Arkansas Medicaid Program Overview



SFY 2012


Andrew Allison, Director
DHS - Division of Medical Services
Donaghey Plaza South
PO Box 1437 Slot S401
Little Rock AR 72203-1437
(501) 683-4997
(800) 482-5431

ARKANSAS DEPARTMENT OF HUMAN SERVICES

DHS Mission Statement

Together we improve the quality of life of all Arkansans by protecting the vulnerable, fostering independence and promoting better health.

DHS Vision

Arkansas citizens are healthy, safe and enjoy a high quality of life.

DMS Mission Statement

To ensure that high-quality and accessible health care services are provided to citizens of Arkansas who are eligible for Medicaid or Nursing Home Care.

Our Core Values

- Compassion
- Courage
- Respect
- Integrity
- Trust

Our Beliefs

- Every person matters.
- Families matter.
- Empowered people help themselves.
- People deserve access to good health care.
- We have a responsibility to provide knowledge and services that work.
- Partnering with families and communities is essential to the health and well-being of Arkansans.
- The quality of our services depends upon a knowledgeable and motivated workforce.

Physical Address

700 Main Street (Corner of 7th and Main)
Donaghey Plaza South
Little Rock, Arkansas 72201

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services

Department of Human Services

P.O. Box 1437, Slot S-401 · Little Rock, AR 72203-1437
501-682-8292 · Fax: 501-682-1197

Welcome to the 2012 overview of the Arkansas Medicaid Program. This booklet provides an extensive look at statistics and essential information about Medicaid in our state, including individual services covered, who depends on those services, what they cost and how we pay for them.

Beyond the data compiled in this manual, it's important to know that Arkansas Medicaid has been exploring opportunities for improving health care for beneficiaries while saving tax dollars. Our state is quickly becoming a leader in implementing a new sustainable health care model—the Arkansas Health Care Payment Improvement Initiative. The plan improves upon the existing fee-for-service model with a payment system based on episodes of care. Though some aspects of this initiative have been tried elsewhere, Arkansas is the first to use this approach statewide, with both public and private payers.

The payment initiative is part of a larger effort to improve the state's overall health care system. We are in the process of building a new Medicaid Management Information System, which will expedite processing information for providers and patients. Plus, we are assisting Arkansas Medicaid providers in converting patients' records from paper to electronic form.

Arkansas Medicaid continues working with providers and stakeholders to deliver high-quality health care and secure access to services for our state's elderly, disabled and children. Through all of our new initiatives, the Division of Medical Services maintains focus on the core mission of Arkansas Medicaid—protecting the vulnerable, fostering independence and promoting better health for all Arkansans. We hope this overview of the program will help you understand the steps we are taking to achieve these goals.

Andrew Allison
Director,
Division of Medical Services

Contents

About the Arkansas Medicaid Overview Booklet

The Arkansas Medicaid overview booklet is produced annually by the Division of Medical Services (DMS) and Hewlett-Packard (HP). This overview is designed to give a high-level understanding of the Arkansas Medicaid program, its funding, covered services and how the program is administered. Statistics included in this overview come from many sources including the Department of Human Services (DHS) Statistical Report, On Demand reports from the Decision Support System (DSS), the University of Arkansas at Little Rock (UALR) and other reports from units at DMS, HP and Arkansas Foundation for Medical Care (AFMC).

All acronyms used in this booklet are defined in the glossary beginning on page i of the appendices.



What is Medicaid?

Medicaid is a joint federal and state program that provides necessary medical services to eligible persons based on financial need and/or health status. Title XIX of the Social Security Act provides for federal grants to the states for medical assistance programs. Title XIX, popularly known as Medicaid, enables states to furnish:

- Medical assistance to those who have insufficient incomes and resources to meet the costs of necessary medical services and
- Rehabilitation and other services to help families and individuals become or remain independent and able to care for themselves.

Each state has a Medicaid program to meet the federal mandates and requirements as laid out in Title XIX. Arkansas, however, established a medical care program twenty-six (26) years before passage of the federal laws requiring health care for the needy; Section 7 of Act 280 of 1939 and Act 416 of 1977 authorized the State of Arkansas to establish and maintain a medical care program for the indigent. The Medicaid program was implemented in Arkansas on January 1, 1970. The Department of Human Services administers the Arkansas Medicaid program through the Division of Medical Services.

Who Qualifies for Arkansas Medicaid?

Individuals are certified as eligible for Arkansas Medicaid services through either county Human Services Offices or District Social Security Offices. The Social Security Administration automatically sends Supplemental Security Income recipient information to the Department of Human Services. Eligibility depends on age, income and assets. Most people who qualify for Arkansas Medicaid are one of the following:

- Age sixty-five (65) and older
- Under age nineteen (19)
- Blind
- Pregnant
- The parent or the relative who is the caretaker of a child with an absent, disabled or unemployed parent
- Living in a nursing home
- Under age twenty-one (21) and in foster care
- In medical need of certain home and community-based services
- Persons with breast or cervical cancer
- Disabled, including working disabled

Current Federal Poverty Levels

Monthly Levels*

(Effective April 1, 2012 through March 31, 2013)
Family Medicaid Categories

Family size	ARKids A Children six (6) and over and AR Health Care Access 100%	ARKids A Children under age six (6) 133%	Transitional Medicaid 185%	SOBRA Pregnant Women, Family Planning and ARKids First B 200%
One (1)	$930.83	$1,238.00	$1,722.04	$1,861.66
Two (2)	$1,260.83	$1,676.90	$2,332.54	$2,521.66
Three (3)	$1,590.83	$2,115.80	$2,943.04	$3,181.66
Four (4)	$1,920.83	$2,554.70	$3,553.54	$3,841.66
Five (5)	$2,250.83	$2,993.60	$4,164.04	$4,501.66
Six (6)	$2,580.83	$3,432.50	$4,774.54	$5,161.66
Seven (7)	$2,910.83	$3,871.40	$5,385.04	$5,821.66
Eight (8)	$3,240.83	$4,310.30	$5,995.54	$6,481.66
Nine (9)	$3,570.83	$4,749.20	$6,606.04	$7,141.66
Ten (10)	$3,900.83	$5,188.10	$7,216.54	$7,801.66
For each additional member add:	$330.00	$438.90	$610.50	$660.00

Aid to the Aged, Blind and Disabled Medicaid Categories

	ARSeniors Equal to or below 80%	QMB Equal To or Below 100%	SMB Between 100% & 120%	QI-1 At least 120% but less than 135%	QDWI & TB Equal To or Below 200%	Working Disabled 250%
Individual	$744.66	$930.83	$1,117.00	$1,256.63	$1,861.66	$2,327.08
Couple	$1,008.66	$1,260.83	$1,513.00	$1,702.13	$2,521.66	$3,152.08
For each additional family member in the Working Disabled category add:						$825.00

*To qualify for Arkansas Medicaid and other assistance, beneficiaries' income must be at or below the Federal Poverty Levels stated above.

How is Medicaid Funded?

Funding for Medicaid is shared between the federal government and the states with the federal government matching the state share at an authorized rate between fifty (50) and ninety (90) percent, depending on the program. The federal participation rate is adjusted each year to compensate for changes in the per capita income of each state relative to the nation as a whole.

- Arkansas funded approximately 29.12% of Arkansas Medicaid Program-related costs in SFY 2012; the federal government funded approximately 70.88%. State funds are drawn directly from appropriated state general revenues, license fees, drug rebates, recoveries and the Arkansas Medicaid Trust Fund.
- Administrative costs for Arkansas Medicaid are generally funded 50% by Arkansas and 50% by the federal government; some specialized enhancements are funded 75% or 90% by the federal government.

SFY 2012 Arkansas Medicaid Operating Budget

	(Million)
General Revenue	$691.6
Other Revenue	$439.7
Quality Assurance Fee	$69.2
Trust Fund	$159.5
Federal Revenue	$3,259.8
Total Program	$4,619.8

Arkansas Medicaid program only—does not include administration or other appropriations.

How is Arkansas Medicaid Administered?

The Arkansas Department of Human Services administers the Arkansas Medicaid program through the Division of Medical Services (DMS). Arkansas Medicaid is detailed in the Arkansas Medicaid State Plan, Arkansas Medicaid Waiver Programs and through provider manuals. The Centers for Medicare and Medicaid Services (CMS) administers the Medicaid Program for the U.S. Department of Health and Human Services. CMS authorizes federal funding levels and approves each state's State Plan and Waivers to ensure compliance with human services federal regulations.

Administration Statistics

In SFY 2012, the Division of Medical Services Program Development and Quality Assurance (PD/QA) Unit processed:

- Eleven (11) State Plan amendments,
- Ninety-seven (97) provider manual updates,
- Seven (7) official notices and notices of rule making,
- Eleven (11) provider letters regarding changes to the Preferred Drug List, and
- Four (4) pharmacy memorandums.

In SFY 2012, our fiscal agent, Hewlett-Packard, had provider representatives attend and conduct fifty-one (51) workshops around the state. The provider representatives also conducted two thousand seven hundred and thirty-two (2,732) provider visits. The Provider Assistance Center responded to ninety five thousand five hundred and ninety (95,590) voice calls and one hundred seventy six thousand eight hundred and eighty-one (176,881) automated calls.

In 2012, MMCS Provider Relations Representatives contacted a quarterly average of forty-seven (47) hospitals, seven hundred and twenty-five (725) clinics and one thousand nine hundred and sixty-seven (1,967) physicians. Although routine visits were down slightly from the previous year due to employee sick leave, all providers were seen and had continuous communication.

What Services are Covered by Arkansas Medicaid?

Mandatory Services

Certified Nurse-Midwife Services	All ages
Child Health Services Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	Under age twenty-one (21)
Family Planning Services and Supplies	All ages
Federally Qualified Health Center (FQHC)	All ages
Home Health Services	All ages
Hospital Services - Inpatient and Outpatient	All ages
Laboratory and X-Ray	All ages
Medical and Surgical Services of a Dentist	All ages
Nurse Practitioner (Pediatric, Family, Obstetric-Gynecologic and Gerontological)	All ages

Nursing Facility Services	Age twenty-one (21) and older
Physician Services	All ages
Rural Health Clinic (RHC)	All ages
Transportation (to and from medical providers when medically necessary)	All ages

Optional Services

Ambulatory Surgical Center Services	All ages
Audiological Services	Under age twenty-one (21)
Certified Registered Nurse Anesthetist (CRNA) Services	All ages
Child Health Management Services (CHMS)	Under age twenty-one (21)
Chiropractic Services	All ages
Dental Services	All ages
Developmental Day Treatment Clinic Services (DDTCS)	Pre-school and age eighteen (18) and older
Developmental Rehabilitation Services	Under age three (3)
Domiciliary Care Services	All ages
Durable Medical Equipment	All ages
End-Stage Renal Disease (ESRD) Facility Services	All ages
Hearing Aid Services	Under age twenty-one (21)
Hospice Services	All ages
Hyperalimentation Services	All ages
IndependentChoices	Age eighteen (18) and older
Inpatient Psychiatric Services	Under age twenty-one (21)
Intermediate Care Facility (ICF) Services	All ages
Licensed Mental Health Practitioner Services	Under age twenty-one (21)
Medical Supplies	All ages
Medicare Crossovers	All ages
Nursing Facility Services	Under age twenty-one (21)
Occupational, Physical and Speech Therapy Services	Under age twenty-one (21)
Orthotic Appliances	All ages
Personal Care Services	All ages
Podiatrist Services	All ages
Portable X-Ray	All ages
Prescription Drugs	All ages
Private Duty Nursing Services	All ages
Program of All-Inclusive Care for the Elderly (PACE)	Age fifty-five (55) and older

Prosthetic Devices	All ages
Rehabilitative Hospital Services	All ages
Rehabilitative Services for:	
• Persons with Mental Illness (RSPMI)	All ages
• Persons with Physical Disabilities (RSPD), and Youth and Children	Under age twenty-one (21)
Respiratory Care Services	Under age twenty-one (21)
School-Based Mental Health Services	Under age twenty-one (21)
Targeted Case Management for:	
• Children's Services (Title V), SSI, TEFRA, EPSDT, Division of Children and Family Services, and Division of Youth Services	Under age twenty-one (21)
• Developmentally Disabled Adults	All ages
• Adults	Age sixty (60) and older
• Pregnant Women	All ages
Tuberculosis Services	All ages
Ventilator Equipment	All ages
Visual Care Services	All ages

Waivers Approved by the Centers for Medicare and Medicaid Services (CMS)

Alternatives for Adults with Physical Disabilities (AAPD)	Age twenty-one (21) through sixty-four (64)
ARHealthNetWorks	Age nineteen (19) through sixty-four (64)
ARKids B	Age eighteen (18) and under
Developmental Disabilities Services (DDS)/Alternative Community Services	All ages
Elder Choices	Age sixty-five (65) and older
Living Choices (Assisted Living)	Age twenty-one (21) and older
Non-Emergency Transportation (NET)	All ages
Tax Equity Fiscal Responsibility Act (TEFRA) of 1982	Under age twenty-one (21)
Women's Health (Family Planning)	All ages

Benefit Limitations on Services

The Arkansas Medicaid Program does have limitations on the services that are provided. The major benefit limitations on services for adults (age twenty-one (21) and older) are as follows:

- Twelve (12) visits to hospital outpatient departments allowed per state fiscal year.

