ARMedicaid

SFY 2017

Division of Medical Services
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ARKANSAS DEPARTMENT OF HUMAN SERVICES

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 (DMS) Mission Statement

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

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.

About this Booklet

The Arkansas Medicaid overview booklet is produced annually by the Division of Medical Services (DMS) and DXC Technology. 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, reports from the Decision Support System, the University of Arkansas at Little Rock website and other reports from units at DMS, DXC Technology and Arkansas Foundation for Medical Care. All acronyms used in this booklet are defined in the glossary beginning on page i of the appendices. Some information in this publication will differ from the Financial Outlook due to data pulls and systems.

Our Core Values

- Compassion
- Courage
- Respect
- Integrity
- Trust

Physical Address

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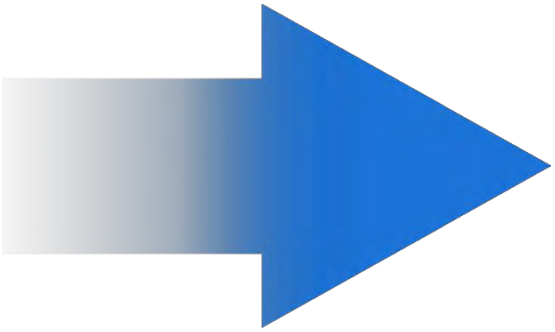


Contents

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.
- 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 Division of Medical Services. 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 County Staff located in DHS County Offices or by District Social Security Offices.

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 95 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 30.31% of Arkansas Medicaid Program-related costs in State Fiscal Year 2017; the federal government funded approximately 69.69%. 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 2017 Arkansas Medicaid Operating Budget*

	(Millions)
General Revenue	$1,004.0
Other Revenue	$344.7
Quality Assurance Fee	$86.8
Hospital Provider Tax	$86.2
Intermediate Care Facilities for Individuals with Intellectual Disabilities Provider Tax	$11.1
Trust Fund	$61.1
Federal Revenue	$5,510.2
Total Program	$7,104.1

*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) 2017, the Division of Medical Services Program Development and Quality Assurance Unit processed:

- 9 State Plan amendments
- 71 provider manual updates
- 5 official notices and notices of rule making
- 4 provider letters regarding changes to the Preferred Drug List and pharmacy memorandums

In SFY 2017, our fiscal agent, DXC Technology, responded to 94,697 voice calls, 145,895 automated calls and 33,039 written inquiries. DXC Technology Provider Enrollment responded to 35,699 calls, received 13,547 applications, and worked 13,395 applications for prospective or reenrolling providers. DXC Technology provider representatives conducted 1,144 provider visits, 24 workshops around the state and 5 virtual training sessions reaching 26 providers.

In SFY 2017, Medicaid Managed Care Services (MMCS) Provider Relations Outreach Specialists contacted a quarterly average of 167 hospitals and 1,207 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 (Pediatric, Family, Obstetric-Gynecologic and Gerontological)	All ages
Nursing Facility Services	Age 21 and older
Physician Services	All ages
Rural Health Clinic	All ages
Transportation (Emergency ambulance transportation and Non-Emergency Transportation [NET waiver] 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 (not a medical service)	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 (RSPMI)	All ages
• Persons with Physical Disabilities (RSPD), 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), 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
Ventilator Equipment	All ages
Visual Care Services	All ages

Waivers Approved by the Centers for Medicare and Medicaid Services

ARChoices	Age 21 and older, who would require an intermediate level of care in a nursing home without the waiver; Ages 21 through 64 with a physical disability as determined through Social Security Administration or Medical Review Team
Arkansas Works	Childless Adults Age 19-64 and Parent/Caretakers 19-64
Autism Waiver	Age 18 months through 6 years
Developmental Disabilities Services/Alternative Community Services	All ages
Living Choices Assisted Living	Age 21 and older
Non-Emergency Transportation	All ages
TEFRA	Under age 19

Services Covered by Arkansas Child Health Insurance Program

ARKids First-B	Under age 19 and Unborn Child

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 age 18 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 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 for most office visits and $5 per prescription (and must use generic drugs). 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) beneficiaries whose custodial parent(s)' income is in excess of 150% of the Federal Poverty level must pay a premium. TEFRA beneficiaries whose custodial parent(s)' 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.

Who Qualifies?

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 DHS. Non-SSI eligibility depends on age, income and assets. Most people who qualify for Arkansas Medicaid are

- Age 65 and older
- Under age 19
- Age 19 to 64 not receiving Medicare (the new Arkansas Works Program)
- Blind
- Pregnant
- The parent or the relative who is the caretaker of a child
- Living in a nursing home
- Under age 21 and in foster care
- A former foster care recipient between the ages of 18 and 26 who aged out of the Arkansas Foster Care program
- In medical need of certain home and community-based services
- Disabled, including working disabled

Current Federal Poverty Levels

Monthly Levels* for Families and Individuals by Medicaid Categories

(Effective April 1, 2017 through March 31, 2018)

Family size	Adult Expansion Group 133%	Adult Expansion Group with 5% Disregard 138%	ARKids First-A 142%	ARKids First-A with 5% Disregard 147%	ARKids First-B 211%	ARKids First-B with 5% Disregard 216%
1	$1,336.65	$1,386.90	$1,427.10	$1,477.35	$2,120.55	$2,170.80
2	$1,799.93	$1,867.60	$1,921.73	$1,989.40	$2,855.53	$2,923.19
3	$2,263.22	$2,348.30	$2,416.37	$2,501.45	$3,590.52	$3,675.61
4	$2,726.50	$2,829.00	$2,911.00	$3,013.50	$4,325.50	$4,428.00
5	$3,189.78	$3,309.70	$3,405.63	$3,525.55	$5,060.48	$5,180.39
6	$3,653.07	$3,790.40	$3,900.27	$4,037.60	$5,795.47	$5,932.81
7	$4,116.35	$4,271.10	$4,394.90	$4,549.65	$6,530.45	$6,685.20
8	$4,579.63	$4,751.80	$4,889.53	$5,061.70	$7,265.43	$7,437.59
9	$5,042.92	$5,232.50	$5,384.17	$5,573.75	$8,000.42	$8,190.01
10	$5,506.20	$5,713.20	$5,878.80	$6,085.80	$8,735.40	$8,942.40
For each additional member add:	$463.28	$480.70	$494.63	$512.05	$734.98	$752.39

Monthly Levels (continued)

Family size	Full Pregnant Women & Parent Caretaker Relative (monthly dollar amount)	Transitional Medicaid 185%	Limited Pregnant Women / Unborn Child 209%	Limited Pregnant Women/ Unborn Child with 5% Disregard 214%
1	$124.00	$1,859.25	$2,100.45	$2,150.70
2	$220.00	$2,503.66	$2,828.46	$2,896.13
3	$276.00	$3,148.09	$3,556.49	$3,641.57
4	$334.00	$3,792.50	$4,284.50	$4,387.00
5	$388.00	$4,436.91	$5,012.51	$5,132.43
6	$448.00	$5,081.34	$5,740.54	$5,877.87
7	$505.00	$5,725.75	$6,468.55	$6,623.30
8	$561.00	$6,370.16	$7,196.56	$7,368.73
9	$618.00	$7,014.59	$7,924.59	$8,114.17
10	$618.00	$7,659.00	$8,652.60	$8,859.60
For each additional member add:	9 and greater $618.00	$644.41	$728.01	$745.43

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 Equal to or below 200%
Individual	$804.00	$1005.00	$1,206.00	$1,356.75	$2,010.00
Couple	$1,082.66	$1,353.33	$1,624.00	$1,827.00	$2,706.66

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

Who We Serve

Unduplicated Beneficiary Counts and Claim Payments by Age

Source: DMS/DSS Lab

Percentage of Change in Enrollees and Beneficiaries from SFY 2016 to SFY 2017

	SFY16	SFY17	% Change
Medicaid enrollees	1,132,517	1,166,967	3.0%
Medicaid beneficiaries	1,106,471	1,175,155	6.2%

Source: DMS

Newborns Paid for by Arkansas Medicaid

	SFY15	SFY16	% Change
Newborns paid for by Arkansas Medicaid	23,035	24,513	6.42%

Arkansas Medicaid is a critical component of healthcare financing for children and pregnant women. Through ARKids First and other programs, Arkansas Medicaid insures approximately 524,725 children and, according to recent data, paid for approximately 63.6%** of all births in Arkansas during SFY 2016.

