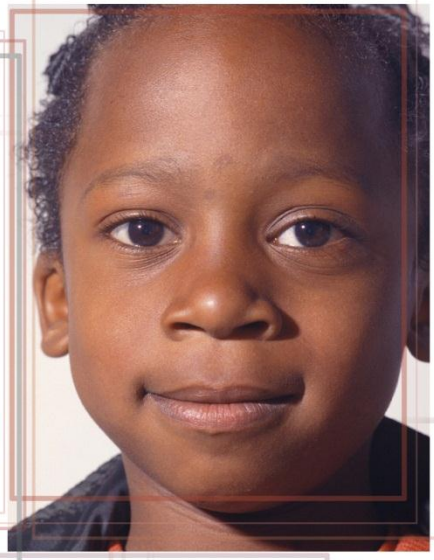
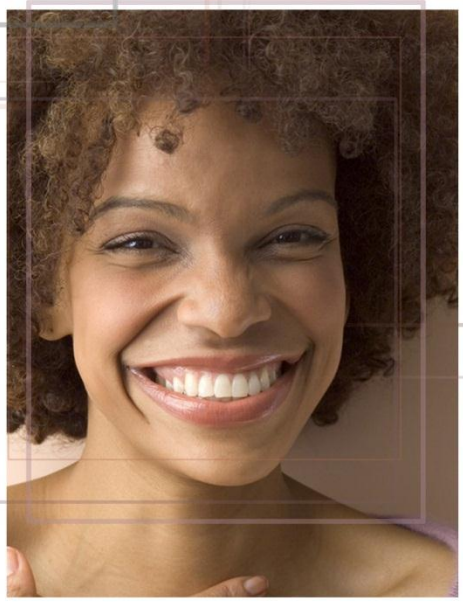
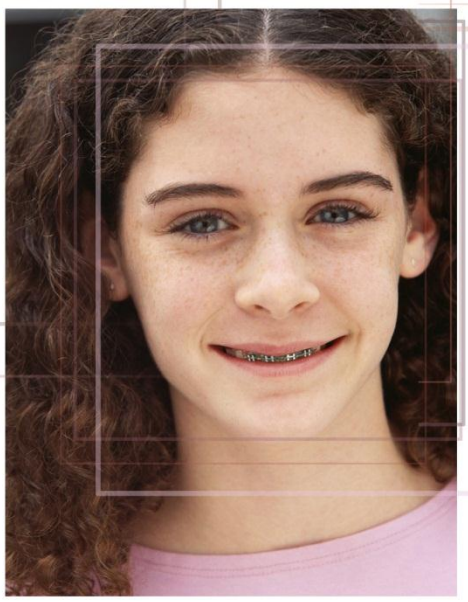
Arkansas Medicaid Program Overview

SFY 2013

ARKANSAS DEPARTMENT OF HUMAN SERVICES

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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.

Division of Medical Services 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

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Little Rock, Arkansas 72201

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Department of Human Services

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Welcome to the 2013 overview of the Arkansas Medicaid Program. This booklet provides a general understanding of how Medicaid works in our state, including the health care services covered, who depends on these services, how we pay for them and the new directions we are taking to improve our overall health care system in Arkansas.

Arkansas Medicaid enjoyed a strong year of innovation and cost containment in 2013. Even as enrollment increased, Arkansas Medicaid experienced its lowest annual growth rate in 30 years. A variety of factors contributed to the growth rate reduction. This reduction is consistent with the goals of the Arkansas Health Care Payment Improvement Initiative (APII). We continue advancing this groundbreaking initiative by creating new episodes of care, and our biggest endeavor yet, the Patient-Centered Medical Home (PCMH) program. PCMH is a key component of APII that rewards team-based care and promotes early intervention to reduce complications and associated health care costs.

This past year, Arkansas also took center stage in the national debate on health care improvement by becoming the first state to offer an alternative to Medicaid expansion. The Arkansas Health Care Independence Act of 2013 allows our state to pay for private insurance instead of traditional Medicaid coverage for Arkansans with incomes up to 138 percent of the Federal Poverty Level.

As Arkansas leads the nation in key health care initiatives, the state is also in the process of building a new Medicaid Management Information System, which will expedite processing information for providers and beneficiaries. Additionally, we are assisting Arkansas Medicaid providers in converting beneficiaries' records from paper to electronic form and helping them prepare to comply with new International Classification of Diseases (10th Edition, Clinical Modification/Procedure Coding System) billing requirements that take effect in 2014.

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, PhD
Director,
Division of Medical Services

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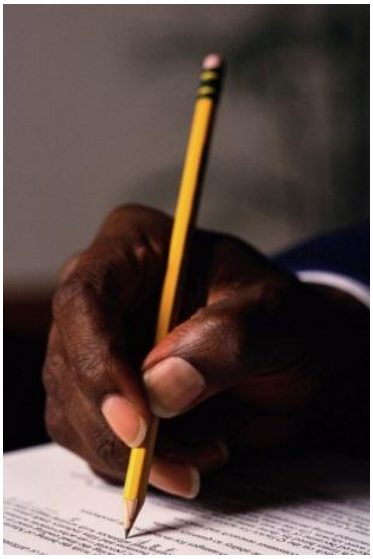
About the Arkansas Medicaid Program Overview Booklet

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 Statistical Report, OnDemand reports from the Decision Support System, the University of Arkansas at Little Rock website and other reports from units at DMS, HP and Arkansas Foundation for Medical Care.



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

If you have questions, comments or suggestions about the Arkansas Medicaid Program Overview booklet, please contact us at OverviewFeedback@arkansas.gov to share your thoughts and let us know how you use the overview booklet. We value your feedback about this publication!

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. In 1965, Title XIX of the Social Security Act created grant programs to provide 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 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 (DHS) is the single Arkansas state agency authorized and responsible for regulating and administering the Medicaid program. DHS administers the Arkansas Medicaid Program through the Department of Medical Services. The Centers for Medicare and Medicaid Services (CMS) administer 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.

Who Qualifies for Arkansas Medicaid?

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

- Age 65 and older;
- Under age 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 21 and in foster care;
- In medical need of certain home and community-based services;
- Persons with breast or cervical cancer or
- Disabled, including working disabled.

Current Federal Poverty Levels

Monthly Levels*

(Effective April 1, 2013 through March 31, 2014)
Family Medicaid Categories

Family size	ARKids First-A Children age 6 and over and AR Health Care Access 100%	ARKids First-A Children under age 6 133%	Transitional Medicaid 185%	Sixth Omnibus Budget Reconciliation Act Pregnant Women, Family Planning and ARKids First-B 200%
1	$957.50	$1,273.48	$1,771.38	$1,915.00
2	$1,292.50	$1,719.03	$2,391.13	$2,585.00
3	$1,627.50	$2,164.58	$3,010.88	$3,255.00
4	$1,962.50	$2,610.13	$3,630.63	$3,925.00
5	$2,297.50	$3,055.68	$4,250.38	$4,595.00
6	$2,632.50	$3,501.23	$4,870.13	$5,265.00
7	$2,967.50	$3,946.78	$5,489.88	$5,935.00
8	$3,302.50	$4,392.33	$6,109.63	$6,605.00
9	$3,637.50	$4,837.88	$6,729.38	$7,275.00
10	$3,972.50	$5,283.43	$7,349.13	$7,945.00
For each additional member add:	$335.00	$445.55	$619.75	$670.00

Aid to the Aged, Blind and Disabled Medicaid Categories

	ARSeniors Equal to or below 80%	Qualified Medicaid Beneficiary Equal to or below 100%	Specified Low-Income Medicare Beneficiary Between 100% and 120%	Qualifying Individuals-1 Group At least 120% but less than 135%	Qualified Disabled and Working Individuals and Tuberculosis Equal to or below 200%	Working Disabled 250%
Individual	$766.00	$957.50	$1,149.00	$1,292.63	$1,915.00	$2,393.75
Couple	$1,034.00	$1,292.50	$1,551.00	$1,744.88	$2,585.00	$3,231.25
For each additional family member in the Working Disabled category add:						$837.50

*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 50 and 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 29.69% of Arkansas Medicaid Program-related costs in State Fiscal Year 2013; the federal government funded approximately 70.31%. 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 2013 Arkansas Medicaid Operating Budget*

	(Millions)
General Revenue	$795.7
Other Revenue	$218.8
Quality Assurance Fee	$80.3
Hospital Provider Tax	$61.5
Intermediate Care Facilities for Individuals with Intellectual Disabilities Provider Tax	$10.9
Trust Fund	$270.2
Federal Revenue	$3,349.7
Total Program	$4,787.1

*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. 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 State Fiscal Year (SFY) 2013, the Division of Medical Services Program Development and Quality Assurance Unit processed:

- 10 State Plan amendments,
- 111 provider manual updates,
- 8 official notices and notices of rule making,
- 4 provider letters regarding changes to the Preferred Drug List, and
- 5 pharmacy memorandums.

In SFY 2013, our fiscal agent, Hewlett-Packard, had provider representatives attend and conduct 59 workshops around the state. The provider representatives also conducted 2,530 provider visits. The Provider Assistance Center responded to 81,753 voice calls and 141,327 automated calls.

In SFY 2013, Medicaid Managed Care Services Provider Relations Representatives contacted a quarterly average of 46 hospitals, 971 clinics and 2,806 physicians.