- A total of twelve (12) office visits allowed per state fiscal year for any combination of the following: certified nurse midwife, nurse practitioner, physician, medical services provided by a dentist, medical services furnished by an optometrist and Rural Health Clinics.
- One (1) basic family planning visit and three (3) periodic family planning visits per state fiscal year. Family planning visits are not counted toward other service limitations.
- Lab and x-ray services limited to total benefit payment of $500 per state fiscal year for outpatient services, except for Magnetic Resonance Imaging and cardiac catheterization and for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) beneficiaries.
- Three (3) pharmaceutical prescriptions are allowed per month (family planning and tobacco cessation prescriptions are not counted against benefit limit; unlimited prescriptions for nursing facility beneficiaries and EPSDT beneficiaries under age twenty-one (21)). Extensions are considered up to a maximum of six (6) prescriptions per month for beneficiaries at risk of institutionalization. Beneficiaries receiving services through the Assisted Living waiver may receive up to nine (9) medically necessary prescriptions per month. Medicare-Medicaid beneficiaries (dual eligibles) receive their drugs through the Medicare Part D program as of January 1, 2006.
- Inpatient hospital days limited to twenty-four (24) per state fiscal year, except for EPSDT beneficiaries and certain organ transplant patients.
- Co-insurance: Some beneficiaries must pay 10% of first Medicaid covered day of hospital stay.
- Beneficiaries in the Working Disabled aid category must pay 25% of the charges for the first Medicaid covered day of inpatient hospital services and must also pay co-insurance for some additional services.
- Some beneficiaries must pay $.50 - $3 of every prescription, and $2 on the dispensing fee for prescription services for eyeglasses. Beneficiaries in the Working Disabled aid category must pay a higher co-payment for these services and also must pay co-payments for some additional services.

Additional Information for Limitations Relating to Children

The families of some children are responsible for co-insurance, co-payments, or premiums.

- Co-insurance: ARKids B beneficiaries must pay 10% of the charges for the first Medicaid covered day of inpatient hospital services and must also pay co-insurance for some outpatient and Durable Medical Equipment services.
- Co-Pay: ARKids B beneficiaries must pay a co-payment for most services; for example $10.00 for most office visits and $5.00 for most prescription drugs (and must use generic drugs and rebate manufacturer). ARKids B beneficiaries' annual cost-sharing is capped at 5% of the family's gross annual income.
- Premiums: Based on family income certain Tax Equity Fiscal Responsibility Act (TEFRA) beneficiaries must pay a premium. TEFRA families whose income is at or below 150% of the Federal Poverty level cannot be assessed a premium.

NOTE: Any and all exceptions to benefit limits are based on medical necessity.

SFY 2012 in Review

State Fiscal Year 2012 was a highly productive year for Arkansas Medicaid and the work done will provide a strong foundation for innovation in the future. We initiated the first phase of the Arkansas Health Care Payment Improvement Initiative (the Initiative). Arkansas Medicaid, in conjunction with private insurance plans, is developing and implementing the nation's first statewide payment-transformation initiative that moves away from the fee-for-service payment model and moves toward paying for high-quality episodes of care. The goal of the Initiative is to improve patient care while slowing the rate of financial growth in the Arkansas Medicaid program. It requires increased coordination of patient care among providers, which will help eliminate excessive costs from repetitive or unnecessary tests, procedures, and other medical services. In addition, the Initiative promotes sharper focus on the results of coordinated care in order to achieve better health outcomes for all Arkansans.

As Arkansas Medicaid enters the second phase of the Electronic Health Record Payment Initiative, we continue to develop better information technology systems. As a part of the American Recovery and Reinvestment Act, Arkansas Medicaid is partnered with other organizations and agencies to invest in Health Information Technology. Over the past fiscal year, many Arkansas hospitals and thousands of health care providers across the state began the process of converting patient records from paper to electronic form. This federally-funded program, overseen by Arkansas Medicaid, has had great success so far, and we anticipate maintaining that momentum as more hospitals and providers commit to making the transition to electronic health records.

Arkansas Medicaid has refined its fiscal agent proposals and in the next year, will reinstate the procurement process to replace the current Medicaid Management Information System (MMIS). This is a large undertaking as the new MMIS will be very different from the current system, but will greatly improve operations, processes and efficiency across the Arkansas Medicaid program. In addition, Arkansas Medicaid is actively working with the Office of Health Information Technology (OHIT) to plan a state-wide Health Information Exchange to improve health care through real time exchange of health information.

On the programmatic side, State Medicaid Programs across the country began receiving guidance from the Centers for Medicare and Medicaid Services regarding the implementation of the Affordable Care Act (ACA). Many ACA programs, policies and initiatives are in the planning stages while others are already in place. Arkansas Medicaid applied for and received a two-year planning grant for Health Homes for the Chronically Ill. Arkansas Medicaid also implemented the National Correct Coding Initiative, which allowed Arkansas Medicaid to apply edits to its claim processing system consistent with those used by Medicare.

Arkansas Medicaid is committed to ensuring all our beneficiaries have access to the best medical care possible. The program continues to work with providers and their professional organizations across Arkansas to increase the use of technology in the delivery and administration of services, to identify and support use of the best evidence-based practices and to ensure access to services in all areas of the state.

Arkansas Medicaid Operations

In SFY 2012, our fiscal agent, Hewlett-Packard, processed more than thirty-eight (38) million provider-submitted claims for twelve thousand one hundred and forty-six (12,146) providers on behalf of more than seven hundred seventy six thousand and fifty-two (776,052) Arkansans. They responded to ninety-five thousand five hundred and ninety (95,590) voice calls, one hundred seventy-six thousand eight hundred and eighty-one (176,881) automated calls and twenty nine thousand seven hundred and twelve (29,712) written inquiries and conducted two thousand seven hundred and thirty-two (2,732) provider visits and fifty-one (51) workshops around the state. Ninety-nine percent (99%) of claims were processed within thirty (30) days, with the average receipt-to-adjudication time of approximately 2.1 days. On average, providers received their payments within a week of claim submission.

Arkansas Medicaid is a critical component of health care financing for children and pregnant women. Through ARKids First and other programs, Arkansas Medicaid insures approximately four hundred ninety four thousand and sixty-three (494,063) children and according to recent data, paid for approximately 66%* of all births in Arkansas.

*This calculation is based on SFY11 data, which is the most recent available.

Office of Long Term Care

The Office of Long Term Care (OLTC) has undertaken a number of initiatives to promote the concept of culture change in long-term care (LTC) facilities. They have contracted with the Arkansas Foundation for Medical Care's (AFMC) Arkansas Innovative Performance Program (AIPP) to conduct trainings, develop facility mentoring and sponsor nationally-recognized speakers in the area of culture change. The term "culture change" refers to the concept of person-centered care, promotion of resident choice and development of the most home-like environment possible.

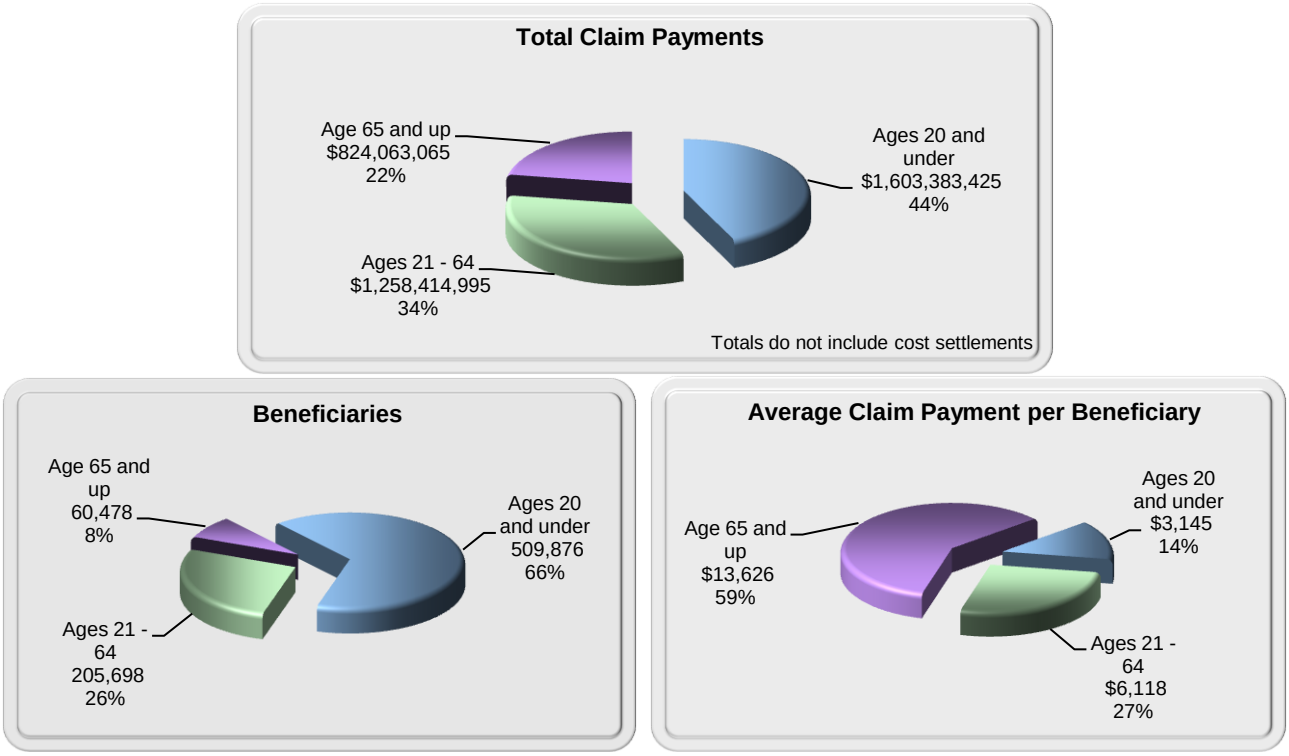
OLTC has undertaken a number of initiatives to promote specialized training for Dementia Care in long-term care facilities. OLTC is working collaboratively with the Arkansas Heath Care Association, AFMC, and the Arkansas LTC Ombudsman Program to conduct trainings, develop facility mentoring, and sponsor nationally-recognized speakers in the area of dementia care.

Additionally, they have developed a survey tool to recognize potential gaps in Emergency Preparedness in Arkansas nursing homes, assisted living and residential care facilities. Statewide training for emergency preparedness will be provided through a collaborative effort with AFMC's AIPP for LTC, Arkansas Health Care Association, the Arkansas Department of Emergency Management, the Arkansas Department of Health, and the Arkansas Ombudsman.

SFY 2012 Statistics

Beneficiary Information

Unduplicated Beneficiary Counts and Claim Payments by Age



Source: OnDemand HMGR580J

Percentage of Change in Enrollees and Beneficiaries from SFY 2011 to SFY 2012

	SFY11	SFY12	% Change
Medicaid enrollees	785,446	795,889	1.3%
Medicaid beneficiaries	770,792	776,050	0.7%

Newborns paid for by Arkansas Medicaid

	SFY10	SFY11	% Change
Newborns paid for by Arkansas Medicaid	25,659	24,995	-2.59%

The medical cost for 66%* of all babies born to Arkansas residents during SFY 2011 was paid for by Medicaid.

Source: DHS- DMS

*This calculation is based on SFY11 data, which is the most recent available.