Source: Department of Human Services (DHS) – Division of Medical Services and the Arkansas Department of Health
**This calculation is based on SFY16 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	3,141,259	40%
Elderly (65 and older)	457,084	14%
Adults (21 through 64)	1,809,978	31%
Children (20 and under)	874,197	74%

** This calculation is based on the Arkansas population for 2015, which is the most recent available.
Source: University of Arkansas at Little Rock, DMS, DSS Lab

Arkansas Medicaid Enrollees by Aid Category – 5 year Comparison

Due to the changeover in computer systems, this information is not readily available.

Who Provides Services

Number of Enrolled Arkansas Medicaid Providers

Arkansas Medicaid has approximately 45,979 enrolled providers.

Number of Participating Arkansas Medicaid Providers

Approximately 11,859 or 26% are participating providers.

Top 10 Provider Types Enrolled in Arkansas Medicaid

1	Physicians (10,655)
2	Individual Occupational, Physical and Speech Therapy Services Providers (4,158)
3	Nurse Practitioner (2,376)
4	Physicians Groups (2,362)
5	*Dental Services (1,250)
6	Pharmacy (962)
7	Prosthetic Services/Durable Medical Equipment (672)
8	Hospital (630)
9	Visual Care – Optometrist Optician (616)
10	ARChoices (404)

*Includes orthodontists, oral surgeons and dental groups
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.)

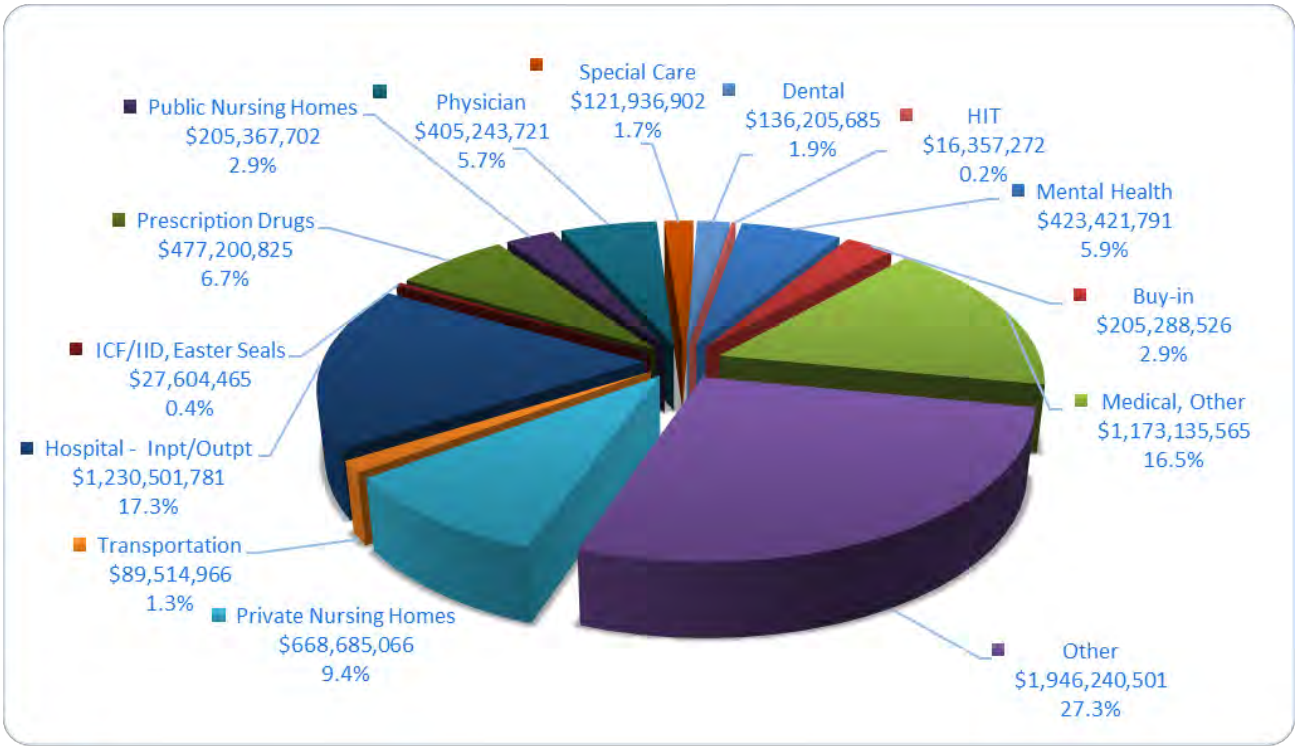
Arkansas Medicaid Operations

In State Fiscal Year 2017, our fiscal agent, DXC Technology, processed more than 45 million provider-submitted claims for 11,859 providers on behalf of more than 1,106,471 Arkansans with an average processing time of 2.0 days. The Provider Assistance Center responded to 94,697 voice calls, 145,895 automated calls and 33,039 written inquiries. DXC Technology Provider Enrollment responded to 35,699 calls, received 13,547 applications, and worked 13,395 applications for prospective or reenrolling providers. DXC Technology provider representatives conducted 1,144 provider visits, 24 workshops around the state and 5 virtual training sessions reaching 26 providers.

Sources: HMDR215J, HMGR526J

Expenditures

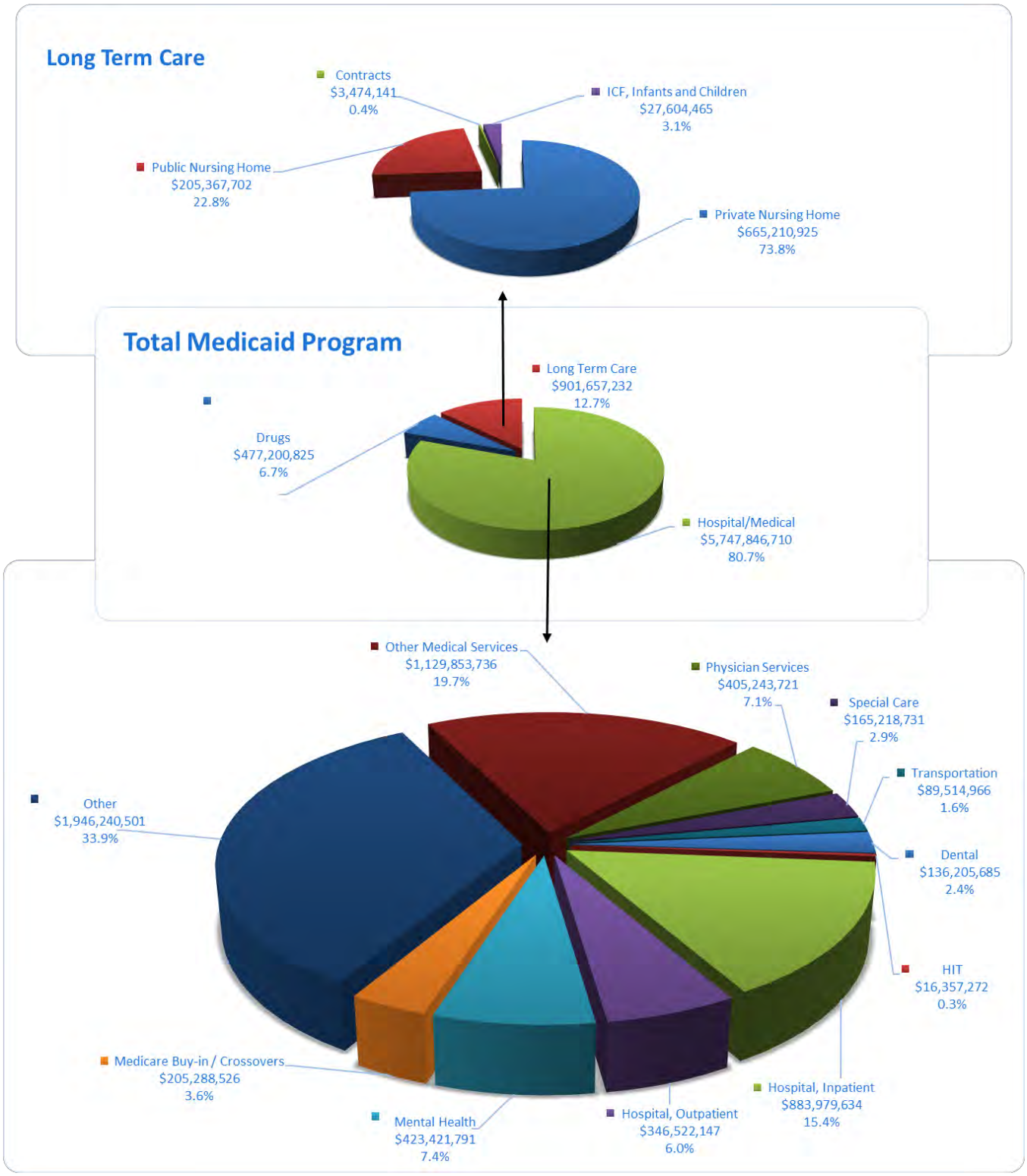
Total Arkansas Medicaid Expenditures SFY17



