



## Arkansas Medicaid Program Overview State Fiscal Year 2009



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Division of Medical Services

## DHS Mission Statement

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

## DHS Vision

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

## DMS Mission Statement

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

## Our Core Values

- Compassion
- Courage
- Respect
- Integrity
- Trust

## Our Beliefs

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



## Main Office Location

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Welcome from the Division of Medical Services, Arkansas Medicaid Program. As the new director of the Medicaid program, I have learned the benefits our program provides to the people of Arkansas, such as better health, quality providers, and financial relief during economic hardships. Therefore, I am eager to share with you what our program does for this state. This high-level information will give you a better understanding of the Arkansas Medicaid Program, how it is funded, and where these important tax dollars are spent.

Only a small percentage of the annual Medicaid budget is spent on administrative services performed by the state, which means more dollars are spent fulfilling our mission and serving our beneficiaries. This statistical information about the beneficiary and provider communities shows our program administrators' commitment to responsible stewardship of critical resources, ensuring more return for the people of Arkansas in health benefits and economic reinvestment of tax dollars in our state. We are proud that our program serves 750,000 individuals each year, offering more than 50 healthcare programs and waivers through a network of 27,000 providers.

Thank you in advance for your review of this information. Please do not hesitate to contact us if you have questions about our program.

A handwritten signature in black ink that reads "Eugene I. Gessow".

Eugene I. Gessow  
Director,  
Division of Medical Services



# Arkansas Medicaid Program Overview

## SFY 2009

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## What is Medicaid?

Medicaid is a joint federal-state program of medical assistance for eligible individuals based on financial need and/or health status. Title XIX of the Social Security Act created grant programs popularly called "Medicaid" in 1965. Medicaid furnishes medical assistance to those who have insufficient incomes and resources to meet the costs of necessary medical services. Medicaid provides rehabilitation and other services to help families and individuals become or remain independent and able to care for themselves.

Each state has some type of 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 January 1, 1970. The Arkansas Department of Human Services administers the Medicaid program through the Arkansas Division of Medical Services.

## Who Qualifies for Medicaid?

Individuals are certified as eligible for Medicaid services through the state's county Human Services Offices or District Social Security Offices. The Social Security Administration automatically sends SSI recipient information to DHS. Eligibility depends on age, income, and assets. Most people who can get Medicaid are in one of these groups:

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



# Arkansas Medicaid Program Overview

## SFY 2009

### 2009 Federal Poverty Levels

#### Monthly Levels (April 1, 2009 through March 31, 2010) Family Medicaid Categories

Family size	<i>ARKids A Children 6 and over and AR Health Care Access</i>	<i>ARKids A Children under age 6</i>	<i>Transitional Medicaid</i>	<i>SOBRA Pregnant Women, Family Planning, and ARKids First B</i>
	100%	133%	185%	200%
1	\$902.50	\$1,200.33	\$1,669.63	\$1,805.00
2	\$1,214.17	\$1,614.85	\$2,246.21	\$2,428.34
3	\$1,525.83	\$2,029.35	\$2,822.79	\$3,051.66
4	\$1,837.50	\$2,443.88	\$3,399.38	\$3,675.00
5	\$2,149.17	\$2,858.40	\$3,975.96	\$4,298.34
6	\$2,460.83	\$3,272.90	\$4,552.54	\$4,921.66
7	\$2,772.50	\$3,687.43	\$5,129.13	\$5,545.00
8	\$3,084.17	\$4,101.95	\$5,705.71	\$6,168.34
9	\$3,395.84	\$4,516.47	\$6,282.30	\$6,791.68
10	\$3,707.51	\$4,930.99	\$6,858.89	\$7,415.02
For each additional member add:	\$311.67	\$414.52	\$576.59	\$623.34

#### Aid to the Aged, Blind and Disabled Medicaid Categories

	<i>ARSeniors Equal to or below 80%</i>	<i>QMB Equal To or Below 100%</i>	<i>SMB Between 100% &amp; 120%</i>	<i>QI-1 At least 120% but less than 135%</i>	<i>QDWI &amp; TB Equal To or Below 200%</i>	<i>Working Disabled 250%</i>
Individual	\$722.00	\$902.50	\$1,083.00	\$1,218.38	\$1,805.00	\$2,256.25
Couple	\$971.34	\$1,214.17	\$1,457.00	\$1,639.13	\$2,428.34	\$3,035.42
For each additional family member in the Working Disabled category add:						\$779.18

\*Acronyms are defined in the glossary in the appendices of this booklet.

## How is Medicaid Funded?

Funding 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 funds approximately 22.08% of Arkansas Medicaid program-related costs; the federal government funds approximately 77.92%. State funds are drawn directly from appropriated state general revenues, license fees, drug rebates, recoveries and the 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.

## How is Medicaid Administered?

The Arkansas Department of Human Services administers the Medicaid program through the Arkansas Division of Medical Services (DMS). Arkansas Medicaid is detailed in the Arkansas Medicaid State Plan 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, ensuring compliance with human services federal regulations.

### Administration Statistics

In SFY 2009, the DMS Program Development and Quality Assurance (formerly Program Planning and Development) area processed

- 17 State Plan amendments
- 87 provider manual updates
- 9 official notices
- 3 provider memorandums
- 4 pharmacy provider memorandums



Medicaid's fiscal agent, Hewlett Packard (HP) Provider Representatives held 34 training sessions in 2009.

Medicaid Managed Care Service (MMCS) Provider Relations Representatives exhibited and presented at 72 conferences statewide in 2009.

In 2009, MMCS Provider Relations Representatives contacted a quarterly average of

- 72 hospitals
- 1,196 clinics
- 2,392 physicians

## What Programs are Provided by Arkansas Medicaid?

Medicaid pays for a wide range of medical services. The Medical Assistance (Medicaid) Office can assist with determining if Medicaid pays for a specific service. Many benefits have limits, especially for adults. Limits may be daily, weekly, monthly, or annually. There are also services that have an overall dollar amount limit per time period. Some services require a referral from the beneficiaries' PCPs. Services may be rendered by both private and public providers. All services, by definition or regulation, fall into one of the following groups:

- mandatory services required by the federal government.
- additional services that the state provides to individuals under age 21 eligible for the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program.
- optional services that the state has elected to provide. Many of these optional services enable beneficiaries to receive care in less costly home- or community-based settings. The specific optional service is approved in advance by CMS.
- waiver and demonstration services that are CMS approved. Most often these services are targeted to specific populations.

### Services Mandated by Federal Government

- \*\*Child Health Services Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
- \*\*Family Planning
- \*\*Federally Qualified Health Centers (FQHC)
- \*\*Home Health
- \*\*Hospital, Inpatient and Outpatient
- \*\*Laboratory and X-Ray
- Medical and Surgical Services of a Dentist
- Certified Nurse Midwife
- \*\*Nurse Practitioner (Family and Pediatric)
- \*\*Nursing Facility Services (Age 21 or Older)
- \*\*Physician
- \*\*Rural Health Clinics (RHC)
- \*\*Transportation to and from medical providers is also a federal requirement when the transportation is medically necessary.

\*\*This program has an associated factsheet in the appendices of this booklet.

### Additional Services Provided for Individuals Under Age 21 Eligible for EPSDT

- Audiological Services
- \*\*Child Health Management Services (CHMS)
- \*\*Dental Services
- \*\*Developmental Day Treatment Clinic Services (DDTCS) (Preschool and Age 18 or Older)
- Developmental Rehabilitation Services (Under Age 3)
- \*\*Inpatient Psychiatric Services
- \*\*Licensed Mental Health Practitioner Services
- \*\*Nursing Facility Services
- \*\*Occupational, Physical, Speech Therapy Services
- \*\*Private Duty Nursing Services for Ventilator-Dependent and for High-Tech Non-Ventilator Dependent Persons
- \*\*Prosthetic Devices
- Rehabilitative Services for Persons with Physical Disabilities (RSPD)
- Rehabilitative Services for Youth and Children (RSYC)
- Respiratory Care Services
- School-Based Mental Health Services
- Targeted Case Management for Beneficiaries of Children's Services
- Targeted Case Management for Beneficiaries of Children's Services who are SSI Beneficiaries or TEFRA Waiver Beneficiaries (Under Age 16)
- Targeted Case Management for Beneficiaries in the Division of Children and Family Services
- Targeted Case Management for Beneficiaries in the Division of Youth Services
- Targeted Case Management for Beneficiaries Age 21 and Under with a Developmental Disability
- Targeted Case Management Services for Other Beneficiaries

\*\*This program has an associated factsheet in the appendices of this booklet.

## Arkansas Medicaid Optional Services

- \*\*Ambulatory Surgical Center Services
- \*\*Certified Registered Nurse Anesthetist (CRNA)
- \*\*Chiropractic Services
- \*\*Dental Services (Age 21 and Over)
- \*\*Developmental Day Treatment Clinic Services (DDTCS) (Preschool and Age 18 or Older)
- Domiciliary Care Services
- \*\*Durable Medical Equipment
- End-Stage Renal Disease (ESRD) Facility Services
- \*\*Hospice Services
- \*\*Hyperalimentation Services
- \*\*IndependentChoices
- Intermediate Care Facility Services for Mentally Retarded
- Medical Supplies
- Medicare/Medicaid Crossovers
- Orthotic Appliances
- PACE (Program of All-Inclusive Care for the Elderly)
- \*\*Personal Care Services
- Podiatrist Services
- Portable X-Ray Services
- \*\*Prescription Drugs
- \*\*Private Duty Nursing Services for Ventilator-Dependent
- \*\*Prosthetic Devices
- Radiation Therapy Center
- Rehabilitative Hospital Services
- \*\*Rehabilitative Services for Persons with Mental Illness (RSPMI)
- Targeted Case Management for Pregnant Women
- Targeted Case Management Services for Beneficiaries (Age 60 and Older)
- Targeted Case Management for Beneficiaries Age 22 and Over with a Developmental Disability
- \*\*Ventilator Equipment
- \*\*Visual Care Services

\*\*This program has an associated factsheet in the appendices of this booklet.