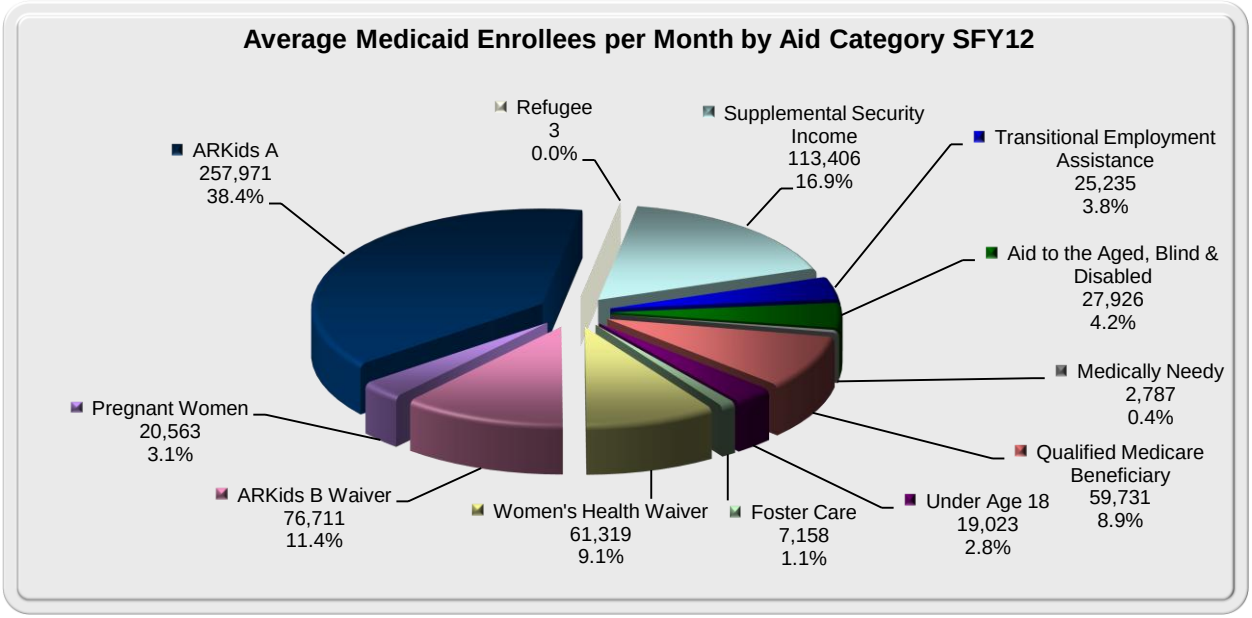
Percentage of Population Served by Arkansas Medicaid

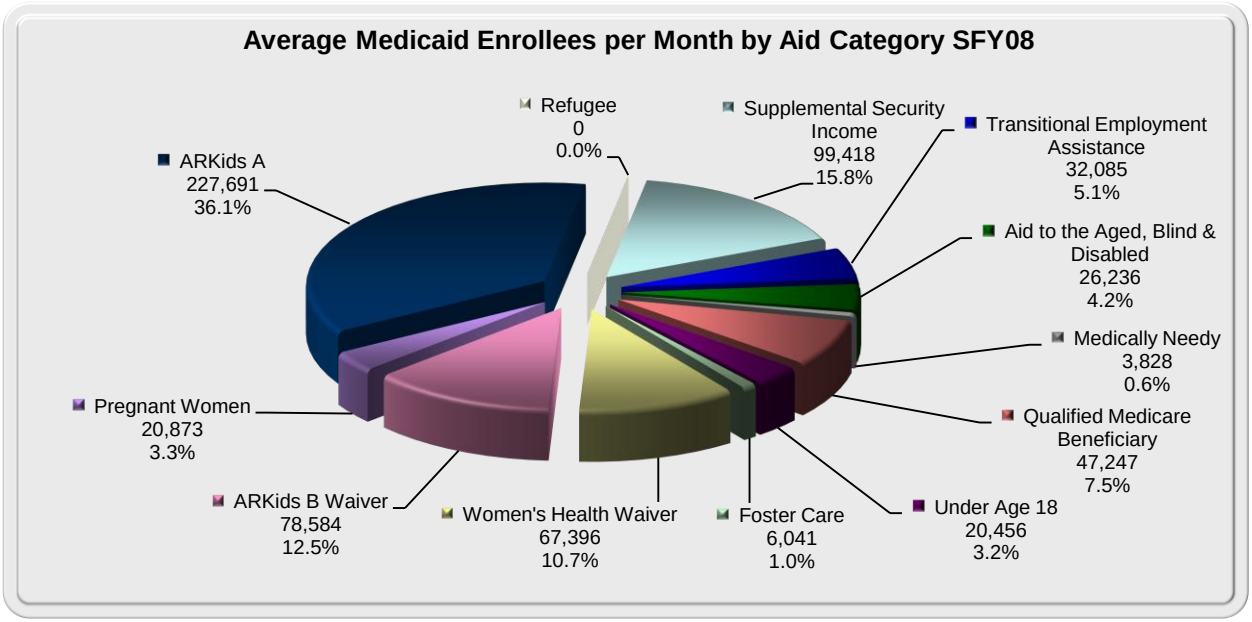
Age group	Arkansas Population	% of Population Served by Arkansas Medicaid**
All ages	2,951,522	26%
Elderly (sixty-five (65) and older)	425,867	14%
Adults (twenty-one (21)through sixty-four (64))	1,681,290	12%
Children (twenty (20) and under)	844,365	60%

** This calculation is based on the Arkansas population for 2011, which is the most recent available.

Source: UALR, OnDemand HMGR580J

Arkansas Medicaid Enrollees by Aid Category – 5 year comparison



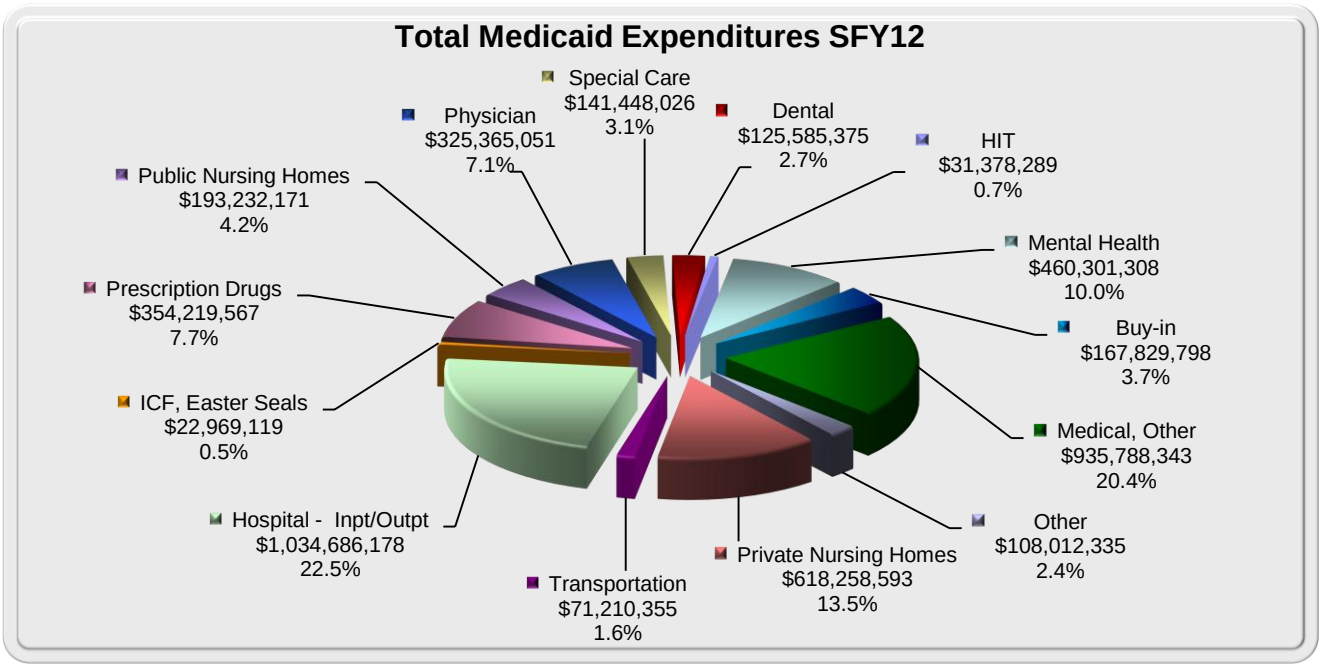


NOTE: These are individuals who have enrolled in the program and may or may not have received services. Enrollees may have multiple aid categories and are therefore counted in each of those categories.

Source: ACES IM-2414

Expenditures

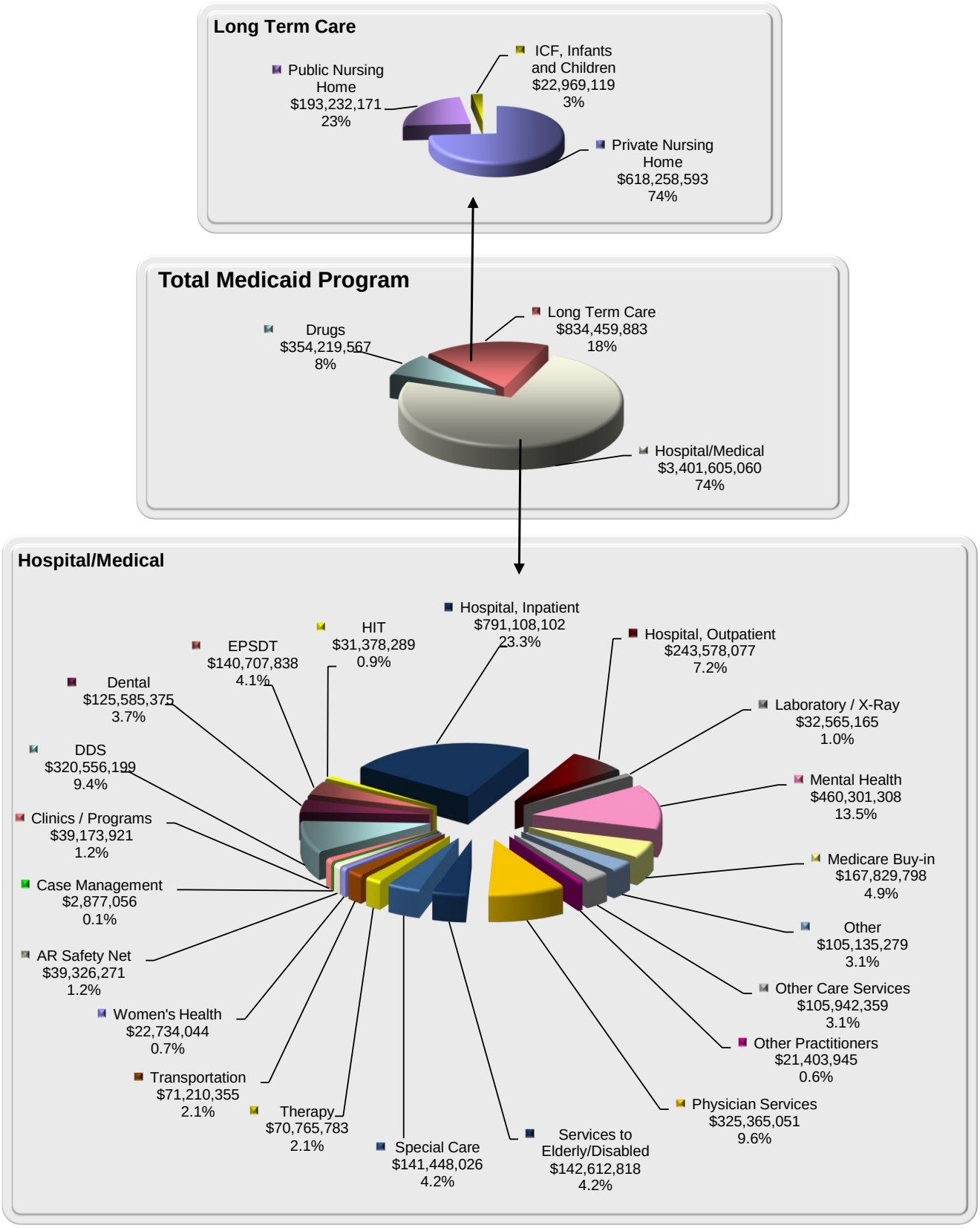
Total Arkansas Medicaid Expenditures



- Special Care includes Home Health, Private Duty Nursing, Personal Care and Hospice Services.
- Transportation includes emergency and non-emergency transportation.
- Other includes vendor contracts for Hospital/Medical, Targeted Case Management, and other adjustments.
- Buy-in includes Medicare premiums.
- Prescription Drugs includes regular prescription drugs, Family Planning drugs, Medicare Part D benefit payments, and contracts related to the Prescription Drug Program.

Source: DHS Annual Statistical Report

Arkansas Medicaid Program Benefit Expenditures



Source: Arkansas Medicaid Category of Service Report

Drug Rebate Collections

The Omnibus Budget Reconciliation Act of 1990 requires manufacturers who want outpatient drugs reimbursed by State Medicaid programs to sign a federal rebate contract with the Centers for Medicare and Medicaid Services (CMS). Until 2008, this only affected those drugs reimbursed through the pharmacy program. The Federal Deficit Reduction Act of 2005 required a January 2008 implementation of the submission of payment codes to include a National Drug Code (NDC) number on professional and institutional outpatient provider claims. The NDC number is used for the capture and payment of rebate. An extension was granted by CMS for Arkansas Medicaid to allow implementation of institutional outpatient provider claims to June 30, 2008. Each quarter, eligible rebate drugs paid by Arkansas Medicaid are invoiced to the manufacturers. The manufacturers submit payment to the state. Those payments are then shared with CMS as determined by the respective match rates.

Rebate Dollars Collected	
Total SFY 2012	$147,099,432
State portion	$42,830,224
Federal portion	$104,269,208

Economic Impact of Arkansas Medicaid

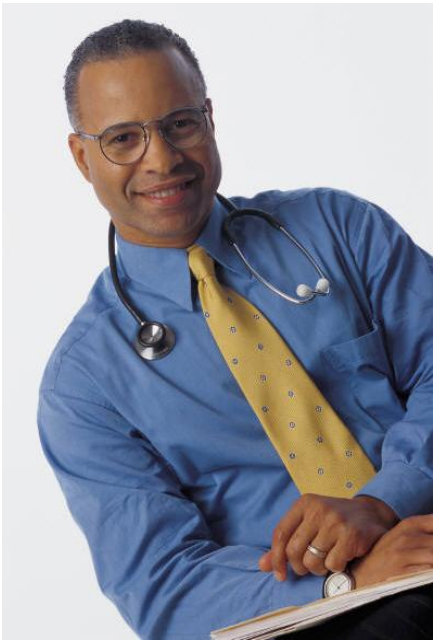
Program Costs			
State Fiscal Year (SFY)	Total (in mil)	Unduplicated Beneficiaries	Average Annual Cost per Beneficiary
2005	$3,007	688,150	$4,370
2006	$3,137	729,800	$4,298
2007	$3,299	742,965	$4,440
2008	$3,533	744,269	$4,747
2009	$3,716	747,851	$4,969
2010	$4,102	755,607	$5,429
2011	$4,379	770,792	$5,681
2012	$4,590	776,050	$5,915
2013*	$4,935	782,857	$6,304

Program costs only—does not include administration or other appropriations.