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 21
Family Planning Services and Supplies	All ages
Federally Qualified Health Center	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	All ages
Nursing Facility Services	Age 21 and older
Physician Services	All ages
Rural Health Clinic	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 21
Certified Registered Nurse Anesthetist Services	All ages
Child Health Management Services	Under age 21
Chiropractic Services	All ages
Dental Services	All ages
Developmental Day Treatment Clinic Services	Pre-school and age 18 and older
Developmental Rehabilitation Services	Under age 3
Domiciliary Care Services	All ages
Durable Medical Equipment	All ages
End-Stage Renal Disease Facility Services	All ages
Hearing Aid Services	Under age 21
Hospice Services	All ages

Hyperalimentation Services	All ages
IndependentChoices	Age 18 and older
Inpatient Psychiatric Services	Under age 21
Intermediate Care Facilities for Individuals with Intellectual Disabilities	All ages
Licensed Mental Health Practitioner Services	Under age 21
Medical Supplies	All ages
Medicare Crossovers	All ages
Nursing Facility Services	Under age 21
Occupational, Physical and Speech Therapy Services	Under age 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	Age 55 and older
Prosthetic Devices	All ages
Rehabilitative Hospital Services	All ages
Rehabilitative Services for:	
• Persons with Mental Illness	All ages
• Persons with Physical Disabilities, and Youth and Children	Under age 21
Respiratory Care Services	Under age 21
School-Based Mental Health Services	Under age 21
Targeted Case Management for:	
• Children's Services (Title V), Supplemental Security Income, Tax Equity Fiscal Responsibility Act (TEFRA) of 1982, EPSDT, Division of Children and Family Services, and Division of Youth Services	Under age 21
• Developmentally Disabled Adults	All ages
• Adults	Age 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

Alternatives for Adults with Physical Disabilities	Age 21 through 64
ARHealthNetworks ARHealthNetworks will not be renewed beyond the waiver's December 31, 2013 end date.	Age 19 through 64
ARKids First-B	Age 18 and under
Autism Waiver	Age 18 months through 6 years
Developmental Disabilities Services/Alternative Community Services	All ages
ElderChoices	Age 65 and older
Living Choices Assisted Living	Age 21 and older
Non-Emergency Transportation	All ages
TEFRA of 1982	Under age 21
Women's Health (Family Planning) Women's Health (Family Planning) will not be renewed beyond the waiver's December 31, 2013 end date. Family planning services and supplies will continue to be covered.	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 21 and older) are as follows:

- 12 visits to hospital outpatient departments allowed per State Fiscal Year (SFY).
- A total of 12 office visits allowed per SFY 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.
- 1 basic family planning visit and 3 periodic family planning visits per SFY. Family planning visits are not counted toward other service limitations.
- Lab and X-Ray services limited to total benefit payment of $500 per SFY for outpatient services, except for Magnetic Resonance Imaging and cardiac catheterization and for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) beneficiaries.
- 3 pharmaceutical prescriptions are allowed per month (family planning and tobacco cessation prescriptions are not counted against benefit limit) – extensions are considered up to a maximum of 6 prescriptions per month for beneficiaries at risk of institutionalization; unlimited prescriptions for nursing facility beneficiaries and EPSDT beneficiaries under age 21. Beneficiaries receiving services through the Living Choices Assisted Living waiver may receive

up to 9 medically necessary prescriptions per month. Medicare-Medicaid beneficiaries (dual eligible) receive their drugs through the Medicare Part D program as of January 1, 2006.

- Inpatient hospital days limited to 24 per SFY, except for EPSDT beneficiaries and certain organ transplant patients.
- Co-insurance: Some beneficiaries must pay 10% of the first Medicaid-covered day of a 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.
- Beneficiaries 18 years of age and older (except long term care) must pay $.50 – $3 of every prescription drug, 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 with Medicaid coverage are responsible for co-insurance, co-payments, or premiums.

- Co-insurance: ARKids First-B beneficiaries must pay 10% of the charges for the first Medicaid-covered day of inpatient hospital services and must also pay $10.00 per visit co-insurance for outpatient hospital services and 10% of Medicaid allowed cost per Durable Medical Equipment item.
- Co-payments: ARKids First-B beneficiaries must pay a co-payment for most services, such as $10.00 for most office visits and $5.00 for most prescription drugs (and must use generic drugs and a rebate manufacturer). ARKids First-B beneficiaries' annual cost-sharing is capped at 5% of the family's gross annual income after State allowable income disregards.

- Premiums: Based on family income, certain Tax Equity Fiscal Responsibility Act (TEFRA) of 1982 beneficiaries must pay a premium. TEFRA families whose income is at or below 150% of the Federal Poverty level cannot be assessed a premium.

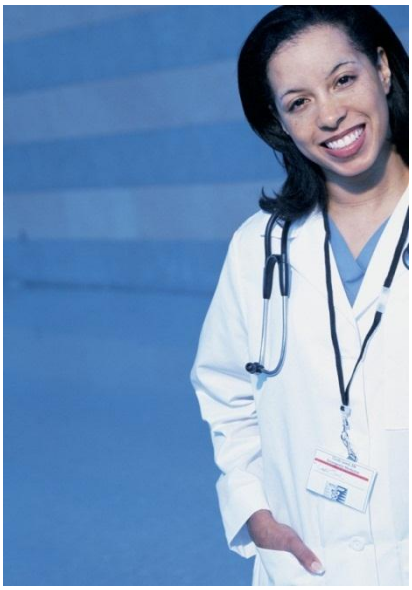
NOTE: Any and all exceptions to benefit limits are based on medical necessity.

State Fiscal Year 2013 in Review

State Fiscal Year 2013 saw the implementation and development of several programs that will provide a strong foundation of innovation and success for Arkansas Medicaid. We released the Health Care Independence Program (HCIP) to comply with the Affordable Care Act (ACA) requirement to expand Medicaid. The ACA mandates that states cover individuals with incomes from 100 to 138 percent of the Federal Poverty Level by January 1, 2014. The HCIP emerged as an alternative national model for covering this newly eligible population of beneficiaries. Under the HCIP, Federal aid that would normally cover the cost of Medicaid coverage will instead help pay for private insurance plans for eligible beneficiaries. Arkansas received Federal approval for the waiver September 27, 2013 and has launched the portal that beneficiaries will use to select their plans. Coverage is expected to begin January 1, 2014.

In addition, the Arkansas Health Care Payment Improvement Initiative (APII) entered its second year, fulfilling its objective of rewarding providers for offering cost-effective, team-based, quality care for defined conditions and procedures known as “Episodes of Care.” An episode of care is the collection of care provided to treat a particular condition for a given length of time. Arkansas Medicaid has developed 13 such episodes so far and implemented 6 of them: Acute Ambulatory Upper Respiratory Infection, Perinatal Care, Attention Deficit Hyperactivity Disorder (ADHD), Congestive Heart Failure, Total Joint Replacement and Oppositional Defiant Disorder. We released the first episodes of care performance reports and an ADHD supplemental report containing information about excluded episodes.

Continuing our commitment to establish a cost-effective, patient-centered health care system, Arkansas Medicaid released preliminary documents for the Patient-Centered Medical Home (PCMH) program. Widely used around the country, the PCMH program is a team-based care delivery model led by a primary care provider who manages a beneficiary’s comprehensive health needs. By focusing on prevention and proactively managing chronic disease, the PCMH program can significantly improve health care in Arkansas. As a vital component of APII, the PCMH program complements the progress we have made with episodes of care. The program rewards providers enrolled in the PCMH program who meet defined metrics of care coordination and general practice investment, and who practice transformation. By paying for patient results and outcomes instead of services, Arkansas Medicaid will be able to control costs while improving quality of care. Providers began enrolling in the PCMH program on October 1, 2013.



As Arkansas Medicaid enters the third 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 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.

While we are proud of the growth and innovation in our program, Arkansas Medicaid is also looking forward to program changes for the next fiscal year. We have begun making preparations for the conversion to International Classification of Diseases (10th Edition, Clinical Modification/Procedure Coding System) billing codes and are on track to meet the October 1, 2014 conversion deadline. In 2014, we expect to award the contract for a replacement Medicaid Management Information System (MMIS). While the new MMIS will be markedly different from the current system, it will greatly improve operations, processes and efficiency across the Arkansas Medicaid Program. In the coming year, we will continue enhancing our programs and initiatives to cultivate a better, healthier Arkansas.

Arkansas Medicaid Operations

In State Fiscal Year 2013, our fiscal agent, Hewlett-Packard, processed more than 40 million provider-submitted claims for 11,791 providers on behalf of more than 777,922 Arkansans. They responded to 81,753 voice calls, 141,327 automated calls and 31,055 written inquiries and conducted 2,530 provider visits and 59 workshops around the state. Of claims processed, 99% were done within 30 days, with the average receipt-to-adjudication time of approximately 3.1 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 494,946 children and, according to recent data, paid for approximately 65%* of all births in Arkansas.

*This calculation is based on SFY12 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. 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. The OLTC has 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 OLTC has also begun promoting specialized training for Dementia Care in long term care facilities. The OLTC is working collaboratively with the Arkansas Heath Care Association, AFMC, and the Arkansas LTC

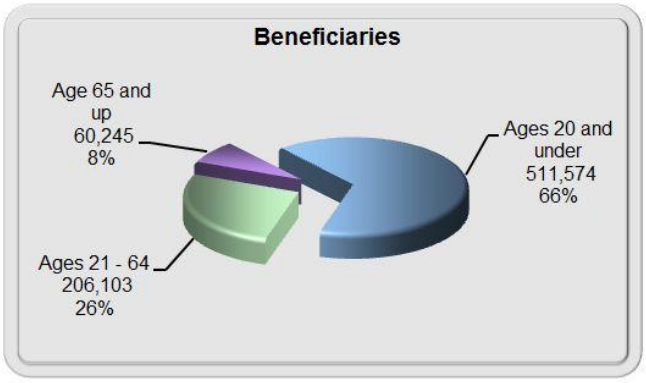
Ombudsman Program to conduct trainings, develop facility mentoring and sponsor nationally-recognized speakers in the area of dementia care.