## Approved Medicaid Waivers

- \*\*Alternatives for Adults with Physical Disabilities (AAPD) Waiver
- Arkansas Health Net
- \*\*ARKids First-B Waiver
- \*\*DDS Alternative Community Services (ACS) Waiver
- \*\*ElderChoices Waiver
- Living Choices Assisted Living Waiver
- \*\*Non-Emergency Transportation (NET)
- Tax Equity and Fiscal Responsibility Act (TEFRA)
- \*\*Women's Health (Family Planning)

\*\*This program has an associated factsheet in the appendices of this booklet.

### \*Major Benefit Limitations on Services for Adults (Age 21 and Older)

There are additional established benefit limits for other services. The following includes benefit limits for certain programs.

- Twelve visits to hospital outpatient departments allowed per state fiscal year.
- A total of twelve office visits allowed per state fiscal year for any combination of the following: certified nurse midwife, nurse practitioner, physician, medical services provided by a dentist, medical services furnished by an optometrist and rural health clinics.
- One basic family planning visit and three (3) periodic family planning visits per state fiscal year. Family planning visits are not counted toward other service limitations.
- Lab and x-ray services limited to total benefit payment of \$500 per state fiscal year, except for EPSDT beneficiaries.
- Three pharmaceutical prescriptions, including refills, allowed per month (family planning and smoking cessation prescriptions are not counted against benefit limit; unlimited prescriptions for nursing facility beneficiaries and EPSDT beneficiaries under age 21). Extensions will be considered up to a maximum of six (6) prescriptions per month for beneficiaries at risk of institutionalization.
- Inpatient hospital days limited to 24 per state fiscal year, except for EPSDT beneficiaries and certain organ transplant patients.
- Co-insurance: Some beneficiaries must pay 10% of first Medicaid covered day of hospital stay.
- Beneficiaries in the Working Disabled Aid Category must pay 25% of the charges for the first Medicaid covered day of inpatient hospital services and must also pay co-insurance for some additional services.
- Some beneficiaries must pay \$.50 - \$3 of every prescription, and \$2 on the dispensing fee for prescription services for eyeglasses. Beneficiaries in the Working Disabled aid category must pay a higher co-payment for these services and also must pay co-payments for some additional services.

### Additional Information for Children's Services

- Some parents/guardians of children are responsible for coinsurance, co-payments, or premiums.
- Co-insurance: ARKids B beneficiaries must pay 20% of the charges for the first Medicaid covered day of inpatient hospital services and must also pay co-insurance for some outpatient services.
- Co-Pay: ARKids B beneficiaries must pay a higher co-payment for inpatient services and also must pay co-payments for some outpatient services.
- Premiums: Based on family income certain TEFRA beneficiaries must pay a premium.

\* *Exceptions to benefit limits are based on medical necessity.*



## State Fiscal Year 2009 in Review

Growth in the Arkansas Medicaid program, both in terms of expenditures and number of beneficiaries served, continues to outpace growth in staffing. We are able to accomplish these results through better program management, increased use of technology, and continued process improvements.

Arkansas Medicaid management and staff are committed to ensuring that all Medicaid-eligible Arkansans have access to the best medical services possible. We work with providers and their professional organizations across the state to increase the use of technology in the delivery and administration of services, to identify and support use of the best evidence-based practices, and to ensure access to those services in all areas of the state. We are proud of the accomplishments made in the 2009 Medicaid program and look forward to an even better 2010!



### Medicaid Operations

In State Fiscal Year (SFY) 2009, Medicaid's fiscal agent, Hewlett Packard (HP), processed more than 35 million claims for more than 12,000 providers on behalf of more than 750,000 Arkansans. They responded to more than 164,000 voice calls, 235,000 automated calls, nearly 22,000 written inquiries, and conducted over 1,200 provider visits and 18 workshops around the state.

Medicaid processes 99% of claims within 30 days with the average claim being processed in under 2.5 days. That means on average providers are receiving their payments within a week of their claim submissions.

Medicaid is a critical component of health care financing for children and pregnant women. Through ARKids First and other programs, Medicaid insures approximately 400,000 children. In SFY 2009, Medicaid paid for approximately 63% of all births in Arkansas.

### Adult Dental Services

In August 2009, Arkansas Medicaid became a leader in promoting oral health for adults by providing limited coverage for beneficiaries ages 21 and over. The Arkansas program surpasses most Medicaid adult dental programs by offering preventative services such as cleanings and fluoride, in addition to restorative and emergency services. To date, the program has served approximately 15,000 adults in need of dental services.

### e-Prescribing

Arkansas Medicaid implemented e-Prescribing in December 2008. e-Prescribing provides bi-directional electronic delivery of prescriptions between physicians and pharmacies of the recipient's choice. e-Prescribing also provides physicians with access to critical information so they can make safer and better informed decisions.

As part of the implementation, Medicaid actively encouraged providers to implement e-Prescribing by providing training and on-site assessments. In December 2008, there were only 345 prescribers actively routing electronic prescriptions to pharmacies. Today, there are almost 1,000 prescribers e-Prescribing with a pharmacy participation rate of 72%. This has translated into the number of e-Prescription transactions in Arkansas growing from 347,000 in 2008 to nearly 1.6 million in 2009. That's over a 450% increase.

### Contract Monitoring Unit

The Contract Monitoring Unit is a new work unit that monitors DMS contracts for quality and compliance. In the seven months the unit has been operational, it has developed an auditing process that is applied in a fair and consistent manner. The section has audited seven contracts, written and reviewed several RFPs, and worked with contractors to resolve issues relating to invoices and client safety.

### Office of Long Term Care

The Office of Long Term Care developed the infrastructure for Green House® facilities, a non-traditional design for long term living utilizing universal workers and the Eden Alternative philosophy. Green House® facilities are designed, built and operated in a residential model with no more than twelve residents living in each home. Arkansas' position is unique in the nation in that its implementation is designed to encourage Green House® facilities to accept Medicaid residents. In the first year of the pilot program, there was one Green House® facility licensed and operating in Arkansas, with two more facilities becoming operational within this calendar year. The project required the cooperation of CMS and the endorsement and assistance of the Governor and the General Assembly.



### PACE (Program for All-inclusive Care for the Elderly)

PACE is a new Medicaid program and one of the first rural programs approved by CMS with 33 participants currently being served in the Northeast region of the State.

### Program Budgeting and Analysis Unit

The Program Budgeting and Analysis Unit was developed this year to assist in analyzing waiver budget information to ensure waivers are budget neutral, and that any requested rate increase is necessary, fair and affordable. This unit also analyzes overall DMS expenditures to identify trends and assist in management decision making.

### System of Care Initiatives

The DMS Behavioral Health Unit has been instrumental in generating several positive changes related to the Arkansas System of Care initiative which was mandated by Act 2209 of the 85th General Assembly, 2005. The primary purpose of the Arkansas System of Care is to address challenges affecting each child's emotional well-being, improve appropriate child development and increase each child's chance to arrive at adulthood as a productive, functioning member of society. This unit led the successful implementation of Rehabilitative Services for Persons with Mental Illness (RSPMI) policy revisions to define services and their delivery on a more individualized basis. It is assisting with the launch and implementation of an outcomes measurement and tracking system for children and adolescents (Y-OQ®) to be mandated for use by all RSPMI providers by July 1, 2010.

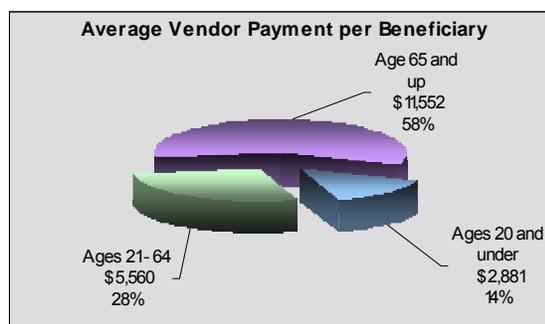
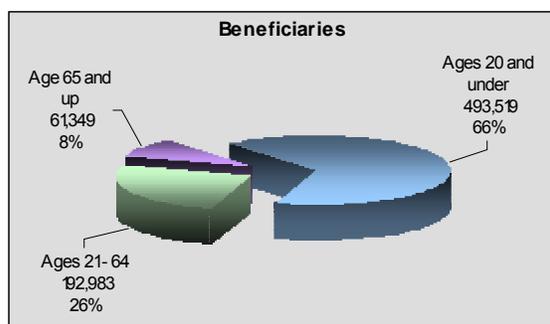
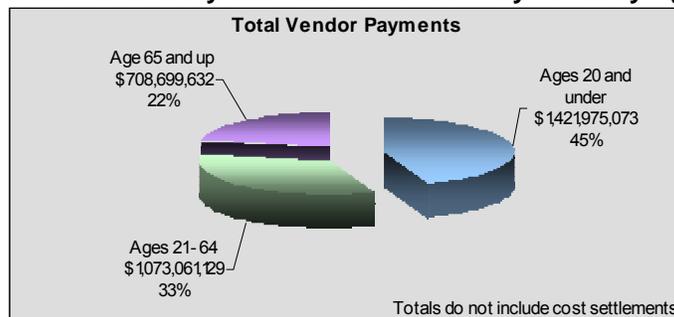
### Third Party Liability

Third Party Liability (TPL) collections and cost avoidance have doubled from 2007-2009 (\$28 mil. to \$56 mil.). To further enhance collections, TPL has contracted with HMS to implement electronic billing for the collection of post payment recoveries. Also, a supplemental insurance file tape was added to MMIS that will increase cost avoidance and limit Medicaid's liability. Finally, online access to insurance information was completed that will again allow cost avoidance and expedite the collection of post payment recoveries.