*Estimated

Arkansas Budget and Medicaid percentage		
	SFY 2012	Medicaid Represents
State of Arkansas Budget	$24.2 billion	19.1%
State General Revenue Funded Budget	$4.6 billion	15.1%

Arkansas Medicaid Providers



Number of enrolled providers

Arkansas Medicaid has approximately thirty eight thousand and three hundred (38,300) enrolled providers.

Number of participating providers

Approximately twelve thousand one hundred and forty-six (12,146) (32%) are participating providers.

Number of claims processed and approximate processing time

Thirty-eight (38) million provider-submitted claims were processed in SFY 2012 with an average processing time of 2.1 days.

Sources: HMDR215J, HMGR526J

NOTE: The count for participating providers includes all providers and provider groups who have submitted claims. It does not include individual providers who may have actually performed services but are part of the provider group, that submitted claims for those services.

(See Number of Providers by County in appendices.)

Top ten (10) provider types enrolled

1	Physicians (8,045)
2	Individual Occupational, Physical and Speech Therapy Services Providers (2,395)
3	Alternatives for Adults with Physical Disabilities (APD) Waiver Attendant Care (2,378)
4	Physicians Groups (1,808)
5	*Dental Services (963)
6	Pharmacy (862)
7	Nurse Practitioner (770)
8	Prosthetic Services/Durable Medical Equipment (746)
9	Visual Care - Optometrist Optician (514)
10	Hospital (476)

*Includes orthodontists, oral surgeons and dental groups

Understanding DMS and Arkansas Medicaid

The Division of Medical Services (DMS) houses two major programs under one administration: Arkansas Medicaid and the Office of Long Term Care (OLTC). Medicaid is a joint federal-state program of medical assistance for eligible individuals based on financial need and/or health status. In 1965, Title XIX of the Social Security Act created grant programs popularly called “Medicaid”. Medicaid furnishes medical assistance to those who have insufficient incomes and resources to meet the costs of necessary medical services. Medicaid provides rehabilitation and other services to help families and individuals become or remain independent and able to care for themselves.

The Department of Human Services (DHS) is the single state agency authorized and responsible for regulating and administering the program. DHS administers the Arkansas Medicaid Program through the DMS. The Centers for Medicare and Medicaid Services (CMS) administers the Medicaid Program for the U.S. Department of Health and Human Services. CMS authorizes federal funding levels and approves each state’s State Plan, ensuring compliance with federal regulations. Individuals are certified as eligible for Arkansas Medicaid services by DHS Field Staff located in DHS County Offices or by District Social Security Offices.

In addition to Arkansas Medicaid Services, DMS also houses the OLTC. Each year, more than twenty five thousand (25,000) Arkansans with chronic, long-term medical needs require services in long-term care facilities. These individuals live in the approximately four hundred and fifty (450) long-term care facilities licensed to provide long-term care services in Arkansas. These facilities include Nursing Facilities, Intermediate Care Facilities for Individuals with Intellectual Disabilities, Adult Day Care, Adult Day Health Care, Post Acute Head Injury Facility, Residential Care Facilities and Assisted Living Facilities. Improving the quality of life for residents and protecting their health and safety through enforcing state and federal standards are primary goals of Arkansas Medicaid's OLTC. Using qualified health care professionals, OLTC surveys or inspects all facilities to ensure residents receive the care they need in a clean, safe environment and are treated with dignity and respect.

In addition to surveying facilities, OLTC administers the Nursing Home Administrator Licensure program, Criminal Background program and Certified Nursing Assistant registry and training program; processes Medical Needs Determinations for Nursing Home and Waivers, and operates a Complaints Unit.

DMS is divided into seven (7) major units:

- Health Care Innovation
- Long Term Care
- Medicaid Information Management
- Pharmacy
- Policy, Program and Contract Oversight
- Program and Administrative Support
- Program and Provider Management

(See the DMS Organizational Chart in the appendices.)

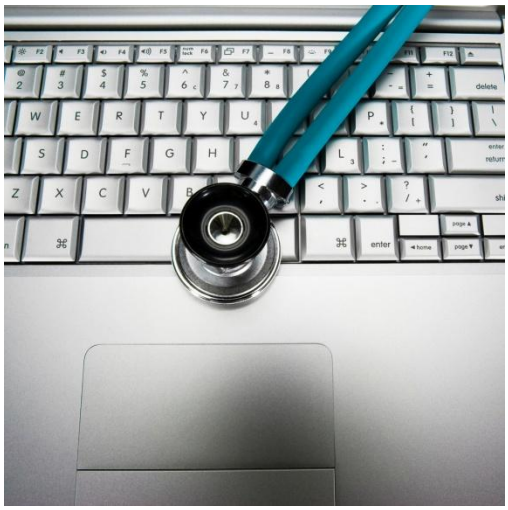
Health Care Innovation

Arkansas Medicaid is creating a patient-centered health care system that embraces the Triple Aim:

1. improving the health of the population;
2. enhancing the patient experience of care, including quality, access and reliability; and
3. reducing, or at least controlling, the cost of health care.

This will be accomplished by transforming the vast majority of care and payment from fragmented, fee-for-service models that reward providers for volume to models that reward and support providers for delivering improved outcomes and high quality, cost effective care. The Health Care Innovation Area is responsible for directing the operations and activities to redesign the Arkansas Medicaid payment and service delivery systems by working with multi-payers, staff and contractors to design and deliver episodes of care for acute conditions; implement new models of population based health for chronic conditions; develop and coordinate infrastructure requirements; and facilitate stakeholder, provider and patient engagement.

In July 2012, the Division of Medical Services (DMS) launched five (5) episodes on a statewide, multi-payer basis that impacted over one thousand (1,000) providers in Arkansas through the Arkansas Health Care Payment Improvement Initiative. In addition to obtaining the state, federal regulatory and legislative approvals to launch this first wave of the episode-based payment model, DMS has made significant progress in the implementation of health information-related technology. This progress includes an Arkansas Medicaid-developed and deployed statewide analytics engine to calculate per-episode costs and generate provider reports, as well as a collaboration between Arkansas Medicaid and Arkansas Blue Cross Blue Shield to implement the multi-payer provider portal where providers can enter data and access reports. Furthermore, Arkansas Medicaid has completed a Request for Information process to better understand the capabilities of existing episode-based payment software solutions. These efforts have promoted a common understanding between Arkansas Medicaid and private payers regarding the options for creating a scalable, multi-payer analytic solution.



Long Term Care

The Office of Long Term Care (OLTC) professional surveyors conduct annual Medicare, Medicaid and State Licensure surveys of Arkansas' two hundred and twenty-nine (229) Nursing Facilities and forty (40) Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFID), including five (5) Human Development Centers. Annual and complaint surveys are also conducted in thirty-nine (39) Adult Day Care and Adult Day Health Care facilities and two (2) Post Acute Head Injury Facilities throughout the state. Semi-annual surveys are conducted in the sixty-seven (67) Residential Care Facilities, seventy-seven (77) Assisted Living Facilities and eighteen (18) Alzheimer's Special Care Units. Additionally, annual Civil Rights surveys are conducted in one hundred and ten (110) hospitals. In SFY 2012, twenty-nine (29) face-to-face medical need determination visits were made throughout the state.

In addition to its role inspecting long-term care facilities, the OLTC provides training and educational opportunities to various health care providers to ensure that facilities provide the highest level of care possible. OLTC staff provided approximately one hundred and ninety-five (195) hours of continuing education through sixty-five (65) workshops/seminars to over one thousand eight hundred and forty-eight (1,848) staff members in the nursing home

and assisted living industry during SFY 2012. Furthermore, there were two hundred and seventy-five (275) agendas submitted from outside sources for review to determine one thousand five hundred and thirty-one (1,531) contact hours for nursing home administrators.

The Nursing Home Administrator Licensure Unit processed renewals for six hundred and sixty-four (664) licensed administrators and seventy-one (71) license applications and issued fifty-two (52) new licenses and seven (7) temporary licenses. Additionally, OLTC administered the state nursing home administrator examination to sixty-eight (68) individuals.

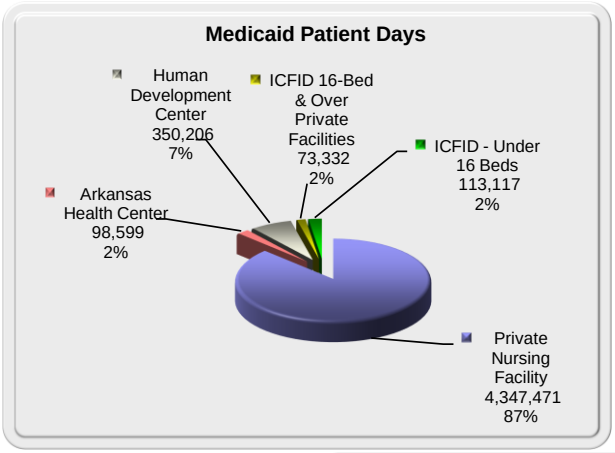
The Criminal Record Check Program applies to all categories of licensed long-term care facilities consisting of over five hundred and eleven (511) affected facilities. During SFY 2012, there were thirty-four thousand five hundred and seventy-five (34,575) state record checks processed through OLTC and twenty thousand five hundred and forty-eight (20,548) federal record checks processed with a total of nine hundred and seventy-seven (977) disqualifications under both categories combined (1.65% of the disqualifications were due to the total number of state background checks performed).

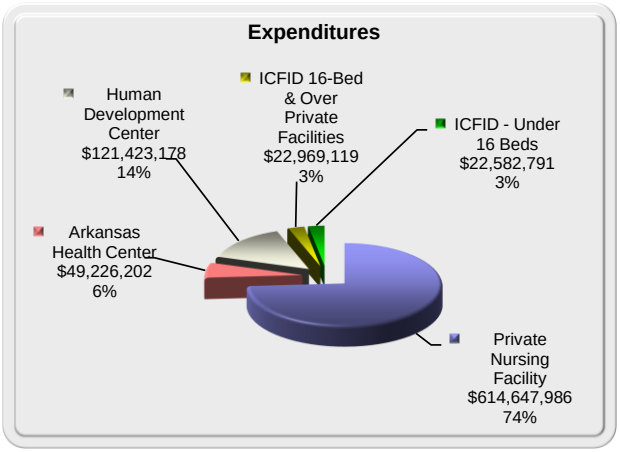
At the end of SFY 2012, the Registry for Certified Nursing Assistants (CNAs) contained thirty thousand eight hundred and seventy-eight (30,878) active and sixty-seven thousand nine hundred and forty-one (67,941) inactive names. In addition to maintaining the Registry for CNAs, the OLTC also manages the certification renewal process for CNAs, approves and monitors nursing assistant training programs, manages the statewide competency testing services and processes reciprocity transfers of CNAs coming into and leaving Arkansas.

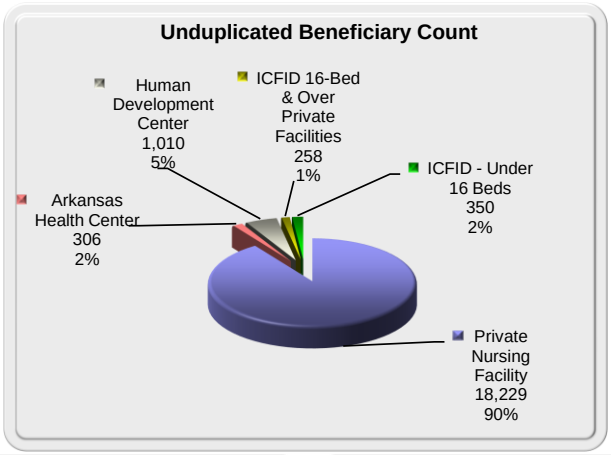
The Medical Need Determination Unit processed approximately one thousand three hundred and thirty-two (1,332) Arkansas Medicaid nursing facility applications per month while maintaining approximately twelve thousand six hundred and nine (12,609) active cases. The unit also processed eleven thousand two hundred and forty-three (11,243) assessments, two thousand four hundred and thirty-six (2,436) changes of condition requests, five hundred and forty-four (544) transfers, one thousand eight hundred and fifty-six (1,856) utilization review requests and three thousand and fifty-two (3,052) applications/reviews for ICFID, which includes one hundred and seventy-eight (178) new assessments and thirty-eight (38) transfers during the year. Additionally, the unit completed fourteen thousand and eighty-one (14,081) applications/reviews/waivers for other medical programs within the Department of Human Services during SFY 2012.

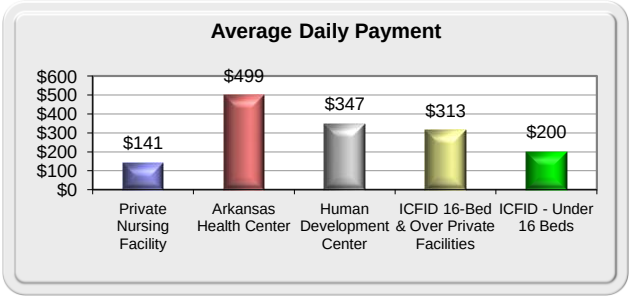
The OLTC Complaint Unit staffs a registered nurse and licensed social worker who record the initial intake of complaints against long-term care facilities. When this occurs, the OLTC performs an on-site complaint investigation. They are often able to resolve the issues with the immediate satisfaction of the involved parties. The OLTC received nine hundred and forty-eight (948) nursing home complaints during SFY 2012 regarding the care or conditions in long-term care facilities.