Special Care includes Home Health, Private Duty Nursing, Personal Care and Hospice Services.
Transportation includes emergency and non-emergency transportation.
Other administrative expenditures, Medicare co-pay and deductibles.
ICF/IID is an abbreviation for Intermediate Care Facility for Individuals with Intellectual Disabilities.

Source: Department of Human Services Annual Statistical Report

Arkansas Medicaid Program Benefit Expenditures



Source: DMS Financial Activities

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.

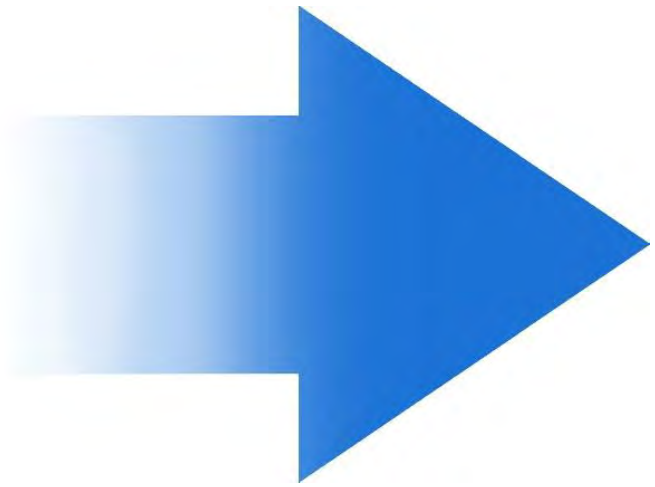
Rebate Dollars Collected	
Total State Fiscal Year 2017	$232,770,495
State portion	$56,925,295
*Federal portion	$175,845,200

*Note: Federal includes Share at regular FMAP and 95% FMAP ACA Offset (began January 1, 2017).

Economic Impact of Arkansas Medicaid

Program Costs			
State Fiscal Year (SFY)	Total (in mil)	Unduplicated Beneficiaries	Average Annual Cost per Beneficiary
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	$5,122	902,378	$5,678
*2015	$6,263	1,009,856	$6,202
2016	$6,553	1,106,471	$5,922
2017	$7,104	1,175,155	$6,045
**2018	$7,332	1,175,155	$6,239

Arkansas Budget and Medicaid percentage		
	SFY 2017	Medicaid Represents
State of Arkansas Budget	$30.6 billion	23.2%
State General Revenue Funded Budget	$5.3 billion	18.9%



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

*2015 Unduplicated Count: Regular Medicaid-734,898, Private Option-274,958. The regular Medicaid count excludes all beneficiaries that ever had Private Option eligibility at any time during the SFY period.

**2018-Estimated AOP, Estimated Beneficiaries as of June 30, 2017.

Understanding the Division of Medical Services

The Department of Human Services (DHS) is the single state agency authorized and responsible for regulating and administering the Arkansas Medicaid program. This program and related areas are located within the Division of Medical Services (DMS).

The Division of Medical Services houses two major programs under one administration:

- **Medicaid**
  Medicaid is a joint federal-state program that provides medical assistance for eligible individuals based on financial need and/or health status. Medicaid furnishes medical assistance to those who have insufficient incomes and resources to meet the costs of necessary medical services. It also provides rehabilitative and other services to help families and individuals become or remain independent and able to care for themselves.

  DHS is the single state agency authorized and responsible for regulating and administering the program. DHS administers the Medicaid Program through 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 Medicaid services by DHS Field Staff located in DHS County Offices or by District Social Security Offices.

  A list of covered services can be found beginning on page 5 of this publication. Mandatory services are required by the federal government. Optional services are those which the state has elected to provide. Many of these optional services enable beneficiaries to receive care in less costly home- or community-based settings. Optional services are approved in advance by CMS and are funded at the same level as mandatory services.

- **Office of Long Term Care**
  Each year, more than 25,000 Arkansans who have chronic, long-term medical needs require services in long-term care facilities. These individuals live in approximately 225 nursing facilities and 41 Intermediate Care Facilities for Individuals with Intellectual Disabilities that are licensed to provide long-term care services in Arkansas.

  Improving the quality of life for residents and protecting their health and safety through enforcement of state and federal standards are primary goals of Arkansas Medicaid's Office of Long Term Care (OLTC). Using qualified healthcare professionals, OLTC inspects all facilities to ensure residents receive the care they need in a clean, safe environment and that they are treated with dignity and respect.

  The Office of Long Term Care (OLTC) also surveys Adult Day Care, Adult Day Health Care, Post Acute Head Injury Facility, Residential Care Facilities, and Assisted Living Facilities. In addition to surveying facilities, OLTC administers the Nursing Home Administrator Licensure program, Criminal Background program, Certified Nursing Assistant registry and training program, processes Medical Needs Determinations for Nursing Home and Waivers and operates a Complaints Unit.

These programs are designed to serve Arkansans throughout the state. The following pages highlight the State Fiscal Year 2017 performance of these programs.

Administrative Unit Descriptions

Medicaid Data Security Unit

The Medicaid Data Security Unit works with the DHS Privacy Officer on Health Insurance Portability and Accountability Act (HIPAA) compliance in order to maintain the privacy and security of patient information and assist contractors with adhering to DHS policies and procedures. The Security Unit also monitors and performs technical audits on contractors and researchers who use Medicaid data. A Data Security Committee evaluates requests to use Medicaid data for research projects and publications to ensure HIPAA compliance.

Medicaid Information Management

The Medicaid Information Management (MIM) Unit is responsible for the operations and support of the Medicaid Management Information System (MMIS), which processes all Medicaid claims and provides Medicaid data for program management, research and care planning activities. The Unit serves as the customer support center in maintaining and operating the Information Technology (IT) infrastructure for the Division, including the Medicaid websites.

For State Fiscal Year 2017, MIM received 15 Security Advisory Committee data requests and the Decision Support Lab output 1,178 reports. The reports produced include information requested by the Arkansas Legislature, Governor's office, press and other private entities seeking Medicaid performance and participation metrics. MIM works diligently to fulfill these requests while respectfully protecting the privacy of our beneficiaries.

Arkansas Medicaid Enterprise (AME) Project Management Office

The Medicaid Management Information System (MMIS) Replacement Project, chartered by the Division, is to implement a new core MMIS, pharmacy point of sale, data warehouse, and decision support system that will modernize existing system functions and significantly enhance the goals of the MMIS, ensuring that eligible individuals receive the healthcare benefits that are medically necessary and that providers are reimbursed promptly and efficiently.

The data warehouse and Fraud and Abuse Detection sub-system for Program Integrity went into production in February of 2015 under a contract with Optum Government Solutions.

The Pharmacy system under Magellan Health went into production in March of 2015. The system has paid more than 5.3 million claims in SFY17 (July 1, 2016 - June 30, 2017) totaling over $423 million.

The new Core MMIS design, development, and implementation contract went into effect in December of 2014 with DXC Technology. The system is targeted to go into production November 1, 2017.