## State Fiscal Year 2009 Statistics

### Beneficiary Information

#### Unduplicated Beneficiary Counts and Vendor Payments by Age SFY 09



Sources: Category of Service Report, HCFA-2082

#### Percent of change in enrollees and beneficiaries from SFY08 to SFY09

	SFY08	SFY09	% Change from Last Year
Medicaid Enrollees	761,162	753,166	-1.1%
Medicaid Beneficiaries	744,269	747,851	0.05%

The numbers of enrollees and beneficiaries are different because not all who are enrolled actually receive Medicaid services.  
Source: HCFA-2082

The medical cost for 63% of all babies born to Arkansas residents during SFY09 was paid for by Medicaid.

Source: Arkansas Department of Human Services, Division of Medical Services

#### Percentage of Population Served by Medicaid

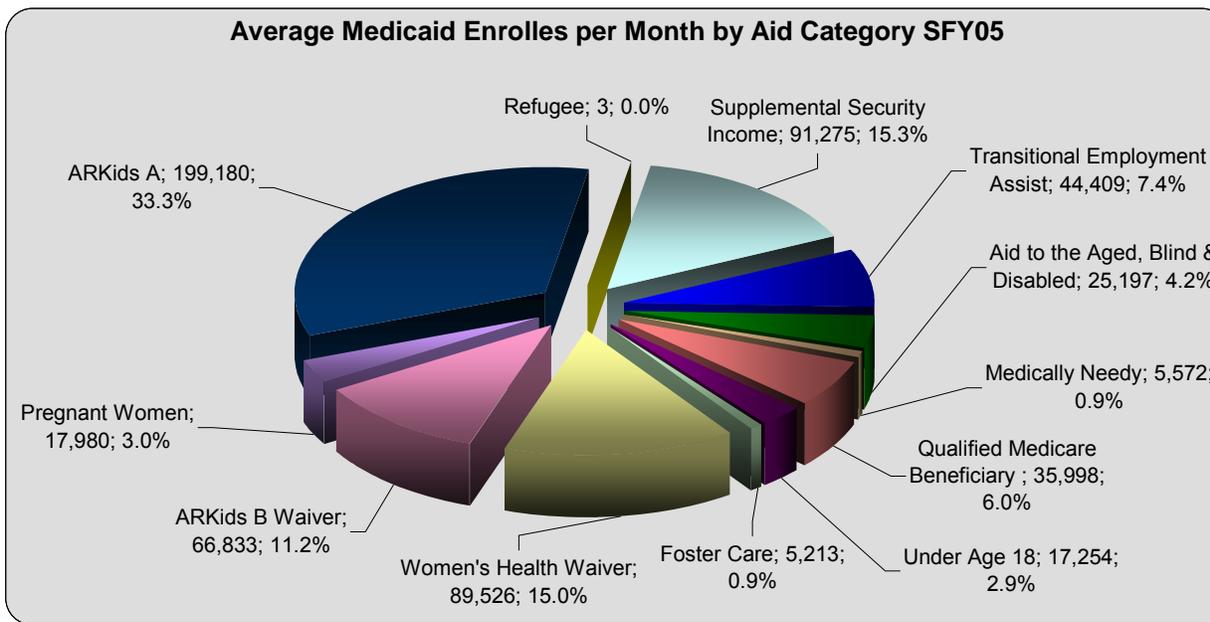
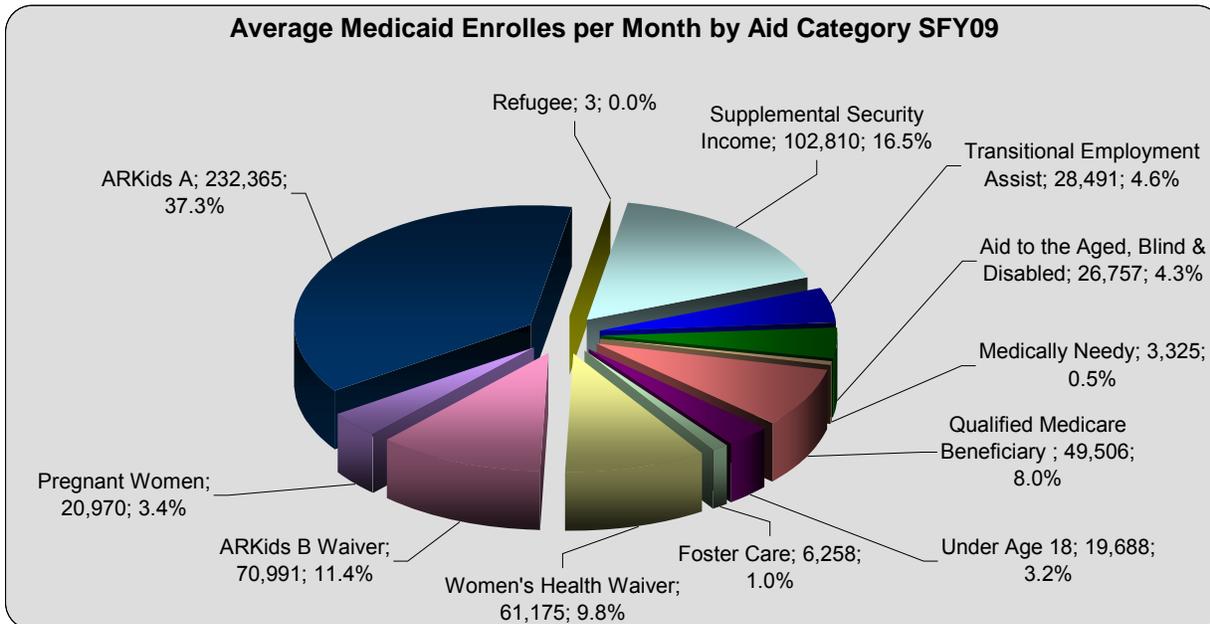
Arkansas Population		% of Population Served by Medicaid
All Ages	2,855,390	26%
Elderly (65 and older)	407,205	15%
Adults (20-64)	1,667,883	12%
Children (19 and under)	780,302	63%

Source: UALR Website

# Arkansas Medicaid Program Overview

## SFY 2009

### Medicaid Enrollees by Aid Category

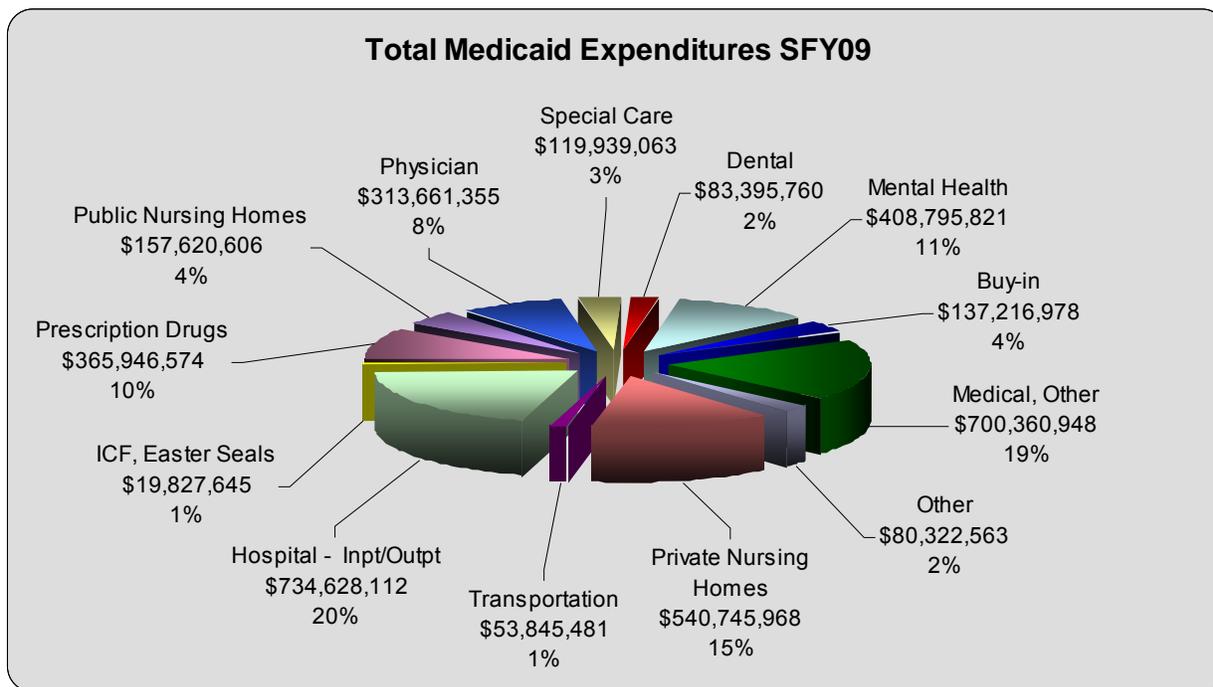


NOTE: Beneficiaries may have multiple aid categories and therefore, are counted in each of those categories.  
 Source: Division of County Operations, ACES IM 2414

# Arkansas Medicaid Program Overview

## SFY 2009

### 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 and crossover claims.
- Prescription Drugs includes regular prescription drugs, Family Planning drugs, Medicare Part D benefit payments, and contracts related to the Prescription Drug Program.

