groups, and consumer advocacy organizations;
- AHCI support for and participation in efforts of the newly formed Allegheny County Coalition for Recovery; and
- Provision of educational exhibits at community events, health fairs, and conferences.

Ombudsman Activities
Contacts with the AHCI Ombudsman have increased from an average of 16 per month in CY 2000 to 47 per month during CY 2001. Of the total Ombudsman contacts during CY 2001, 49% (565) occurred face to face as the result of on-site outreach efforts. The types of inquiries that were received and actions taken by the Ombudsman involved the provision of information and education, and assistance with complaints and grievances, which were consistent with trends seen in the prior year. Within these trends however, there has been a gradual but continuous increase in requests for assistance with problems related to physical health care.

Appendix A

Definitions of Terms

The following is an explanation of terms used to enhance the understanding of the information presented:

- Member – Eligible Medicaid recipients enrolled in the HealthChoices program during the report period. This information is based on member month equivalents reported in the capitation data.
- Consumers – HealthChoices enrollees on whose behalf a claim has been adjudicated for behavioral health services during the report period.
- Paid Claims – Paid claims are used for calculation of numerous reports including outpatient service utilization. Paid claims were reported in the quarter that the claim was adjudicated. This may or may not match the quarter when the service was actually provided.

Appendix B

Descriptions of the Categories of Aid

Category abbreviations are bolded and included in parenthesis. Please note that two categories of members are represented in the "State Only" description below.

- Temporary Assistance to Needy Families (**TANF**) – assistance to families with dependent children who are deprived of the care or support of one or both parents.
- Healthy Beginnings (**HB**) – assistance for women during pregnancy and the postpartum period.
- State Only General Assistance – state funded program for individuals and families whose income and resources are below established standards and who do not qualify for the TANF program. This includes the Categorically Needy (**CATN**) and Medically Need Only (**MEDN**) groups.
- Federally Assisted Medical Assistance for General Assistance Recipients (**FGA**) – federal and state funded program for individuals and families whose income and resources are below established standards and who do not qualify for the TANF program.
- Supplemental Security Income without Medicare (**SSI**) – assistance for people who are aged, blind, or determined disabled for less than two years.
- Supplemental Security Income with Medicare (**SSIM**) – assistance for people who are aged, blind or determined disabled for over two years[1].

[1]From the website: www.ssa.gov/pubs/10024.html#part1