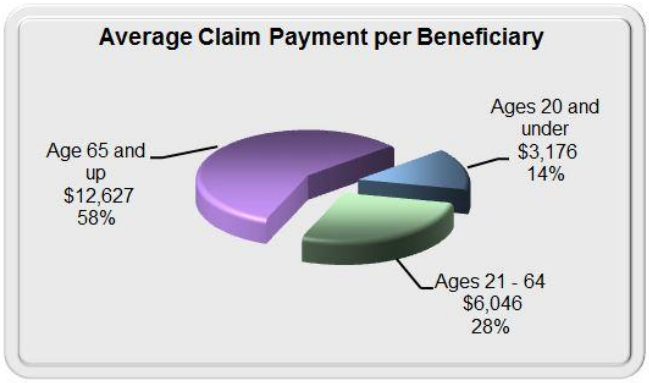
The OLTC has also developed a survey tool to recognize potential gaps in emergency preparedness in Arkansas nursing homes, assisted living and residential care facilities. Statewide training for emergency preparedness was provided through a collaborative effort with AFMC's AIPP for LTC, Arkansas Health Care Association, the Arkansas Department of Emergency Management, the Arkansas Department of Health, and the Arkansas Ombudsman. We continue to work collaboratively toward the development of thorough emergency plans for each facility.

State Fiscal Year (SFY) 2013 Statistics

Beneficiary Information

Unduplicated Beneficiary Counts and Claim Payments by Age





Source: OnDemand HMGR580J

Percentage of Change in Enrollees and Beneficiaries from SFY 2012 to SFY 2013

	SFY12	SFY13	% Change
Medicaid enrollees	795,889	798,188	0.3%
Medicaid beneficiaries	776,050	777,922	0.2%

Newborns Paid for by Arkansas Medicaid

	SFY11	SFY12	% Change
Newborns paid for by Arkansas Medicaid	24,995	24,970	-0.10%

The medical cost for 65%* of all babies born to Arkansas residents during SFY 2012 was paid for by Medicaid.

Source: Department of Human Services (DHS) – Division of Medical Services
*This calculation is based on SFY12 data, which is the most recent available.

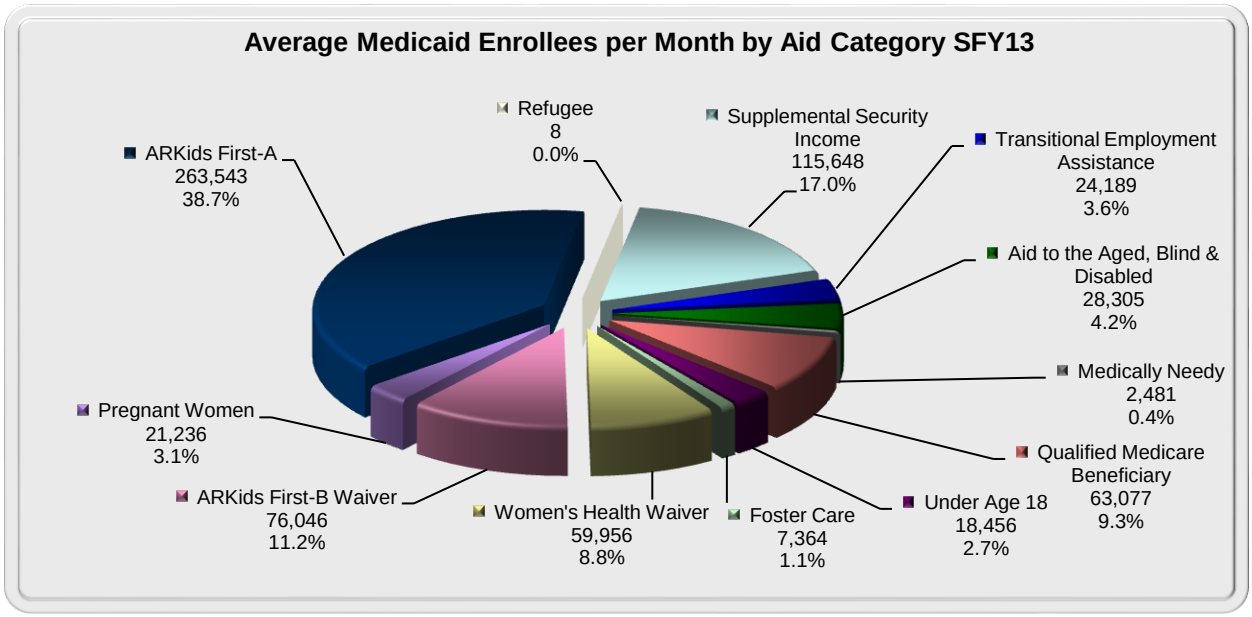
Percentage of Population Served by Arkansas Medicaid

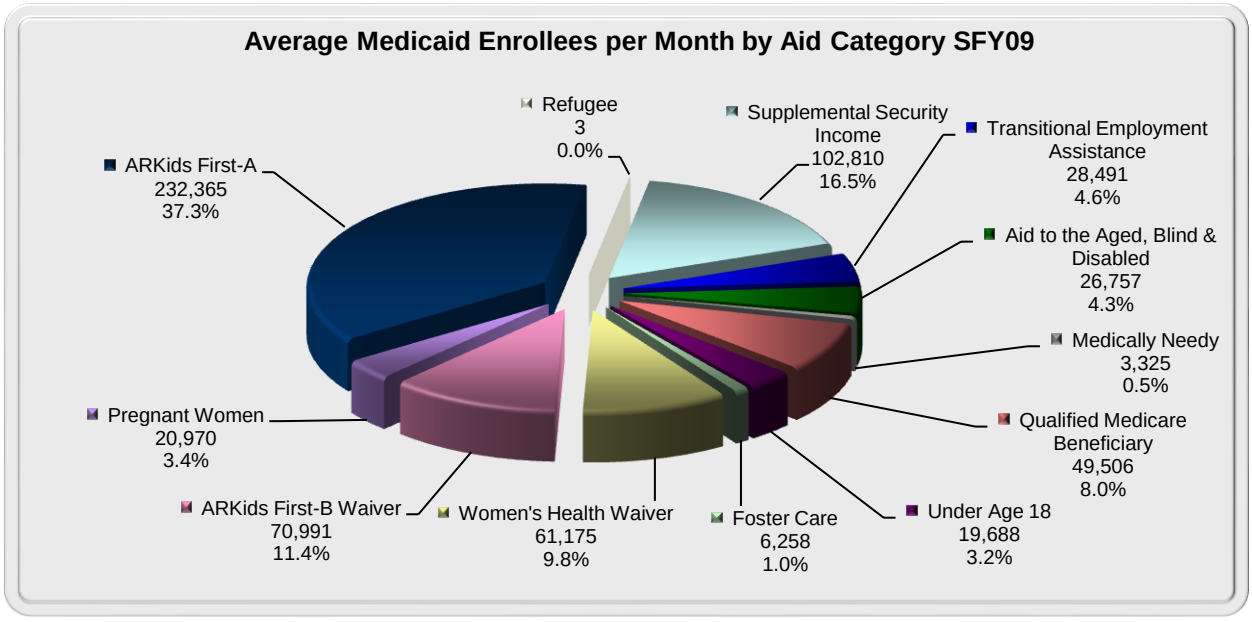
Age group	Arkansas Population	% of Population Served by Arkansas Medicaid**
All ages	2,980,938	26%
Elderly (65 and older)	430,723	14%
Adults (21 through 64)	1,701,187	12%
Children (20 and under)	849,028	60%

** This calculation is based on the Arkansas population for 2012, which is the most recent available.

Source: University of Arkansas at Little Rock, OnDemand HMGR580J

Arkansas Medicaid Enrollees by Aid Category – 5 year Comparison



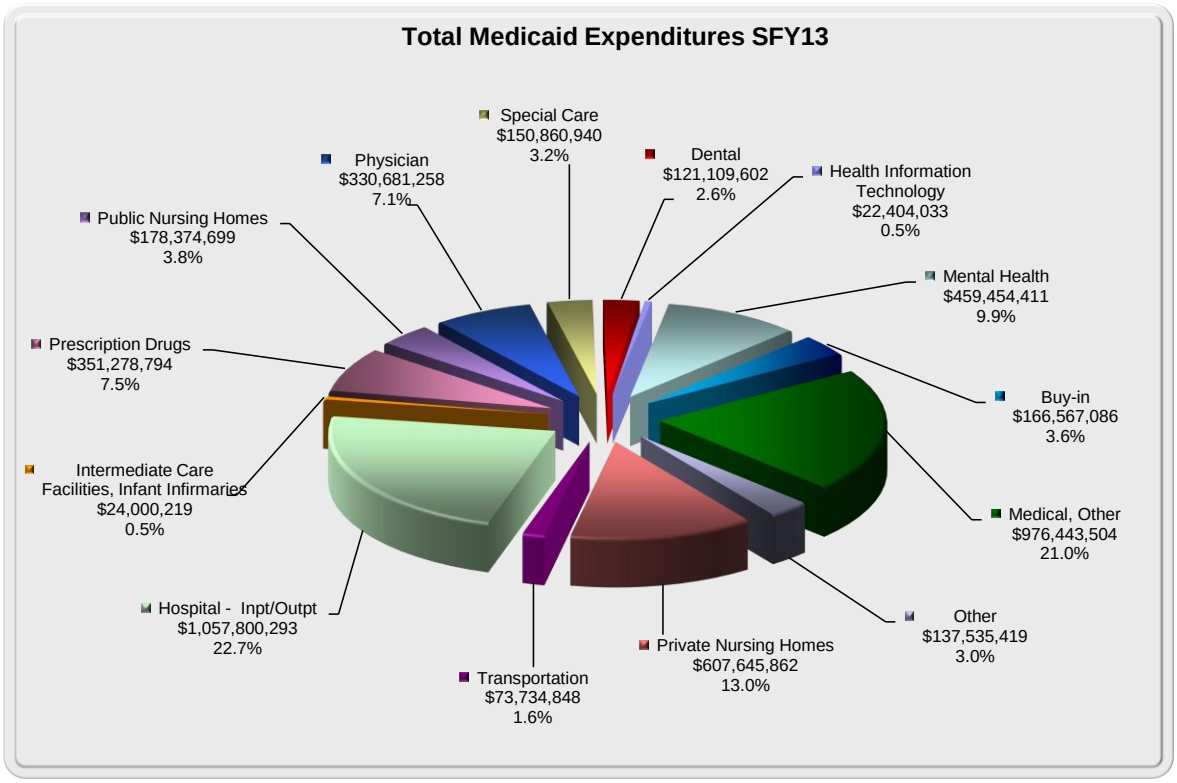


NOTE: These are individuals who have enrolled in the program and may or may not have received services. Enrollees may have multiple aid categories and are therefore counted in each of those categories.