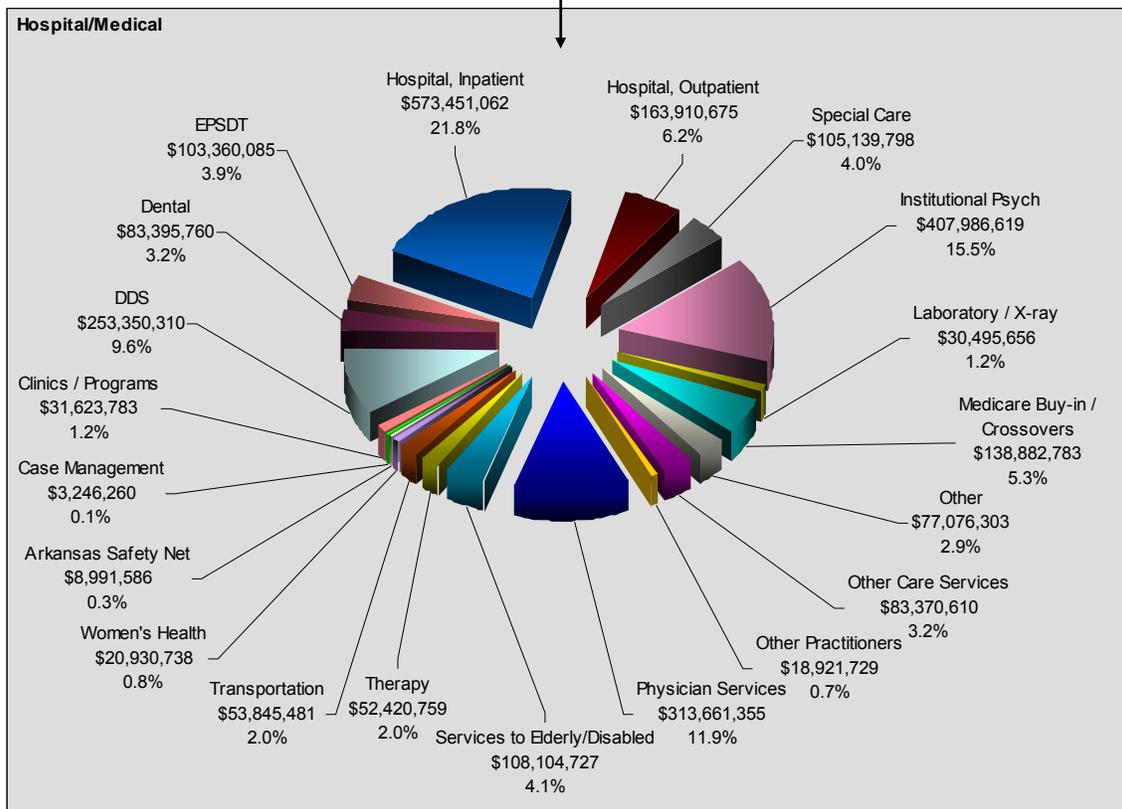
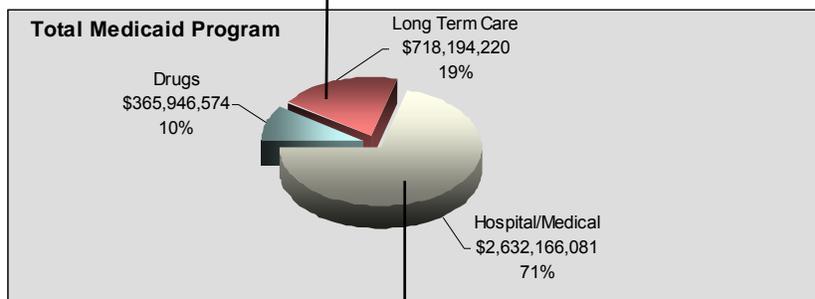
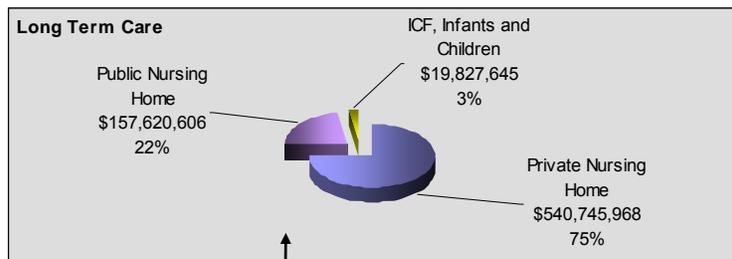
Source: Category of Service Report



# Arkansas Medicaid Program Overview

SFY 2009

## Arkansas Medicaid Program Benefit Expenditures SFY09



Source: Category of Service Report

# Arkansas Medicaid Program Overview

## SFY 2009

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

<i>Rebate Dollars Collected</i>	
Total SFY09	\$121,763,896.12
State portion	\$32,949,596.77
Federal portion	\$88,814,299.35

## Economic Impact of Arkansas Medicaid

<i>Program Costs</i>			
State Fiscal Year (SFY)	Total (in mill)	Unduplicated Beneficiaries	Average Cost
2002	\$2,293	582,379	\$3,937
2003	\$2,464	626,036	\$3,936
2004	\$2,711	663,920	\$4,083
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*	\$4,298	766,043	\$5,611

\*Note: Based on revised 2010 Budget as of 1/19/2010

<i>Arkansas Economics SFY09</i>		
		Medicaid Represents
State of Arkansas Budget	\$22.4 billion	18.5%
State General Revenue Funded Budget	\$4.4 billion	16.5%

## Arkansas Medicaid Providers

Medicaid has approximately 33,500 ENROLLED providers.

Approximately 12,500 (37.5%) are PARTICIPATING providers.

35,075,093 Claims were processed in SFY09 with an average processing time of 2.5 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, who submitted claims for those services.

(See Number of Providers by County in appendices.)

**Top 10 Provider Types Based on Number of Enrolled Providers**

1	Physicians
2	Alternatives for Adults with Physical Disabilities (APD) Waiver Attendant Care
3	Physicians Groups
4	Individual Occupational, Physical, and Speech Therapy Services Providers
5	Prosthetics/Durable Medical Equipment
6	Pharmacy
7	Hospital
8	Visual Care
9	Dental
10	Occupational, Physical, and Speech Therapy Services Groups

## Understanding DMS and Medicaid

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.

The Department of Human Services (DHS) is the single state agency authorized and responsible for regulating and administering the program. DHS administers the Medicaid Program through the Division of Medical Services (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.

- Long Term Care

Each year, more than 23,000 Arkansans who have chronic, long-term medical needs require services in long-term care facilities. These individuals live in the approximately 227 nursing facilities and 41 intermediate care facilities for the mentally retarded 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 enforcing state and federal standards are primary goals of Arkansas Medicaid's Office of Long Term Care (OLTC). Using qualified health care professionals, OLTC inspects all facilities to ensure residents receive the care they need in a clean, safe environment and 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.

(See the DMS Organizational Chart in the appendices.)

### DMS Behavioral Health Unit

The newly formed Behavioral Health Unit is responsible for monitoring the Medicaid approved behavioral health programs. This unit will research and recommend revisions to policy, establish and maintain a scorecard method of rating the quality of provider services, and negotiate, coordinate and monitor the activities of Behavioral Health utilization and peer review contracts. Other responsibilities include leading efforts to establish more accountability for outcomes related to the provision of behavioral health services and collaborating with other DHS divisions to establish goals and objectives for building Children's System of Care and an Adult Recovery Model for mental health care. This unit will participate in ongoing collaboration with other DHS divisions such as Division of Behavioral Health Services (DBHS) to effect further change to the children's system of care and an Adult Recovery Model to reorganize the Behavioral System of Care into a viable, efficient, and quality system.

### Financial Activities

The Financial Activities Unit of 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. Finally, the Financial Activities Unit is responsible for Human Resource functions in DMS.

### Medical Assistance Unit

The Medical Assistance Section contracts with Hewlett Packard (HP) to enroll providers in Medicaid and the ARKids First Program. At the end of the State Fiscal Year 2009 (SFY 2009), there were more than 27,978 enrolled providers in the above programs. More than 9,166 of these providers were physicians and physician groups. The Medical Assistance Unit also responds to the concerns and questions of providers and beneficiaries of Medicaid and ARKids services. In SFY 2009, the Medical Assistance Unit managed 76,266 telephone inquiries including those related to the Early Periodic Screening, Diagnosis and Treatment (EPSDT) and Dental programs. The ARKids First Program for Arkansas children has become a model for similar programs in other states. Other areas administered by the Medical Assistance Section are the Dental, Visual, Non-Emergency Transportation (NET), ARKids B, Medicaid Managed Care Services, ConnectCare and the Primary Care Case Management programs.

	SFY 2009	SFY 2008	SFY 2007
<b>Telephone Inquiries</b>	76,266	73,608	71,462
<b>Written Correspondence</b>	663	1,056	1,989
<b>Fair Hearings</b>	453	418	356

Source: DMS Statistical Report

### Medicaid Data Security Unit

This new Medicaid work unit was implemented in 2009 to provide additional enforcement and monitoring of the privacy and security of patient's information, and also for the implementation, training, and maintaining of a new document imaging system. The imaging software system will replace all paper files and be a step toward developing electronic health records. Also this year, this unit developed a new process for monitoring and managing access to and the security of MMIS data warehouse information. A Data Security Committee evaluates requests for Medicaid data for research projects and publishes requests to ensure HIPAA compliance.

### Office of Long Term Care

Most people think of nursing facilities when they think of the Office of Long Term Care (OLTC). The OLTC professional surveyors conduct annual Medicare and Medicaid and State Licensure surveys of Arkansas' 227 Nursing Facilities and in the state's forty-one (41) Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) including six (6) Human Development Centers. Annual surveys are also conducted in thirty-eight (38) Adult Day Care and Adult Day Health Care facilities and one (1) Post Acute Head Injury Facility throughout the state. Semi-annual surveys are conducted in the seventy-nine (79)

## Arkansas Medicaid Program Overview

SFY 2009

Residential Care Facilities, fifty-two (52) Assisted Living Facilities and five (5) Alzheimer's Special Care Units. In addition, annual Civil Rights surveys were conducted in 113 hospitals, as well as 140 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 help ensure that facilities provide the highest level of care possible to long term care residents. OLTC staff provided approximately 256 hours of continuing education through eighty-seven (87) workshops/seminars to over 2,500 staff members in the nursing home and assisted living industry during SFY 09. In addition, there were 418 agendas submitted from outside sources for review to determine 1,886 contact hours for nursing home administrators.