Data Analytics

The Medicaid Statistical Analytics and Management Unit is responsible for developing and managing workflow processes and projects related to Medicaid data. The unit evaluates new technologies to introduce to the Division in an effort to create efficiencies in time and effort as well as developing and overseeing the Department of Human Services Enterprise Change Control Management.

Services and Support

The Services and Support unit serves as the Division liaison with our Federal partner the Centers for Medicare and Medicaid Services (CMS). The unit creates and provides the Federal documentation necessary for Medicaid to receive Federal funding for all IT projects.

Federal funding provided by CMS is approved, allocated and tracked based on the Federal Fiscal Year (FFY) (October 1 – September 30). For FFY-2017 (Oct. 2016 – Sept. 2017), CMS approved over $231,915,548 towards the costs of various DHS Medicaid IT projects.

Program Development and Quality Assurance (PD/QA)

The PD/QA Unit develops and maintains the Arkansas Medicaid State 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 programs and the resulting provider manuals. Because the Division of Medical Services has administrative and financial authority for all Arkansas Medicaid waiver programs, PD/QA is responsible for monitoring the operation of all Arkansas Medicaid waiver programs operated by other Divisions. PD/QA assures compliance with the Centers for Medicare and Medicaid Services (CMS) requirements for operating waiver programs and monitors for key quality requirements.

The PD/QA Unit also develops and maintains the Arkansas Child Health Insurance Program (CHIP) State Plan. PD/QA is responsible for coordinating the development and research of new 1115(a) demonstration waivers, for the oversight of contractor technical writing of any provider policy manuals that may be developed for demonstration waiver programs, for the completion of initial and renewal request applications for 1115(a) demonstration waiver programs and ensuring that they are completed within federal guidelines, and for coordination of the approval process through both state and federal requirements.

Quality Assurance (QA) Activities for waiver programs include:

- Leading development of new waiver programs.
- Communicating and coordinating with CMS regarding waiver program activities and requirements, including the required renewal process.
- Providing technical assistance and approval to operating agencies regarding waiver program 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 waiver programs.
- Developing provider manuals for waiver programs.

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 healthcare payments to Arkansas Medicaid beneficiaries. These sources include health and liability insurance, court settlements, absent parents and estate recovery.

TPL & Estate Recovery Savings for State Fiscal Year 2017	
Other Collections (Health, Casualty Insurance, Estate Recovery, Miller Trusts, and Small Estates)	$25,543,441.60
Cost Avoidance (Health Insurance)	$30,643,338.52
Total Savings	$56,186,780.12

Source: Division of Medical Services Statistical Report

Utilization Review

The Utilization Review (UR) section administers multiple medical programs and services. UR monitors the performance of contracted Quality Improvement Organizations (QIO) 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 age 22 and older and extension of benefits of incontinence products and medical supplies for eligible beneficiaries.
- Prior authorizations and extension of benefits for the following programs: Inpatient and Outpatient Hospitalization, Inpatient Psychiatric under the age of 21, 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 healthcare 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 healthcare determinations related to specific rules, laws and policies affecting program coverage.
- Review of evolving medical technology 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.
- Interact with provider groups and levels of federal and state government, including the legislature and governor's office.
- Participate in both beneficiary and provider appeals and hearing processes.

Program and Provider Management

Continuity of Care and Coordination of Coverage

The Continuity of Care and Coordination of Coverage unit is responsible for coordinating DMS efforts in the implementation of the Health Care Independence program and the transition to Arkansas Works. The unit assists with coordination of coverage for enrollees as they move in and out of Medicaid and transition to private health insurance programs. Additionally, this unit supports other Medicaid initiatives and coordinates with all of DMS and several other DHS divisions and State agencies.

Behavioral Health Services

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. Other responsibilities include monitoring the quality of treatment services, prior authorization 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. These opportunities are designed to assist providers in evaluating and improving their programs to offer the highest quality of care to Arkansas Medicaid beneficiaries. The Behavioral Health Unit further collaborates and supports other Department of Human Services divisions to design and implement a statewide transformation of the current behavioral health system under the umbrella of the Arkansas Health Care Payment Improvement Initiative. The overarching goal of the Behavioral Health Unit is to be instrumental in the development of a successful, efficient and quality-driven system of care.

Electronic Health Records Unit

Arkansas Medicaid administers a financial incentive payments to providers, ensuring proper payments through auditing and monitoring, and participating in statewide efforts to promote interoperability and meaningful use of Electronic Health Records (EHR) beginning 2011. The HIT provision of the American Recovery and Reinvestment Act (ARRA) of 2009 afford states and their Medicaid providers an opportunity to leverage existing HIT efforts to achieve the vision of interoperable information technology for health care.

Under the direction of the Electronic Health Record Unit (EHRU), classes of Medicaid professionals are eligible to receive Medicaid incentive payments. Eligible professionals (EPs) include physicians, dentists, certified nurse-midwives, nurse practitioners, and physician assistants who are practicing in Federally

Qualified Health Centers (FQHCs) or Rural Health Clinics (RHCs). Eligible hospitals that may participate are acute care hospitals and children's hospitals. To receive the Medicaid financial incentive, providers must be able to demonstrate certified adoption, implementation, or upgrading of EHR technology, followed in subsequent years by demonstrated meaningful use. Payments or reimbursements of up to $63,750 may be provided to offset the cost associated with implementing an EHR system to a participating clinic.

The EHRU's key function is to coordinate oversight for providers statewide by addressing issues that arise from the EHR incentive payment program. The EHRU identifies areas of risk in the eligibility determination, meaningful use, and payment processes and reviews that will mitigate the risk of making an improper payment. The EHRU conduct audits of providers' attestation forms for eligibility, validation of meaningful use, and conducting post and pre-payment reviews.

Health Care Innovation

The Health Care Innovation (HCI) Unit is responsible for coordinating the operations and activities to design the Arkansas Health Care Payment Improvement Initiative (APII) and service delivery systems. The unit works with multi-payers, staff and contractors to design and deliver/implement two primary types of population-based healthcare payment systems:

- Retrospective Episodes of Care for acute conditions
- Patient Centered Medical Homes for chronic conditions

In addition, HCI works to develop and coordinate improved payment systems infrastructure requirements and to facilitate stakeholder, provider and beneficiary engagement through the APII.

Now in its fourth year of work, HCI continues its mission to improve the health of the population, enhance the patient care experience and reduce the cost of health care. The goal is to move Arkansas's health system from a fee-for-service model that rewards volume to an alternative payment model that rewards high-quality, effective outcomes for patients by aligning financial incentives for how care is delivered.

Patient-Centered Medical Homes (PCMH), while not a physical location, embody prevention and wellness efforts of patient-centered and coordinated care across all provider disciplines. With the goal of promoting and rewarding prevention and early intervention, a coordinated team-based care and clinical innovation results in more efficient delivery system of high-quality care.

PCMHs helps achieve Arkansas's triple aim of improving population health, enhancing the patient experience and controlling the cost of care. PCMH seeks to do this by investing more in primary care. This means higher take-home pay for PCPs, as well as smoother practice processes and workflows.

Another segment of Health Care Innovation that has already been implemented is the Retrospective Episodes of Care (EOC). To date, 14 Episodes have gone live, which are Perinatal, Congestive Heart Failure (CHF), Total Joint Replacement (TJR), Colonoscopy, Cholecystectomy, Attention Deficit/Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder (ODD), Coronary Artery Bypass Graft (CABG), Chronic Obstructive Pulmonary Disease (COPD), Asthma, Tonsillectomy and three types of Upper Respiratory Infections (URI) – Non-specific, Sinusitis and Pharyngitis. Six additional Episodes are in various stages of development and implementation: Appendectomy (APPY), Hysterectomy (HYST), Uncomplicated Pediatric Pneumonia, Urinary Tract Infection (URI), Percutaneous Coronary Intervention (PCI), Comorbid Attention Deficit Hyperactivity Disorder / Oppositional Defiant Disorder. Further Episodes are currently being considered, such as Diabetic Ketoacidosis and Endoscopy (Esophagogastroduodenoscopy, Colonoscopy or combined procedures).