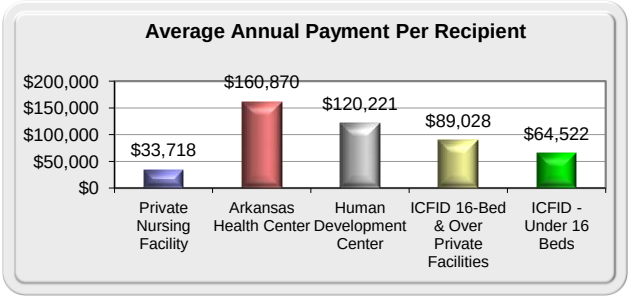
Long Term Care Statistics











The Arkansas Health Center had a mass adjustment process during SFY 12 that normally would have been processed in SFY 11. This mass adjustment was a $4.2 million dollar payout. This additional expenditure causes the Average Daily Payment and Average Annual Payment per Recipient to appear higher than these rates would be for SFY 2012 claims only.

Source: DHS Annual Statistical Report

Medicaid Information Management

Medicaid Data Security Unit

The Medicaid Data Security Unit works with the Department of Human Services (DHS) Health Insurance Portability and Accountability Act (HIPAA) officers in providing HIPAA enforcement. This includes monitoring the privacy and security of patients' information, along with ensuring contractors adhere to DHS Information Technology security policies and procedures. The Security Unit also monitors and performs technical audits on contractors and researchers who use Arkansas Medicaid data. A Data Security Committee evaluates requests utilizing Arkansas Medicaid data for research projects and publication requests to ensure HIPAA compliance.

Systems and Support

The Systems and Support Unit administers the contract for the fiscal agent that operates the Medicaid Management Information System (MMIS), which processes all Arkansas Medicaid claims. The unit's duties include:

- Developing Advanced Planning Documents for Centers of Medicaid and Medicare
- Maintaining system documentation from the contractor
- Developing, tracking and documenting customer service requests for modifications to MMIS
- Approving production system modifications to MMIS and monitoring the fiscal agent contractor's performance
- Performing quality assurance reviews on all edits and audits affecting claims processed by MMIS
- Managing the Division of Medical Services (DMS) SharePoint sites and portals
- Coordinating computer technical support for the DMS division

Pharmacy

Prescription Drug Program

The Prescription Drug Program, an optional Arkansas Medicaid benefit, was implemented in Arkansas in 1973. Under this program, eligible beneficiaries may obtain prescription medication through any of the eight hundred and sixty-two (862) enrolled pharmacies in the state. During SFY 2012, a total of four hundred and fifty-one thousand two hundred and ninety-five (451,295) Arkansas Medicaid beneficiaries used their prescription drug benefits. A total of 4.8 million prescriptions were reimbursed by Arkansas Medicaid for a cost of $309.8 million dollars making the average cost per prescription approximately $64.54. An average cost for a brand name prescription was $235 dollars, representing 19% of the claims and accounting for 67% of expenditures. The average cost for a generic prescription was $26 dollars, representing 81% of claims and accounting for 33% of expenditures.

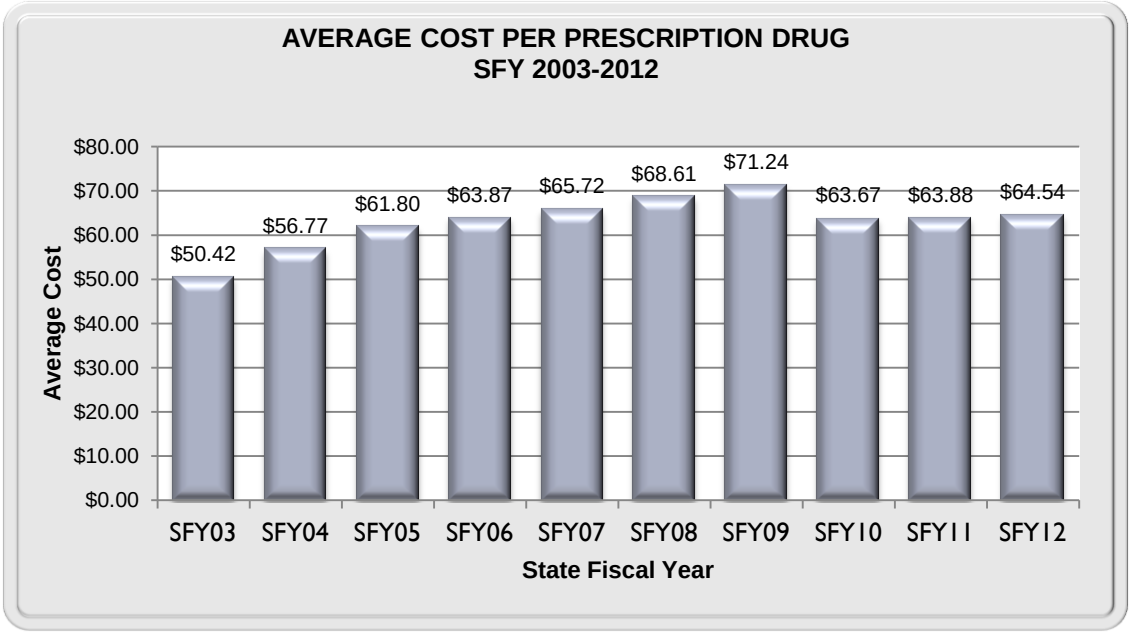
The Prescription Drug Program restricts each beneficiary to a maximum of three (3) prescriptions per month, with the capability of receiving up to six (6) prescriptions by prior authorization. Beneficiaries under twenty-one (21) years of age and certified Long-Term Care (LTC) beneficiaries are not restricted to the amount of prescriptions received per month. Persons eligible under the Assisted Living Waiver are allowed up to nine (9) prescriptions per month.

Beginning January 1, 2006, full benefit, dual-eligible beneficiaries began to receive drug coverage through the Medicare Prescription Drug Benefit (Part D) of the Medicare Modernization Act of 2003, in lieu of coverage through Arkansas Medicaid. Arkansas Medicaid is required to pay the Centers for Medicare and Medicaid Services (CMS)

the State Contribution for Prescription Drug Benefit, sometimes referred to as the Medicare Part D Clawback. This Medicare Part D payment for SFY 2012 was $42,394,776.

Arkansas Medicaid reimbursement for prescription drugs is based on cost and a dispensing fee. Drug costs are established and based upon a pharmacy's Estimated Acquisition Cost (EAC) and the federally-established Generic Upper Limit or State Established Upper Limit. Arkansas Medicaid has a dispensing fee of $5.51 as established by the Division of Medical Services and approved by CMS. The EAC and dispensing fee are based upon surveys that determine an average cost for dispensing a prescription and the average ingredient cost. In March of 2002, a differential fee of $2.00 was established and applied to generic prescriptions for which there is not an upper limit. The following table shows the average cost per prescription drug in the Arkansas Medicaid Program.

Average Cost per Prescription Drug, SFY 2003-2012



Source: HP Healthcare Services

Policy, Program and Contract Oversight

Policy, Program Development and Quality Assurance

The Policy, Program Development and Quality Assurance (PD/QA) Unit develops and maintains the Arkansas Medicaid State Plan and the State's Child Health Insurance Program Plan, leads the development and research of new programs, oversees contractor technical writing of provider policy manuals, coordinates the approval process through both state and federal requirements and coordinates efforts in finalizing covered program services, benefit extension procedures and claims processing. The PD/QA Unit also leads development of new waiver and demonstration programs and the resulting provider manuals. Because the Division of Medical Services has administrative and financial authority for all Arkansas Medicaid waivers and demonstrations, PD/QA is responsible for monitoring operation of all Arkansas Medicaid waivers and demonstration programs operated by other Divisions. PD/QA assures compliance with the Centers for Medicare and Medicaid Services (CMS) requirements for operating waivers and demonstrations and monitors for key quality requirements.

Quality Assurance Activities include:

- Leading development of new waivers and demonstrations
- Communicating and coordinating with CMS regarding waiver and demonstration activities and requirements, including the required renewal process
- Providing technical assistance and approval to operating agencies regarding waiver and demonstration policies, procedures, requirements and compliance
- Performing case reviews, data analysis and oversight activities to help identify problems and assure remediation for compliance with CMS requirements
- Developing QA strategies and interagency agreements for the operation and administration of waivers and demonstrations

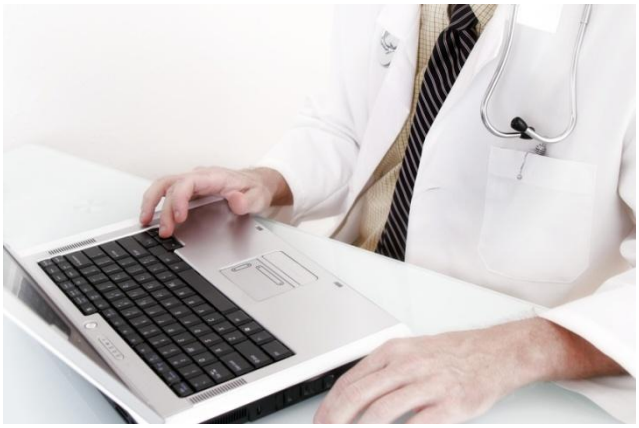
Contract Monitoring

The Contract Monitoring Unit oversees all contracts involving the Division of Medical Services and Arkansas Medicaid. The Unit reviews both the Request for Proposals and the resulting contracts to ensure the requirements for each contract are capable of being met and measured. The Unit makes on-site visits to contractors to establish relationships with the contractors, to review required documentation and to ensure the contractor is providing the services directed under the contract.

Program and Administrative Support

Financial Activities

The Financial Activities Unit of the Division of Medical Services (DMS) is responsible for the Division's budgeting and financial reporting, including the preparation of internal management reports and reports to federal and state agencies. This unit also handles division-level activities related to accounts payable, accounts receivable and purchasing, as well as activities to secure and renew administrative and professional services contracts. The Financial Activities unit is also responsible for Human Resource functions in DMS.



Program Budgeting and Analysis

Program Budgeting and Analysis develops the budgets for all of Arkansas' Medicaid waiver renewals and newly proposed Arkansas Medicaid waiver programs. Depending on the type of waiver that is being renewed or proposed budget neutrality, cost effectiveness or cost neutrality is determined. Currently, Arkansas has nine waiver programs which include four 1115(a) demonstration waivers, four 1915(c) home- and community-based waivers and one 1915(b) Non-Emergency Transportation waiver.

In addition to waiver budgeting, Program Budgeting and Analysis analyzes Arkansas Medicaid programs to determine whether each program is operating within their budget and if program changes should be considered. This unit also performs trend and other financial analysis by type of service, provider, aid category, age of beneficiary, etc.

Provider Reimbursement

Provider Reimbursement develops reimbursement methodologies and rates, identifies budget impacts for changes in reimbursement methodologies, coordinates payments with the Arkansas Medicaid Fiscal Agent and provides reimbursement technical assistance for the following Arkansas Medicaid providers:

- Institutional – The Institutional Section is responsible for processing: all necessary cost settlements for in-state and border city Hospitals, Residential Treatment Units and Federally Qualified Health Clinics; calculating and reimbursing annual hospital Upper Payment Limit amounts, hospital quality incentive payments and hospital Disproportionate Share payments; calculating per diem reimbursement rates for Residential Treatment Centers; processing and implementing all necessary rate changes within Medicaid Management Information System for the above named providers and processing all necessary retroactive reimbursement rate change mass adjustments for these providers.
- Non-Institutional –The Non-Institutional Section is responsible for the maintenance of reimbursement rates and assignment of all billing codes for both institutional and non-institutional per diems, services, supplies, equipment purchases and equipment rental for the following providers: Physician, Dental, Durable Medical Equipment, ARKids, Nurse Practitioner, Nurse Midwife, Child Health Management Services, Developmental Day Treatment Clinic Services, Other.
- Long Term Care (LTC) – The LTC Section reviews annual and semi-annual cost reports submitted by Nursing Facilities and Intermediate Care Facilities for Individuals with Intellectual Disabilities. The cost reports are reviewed for compliance with applicable state and federal requirements and regulations, including desk and on-site reviews. The LTC Section maintains a database of the cost report information, which is used to evaluate cost and develop reimbursement methodologies and rates. The LTC Section is also responsible for processing all necessary retroactive reimbursement rate change mass adjustments for these providers.