The Nursing Home Administrator Licensure Unit processed renewals for 679 licensed administrators, processed eighty-two (82) license applications, and issued seventy (70) new licenses and temporary licenses. In addition, OLTC administered the state nursing home administrator examination to eighty-two (82) individuals.

The Criminal Record Check Program applies to all categories of licensed long-term care facilities consisting of over 450 affected facilities. During SFY 09, there were 36,753 "state" record checks processed through OLTC with 752 disqualifications (2.1%) and 17,489 "federal" record checks processed with 168 disqualifications (1.1%).

At the end of SFY 09, the Registry for Certified Nursing Assistants (CNAs) contained 27,097 "active" and 57,657 "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.

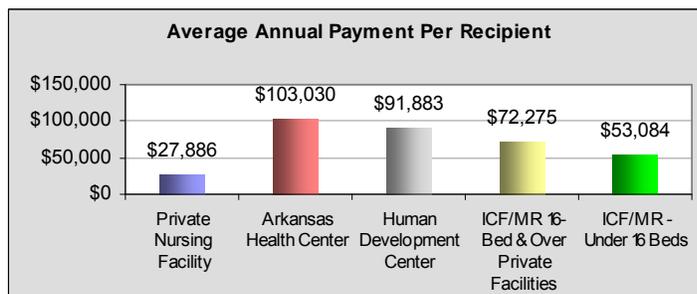
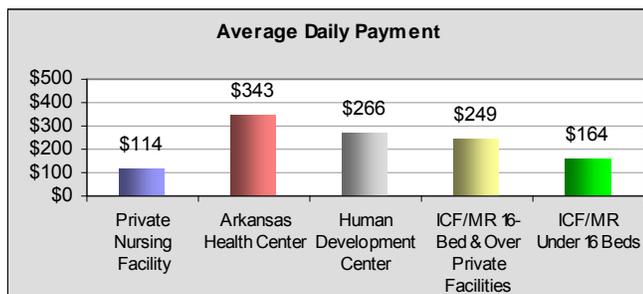
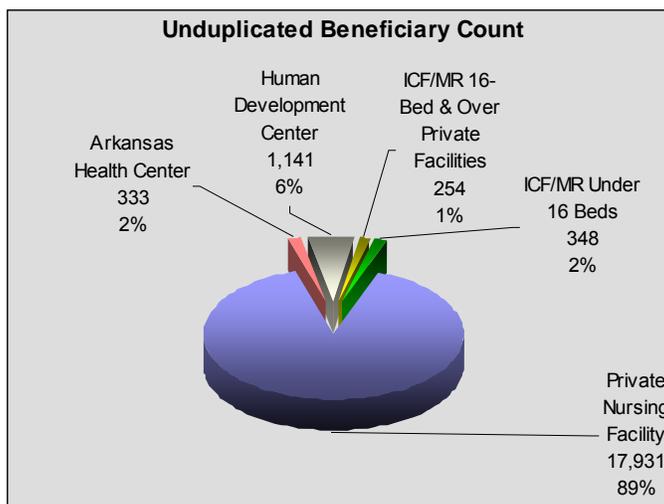
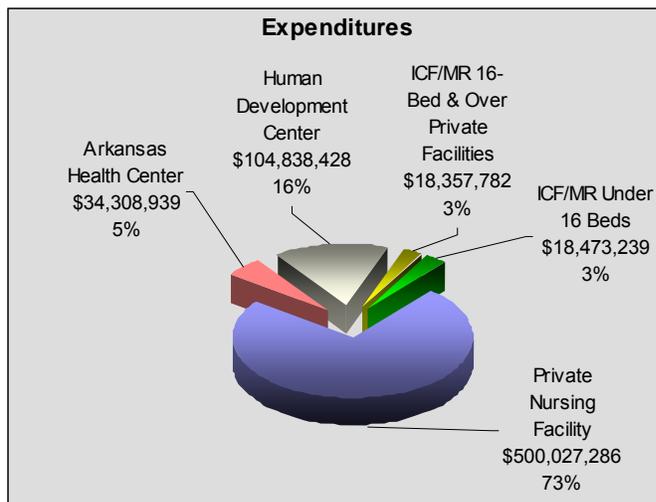
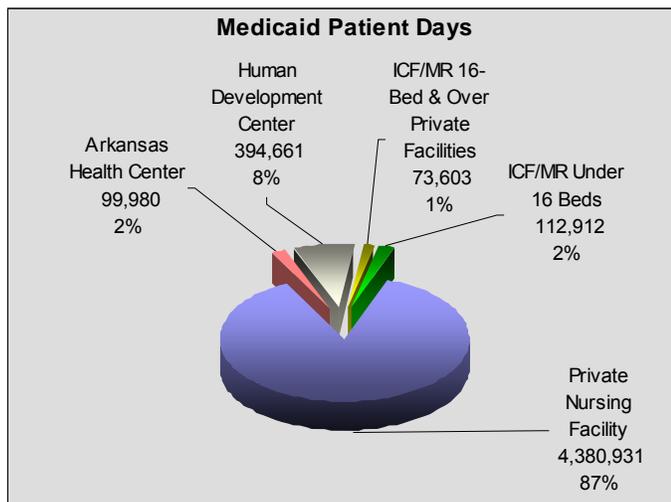
The Medical Need Determination Unit processed approximately 1,234 Medicaid nursing facility applications per month while maintaining approximately 12,162 active cases which includes processing 10,821 assessments, processing over 1,680 changes of condition requests, 537 transfers, and 1,766 utilization review requests during the year. Also processed were 3,248 applications/reviews for ICFs/MR. In addition, over 13,000 applications/reviews/waivers for other medical programs within DHS were made during SFY 09.

The OLTC Complaint Unit staffs a registered nurse and a licensed social worker who record the initial intake of complaints against long-term care facilities. Many times they are able to resolve the issues with immediate satisfaction to the parties involved. When that is not possible, the OLTC performs an on-site complaint investigation. The OLTC received 980 nursing home complaints during SFY 09 regarding the care or conditions in long term care facilities.



# Arkansas Medicaid Program Overview

## SFY 2009



Source: DHS Statistical Report:

## Prescription Drug Program

The Prescription Drug Program, which is an optional Medicaid benefit, was implemented in Arkansas in 1973. Under this program, eligible recipients may obtain prescription medication through any of the **862** enrolled pharmacies in the state. During SFY **2009**, a total of **427,079** Medicaid recipients used their prescription drug benefits. A total of **4.7** million prescriptions were reimbursed by Arkansas Medicaid for a cost of **\$326.3** million dollars; thus making the average cost per prescription approximately **\$69.43**. The average cost for a brand name prescription was **\$186** dollars; although they represented **28%** of the claims, brand name prescriptions accounted for **74%** of our expenditures. The average cost for a generic prescription was **\$26** dollars, representing **72%** of our claims and accounting for **26%** of our expenditures.

The Prescription Drug Program restricts each recipient to a maximum of three prescriptions per month, with the capability of getting up to six prescriptions by prior authorization, except for recipients under 21 and certified Long-Term Care recipients who receive unlimited prescriptions per month. Persons eligible under the Assisted Living Waiver are allowed up to nine 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 rather than through Arkansas Medicaid. Arkansas Medicaid is required to pay Centers for Medicare & Medicaid Services (CMS) the State Contribution for Prescription Drug Benefit, sometimes referred to as the Medicare Part D Clawback. This payment for SFY 2009 was \$37,295,586.

Medicaid reimbursement for prescription drugs is based on cost plus a dispensing fee. Drug costs are established and based upon a pharmacy's estimated acquisition cost (EAC), the federally established generic upper limit (GUL) or state established upper limit (SUL). 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.

## Program Development and Quality Assurance

Formerly two separate units, the Program Planning and Development (PPD) Section and the Waiver Quality Assurance units have been combined. The new Program Development and Quality Assurance (PD/QA) Unit will develop and maintain the Medicaid State Plan and the State's Child Health Insurance Program Plan, lead the development and research of new programs, oversee contractor technical writing of provider policy manuals for each one of the different Medicaid programs, coordinate the approval process through both State and Federal requirements, and coordinate efforts in finalizing covered program services, benefit extension procedures and claims processing. The PD/QA Unit also leads development of new waiver and demonstration programs and demonstration programs and the resulting provider manuals. Because DMS has administrative and financial authority for all Medicaid waivers and demonstrations, PD/QA is responsible for monitoring operation of all Medicaid waivers and demonstration programs operated by other Divisions. PD/QA assures compliance with CMS requirements for operating waivers and demonstrations and monitors for key quality requirements.

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 to operating agencies regarding waiver and demonstration 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.

### Program Integrity

In 2009, Program Integrity (PI) audited 159 providers and identified \$4.8 million in questioned cost and \$29 million in cost avoidance; reviewed 411 questionable enrollment applications, of which 49 were denied; and 45 providers were terminated. The PI unit was instrumental, along with CMS, in establishing the Medicaid Integrity Institute. The goal of the institute is to certify state staff thus increasing the federal match rate for salaries and expenses for certified staff from 50% to 85%. Three Arkansas PI staff received coder certification this year, which is only available to state employees. Arkansas was the first state selected in its region and among the first group of states selected to participate in the new CMS Medi-Medi program which allows a state to look at both Medicaid and Medicare information. Our early selection was based on our active involvement with CMS and state PI groups. The purpose is to conduct joint audits focusing on hospice, durable medical equipment and pharmacy providers.