With Episodes of Care, providers (called Principal Accountable Providers or PAPs) are rewarded for providing high quality, cost efficient care. However, providers whose costs exceed the performance of their peers must make payments back to the Medicaid program. Through the June 2017 reporting period, 41,120 EOC PAP reports were delivered to 2,584 distinct PAPs. Of those reports, 24,914 are EOC-level payment or performance reports and 6,449 are reconciliation reports. Approximately 2.1 billion claims have been processed through the engine for both EOC and PCMH. For EOC, those claims resulted in over 5.3 million beneficiary-level episodes (before exclusions).

Arkansas Blue Cross Blue Shield (BCBS) and QualChoice continue to participate and launch selected episodes of care and are currently developing their own set of PCMHs.

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

Prescription Drug Program

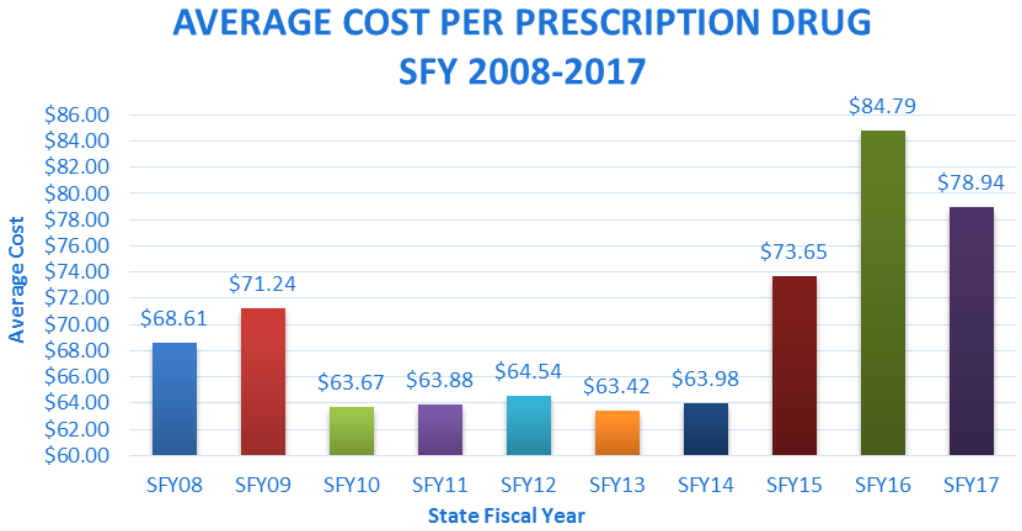
The Prescription Drug Program, an optional Arkansas Medicaid benefit, was implemented in Arkansas in 1973. Under this program, eligible beneficiaries may obtain prescription medication through any of the 957 enrolled pharmacies in the state. During State Fiscal Year (SFY) 2017, a total of 494,445 Arkansas Medicaid beneficiaries used their prescription drug benefits. A total of 5.4 million prescriptions were reimbursed by Arkansas Medicaid for a cost of $423.7 million dollars, making the average cost per prescription approximately $78.94. An average

cost for a brand name prescription was $404.08, representing 14% of the claims and accounting for 74% of expenditures. The average cost for a generic prescription was $24.37, representing 86% of claims and accounting for 26% 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 2017 was $51,046,995.

Arkansas Medicaid reimbursement for prescription drugs is based on ingredient cost and a professional dispensing fee. Ingredient costs are established and based on the lesser of methodology using the National Average Drug Acquisition Cost (NADAC), Federal Upper Limit, Usual and Customary, or State Actual Acquisition Cost (SAAC). Arkansas Medicaid has a professional dispensing fee of $9.00 for brand and non-preferred brand medications and $10.50 for generic and preferred brand medications as established by the Division of Medical Services and approved by CMS. The professional dispensing fee is based upon surveys that determine an average cost for dispensing a prescription. The following table shows the average cost per prescription drug in the Arkansas Medicaid Program.



Source: Payout Report

Primary Care Initiatives

Patient-Centered Medical Homes

The Patient-Centered Medical Homes (PCMH) unit oversees three managed-care programs. They are ConnectCare Primary Care Case Management, Patient-Centered Medical Homes and Primary Care Case Management Delta Pilot. All three programs focus on improvement in the area of primary care. Their aim is to improve quality of care and to lower the total cost of care through more efficient care coordination. ConnectCare covers approximately 460,000 beneficiaries. The PCMH program currently covers approximately 330,000 beneficiaries. PCMH is responsible for significant savings to the total cost of care,

and is very popular among providers who receive shared savings incentives when they lower the cost and improve the quality of care. Primary Care Case Management Delta Pilot is under development.

The success of the Arkansas Medicaid PCMH Program is illustrated by the following table.

Medical Practices			
State Calendar Year	**Number Enrolled in PCMH**	**Total Practices***	**Percent Enrolled**
2014	123	259	47%
2015	142	250	57%
2016	179	250	72%
2017	192	252	76%
Primary Care Physicians (PCPs)			
State Calendar Year	**Number Enrolled in PCMH**	**Total PCPs****	**Percent Enrolled**
2014	659	1,074	61%
2015	780	1,074	73%
2016	878	1,010	87%
2017	928	1,068	87%
Medicaid Beneficiaries			
State Calendar Year	**Number Enrolled in PCMH**	**Total Beneficiaries*****	**Percent Enrolled**
2014	295,000	386,000	76%
2015	317,000	386,000	82%
2016	330,000	414,000	80%
2017	356,000	421,000	85%

* This total represents the number of medical practices that are eligible to participate in the PCMH Program. These practices are in the Medicaid Primary Case Management program and have at least 300 beneficiaries attributed to them.

** This total represents the number of primary care physicians that are associated with these practices.

*** This total represents the number of Medicaid beneficiaries that are assigned to these practices through the Medicaid Primary Case Management program.

Surveillance Utilization Review (SUR)

The SUR unit is responsible for monitoring claims processes for Medicaid to seek indicators of fraud, waste or abuse. SUR employs an analytical tool to develop comprehensive reports and works closely with departmental staff to make recommendations on probable abuses of the Medicaid program. SUR works closely with the Arkansas Office of the Medicaid Inspector General and refers all cases to them when fraud, waste or abuse is suspected.

Program and Administrative Support

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.

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 many 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.

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 financial analysis of Medicaid expenditures by category of service, provider type and aid category, and provides any ad hoc managerial reports as requested by DMS leadership.

Provider Enrollment 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, and appeals and hearings. The unit also directly responds to concerns and questions of providers and beneficiaries of Arkansas Medicaid and ARKids services.

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.

Office of Long Term Care

Along with the six major units of Arkansas Medicaid Services, the Division of Medical Services also houses the Office of Long Term Care (OLTC). Most people think of nursing facilities when they think of the OLTC. The OLTC professional surveyors conduct annual Medicare, Medicaid and State Licensure surveys of Arkansas' 228 Nursing Facilities and 41 Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), including five Human Development Centers, and 105 Assisted Living Facilities. Annual and complaint surveys are also conducted in 15 Adult Day Care and Adult Day Health Care facilities and two Post-Acute Head Injury Facilities throughout the state. Semi-annual surveys are conducted in the 51 Residential Care Facilities, and 22 Alzheimer's Special Care Units (20 in Assisted Living Facilities and two in nursing homes). Additionally, annual Civil Rights surveys are conducted in 110 hospitals.

In addition to its role inspecting long-term care facilities, the OLTC provides training and educational opportunities to various healthcare providers to help ensure that facilities provide the highest level of care possible to long term care residents. OLTC staff provided approximately 112 hours of continuing education through 39 workshops/seminars to over 1,465 staff members in the nursing home and assisted living industry during SFY 2017. Furthermore, there were 227 agendas submitted from outside sources for review to determine 1,083.75 contact hours for nursing home administrators.

The Nursing Home Administrator Licensure Unit processed renewals for 637 licensed administrators and 83 license applications, issued 49 new licenses and temporary licenses, and restored 11 licenses. Additionally, OLTC administered the state nursing home administrator examination to 69 individuals. During SFY 2017, the Administrator-in-Training program trained 17 participants.