Source: Arkansas Client Eligibility System 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.

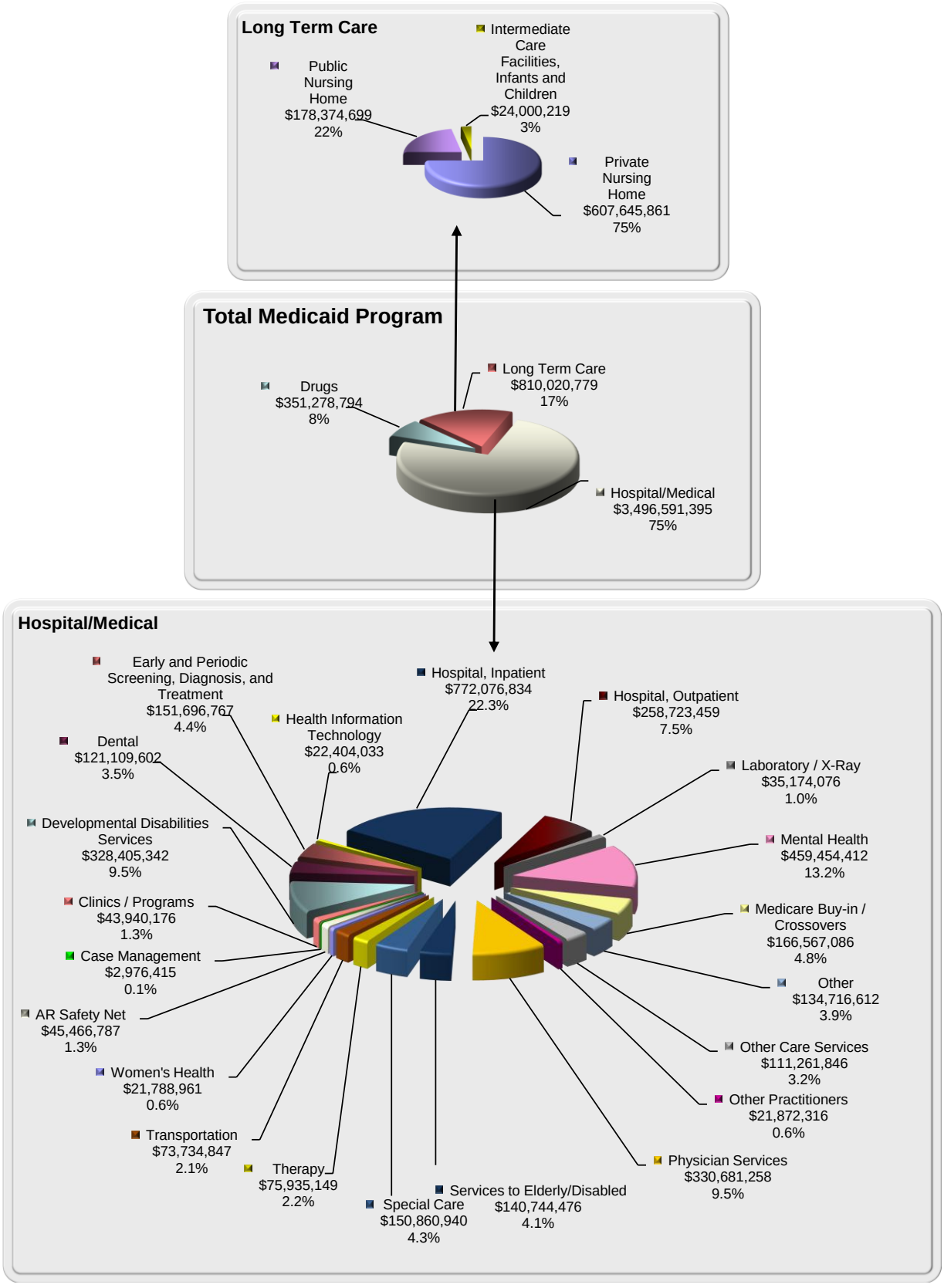
Other includes vendor contracts for Hospital/Medical, Targeted Case Management, and other adjustments.

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: Department of Human Services 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 rebates. CMS granted an extension for Arkansas Medicaid to allow implementation of institutional outpatient provider claims until June 30, 2008. Each quarter, eligible rebate drugs paid by Arkansas Medicaid are invoiced to the manufacturers. The manufacturers then submit payment to the state. Those payments are then shared with CMS as determined by the respective match rates.

Rebate Dollars Collected	
Total State Fiscal Year 2013	$142,975,353
State portion	$32,058,777
Federal portion	$110,916,576

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	$4,658	777,922	$5,988
2014*	$5,236	995,500	$5,260

Arkansas Budget and Medicaid percentage		
	SFY 2013	Medicaid Represents
State of Arkansas Budget	$24.4 billion	19.6%
State General Revenue Funded Budget	$4.7 billion	16.8%

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

*Estimated. 2014 projection is based on implementation of Private Option expansion effective January 1, 2014, savings from Arkansas Payment Improvement Initiative and implementation of other identified efficiencies, which impacts the number of Unduplicated Beneficiaries and Program Costs.

Arkansas Medicaid Providers

Number of Enrolled Providers

Arkansas Medicaid has approximately 40,349 enrolled providers.

Number of Participating Providers

Approximately 11,791 or 29% are participating providers.

Number of Claims Processed and Approximate Processing Time

More than 40 million provider-submitted claims were processed in State Fiscal Year 2013 with an average processing time of 3.1 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 10 Provider Types Enrolled

1	Physicians (8,621)
2	Individual Occupational, Physical and Speech Therapy Services Providers (2,615)
3	Physicians Groups (1,878)
4	Alternatives for Adults with Physical Disabilities Waiver Attendant Care (1,836)
5	*Dental Services (1,036)
6	Pharmacy (886)
7	Nurse Practitioner (880)
8	Prosthetic Services/Durable Medical Equipment (732)
9	Visual Care – Optometrist Optician (530)
10	Hospital (479)

*Includes orthodontists, oral surgeons and dental groups

Understanding the Division of Medical Services, Arkansas Medicaid, and the Office of Long Term Care

The Department of Human Services (DHS) is the single state agency authorized and responsible for regulating and administering Arkansas Medicaid and the Office of Long Term Care (OLTC). These two major programs are housed under the Division of Medical Services (DMS).

Under DMS, Arkansas Medicaid Services is organized into 6 major units, while the OLTC is a separate major unit:

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

(See the DMS Organizational Chart in the appendices.)

Health Care Innovation

The Health Care Innovation Area is responsible for coordinating the operations and activities to redesign the Arkansas Medicaid payment and service delivery systems. This unit works with multi-payers, staff and contractors to design and deliver episodes of care for acute conditions; implement new models of population-based health care for chronic conditions (e.g., patient-centered medical homes and health homes); develop and coordinate infrastructure requirements; and facilitate stakeholder, provider and beneficiary engagement through the Arkansas Health Care Payment Improvement Initiative.

To date, the Division of Medical Services (DMS) has developed 13 episodes of care: Upper Respiratory Infection, Perinatal, Attention Deficit/Hyperactivity Disorder, Congestive Heart Failure, Total Joint Replacement, Cholecystectomy, Colonoscopy, Tonsillectomy, Percutaneous Coronary Intervention, Coronary Artery Bypass Graft, Oppositional Defiant Disorder, Chronic Obstructive Pulmonary Disease, and Asthma. Six of these episodes have been implemented on a statewide basis and have impacted over 1,500 providers in Arkansas. DMS continues to obtain state, federal regulatory and legislative approval to launch the next wave of the episode-based payment model in the second quarter of 2013. Arkansas Blue Cross Blue Shield and QualChoice continue to participate and launch selected episodes of care.

Implementation of the multi-payer provider portal, where providers can enter quality metric data and access historical and performance measurement reports, continues around quality metric portal design for future episodes and provider report format based on lessons learned and feedback.

Efforts have begun to increase toward the development and implementation of assessment-based episodes and enhanced care coordination support through health homes models for developmental disabilities, behavioral health and long term services and supports service populations.

Long Term Care

In addition to the six major units of Arkansas Medicaid Services, the Division of Medical Services also houses the Office of Long Term Care (OLTC). Each year, more than 25,000 Arkansans with chronic, long term medical needs require services in long term care facilities. These individuals live in the approximately 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 (ICFID), Adult Day Care, Adult Day Health Care, Post-Acute Head Injury Facility, Residential Care Facilities and Assisted Living Facilities.

The OLTC's primary goals focus on improving the quality of life for residents and protecting their health and safety through enforcing state and federal standards. Using qualified health care professionals, the 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, the OLTC administers the Nursing Home Administrator Licensure program, Criminal Background program and Certified Nursing Assistant (CNA) registry and training program; processes Medical Needs Determinations for Nursing Home and Waivers and operates a Complaints Unit.