### Third Party Liability

Medicaid is the payer of last resort. As the payer of last resort, federal and state law requires Medicaid agencies to pursue third party resources to reduce Medicaid payments. As a condition of eligibility, Medicaid beneficiaries are required to assign their right to recovery from third parties to the Arkansas Medicaid Program. Medical providers are also required to file claims with potentially liable third parties prior to billing Medicaid for services provided to beneficiaries.

One aspect of Medicaid cost containment is the Third Party Liability Unit of Administrative Support. This unit pursues third party resources (other than Medicaid) responsible for payment of Medicaid beneficiaries' health care. These sources include health and liability insurance, lawsuit settlements, and absent parents.

	<b>SFY 09</b>
Other Collections (Health & Casualty Insurance)	\$27,513,582.26
Cost Avoidance (Health Insurance)	\$28,196,777.06
<b>Total Savings</b>	<b>\$55,710,359.32</b>

Source: DMS Statistical Report

### Program Budgeting and Analysis

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

In addition to waiver budgeting, Program Budgeting and Analysis analyzes other Medicaid programs in order to determine whether or not a particular program is operating within budget and/or whether 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 Medicaid Fiscal Agent and provides reimbursement technical assistance for the following Medicaid providers:

- Institutional – The Institutional Section is responsible for processing all necessary cost settlements, upper payment limit (UPL) payments, quality incentive payments and Disproportionate Share (DSH) payment for these providers.
- Hospital, Residential Treatment Unit (RTU), Rural Health Clinic (RHC), Federally Qualified Health Center (FQHC), Residential Treatment Center (RTC), Other. The Institutional Section is also responsible for processing all necessary cost settlements for these providers.

# Arkansas Medicaid Program Overview

## SFY 2009

- Non-Institutional – Physician, Dental, Durable Medical Equipment, ARKids, Nurse Practitioner, Nurse Midwife, CHMS, DDTCS, Other. The Non-Institutional Section is also responsible for the maintenance of reimbursement rates and assigning all billing codes for both institutional and non institutional per diems, services, supplies, equipment purchases and equipment rental.
- Long Term Care – This Section reviews annual and semi-annual cost reports submitted by Nursing Facility and Intermediate Care Facilities for the Mentally Retarded (ICFs/MR). The cost reports are reviewed for compliance with applicable state and federal requirements and regulations, including both desk reviews and on-site reviews. The Long Term Care Section maintains a database of the cost report information, which is used to evaluate cost and develop reimbursement methodologies and rates. The Long Term Care Section is also responsible for processing all necessary cost settlements for these providers.

### Systems and Support

Systems & Support administers the fiscal agent contract that operates the Medicaid Management Information System (MMIS), which processes all Medicaid claims.

Systems & Support performs the following:

- Develops all Request for Proposals (RFPs) and Advance Planning Documents (APDs) related to the MMIS.
- Develops the contract for the fiscal agent to operate the MMIS and monitors the contractor's performance.
- Maintains system documentation from the contractor.
- Develops, tracks, and documents customer service requests for modifications to the MMIS.
- Approves production system modifications to MMIS.
- Performs quality assurance reviews on all edits and audits affecting claims processed by the MMIS.
- Develops and produces reports from the Medicaid data warehouse.
- Manages and monitors access to the Medicaid data warehouse.
- Monitors the use and security of Arkansas Medicaid data used or accessed by DHS business associates and other outside entities.
- Researches IT security issues, and coordinates IT security compliance and related issues with the DHS HIPPA Security Officer, HP Privacy Officer, and the DHS Office of Systems and Technology.
- Manages DMS SharePoint sites and Portals.

### Utilization Review

The Utilization Review (UR) Section of the Arkansas Medicaid Program provides professional medical utilization reviews for a wide variety of services in a timely, accurate, efficient and cost effective manner. Medicaid UR participates in the development of clinically based standard-of-care coverage determinations and serves as a resource to Arkansas Medicaid providers. UR has a responsibility for assuring quality medical care to Arkansas Medicaid beneficiaries through detection and reporting of quality-of-care concerns to appropriate bodies in addition to protecting the integrity of state and federal funds supporting the Medicaid Program.

Utilization Review provides professional reviews for:

- Pre and Post-Payment reviews of medical services.
- Prior authorization for Private Duty Nursing, Hearing Aids and Hearing aid repair, Extension of benefits for Home Health and Personal Care for beneficiaries over the age of 21. Performs

## Arkansas Medicaid Program Overview

SFY 2009

medical necessity reviews for extension of benefit of incontinence products and medical supplies for eligible beneficiaries.

- Contractors performing prior authorizations and extension of benefits for the following programs: In-patient Psychiatric Services, In-patient and Out-patient Hospitalization, Emergency room utilization, Personal care for beneficiaries under the age of 21, Child Health Management Services, Therapy, RSPMI, Transplants, Durable medical equipment and Hyperalimentation services.
- Out-of-state transportation for beneficiaries for medically necessary services/treatment not available in-state.



## Appendices

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- Medicaid Enrollees by County SFY 2009
- ARKids First-B Enrollees by County SFY 2009
- Map - Expenditures by County SFY 2009
- Medicaid Expenditures by County SFY 2009
- ARKids First-B Expenditures by County SFY 2009
- Map – Provider Waiver Expenditures and Waiver Beneficiary Count by County
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- Map - Number of Providers by County SFY 2009
- Enrolled and Billing Providers by County

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- ARKids First-B
- AAPD Waiver
- Ambulance Services
- Ambulatory Surgical Centers (ASC)
- Chiropractic Services
- Child Health Management Services (CHMS)
- Certified Registered Nurse Anesthetist (CRNA)
- DDS Alternative Community Services (ACS) Waiver
- Developmental Day Treatment Clinic Services (DDTCS)
- Dental Services
- ElderChoices
- (EPSDT)
- Family Planning Services/Women's Health Waiver
- Federally Qualified Health Centers (FQHC)
- Hemodialysis
- Home Health Services
- Hospice Services
- Hospitals
- Hyperalimentation
- IndependentChoices
- Laboratory and X-Ray
- LMHP
- Long Term Care
- Maternity Services
- Medicare Buy-In
- Mental Health
- Non-Emergency Transportation
- Personal Care
- Physician Services
- Prescription Drugs
- Private Duty Nursing
- Prosthetics Services/DMS
- Registered Nurse Practitioner
- Rural Health Clinics (RHC)
- Targeted Case Management
- Therapy Services
- Ventilator Equipment
- Vision Services

Division of Medical Services Contacts

## Glossary

### **AAA**

Area Agency on Aging

### **ACES**

Arkansas Client Eligibility System

### **ACS**

Alternative Community Services

### **Adjudicate**

To determine whether a claim is to be paid or denied

### **ADL**

Activities of Daily Living

### **AEVCS**

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

### **AFDC**

Aid to Families with Dependent Children

### **AFMC**

Arkansas Foundation for Medical Care.

### **AHA**

Arkansas Hospital Association

### **AHQA**

American Healthcare Quality Association

### **AMA**

American Medical Association.

### **ANSI**

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

### **ANSWER**

Arkansas' Networked System for Welfare Eligibility and Reporting

### **AVR**

Automatic Voice Response

### **BCCDT**

Breast and Cervical Cancer Diagnosis and Treatment

### **BO**

Business Objects

### **CHIP**

Children's Health Insurance Program

### **CHMS**

Child Health Management Services

### **CMHC**

Community Mental Health Center

### **CMS**

Centers for Medicare and Medicaid Services

### **COB**

Coordination Of Benefit

### **COBA**

Coordination of Benefits Agreement

### **COTS**

Commercial off-the-shelf software

### **DAAS**

Division of Aging and Adult Services

### **DBHS**

Division of Behavioral Health Services

### **DBS**

Division of Blind Services

### **DCFS**

Division of Children and Family Services

### **DCO**

Division of County Operations

### **DDE**

Direct Data Entry

### **DDI**

Design, Development, and Implementation

### **DDS**

Division of Developmental Disabilities Services

### **DHS**

Department of Human Services

### **DIS**

Department of Information Systems

### **DME**

Durable Medical Equipment

### **DMHS**

Division of Mental Health Services

### **DMS**

Division of Medical Services (Medicaid)