The Criminal Record Check Program applies to all categories of licensed long-term care facilities consisting of over 550 affected facilities. During SFY 2017, there were 42,681 "state" record checks processed through OLTC and 26,160 "federal" record checks processed with a total of 896 disqualifications under both categories combined.

At the end of SFY 2017, the Registry for Certified Nursing Assistants (CNAs) contained 29,724 active and 88,732 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 1,651 Arkansas Medicaid nursing facility applications per month while maintaining approximately 11,890 active cases. The unit also processed 10,326 assessments; 3,001 changes of condition requests; 484 transfers; 1,813 utilization review requests and 1,686 applications/reviews for ICF/IID, which includes 234 new assessments and 12 transfers during the year, and 1,440 reassessments. The unit completed 4,604 TEFRA applications and 133 autism waiver applications. Additionally, the unit completed 13,472 applications/reviews/waivers for other medical programs within the Department of Human Services during SFY 2017.

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 749 nursing home complaints during SFY 2017 regarding care or conditions in facilities.

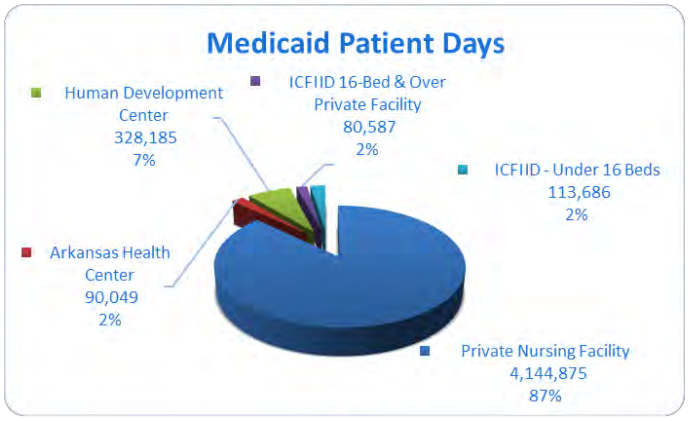
Since 1990, the federal long-term care program has had two levels of facility care under Medicaid. These levels of care are nursing facility services and intermediate care facility services for the intellectually disabled (ICF/IID).

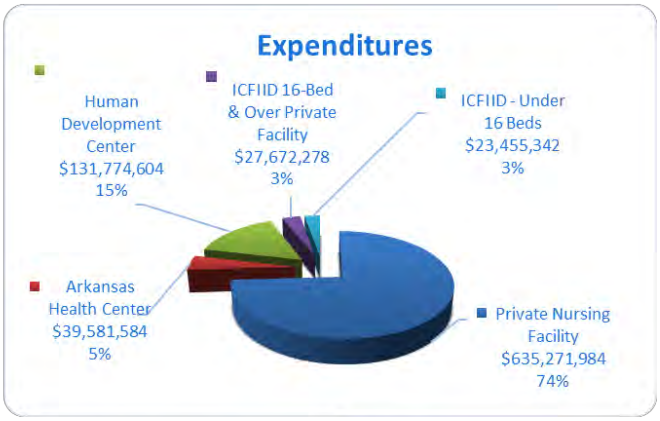
Arkansas classifies state-owned facilities as public and all others as private. Arkansas Health Center is a public nursing facility. The ICF/IID population is divided into the five state-owned Human Development Centers, four private pediatric facilities of which three are for profit, one private nonprofit pediatric facility, and 31 fifteen-bed or less facilities serving adults. The nursing facilities include one public and 227 private under Medicaid.

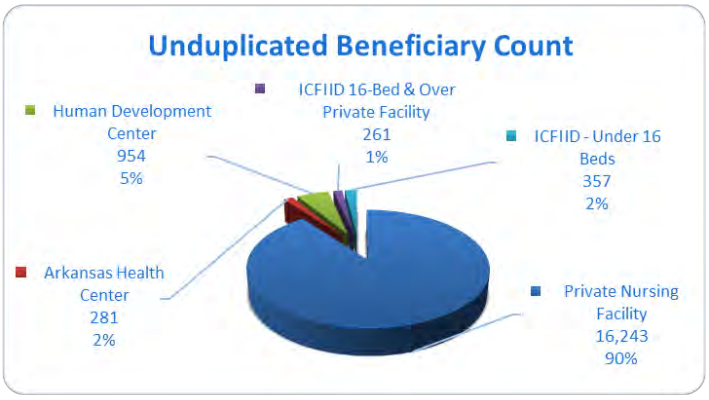
Note: There are two additional private facilities that do not receive Medicaid funding.

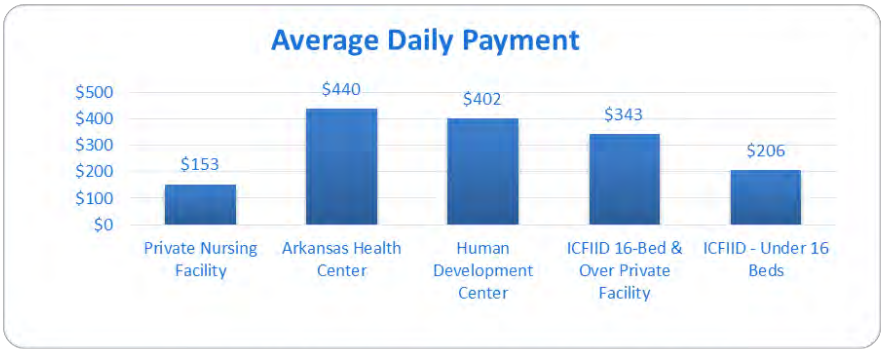
	Nursing Facilities	ICF/IID
Public	Arkansas Health Center Nursing Facility (formerly Benton Services Center)	Arkadelphia Human Development Center, Booneville Human Development Center, Conway Human Development Center, Jonesboro Human Development Center, Warren Human Development Center
Private	Private Nursing Homes (for profit and nonprofit)	Private Pediatric Facilities: Arkansas Pediatric, Brownwood, Millcreek Private Nonprofit Pediatric: Easter Seals Private Nonprofit: 15-Bed or Less Facilities for Adults – 31

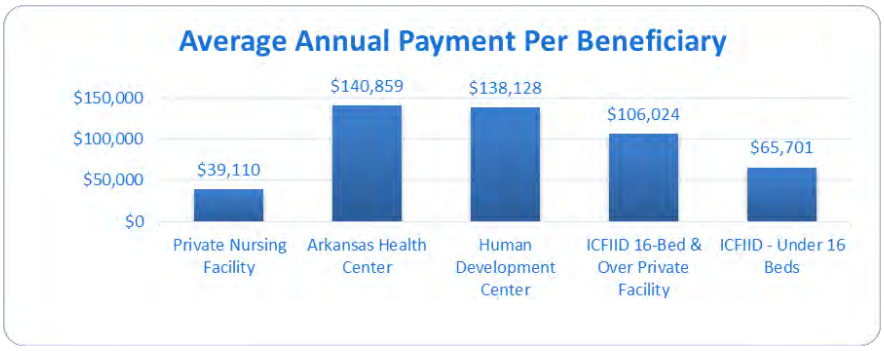
Long Term Care Statistics











Source: Department of Human Services Annual Statistical Report

Appendices

Glossary of Acronyms

ACA
Affordable Care Act

AFMC
Arkansas Foundation for Medical Care

AME
Arkansas Medicaid Enterprise

APII
Arkansas Health Care Payment Improvement Initiative

CHIP
Child Health Insurance Program

CMS
Centers for Medicare and Medicaid Services

CNA
Certified Nursing Assistant

CPCI
Comprehensive Primary Care Initiative

DHS
Department of Human Services

DMS
Division of Medical Services (Medicaid)