The OLTC professional surveyors conduct annual Medicare, Medicaid and State Licensure surveys of Arkansas' 227 Nursing Facilities and 40 ICFIDs, including 5 Human Development Centers. Annual and complaint surveys are also conducted in 39 Adult Day Care and Adult Day Health Care facilities and 2 Post-Acute Head Injury Facilities throughout the state. Semi-annual surveys are conducted in the 65 Residential Care Facilities, 73 Assisted Living Facilities and 10 Alzheimer's Special Care Units. Additionally, annual Civil Rights surveys are conducted in 110 hospitals. In State Fiscal Year (SFY) 2013, 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. The OLTC staff provided approximately 85 hours of continuing education through 47 workshops/seminars to over 1,761 staff members in the nursing home and assisted living industry during SFY 2013. Furthermore, there were 253 agendas submitted from outside sources for review to determine 1,404 contact hours for nursing home administrators.

The Nursing Home Administrator Licensure Unit processed renewals for 667 licensed administrators and 79 license applications and issued 41 new licenses and 12 temporary licenses. Additionally, the OLTC administered the state nursing home administrator examination to 78 individuals.

The Criminal Record Check Program applies to all categories of licensed long term care facilities consisting of over 516 affected facilities. During SFY 2013, there were 34,046 state record checks processed through the OLTC and 19,957 federal record checks processed with a total of 903 disqualifications under both categories combined (2.22% of the disqualifications were due to the total number of state background checks performed).

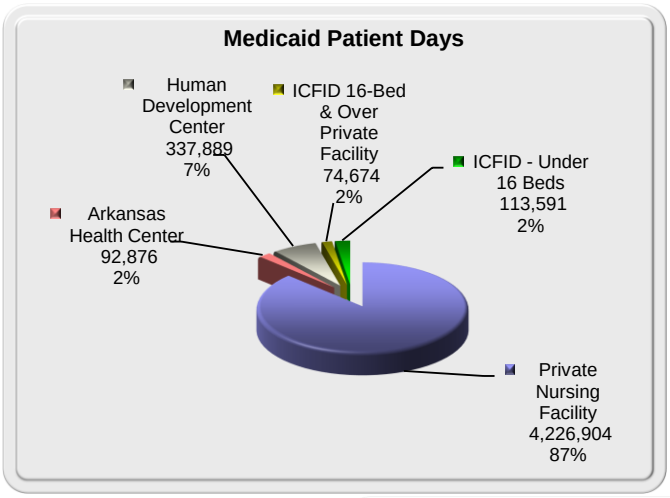
At the end of SFY 2013, the Registry for CNAs contained 30,492 active and 72,526 inactive names. In addition to maintaining the Registry for CNAs, the OLTC also manages the certification renewal process for CNAs, approves and monitors nursing assistant training programs, manages the statewide

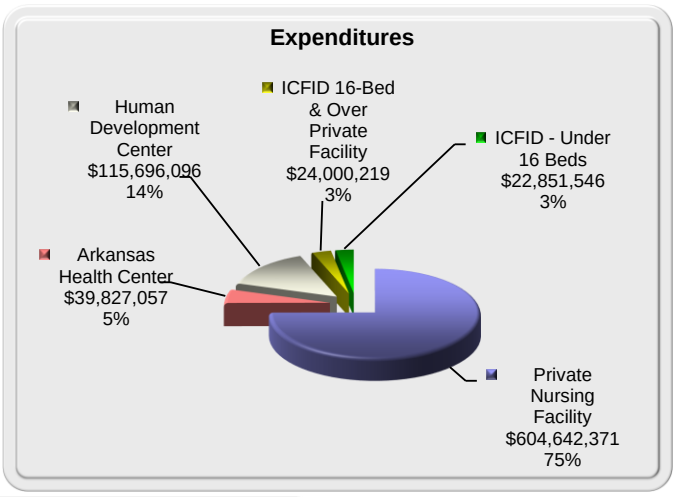
competency testing services and processes reciprocity transfers of CNAs coming into and leaving Arkansas.

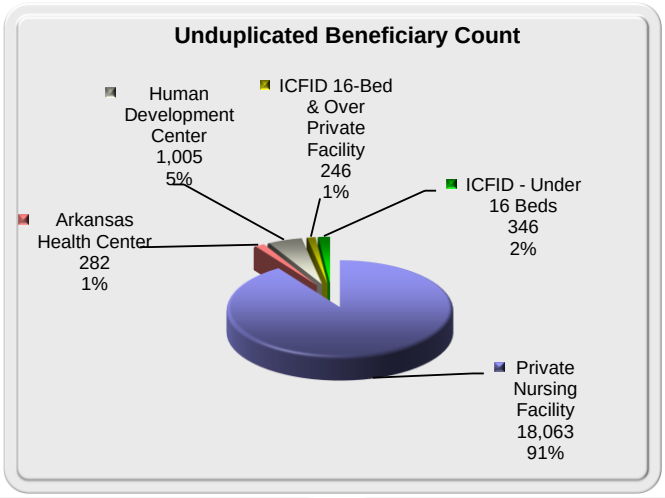
The Medical Need Determination Unit processed approximately 1,296 Arkansas Medicaid nursing facility applications per month while maintaining approximately 12,384 active cases. The unit also processed 10,552 assessments, 2,574 changes of condition requests, 474 transfers, 1,939 utilization review requests and 3,182 applications/reviews for ICFID, which includes 256 new assessments and six transfers during the year. The unit completed 3,979 Tax Equity and Fiscal Responsibility Act of 1982 applications and 85 autism waiver applications. Additionally, the unit completed 13,920 applications/reviews/waivers for other medical programs within the Department of Human Services during SFY 2013.

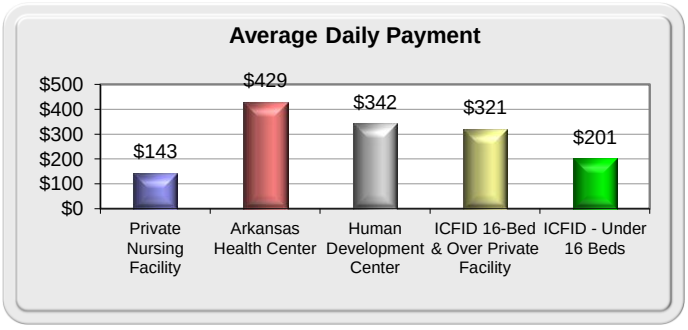
The OLTC Complaint Unit staffs a registered nurse and licensed social worker who record the initial intake of complaints against long term care facilities. When this occurs, the OLTC performs an on-site complaint investigation. Investigators are often able to resolve the issues with the immediate satisfaction of the involved parties. The OLTC received 971 nursing home complaints during SFY 2013 regarding the care or conditions in long term care facilities.

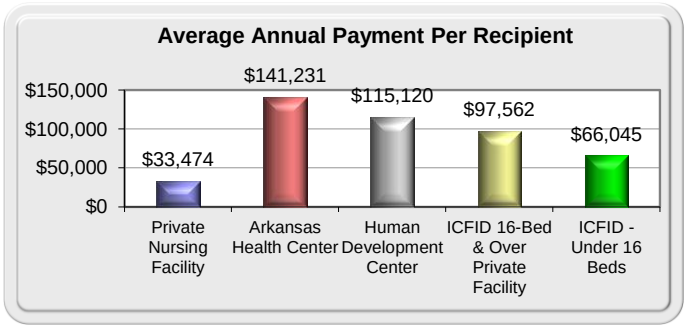
Long Term Care Statistics











Source: Department of Human Services Annual Statistical Report

Medicaid Information Management

The Medicaid Information Management (MIM) section of the Division of Medical Services is responsible for operations and support of the Medicaid Management Information System (MMIS) which processes all Medicaid claims and provides Medicaid data for program management and various research and care planning activities. The MIM section is currently leading an effort to replace our aging MMIS system with a new, more capable system to support the modern Medicaid environment. MIM is currently made up of four work units: Medicaid Data Reporting, Arkansas Medicaid Enterprise Project Management Office, Data Analytics and Systems and Support.

Medicaid Data Reporting Unit

The Medicaid Data Reporting Unit provides reporting functions utilizing data that has been extracted from the Medicaid Management Information System and loaded into a Decision Support System (DSS) data warehouse. The unit's duties include:

- Reviewing and fulfilling ad hoc data and report requests,
- Reviewing and fulfilling Freedom of Information Act requests and
- Scheduling and distributing recurring DSS reports.

In addition, this unit supports Office of Policy and Legal Services and Office of Systems & Technology personnel to ensure that Health Insurance Portability and Accountability Act guidelines are followed as data and report requests are processed.

Arkansas Medicaid Enterprise (AME) Project Management Office

The AME Project Management Office is responsible for managing all projects related to the new Medicaid Management Information System (MMIS). Current activities include:

- Coordinating the issuance, receipt and evaluation of all new MMIS-related Requests for Proposals (RFPs),
- Managing all MMIS-related procurement and implementation project plans,
- Coordinating the award and start of all new MMIS contracts resulting from the RFPs and
- Coordinating the development and implementation of new MMIS system modules and certification of their operation.

Data Analytics

The Medicaid Statistical Analytics and Management Unit is responsible for managing all workflow processes and projects related to Medicaid data. The unit’s activities include:

- Managing all data analytic contractor activities,
- Coordinating and implementing new data activities for Medicaid stakeholders and Federal partners and
- Administering all SharePoint web based services for the Division of Medical Services.

Systems and Support

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

- Developing Advance Planning Documents related to MMIS;
- 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;
- Managing the Division of Medical Services (DMS) SharePoint and DocuShare sites and portals and
- 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 864 enrolled pharmacies in the state. During State Fiscal Year (SFY) 2013, a total of 453,993 Arkansas Medicaid beneficiaries used their prescription drug benefits. A total of 4.8 million prescriptions were reimbursed by Arkansas Medicaid for a cost of $304.4 million dollars making the average cost per prescription approximately $63.42. The average cost for a brand name prescription was $253 dollars, representing 17% of the claims and accounting for 69% of expenditures. The average cost for a generic prescription was $24 dollars, representing 83% of claims and accounting for 31% of expenditures.