### **DSS**

Decision Support System/Data Warehouse

### **DUR**

Drug Utilization Review

### **DYS**

Department of Youth Services

### **EBT**

Electronic Benefit Transfer

### **EFT**

Electronic Funds Transfer

### **EHR**

Electronic Health Records

### **EIN**

Employer's Identification Number

### **EOB**

Explanation Of Benefits

### **EOMB**

Explanation Of Medical Benefits

### **EPSDT**

Early and Periodic Screening, Diagnosis and Treatment

### **ERA**

Electronic Remittance Advice

### **EVS**

Electronic Verification System

### **FFP**

Federal Funding Participation

### **FFS**

Fee For Service

<b><i>FMAP</i></b>	Federal Medical Assistance Payment	<b><i>NPI</i></b>	National Provider Identifier
<b><i>F-MAP</i></b>	Federal Medical Assistance Percentage	<b><i>PA</i></b>	Prior Authorization
<b><i>HCBS</i></b>	Home Community Based Services	<b><i>PACE</i></b>	Program for All-Inclusive Care for the Elderly
<b><i>HCFA</i></b>	Health Care Financing Administration (former name for Centers for Medicare & Medicaid Services)	<b><i>PAM</i></b>	Prior Authorization Management
<b><i>HCQIP</i></b>	Health Care Quality Improvement Program	<b><i>PBM</i></b>	Pharmacy Benefit Manager
<b><i>HHS</i></b>	The federal Department of Health and Human Services	<b><i>PCCM</i></b>	Primary Care Case Management
<b><i>HIE</i></b>	Health Information Exchange	<b><i>PCP</i></b>	Primary Care Provider
<b><i>HIPAA</i></b>	Health Insurance Portability and Accountability Act	<b><i>PDA</i></b>	Personal Digital Assistants
<b><i>ICF/MR</i></b>	Intermediate Care Facility/Mental Retardation	<b><i>PDF</i></b>	Portable Document Format
<b><i>INS</i></b>	Immigration and Naturalization Services	<b><i>PDL</i></b>	Preferred Drug List
<b><i>IRS</i></b>	Internal Revenue Service	<b><i>PDP</i></b>	Prescription Drug Plan
<b><i>IT</i></b>	Information Technology	<b><i>PHI</i></b>	Protected Health Information
<b><i>IVR</i></b>	Interactive Voice Response	<b><i>PHR</i></b>	Personal Health Record
<b><i>IV&amp;V</i></b>	Independent Validation and Verification	<b><i>PMPM</i></b>	Per-Member-Per-Month
<b><i>LTC</i></b>	Long Term Care	<b><i>POC</i></b>	Plan of care
<b><i>MCO</i></b>	Managed Care Organization	<b><i>POS</i></b>	Place of service
<b><i>MHA</i></b>	Mental Health Administration	<b><i>QA</i></b>	Quality Assurance
<b><i>MITA</i></b>	Medicaid Information Technology Architecture	<b><i>QDWI</i></b>	Qualified Disabled and Working Individuals
<b><i>MMA</i></b>	Medicare Modernization Act	<b><i>QI-1</i></b>	Qualifying Individuals-1 group
<b><i>MMCS</i></b>	Medicaid Managed Care Services	<b><i>QMB</i></b>	Qualified Medicaid Beneficiary
<b><i>MMIS</i></b>	Medicaid Management Information System	<b><i>RSPMI</i></b>	Rehabilitative Services for Persons with Mental Illness
<b><i>MPAP</i></b>	Medicare Eligible Pharmacy Assistance Program	<b><i>SCHIP</i></b>	State Children's Health Insurance Program
<b><i>MSIS</i></b>	Medicaid Statistical Management System	<b><i>SLMB</i></b>	Specified Low-income Medicare Beneficiary
<b><i>NCPDP</i></b>	National Council for Prescription Drug Programs	<b><i>SMB</i></b>	Specified Low Income Medicare Beneficiaries
<b><i>NDC</i></b>	National Drug Codes	<b><i>SOBRA</i></b>	Sixth Omnibus Budget Reconciliation Act
<b><i>NPDB</i></b>	National Provider Data Bank	<b><i>SSA</i></b>	Social Security Administration
		<b><i>SSI</i></b>	Supplemental Security Income