Third Party Liability

As the payer of last resort, federal and state statutes require Medicaid agencies to pursue third party resources to reduce Medicaid payments. One aspect of Arkansas Medicaid cost containment is the Third Party Liability Unit of Administrative Support. This unit pursues third party resources (other than Arkansas Medicaid) responsible for health care payments to Arkansas Medicaid beneficiaries. These sources include health and liability insurance, court settlements and absent parents. The savings for SFY 2012 were as follows:

	SFY 2012
Other Collections (Health & Casualty Insurance)	$27,881,725
Cost Avoidance (Health Insurance)	$30,170,614
Total Savings	$58,052,340

Source: DMS Statistical Report

Program and Provider Management

Behavioral Health

The Behavioral Health Unit is responsible for monitoring the Arkansas Medicaid behavioral health programs. This unit researches and analyzes proposed policy initiatives, encourages stakeholder participation and recommends revisions to policy and programming. The behavioral health unit maintains an outcome measurement method to establish more accountability related to the provision of behavioral health services for children and adolescents. Other responsibilities include monitoring the quality of treatment services and benefit extension procedures by performing case reviews, data analysis and oversight activities to help identify problems and assure compliance with Arkansas Medicaid requirements. These responsibilities are accomplished through the negotiation, coordination and assessment of the activities of the Behavioral Health utilization and peer review contracts. In addition to its role in auditing behavioral health programs, the peer review contractors provide training and educational opportunities to providers to support all programs in providing the highest quality of care to Arkansas Medicaid beneficiaries. The unit collaborates with other Department of Human Services divisions to establish goals and objectives for designing a Children's System of Care and an Adult Recovery Model for mental health care to transform and develop the Behavioral System of Care into a viable, efficient and quality-driven process.

Program Integrity - Compliance and Investigations

Program Integrity Compliance and Investigations is responsible for conducting reviews to determine the nature and extent of services billed to the Arkansas Medicaid Program and to verify that Medicaid policies and procedures are being followed. In SFY 2012, Program Integrity (PI) conducted one hundred and twenty-four (124) on-site audits of providers and identified $7.9 million in questioned cost and $18 million in cost avoidance. The unit also performed one thousand three hundred and twenty-eight (1,328) desk reviews on referrals and identified eighty-one thousand dollars ($81,000) in questioned cost. The unit also reviewed four thousand three hundred and sixty-one (4,361) questionable enrollment applications, denied fifty-four (54) questionable applications and terminated one hundred and twenty-eight (128) providers. Twenty PI staff attended various training classes at the Medicaid Integrity Institute in 2012. Arkansas continues participating in the Centers for Medicare and Medicaid Services (CMS) Medi/Medi program which allows a state to look at both Medicaid and Medicare information. PI worked closely with Medi/Medi contractors on various projects in 2012. Arkansas was one of three (3) states selected to participate in Medicaid Integrity Group supplemental audits based on active involvement with CMS and state PI groups.

Program Integrity - Policy and Systems Improvement

Program Integrity Policy and Systems Improvement is a new unit responsible for ensuring that program policy is designed to strengthen the integrity of the Arkansas Medicaid program while avoiding policies that create heightened potential for fraud, waste and abuse. These activities include managing the provider enrollment process, the Survey and Utilization Review Subsystem and the Payment Error Rate Measurement process. Another core responsibility of the unit is to assist in ensuring program integrity as the program designs and implements new payment models and processes.

Dental, Vision and Primary Care Programs

The Dental, Vision and Primary Care Programs Unit oversees multiple programs and services, many of which are provided through professional services contracts. The Unit contracts with the Arkansas Foundation for Medical Care to assist in the administration of the Primary Care Case Management Program, better known as ConnectCare. Primary activities are quality improvement, provider relations and beneficiary outreach and assistance. In addition, the Arkansas Department of Health provides assistance with primary care physician assignments and dental care coordination. The Unit also directly responds to concerns and questions of providers and beneficiaries of Arkansas

Medicaid and ARKids services and administers the Dental and Vision Program. In addition to Dental, Vision and Primary Care programs, the Unit manages the Early and Periodic Screening, Diagnosis and Treatment, ARKids and Non-Emergency Transportation programs.

Utilization Review

The purpose of the Utilization Review (UR) program is to safeguard against unnecessary and inappropriate medical care rendered to Arkansas Medicaid beneficiaries. Medical services and/or records are reviewed for medical necessity, quality of care, appropriateness of place of service and length of stay (inpatient hospital).

Arkansas Medicaid subjects some services to a review process internally or through a contract with a Quality Improvement Organization (QIO). The UR Section of the Arkansas Medicaid Program or the contracted QIO performs professional, medical necessity reviews based on accepted standards of care.

UR provides professional reviews or monitors contractors' performance for the following programs:

- Pre and Post-Payment reviews of medical services
- Prior authorization for Private Duty Nursing, hearing aids, hearing aid repair and wheelchairs
- Extension of benefits for Home Health and Personal Care for beneficiaries over the age of twenty-one (21) and extension of benefits of incontinence products and medical supplies for eligible beneficiaries
- Contractors performing prior authorizations and extension of benefits for the following programs: In-patient and Out-patient Hospitalization, Emergency room utilization, Personal Care for beneficiaries under the age of twenty-one (21), Child Health Management Services, Therapy, Transplants, Durable Medical Equipment and Hyperalimentation services
- Out-of-state transportation for beneficiaries for medically necessary services/treatment not available in-state

Appendices

Glossary of Acronyms

Department of Human Services (DHS) – Division of Medical Services (DMS) Organizational Chart

Maps

- Enrollees by County SFY 2012
- Expenditures by County SFY 2012
- Waiver Expenditures and Waiver Beneficiaries by County SFY 2012
- Providers by County SFY 2012

DMS Contacts

Glossary of Acronyms

AAA
Area Agency on Aging

ACA
Affordable Care Act

ACES
Arkansas Client Eligibility System

ACS
Alternative Community Services

Adjudicate
To determine whether a claim is to be paid or denied

ADH
Arkansas Department of Health

ADL
Activities of Daily Living

ADP
Advance Planning Documents

AEVCS
Automated Eligibility Verification and Claims Submission
On-line system for providers to verify eligibility of beneficiaries and submit claims to fiscal agent

AHCPII
Arkansas Health Care Payment Improvement Initiative

AFDC
Aid to Families with Dependent Children

AFMC
Arkansas Foundation for Medical Care

AHA
Arkansas Hospital Association

AHQA
American Healthcare Quality Association

AIPP
Arkansas Innovative Performance Program

AMA
American Medical Association

ANSI
American National Standards Institute (as used here, refers to health care standard transactions)

ANSWER
Arkansas' Networked System for Welfare Eligibility and Reporting

APII
Arkansas Payment Improvement Initiative

ARRA
American Recovery and Reinvestment Act of 2009

AVR
Automatic Voice Response

BCCDT
Breast and Cervical Cancer Diagnosis and Treatment

BO
Business Objects

CHIP
Children's Health Insurance Program

CHMS
Child Health Management Services

CMHC
Community Mental Health Center

CMS
Centers for Medicare and Medicaid Services

CNA
Certified Nursing Assistant

COB
Coordination of Benefit

COBA
Coordination of Benefits Agreement

COTS
Commercial off-the-shelf software

DAAS
Division of Aging and Adult Services

DBHS
Division of Behavioral Health Services

DBS
Division of Blind Services

DCFS
Division of Children and Family Services

DCO
Division of County Operations

DDE
Direct Data Entry

DDI
Design, Development and Implementation

DDS
Division of Developmental Disabilities Services

DDTCS
Developmental Day Treatment Clinic Services

DHS
Department of Human Services

DIS
Department of Information Systems

DME
Durable Medical Equipment

DMS
Division of Medical Services

DMHS
Division of Mental Health Services

DMS
Division of Medical Services (Medicaid)

DSH
Disproportionate Share

DSS
Decision Support System/Data Warehouse

DUR
Drug Utilization Review

DYS
Department of Youth Services

EAC
Estimated Acquisition Cost

EBT
Electronic Benefit Transfer

EFT
Electronic Funds Transfer

EHR
Electronic Health Record
A subset of a patient's health record in digital format that is capable of being shared electronically across different health care organizations

EIN
Employer's Identification Number

EMR
Electronic Medical Record
A record of clinical services for patient encounters in a care delivery organization.

EOB
Explanation of Benefits

EOMB
Explanation of Medical Benefits

EPSDT
Early and Periodic Screening, Diagnosis and Treatment

ERA
Electronic Remittance Advice

EVS
Electronic Verification System

FFP
Federal Funding Participation

FFS
Fee For Service

FMAP
Federal Medical Assistance Payment

F-MAP
Federal Medical Assistance Percentage

FQHC
Federally Qualified Health Clinic

GUL
Generic Upper Limit

HCBS
Home Community Based Services

HCFA
Health Care Financing Administration (former name for Centers for Medicare & Medicaid Services)

HCQIP
Health Care Quality Improvement Program

HHS
The federal Department of Health and Human Services

HIE
Health Information Exchange

HIPAA
Health Insurance Portability and Accountability Act

HIT
Health Information Technology

HITECH
Health Information Technology for Economic and Clinical Health

HITREC
Health Information Technology Regional Extension Center

HP
Hewlett-Packard

ICFID
Intermediate Care Facilities for Individuals with Intellectual Disabilities