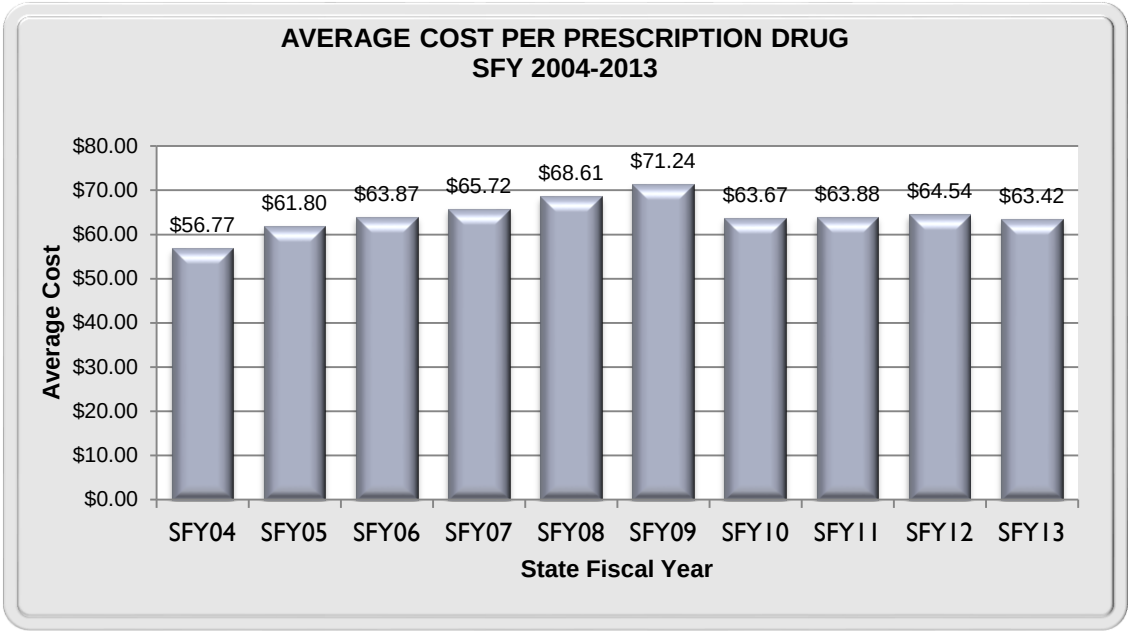
The Prescription Drug Program restricts each beneficiary to a maximum of 3 prescriptions per month, with the capability of receiving up to 6 prescriptions by prior authorization. Beneficiaries under 21 years of age and certified Long Term Care beneficiaries are not restricted to the amount of prescriptions received per month. Persons eligible under the Assisted Living Waiver are allowed up to 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 2013 was $44,589,077.

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, State Fiscal Year (SFY) 2004-2013



Source: Hewlett-Packard Healthcare Services

Policy, Program and Contract Oversight

Contract Oversight

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 Development and Quality Assurance (PD/QA)

The 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. 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 (QA) 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 and
- Developing Provider Manuals for waivers and demonstrations.

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 9 waiver programs which include 4 1115(a) demonstration waivers, 4 1915(c) home- and community-based waivers and 1 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, Certified 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 and Estate Recovery

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 State Fiscal Year (SFY) 2013 were as follows:

	SFY 2013
Other Collections (Health & Casualty Insurance)	$25,929,799
Cost Avoidance (Health Insurance)	$27,713,212
Total Savings	$53,643,011

Source: Division of Medical Services Statistical Report

Programs and Provider Management

Behavioral Health Programs

The Behavioral Health Unit is responsible for administering 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 procedural activities to identify problems and assure compliance with Arkansas Medicaid rules and regulations. 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 develop and implement technical training and educational opportunities to providers to evaluate and improve all programs in offering the highest quality of care to Arkansas Medicaid beneficiaries. The unit collaborates and supports other Department of Human Services divisions to successfully design and implement a Children's System of Care, Arkansas Health Care Payment Improvement Initiative and an Adult Recovery Model for behavioral health care transformation in order to develop the Behavioral System of Care into a successful, efficient and quality-driven process.

Patient-Centered Medical Home and Transportation Programs

This unit manages multiple programs and services, primarily the Primary Care Case Management Program known as ConnectCare. Building on the ConnectCare program, in State Fiscal Year 2013, the unit has focused on the development and implementation of the Comprehensive Primary Care Initiative and the Patient-Centered Medical Home program. The unit also manages several quality improvement projects such as the Centers for Medicare and Medicaid Services Adult Quality Grant and the Inpatient Quality Incentive program. The unit directly administers the Early and Periodic Screening, Diagnosis and Treatment, ARKids First-B, and Non-Emergency Transportation programs.

Program Integrity – Audit/Compliance and Investigations

Program Integrity Audit/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 State Fiscal Year 2013, Program Integrity (PI) conducted 134 on-site audits of providers and identified $3.8 million in questioned cost and $27 million

in cost avoidance. In addition the PI Unit also performed 371 desk reviews relating to Division of Aging and Adult Services and Developmental Disabilities Services duplicate payments referrals and identified $160,000 in questioned cost as well as 36 Health Information Technology desk reviews. The PI Unit also reviewed 3,901 questionable enrollment applications, denied 13 questionable applications and terminated 33 providers. PI Unit staff attended various training classes at the Medicaid Integrity Institute in 2013. Arkansas continues participating in the Centers for Medicare and Medicaid Services (CMS) Medi/Medi program which allows the state to perform dual eligible beneficiary claims analysis as well as analysis of other improper payments from the perspective of both programs. The PI Unit also worked with Medi/Medi contractors on various projects in 2013. The PI Unit contracted with a Recovery Audit Contractor (RAC) and worked closely with the contractor to implement the RAC project. The PI Unit also participated on the pilot project in streamlining a uniform Medicaid data set – Medicaid and Chip Business Information Solutions; in addition, the PI Unit also worked along with CMS and their contractors on the Payment Error Rate Measurement project.

Provider Management and Vision and Dental Programs

In addition to directly managing and administering the Medicaid and ARKids Vision and Dental programs, this unit is responsible for other administrative requirements of the Medicaid program such as: provider enrollment, provider screening, deferred compensation, appeals and hearings and continuous program monitoring through the Survey Utilization Review Subsystem. The unit also directly responds to concerns and questions of providers and beneficiaries of Arkansas Medicaid and ARKids services.

Utilization Review and Medical Programs

Arkansas Medicaid conducts review processes to ensure applicable program policies, laws and rules. Health care determinations are made by the Division of Medical Services, Utilization Review (UR) Section or a Quality Improvement Organization (QIO). The Arkansas Medicaid Program monitors the contracted QIO's review determinations and performance for quality assurance. UR administers the following programs and activities:

- 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 21 and extension of benefits of incontinence products and medical supplies for eligible beneficiaries;
- 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 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;

- Assure compliance of health care coverage benefits as required by regulation, rules, laws and local policy coverage determinations;
- Review of documentation supporting the medical necessity of requested services;
- Analysis of suspended claims requiring manual pricing;
- Review of billing and coding;
- Assist interdepartmental units and other agency divisions regarding health care determinations related to specific rules, laws and policies affecting program coverage;
- Review of evolving medical technological information and contribute to policy changes and program coverage benefits related to specific program responsibility;
- Analysis of information concerning reimbursement issues and assist with resolutions;
- Represent the department in workgroups at the state and local level;
- Conduct continuing evaluations and assessments of performance and effectiveness of various programs and
- Interact with provider groups and levels of federal and state government, including the legislature and governor's office.

Appendices

Glossary of Acronyms

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

Maps

- Enrollees by County State Fiscal Year (SFY) 2013
- Expenditures by County SFY 2013
- Waiver Expenditures and Waiver Beneficiaries by County SFY 2013
- Providers by County SFY 2013

DMS Contacts

Glossary of Acronyms

ACA
Affordable Care Act

ADHD
Attention Deficit Hyperactivity Disorder

AFMC
Arkansas Foundation for Medical Care

AIPP
Arkansas Innovative Performance Program

AME
Arkansas Medicaid Enterprise

APII
Arkansas Health Care Payment Improvement Initiative

CMS
Centers for Medicare and Medicaid Services

CNA
Certified Nursing Assistant

DHS
Department of Human Services

DMS
Division of Medical Services (Medicaid)

DSS
Decision Support System/Data Warehouse

EAC
Estimated Acquisition Cost

EPSDT
Early and Periodic Screening, Diagnosis and Treatment

HCIP
Heath Care Independence Program

HP
Hewlett-Packard

ICFID
Intermediate Care Facilities for Individuals with Intellectual Disabilities