DSS
Decision Support System/Data Warehouse

EAC
Estimated Acquisition Cost

EHRU
Electronic Health Records Unit

EPSDT
Early and Periodic Screening, Diagnosis and Treatment

HCI
Health Care Innovation

HCIP
Heath Care Independence Program

ICF/IID
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

PCP
Primary Care Provider

PD/QA
Program Development and Quality Assurance

QA
Quality Assurance

QIO
Quality Improvement Organization

SFY
State Fiscal Year – July 1 to June 30

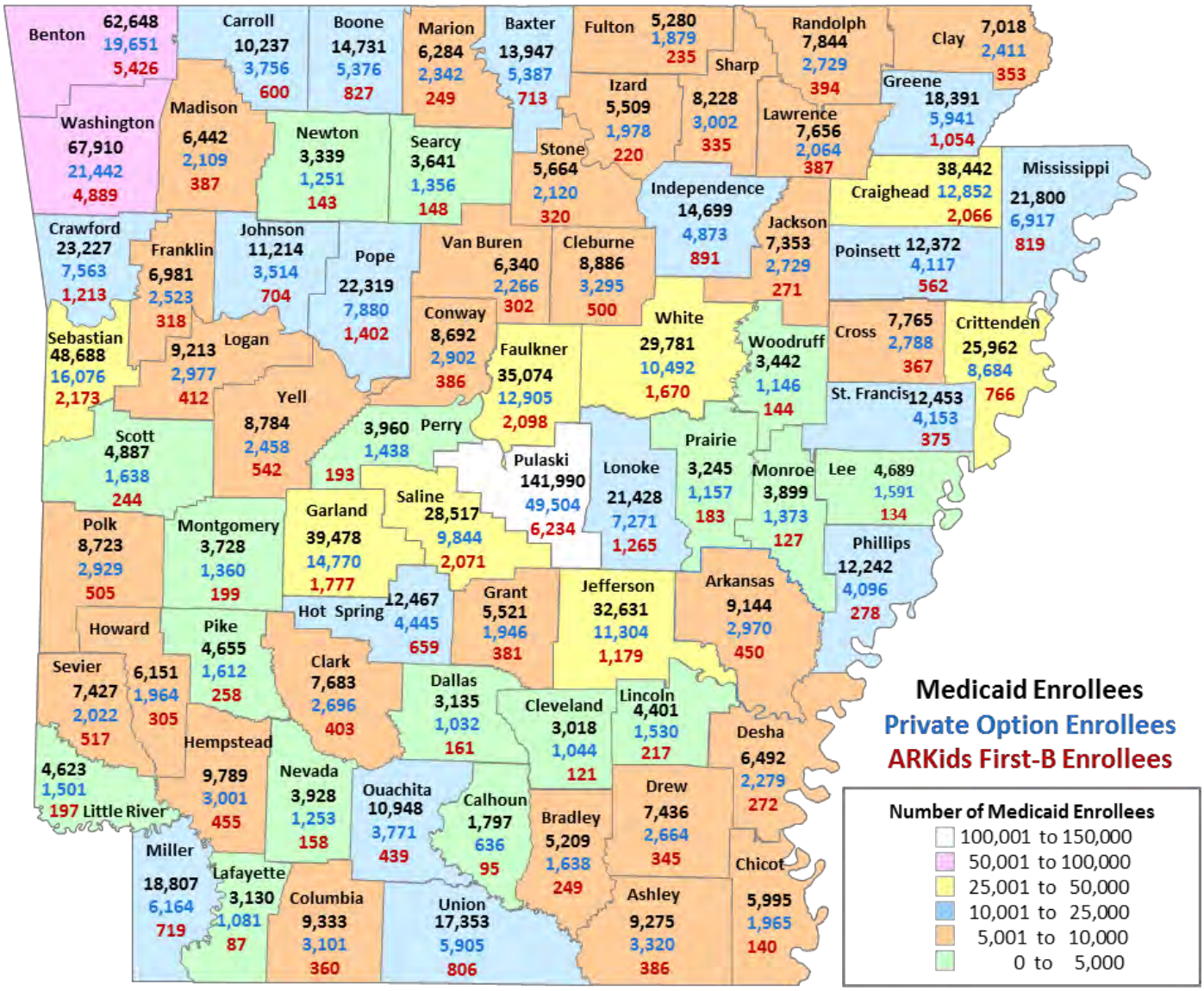
SPA
State Plan Amendment

SURS
Surveillance and Utilization Review Subsystem

TEFRA
Tax Equity and Financial Responsibility Act

UR
Utilization Review

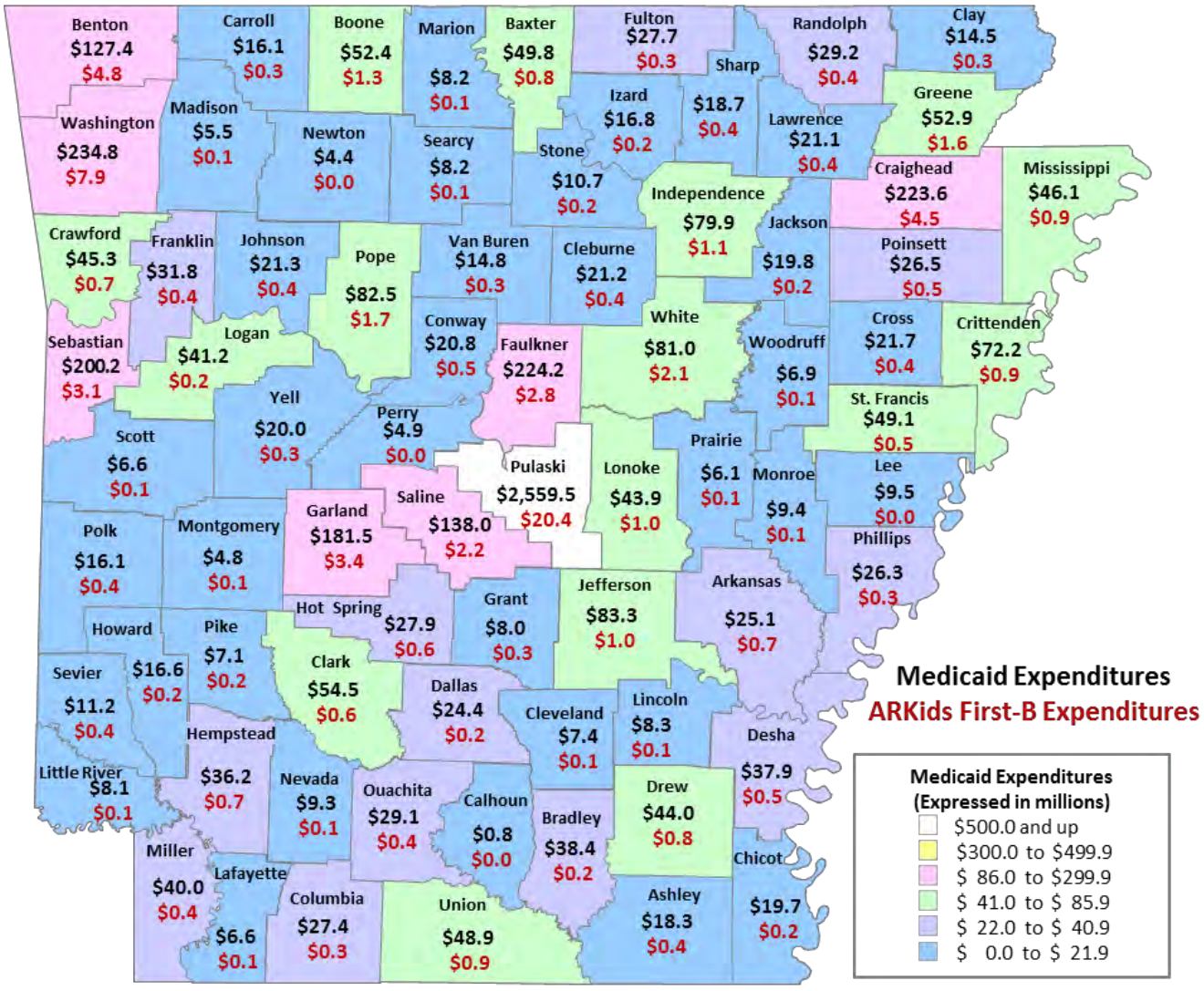
Enrollees by County



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.