INS
Immigration and Naturalization Services

IQI
Inpatient Quality Incentive

IRS
Internal Revenue Service

IT
Information Technology

IVR
Interactive Voice Response

IV&V
Independent Validation and Verification

LTC
Long Term Care

MCO
Managed Care Organization

MDS
Minimum Data Set

MHA
Mental Health Administration

MITA
Medicaid Information Technology Architecture

MMA
Medicare Modernization Act

MMCS
Medicaid Managed Care Services

MMIS
Medicaid Management Information System

MPAP
Medicare Eligible Pharmacy Assistance Program

MRI
Magnetic Resonance Imaging

MSIS
Medicaid Statistical Information System

NCPDP
National Council for Prescription Drug Programs

NDC
National Drug Codes

NET
Non-Emergency Transportation

NPDB
National Provider Data Bank

NPI
National Provider Identifier

OHIT
Office of Health Information Technology

OLTC
Office of Long Term Care

ONC
Office of the National Coordinator for Health Information Technology

PA
Prior Authorization

PACE
Program for All-Inclusive Care for the Elderly

PAM
Prior Authorization Management

PBM
Pharmacy Benefit Manager

PCCM
Primary Care Case Management

PCP
Primary Care Provider

PDA
Personal Digital Assistants

PD/QA
Program Development and Quality Assurance

PDF
Portable Document Format

PDL
Preferred Drug List

PDP
Prescription Drug Plan

PERM
Payment Error Rate Measurement

PHI
Protected Health Information

PHR
Personal Health Record

PI
Program Integrity

PMPM
Per-Member-Per-Month

POC
Plan of care

POS
Place of service

QA
Quality Assurance

QDWI
Qualified Disabled and Working Individuals

QIO
Quality Improvement Organization

QI-1
Qualifying Individuals-1 Group

QMB
Qualified Medicaid Beneficiary

RFI
Request for Information

RFP
Request for Proposals

RSPD
Rehabilitative Services for Individuals with Physical Disabilities

RSPMI
Rehabilitative Services for Persons with Mental Illness

RSYC
Rehabilitative Services for Youth and Children

RTC
Residential Treatment Center

RTU
Residential Treatment Unit

SATS
Substance Abuse Treatment Services

SCHIP
State Children's Health Insurance Program

SFY
State Fiscal Year – July 1 to June 30

SLMB
Specified Low-Income Medicare Beneficiary

SMB
Specified Low-Income Medicare Beneficiaries

SOBRA
Sixth Omnibus Budget Reconciliation Act

SSA
Social Security Administration

SSI
Supplemental Security Income

SSN
Social Security Number

SUL
State Established Upper Limit

SUR
Surveillance and Utilization Review

SURS
Survey and Utilization Review Subsystem

TANF
Temporary Assistance for Needy Families

TB
Tuberculosis

TEFRA
Tax Equity and Financial Responsibility Act

TIN
Tax Identification Number

TPL
Third Party Liability

UR
Utilization Review

UPL
Upper Payment Limit

US
United States

USPS
United States Postal Service

VA
Veterans Administration

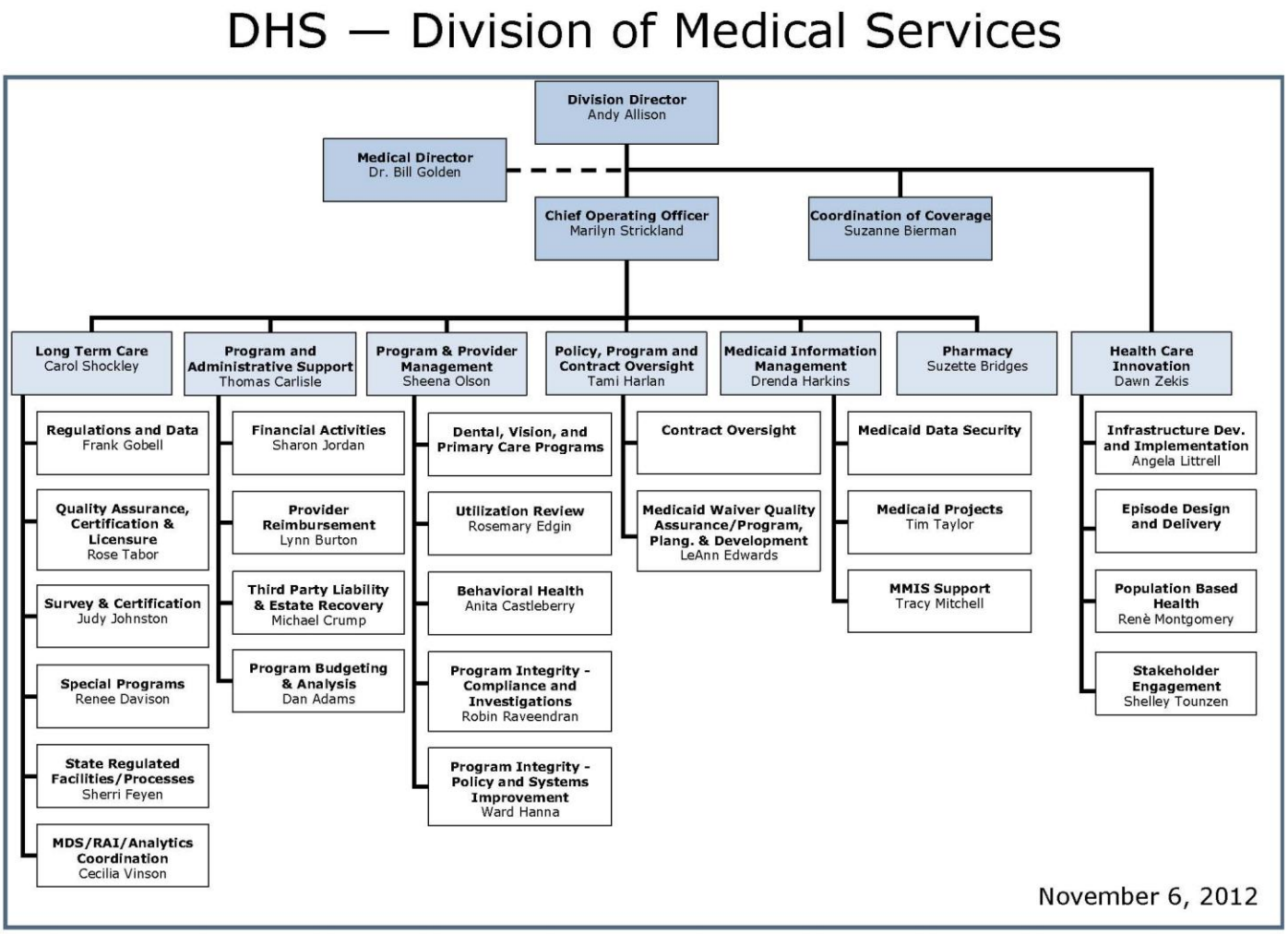
VPN
Virtual Private Network

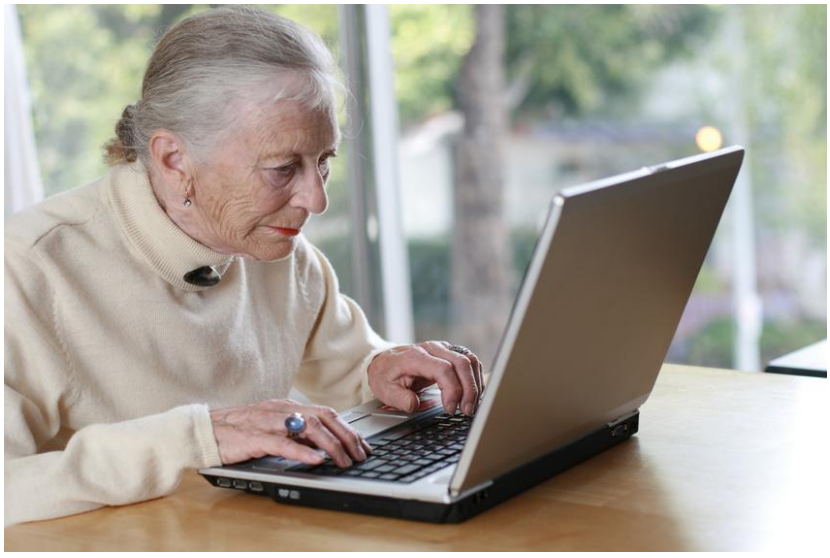
VTE
Venous Thromboembolism

WIC
Women, Infant and Children program

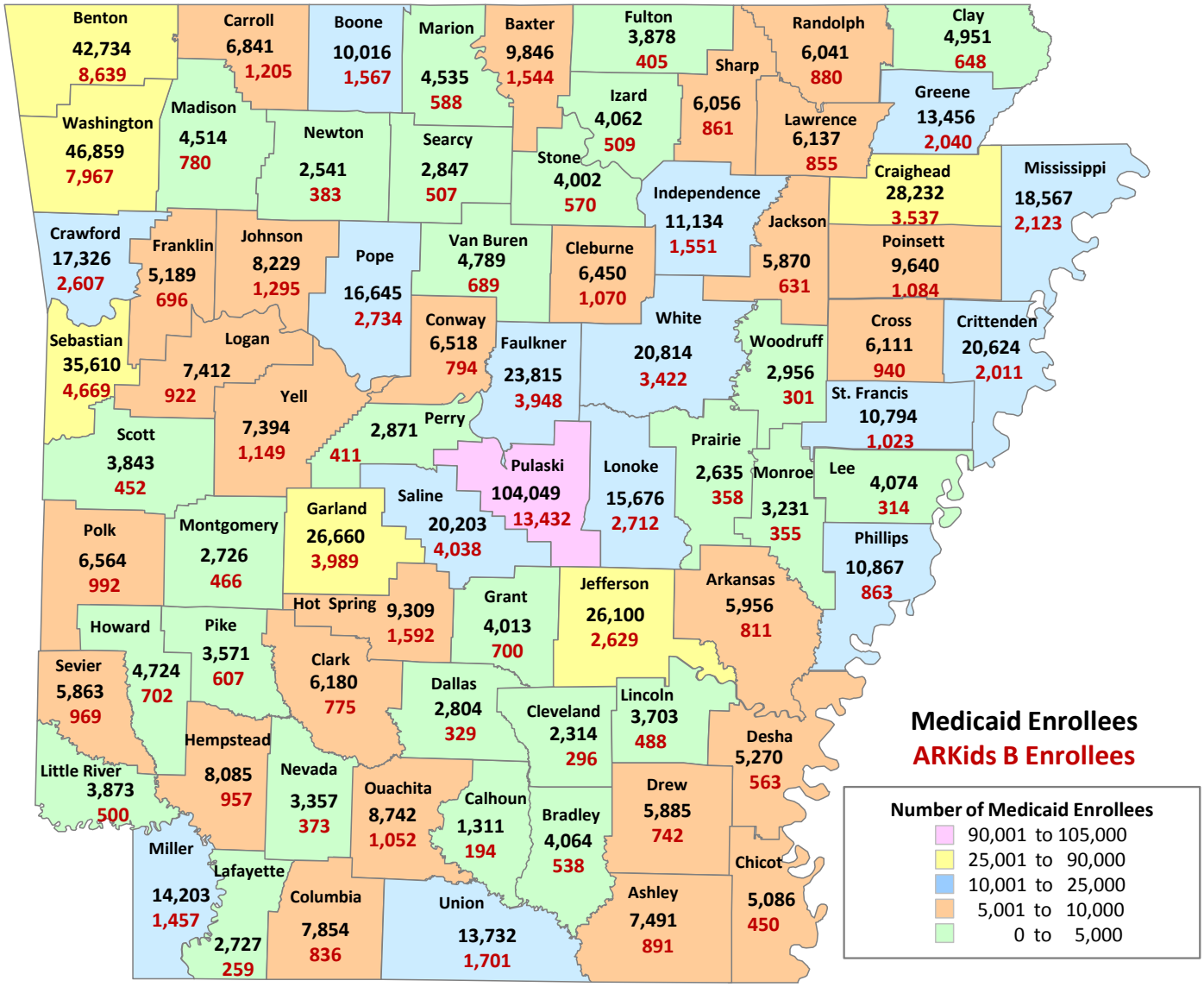
Y-OQ®
Youth Outcome Questionnaire ®

DHS – Division of Medical Services Organizational Chart





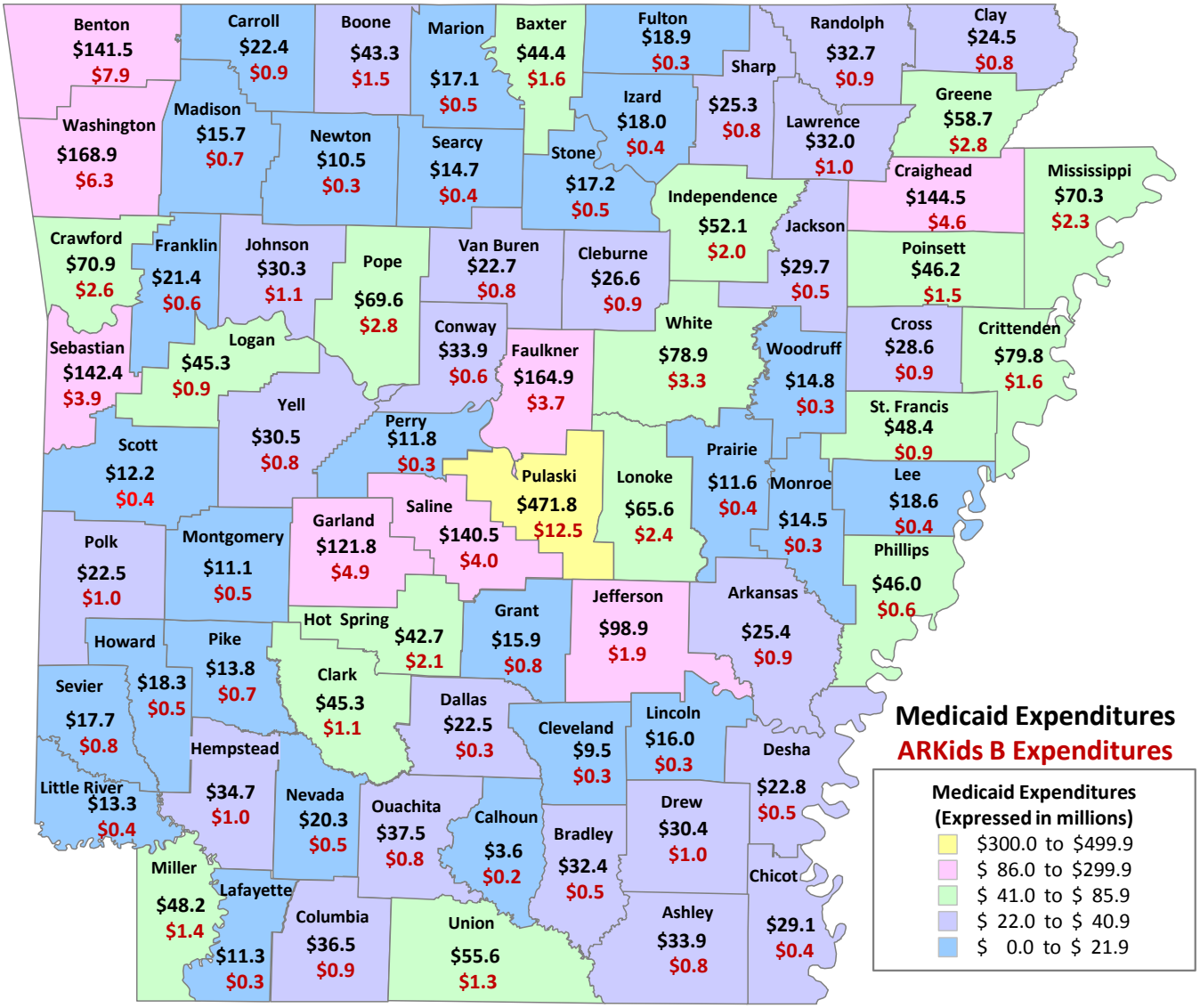
Map - Enrollees by County



Source: DHS, Division of Medical Services
Medicaid Decision Support System

NOTE: These are individuals who have enrolled in the program, and may or may not have received services.