LTC
Long Term Care

MIM
Medicaid Information Management

MMIS
Medicaid Management Information System

NDC
National Drug Code

OLTC
Office of Long Term Care

PCMH
Patient-Centered Medical Home

PD/QA
Program Development and Quality Assurance

PI
Program Integrity

QA
Quality Assurance

QIO
Quality Improvement Organization

RAC
Recovery Audit Contractor

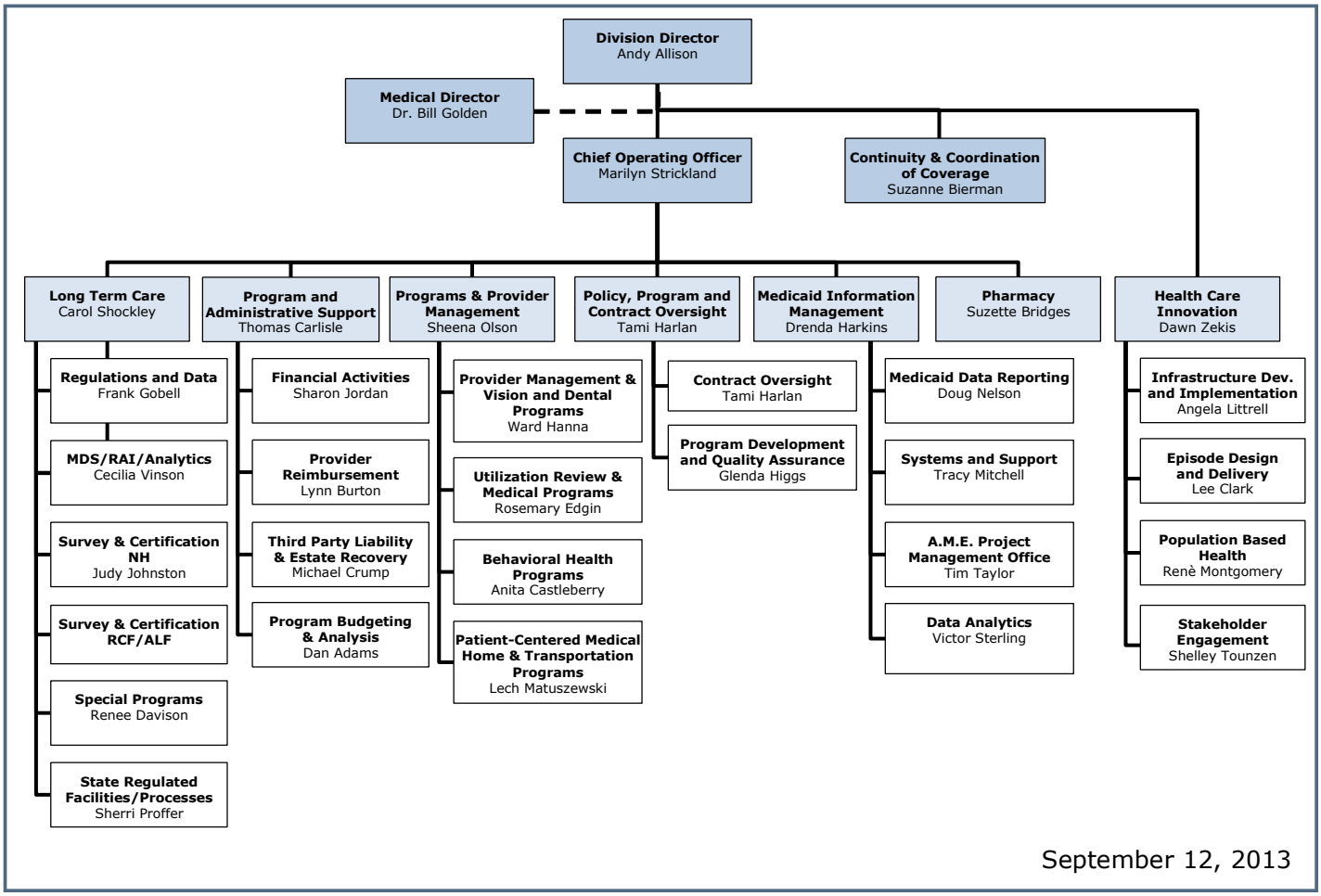
RFP
Request for Proposals

SFY
State Fiscal Year – July 1 to June 30

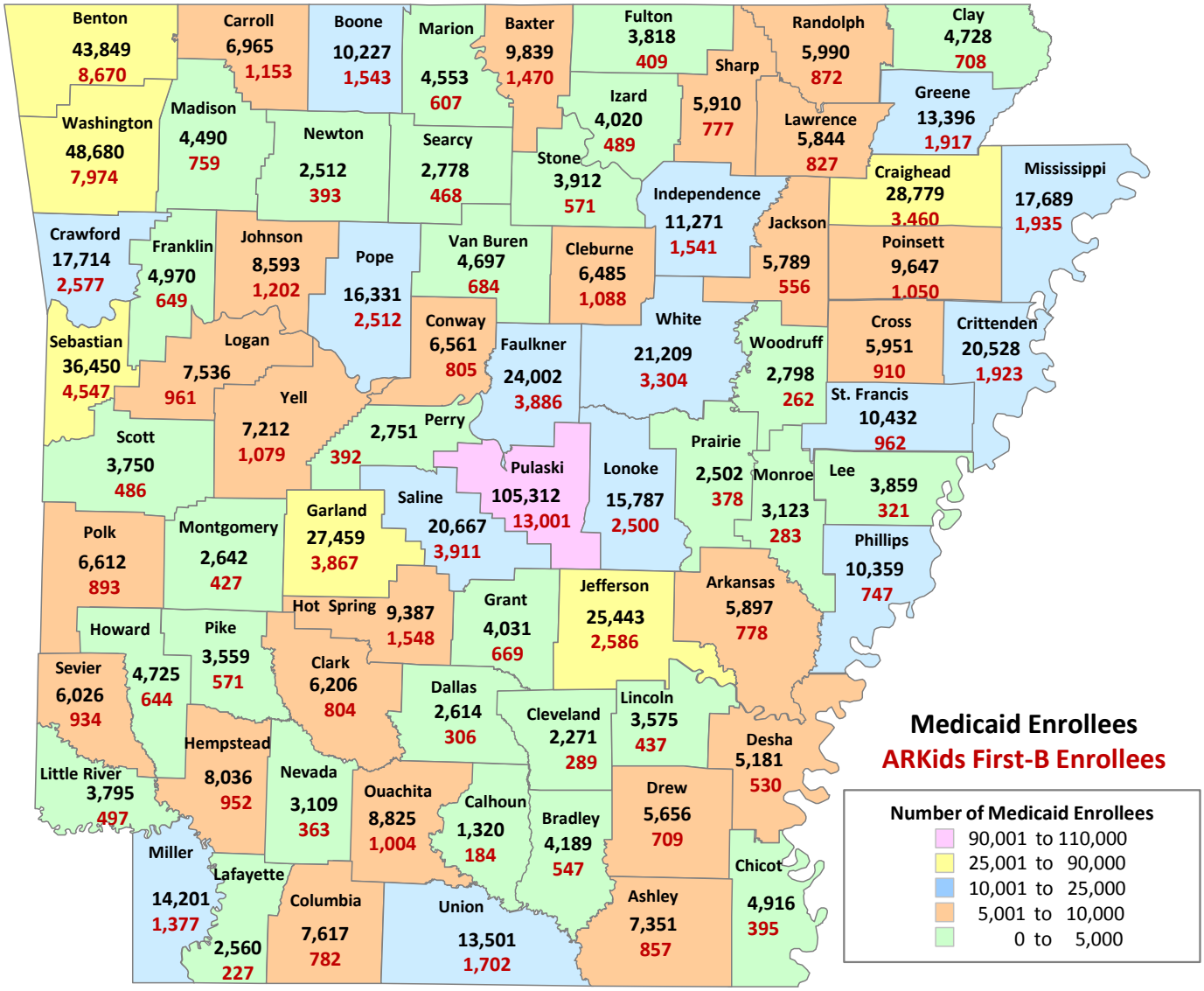
TEFRA
Tax Equity and Financial Responsibility Act

UR
Utilization Review

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



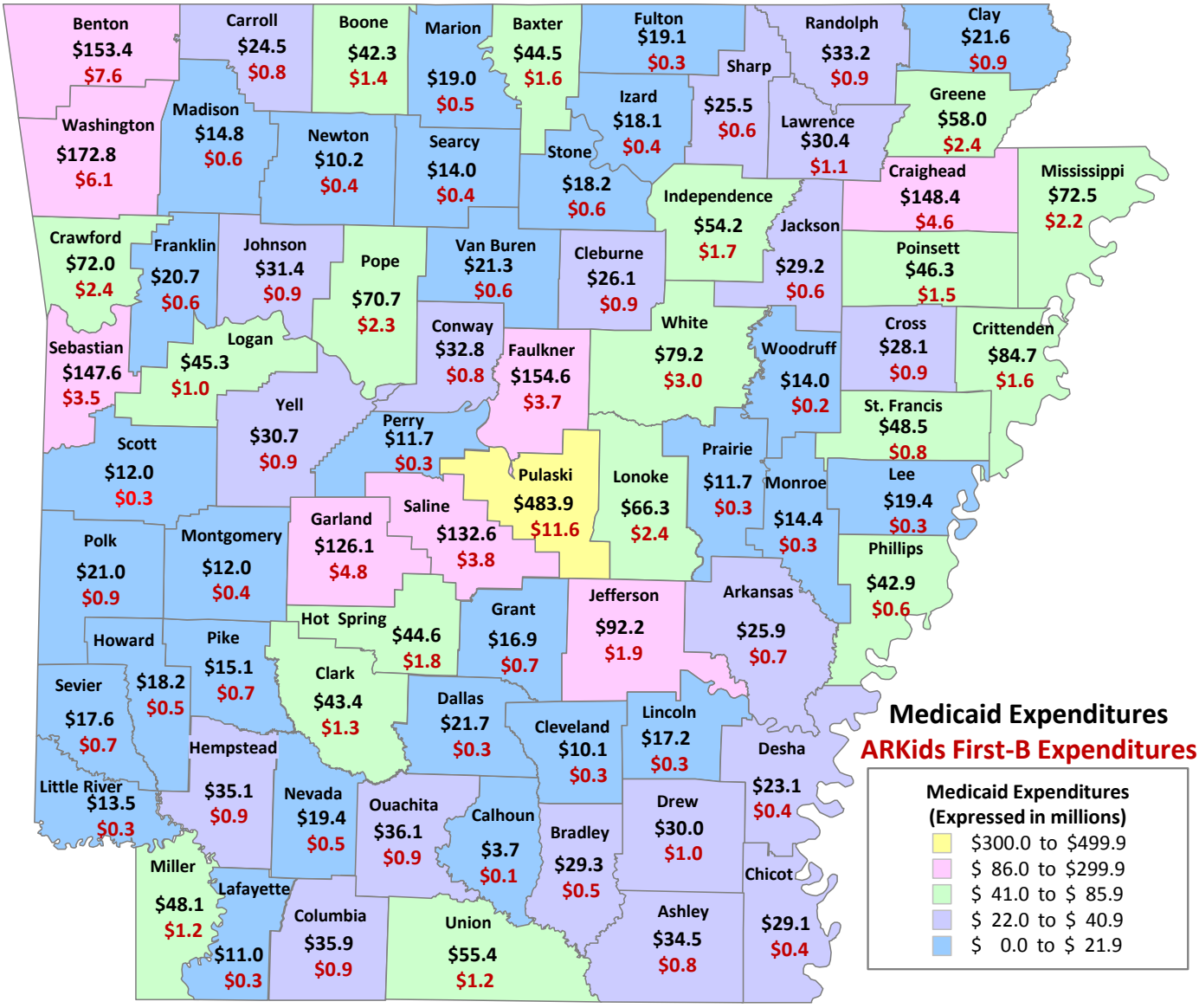
Map – Enrollees by County



Source: Department of Human Services, 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.