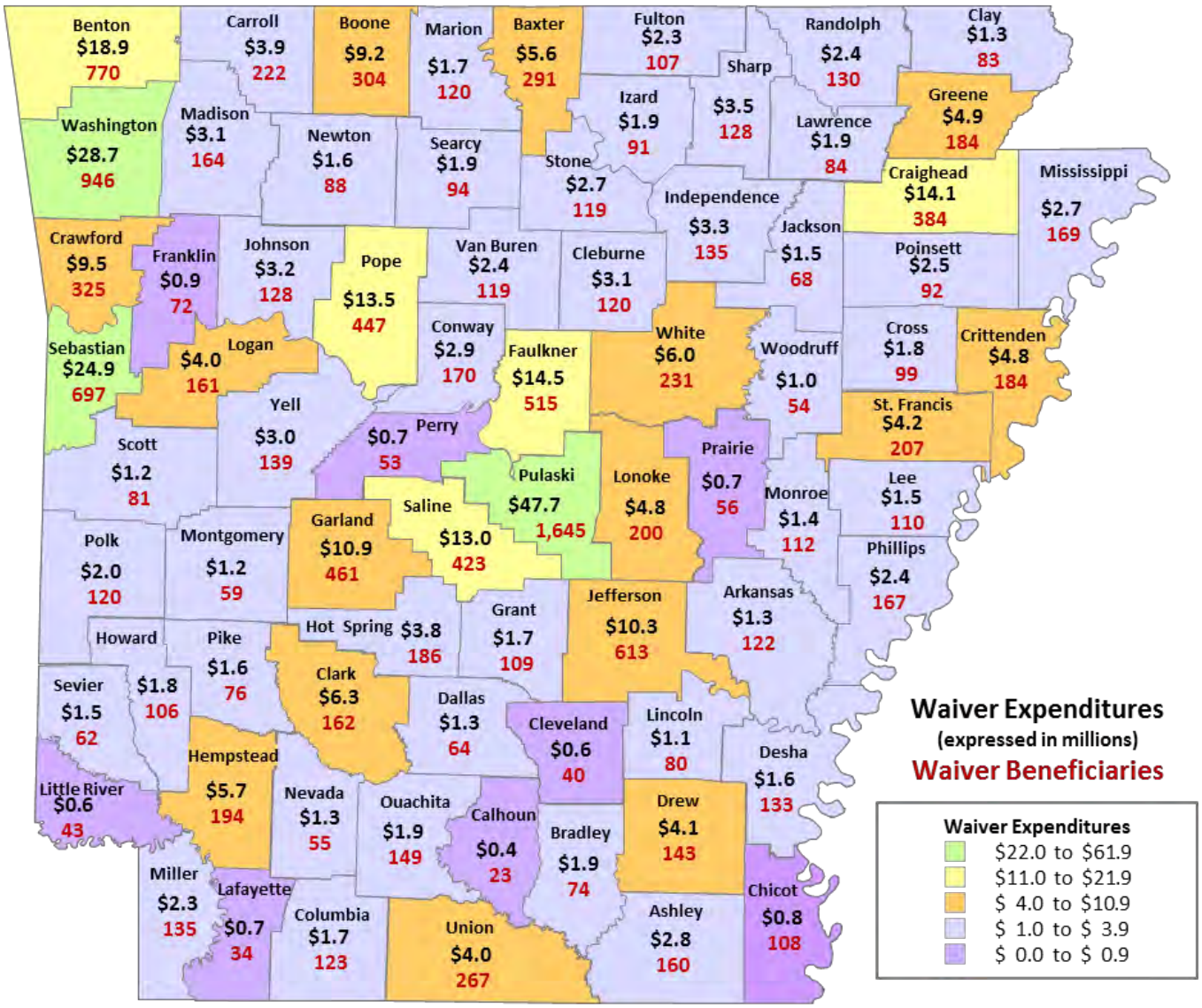
Expenditures by County



Source: Department of Human Services; Division of Medical Services
Medicaid Decision Support System
(Medicaid Expenditures includes ARKids First-A and Private Option.)

NOTE: Does not include Managed Care or Non-Emergency Transportation claims.

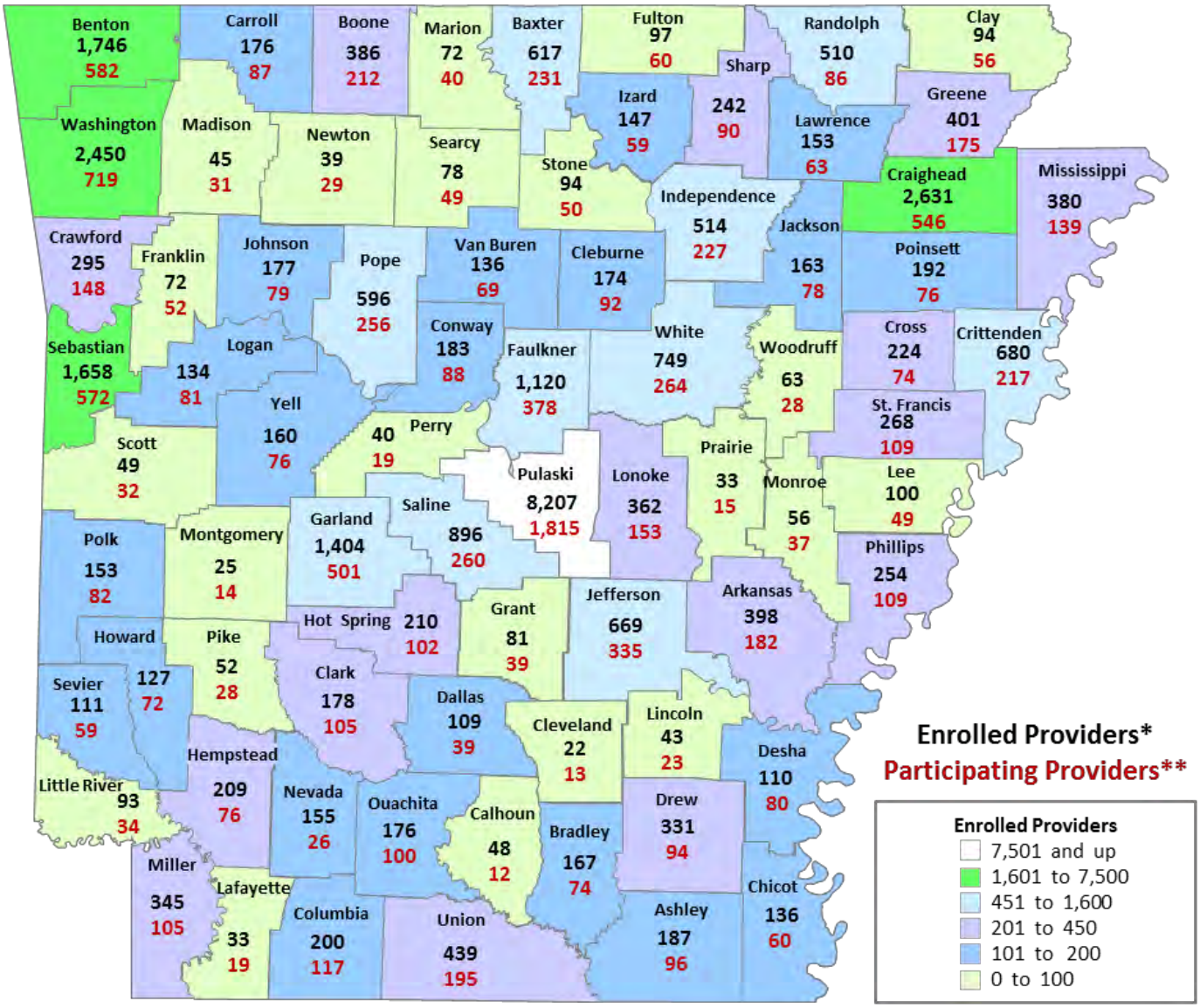
Waiver Expenditures and Waiver Beneficiaries by County



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

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

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 2017

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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	https://afmc.org/
Arkansas Medicaid	https://medicaid.mmis.arkansas.gov
Arkansas Payment Improvement Initiative	http://www.paymentinitiative.org/Pages/default.aspx
ARKids First	http://www.arkidsfirst.com/home.htm
Connect Care	https://afmc.org/individuals/arkansans-on-medicaid/connectcare/
Department of Human Services (DHS)	http://humanservices.arkansas.gov/
DHS County Offices	https://medicaid.mmis.arkansas.gov/general/units/cooff.aspx