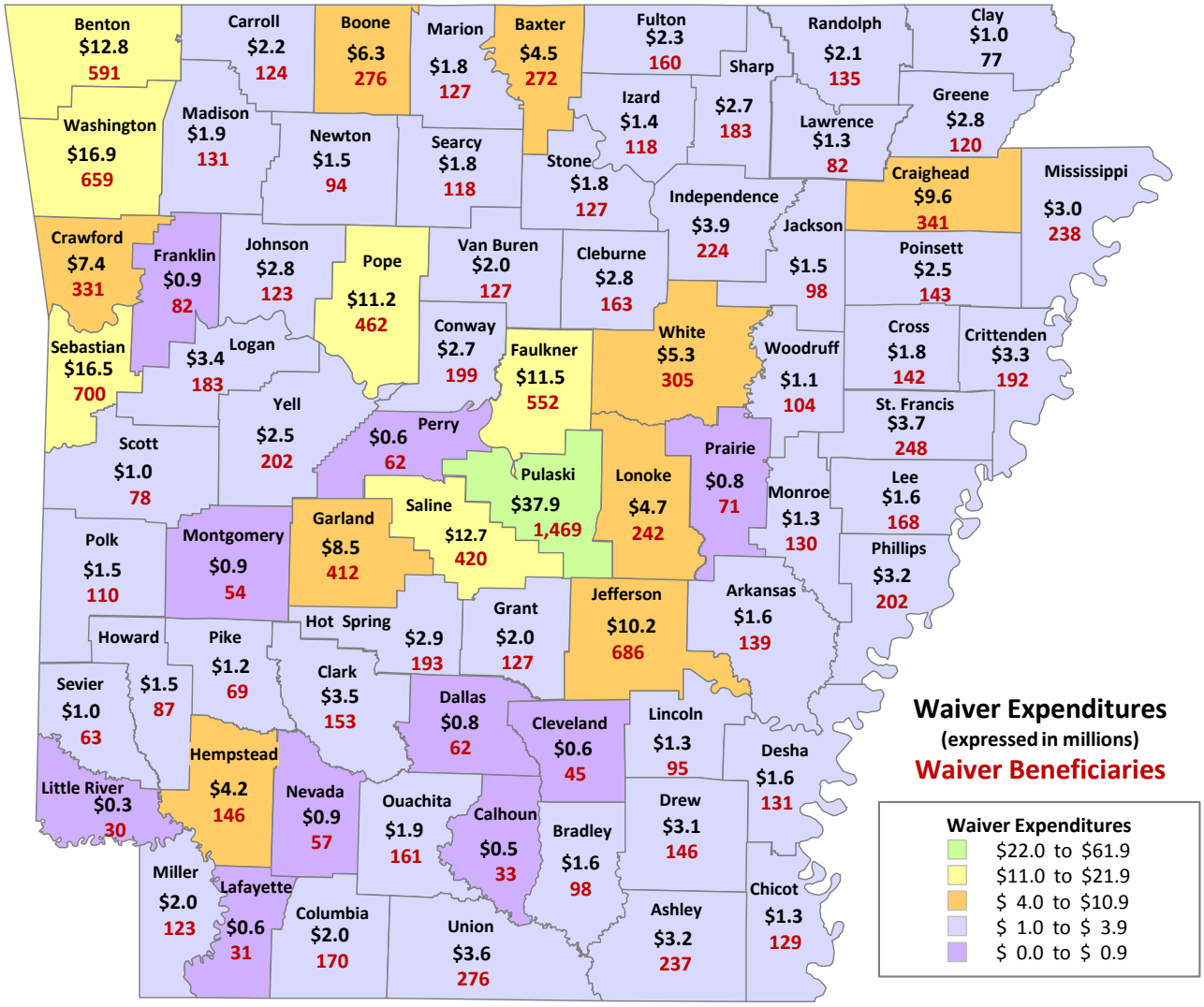
Map - Expenditures by County



Source: DHS; Division of Medical Services
Medicaid Decision Support System

NOTE: Does not include managed care or Non-Emergency Transportation (NET) claims.

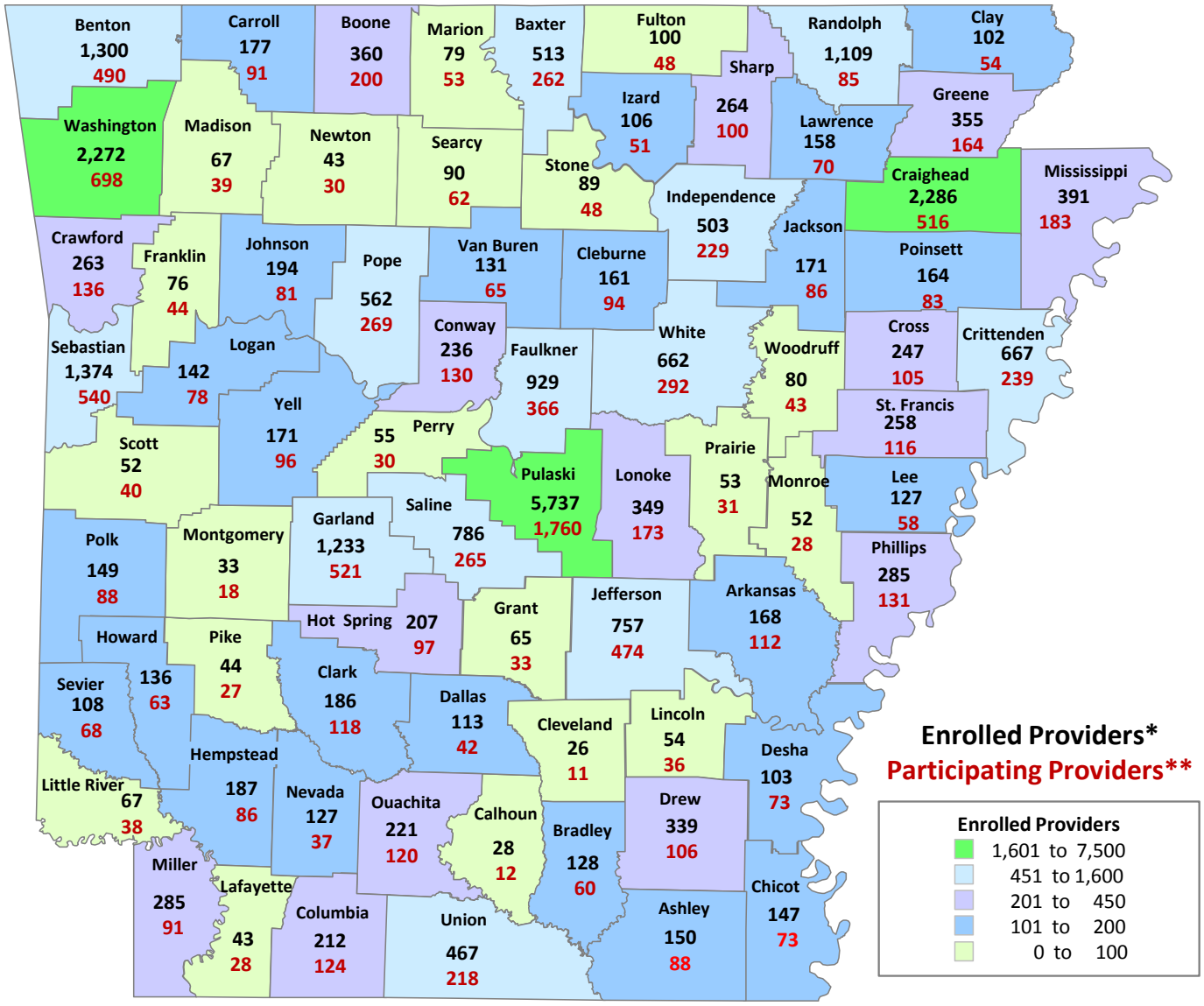
Map - Waiver Expenditures and Waiver Beneficiaries by County



Source: DHS; Division of Medical Services
Medicaid Decision Support System

Waivers included:
Alternatives for Persons with Disabilities (APD)
DDS – Alternative Community Services (ACS)
ElderChoices
Living Choices Assisted Living

Map - Providers by County



Source: DHS; Division of Medical Services
Medicaid Decision Support System

*Enrolled Providers – Providers who have been approved by Medicaid to provider services to Medicaid beneficiaries
**Participating Providers – Providers who billed at least one claim in State Fiscal Year 2012

Division of Medical Services Contacts

All telephone and fax numbers are in area code (501).

Name/e-mail	Title	Voice	Fax	Mail slot
Andrew Allison Andy.Allison@arkansas.gov	Director, Division of Medical Services	683-4997	682-1197	S-401
Suzanne Bierman Suzanne.Bierman@arkansas.gov	Assistant Director, Coordination of Coverage	320-6003	682-8873	S-416
Suzette Bridges Suzette.Bridges@arkansas.gov	Assistant Director, Pharmacy	683-4120	683-4124	S-415
Lynn Burton Lynn.Burton@arkansas.gov	Business Operations Manager, Provider Reimbursement	682-1875	682-3889	S-416
Thomas Carlisle Thomas.Carlisle@arkansas.gov	Assistant Director, Administrative Services and Chief Financial Officer	682-0422	682-2263	S-416
Anita Castleberry Anita.Castleberry@arkansas.gov	Medical Assistance Manager, Behavioral Health Unit	682-8154	682-8013	S-420
Michael Crump Michael.Crump@arkansas.gov	Business Operations Manager, Third Party Liability	683-0596	682-1644	S-296
Rosemary Edgin Rosemary.Edgin@arkansas.gov	Nurse Manager, Utilization Review	682-8464	682-8013	S-413
LeAnn Edwards LeAnn.Edwards@arkansas.gov	Business Operations Manager, Program Development and Quality Assurance	320-6424	682-2480	S-295
Frank Gobell Frank.Gobell@arkansas.gov	Business Operations Manager, Long Term Care – Regulations and Data	682-6298	682-1197	S-409
William Golden William.Golden@arkansas.gov	Medical Director, Health Policy	682-8302	682-1197	S-401
Ward Hanna Ward.Hanna@arkansas.gov	Business Operations Manager, Program Integrity – Policy and Systems Improvement	683-2790	682-1197	S-414
Drenda Harkins Drenda.Harkins@arkansas.gov	Assistant Director, Medicaid Information Management	320-6232	682-5318	S-416
Tami Harlan Tami.Harlan@arkansas.gov	Assistant Director, Policy, Programs and Contracts Oversight Unit	320-6421	682-8013	S-413
Glenda Higgs Glenda.Higgs@arkansas.gov	Medical Assistance Manager, Program Development and Quality Assurance	320-6425	682-2480	S-295

Sharon Jordan Sharon.Jordan@arkansas.gov	Business Operations Manager, Financial Activities	682-8489	682-2263	S-416
Angela Littrell Angela.Littrell@arkansas.gov	Business Operations Manager, Health Care Innovation	320-6203	682-8873	S-416
Judith E. McGhee Judith.McGhee@arkansas.gov	Medical Director, Health Reviews	682-9868	682-8013	S-412
Jeannie Moore Jeannie.Moore@arkansas.gov	Administrative Assistant, Division of Medical Services – Director	683-4997	682-1197	S-401
Sheena Olson Sheena.Olson@arkansas.gov	Assistant Director, Program and Provider Management	683-5287	682-1197	S-410
Roger Patton Roger.Patton@arkansas.gov	Information Systems Manager, Coordination of Coverage	320-6540	683-5318	S-417
Robin Raveendran Robin.Raveendran@arkansas.gov	Business Operations Manager, Program Integrity	682-8173	682-1197	S-414
Carol Shockley Carol.Shockley@arkansas.gov	Assistant Director, Long Term Care	682-8487	682-1197	S-409
Tom Show Tom.Show@arkansas.gov	Medical Assistance Manager, Non-Institutional Reimbursement	682-2483	682-3889	S-416
Brenda Sliger Brenda.Sliger@arkansas.gov	Administrative Assistant, Division of Medical Services – Chief Operating Officer	682-8329	682-1197	S-401
Victor Sterling Victor.Sterling@arkansas.gov	Medicaid Data Security Administrator, Medicaid Information Management	320-6539	682-5318	S-417
Marilyn Strickland Marilyn.Strickland@arkansas.gov	Chief Operating Officer, Division of Medical Services	682-8330	682-1197	S-401
Tim Taylor Tim.Taylor@arkansas.gov	PMO Deputy Director, Medicaid Information Management	320-6538	682-8873	S-416
Dawn Zekis Dawn.Zekis@arkansas.gov	Director, Health Care Innovation	683-0173	682-8873	S-416



Phone Numbers and Internet Resources

Quick Reference Guide

Adoptions	501-682-8462
ARKids First	501-682-8310
Child Care Licensing	501-682-8590
Child Welfare Licensing	501-321-2583
Children's Medical Services	501-682-2277
Client Advocate	501-682-7953
ConnectCare (Primary Care Physicians)	501-614-4689
Director's Office	501-682-8650
Food Stamps	501-682-8993
Foster Care	501-682-1569
Juvenile Justice Delinquency Prevention	501-682-1708
Medicaid	501-682-8340
Nursing Home Complaints	501-682-8430
Press Inquiries	501-682-8650
Services for the Blind	501-682-5463
State Long Term Care Ombudsman	501-682-8952
Transitional Employment Assistance (TEA)	501-682-8233
Volunteer Information	501-682-7540

Hotlines

Adoptions	1-888-736-2820
Adult Protective Services	1-800-482-8049
ARKids First	1-888-474-8275
Child Abuse	1-800-482-5964
Child Abuse TDD	1-800-843-6349
Child Care Assistance	1-800-322-8176
Child Care Resource and Referral	1-800-455-3316
Child Support Information	1-877-731-3071
ConnectCare (Primary Care Physicians)	1-800-275-1131
Choices in Living Resource Center	1-866-801-3435
General Customer Assistance	1-800-482-8988
General Customer Assistance TDD	1-501-682-8820
Fraud and Abuse Hotline	1-800-422-6641
Medicaid Transportation Questions	1-888-987-1200
Senior Medicare Fraud Patrol	1-866-726-2916
Employee Assistance Program	1-866-378-1645

Internet Resources

ACCESS Arkansas	https://access.arkansas.gov
Arkansas Foundation for Medical Care	http://www.afmc.org
Arkansas Medicaid	http://www.medicaid.state.ar.us
ARKids First	http://www.arkidsfirst.com/home.htm
Connect Care (Primary Care Physicians)	http://www.seeyourdoc.org
Department of Human Services (DHS)	http://www.arkansas.gov/dhs
DHS County Offices	http://www.medicaid.state.ar.us/general/units/cooff.aspx