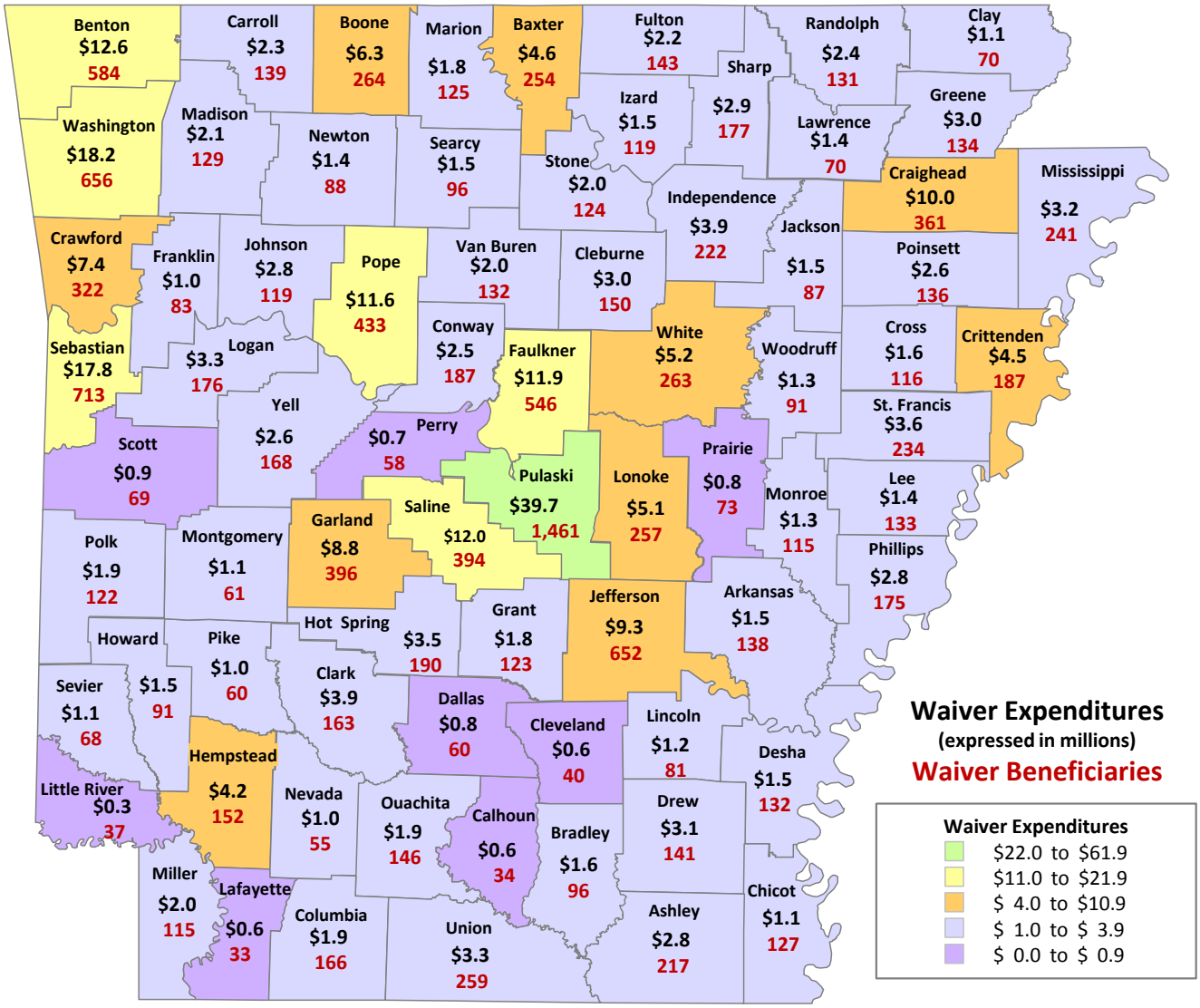
Map – Expenditures by County



Source: Department of Human Services; Division of Medical Services
Medicaid Decision Support System

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

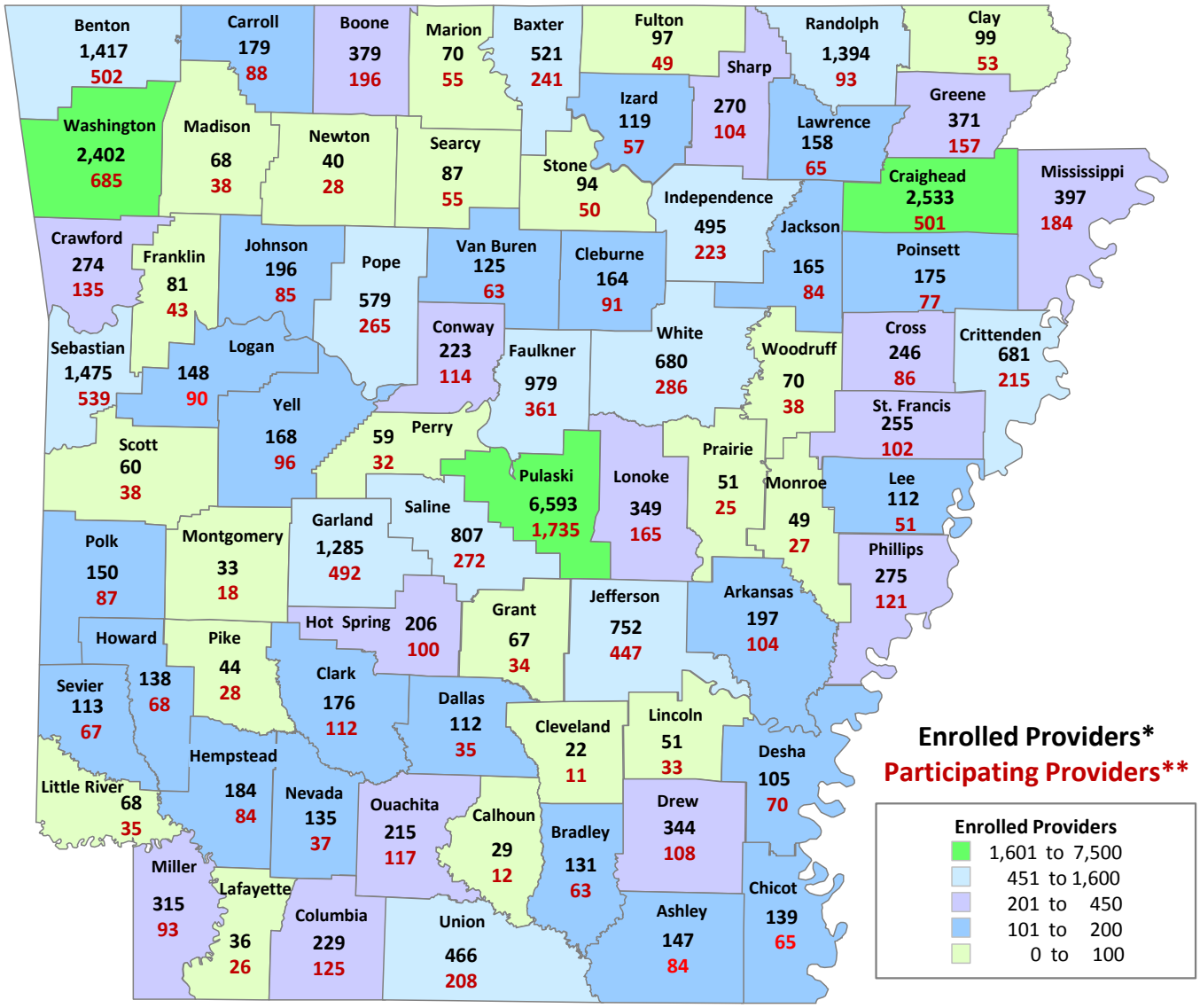
Map – Waiver Expenditures and Waiver Beneficiaries by County



Source: Department of Human Services; Division of Medical Services
Medicaid Decision Support System

Waivers included:
Alternatives for Persons with Disabilities
Developmental Disabilities Services – Alternative Community Services
ElderChoices
Living Choices Assisted Living

Map – Providers by County



Source: Department of Human Services; Division of Medical Services
Medicaid Decision Support System

*Enrolled Providers – Providers who have been approved by Medicaid to provide services to Medicaid beneficiaries
**Participating Providers – Providers who billed at least one claim in State Fiscal Year 2013

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

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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	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 Telecommunications Device for the Deaf (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
Arkansas Payment Improvement Initiative	http://www.paymentinitiative.org/Pages/default.aspx
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