***SSN***

Social Security Number

***SUR***

Surveillance and Utilization Review

***TANF***

Temporary Assistance for Needy Families

***TB***

Tuberculosis

***TEFRA***

Tax Equity and Financial Responsibility Act

***TIN***

Tax Identification Number

***TPL***

Third Party Liability

***UR***

Utilization Review

***US***

United States

***USPS***

United States Postal Service

***VA***

Veterans Administration

***VPN***

Virtual Private Network

***WIC***

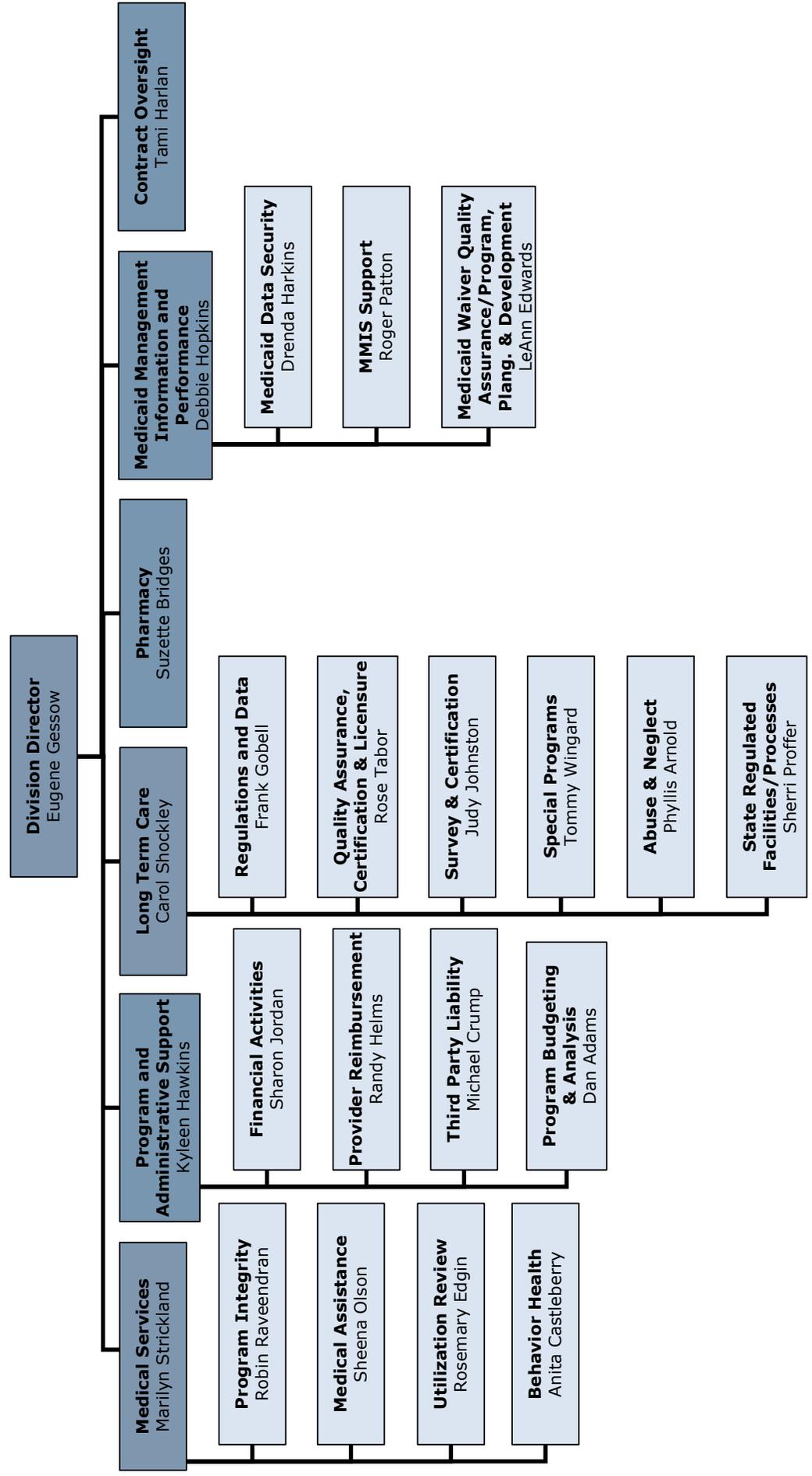
Women, Infant and Children program

***Y-OQ®***

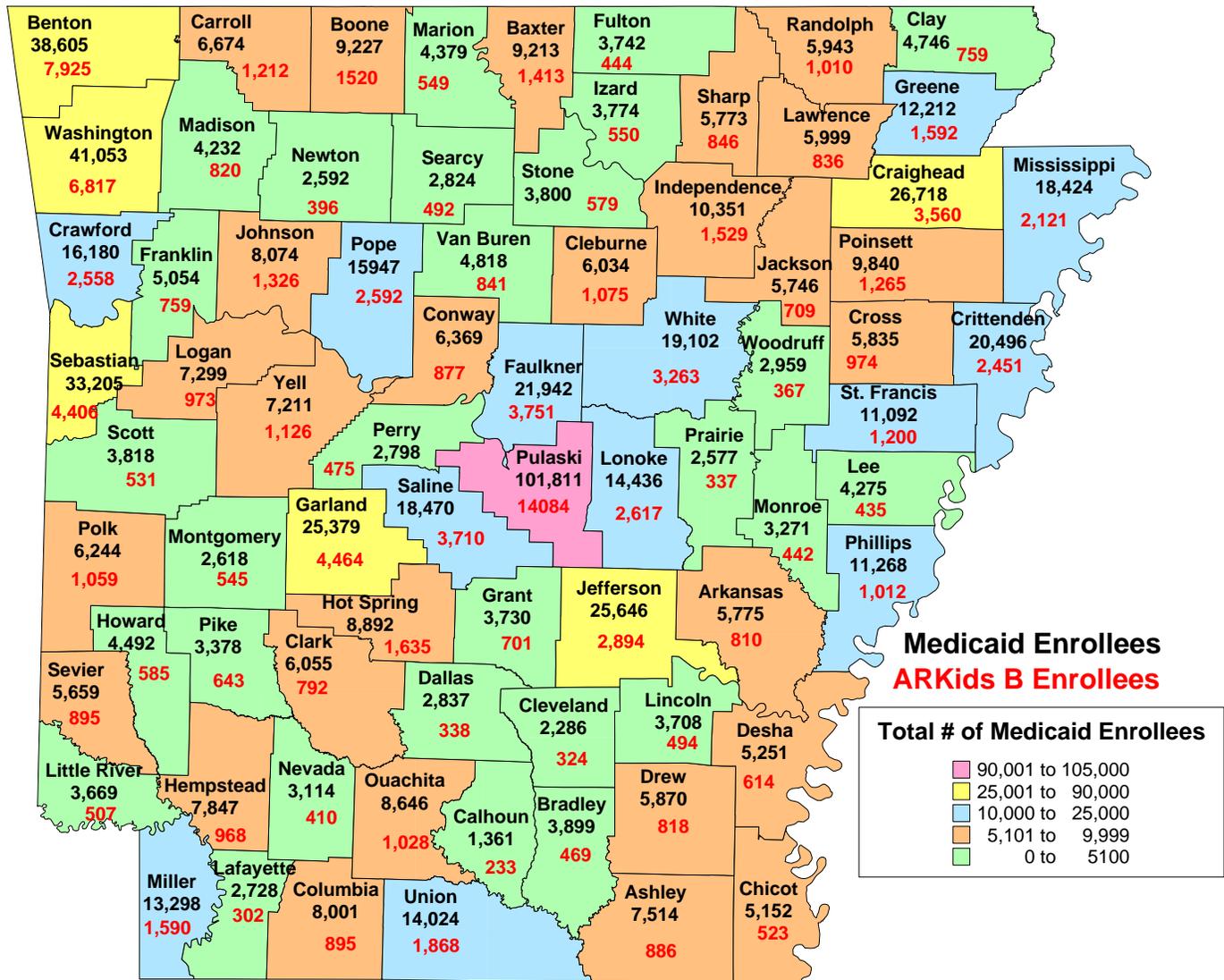
Youth Outcome Questionnaire™



# DHS — Division of Medical Services



## Enrollees by County SFY 2009



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

## Medicaid Enrollees by County SFY 2009

<i>Eligibility County Description</i>	<i>Enrollee Count</i>	<i>Eligibility County Description</i>	<i>Enrollee Count</i>	<i>Eligibility County Description</i>	<i>Enrollee Count</i>
01 - Arkansas	5,775	26 - Garland	25,379	51 - Newton	2,592
02 - Ashley	7,514	27 - Grant	3,730	52 - Ouachita	8,646
03 - Baxter	9,2130	28 - Greene	12,212	53 - Perry	2,798
04 - Benton	38,605	29 - Hempstead	7,847	54 - Phillips	11,268
05 - Boone	9,227	30 - Hot Spring	8,892	55 - Pike	3,378
06 - Bradley	3,899	31 - Howard	4,492	56 - Poinsett	9,840
07 - Calhoun	1,361	32 - Independence	10,351	57 - Polk	6,244
08 - Carroll	6,674	33 - Izard	3,774	58 - Pope	15,947
09 - Chicot	5,152	34 - Jackson	5,746	59 - Prairie	2,577
10 - Clark	6,055	35 - Jefferson	25,646	60 - Pulaski	101,811
11 - Clay	4,746	36 - Johnson	8,074	61 - Randolph	5,943
12 - Cleburne	6,034	37 - Lafayette	2,728	62 - Saline	18,470
13 - Cleveland	2,286	38 - Lawrence	5,999	63 - Scott	3,818
14 - Columbia	8,001	39 - Lee	4,275	64 - Searcy	2,824
15 - Conway	6,369	40 - Lincoln	3,708	65 - Sebastian	33,205
16 - Craighead	26,718	41 - Little River	3,669	66 - Sevier	5,659
17 - Crawford	16,180	42 - Logan	7,299	67 - Sharp	5,773
18 - Crittenden	20,496	43 - Lonoke	14,436	68 - St. Francis	11,092
19 - Cross	5,835	44 - Madison	4,232	69 - Stone	3,800
20 - Dallas	2,837	45 - Marion	4,379	70 - Union	14,024
21 - Desha	5,251	46 - Miller	13,298	71 - Van Buren	4,818
22 - Drew	5,870	47 - Mississippi	18,424	72 - Washington	41,053
23 - Faulkner	21,942	48 - Monroe	3,271	73 - White	19,102
24 - Franklin	5,054	49 - Montgomery	2,618	74 - Woodruff	2,959
25 - Fulton	3,742	50 - Nevada	3,114	75 - Yell	7,211

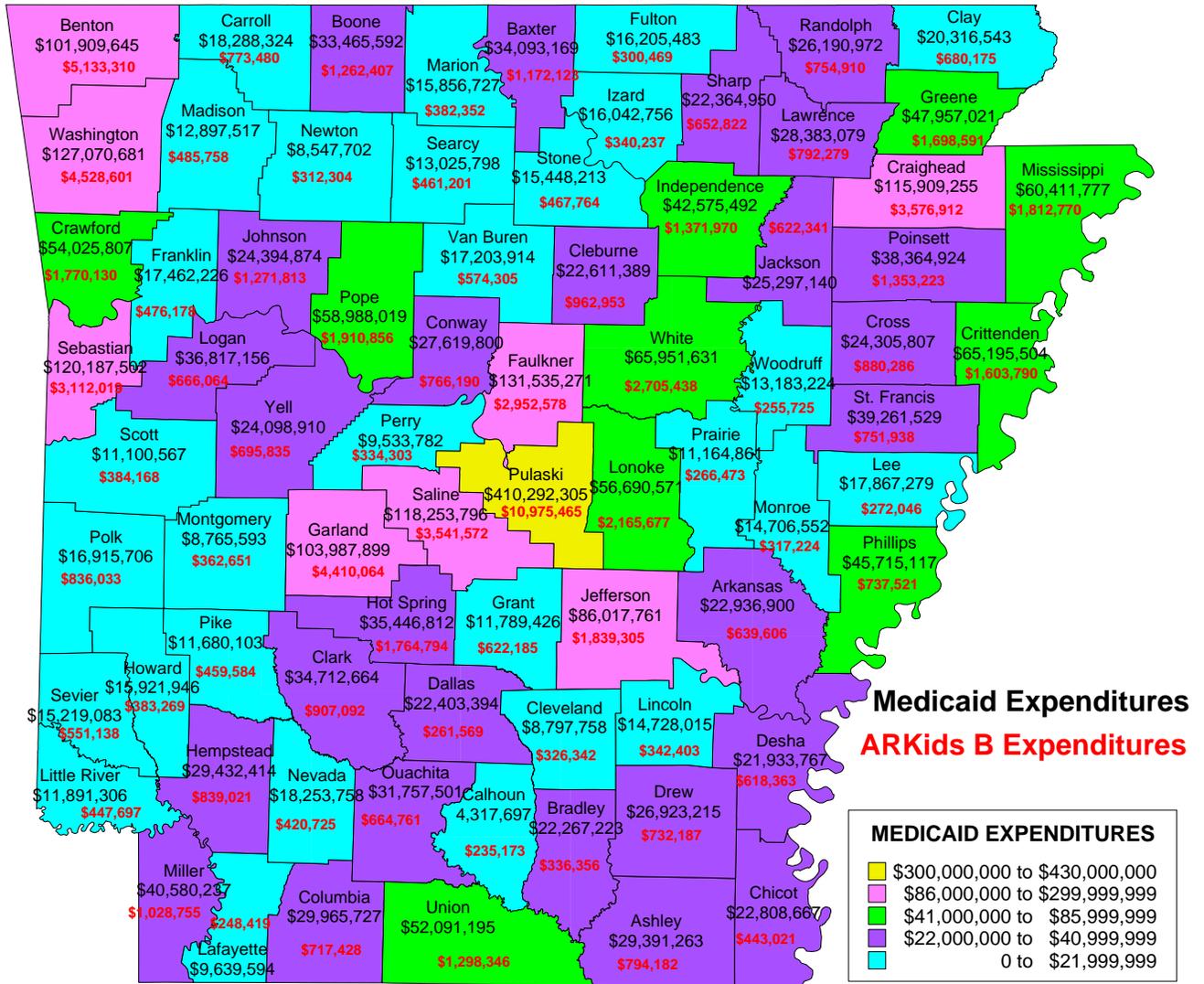
Enrollees who moved from one county to another during the year are included in counts for both counties.

## ARKids First-B Enrollees by County SFY 2009

<i>Eligibility County Description</i>	<i>Enrollee Count</i>	<i>Eligibility County Description</i>	<i>Enrollee Count</i>	<i>Eligibility County Description</i>	<i>Enrollee Count</i>
01 - Arkansas	810	26 - Garland	4,464	51 - Newton	396
02 - Ashley	886	27 - Grant	701	52 - Ouachita	1,028
03 - Baxter	1,413	28 - Greene	1,592	53 - Perry	475
04 - Benton	7,925	29 - Hempstead	968	54 - Phillips	1,012
05 - Boone	1,520	30 - Hot Spring	1,635	55 - Pike	643
06 - Bradley	469	31 - Howard	585	56 - Poinsett	1,265
07 - Calhoun	233	32 - Independence	1,529	57 - Polk	1,059
08 - Carroll	1,212	33 - Izard	550	58 - Pope	2,592
09 - Chicot	523	34 - Jackson	709	59 - Prairie	337
10 - Clark	792	35 - Jefferson	2,894	60 - Pulaski	14,084
11 - Clay	759	36 - Johnson	1,326	61 - Randolph	1,010
12 - Cleburne	1,075	37 - Lafayette	302	62 - Saline	3,710
13 - Cleveland	324	38 - Lawrence	836	63 - Scott	531
14 - Columbia	895	39 - Lee	435	64 - Searcy	492
15 - Conway	877	40 - Lincoln	494	65 - Sebastian	4,406
16 - Craighead	3,560	41 - Little River	507	66 - Sevier	895
17 - Crawford	2,558	42 - Logan	973	67 - Sharp	846
18 - Crittenden	2,451	43 - Lonoke	2,617	68 - St. Francis	1,200
19 - Cross	974	44 - Madison	820	69 - Stone	579
20 - Dallas	338	45 - Marion	549	70 - Union	1,868
21 - Desha	614	46 - Miller	1,590	71 - Van Buren	841
22 - Drew	818	47 - Mississippi	2,121	72 - Washington	6,817
23 - Faulkner	3,751	48 - Monroe	442	73 - White	3,263
24 - Franklin	759	49 - Montgomery	545	74 - Woodruff	367
25 - Fulton	444	50 - Nevada	410	75 - Yell	1,126

Enrollees who moved from one county to another during the year are included in counts for both counties.

## Expenditures by County SFY 2009



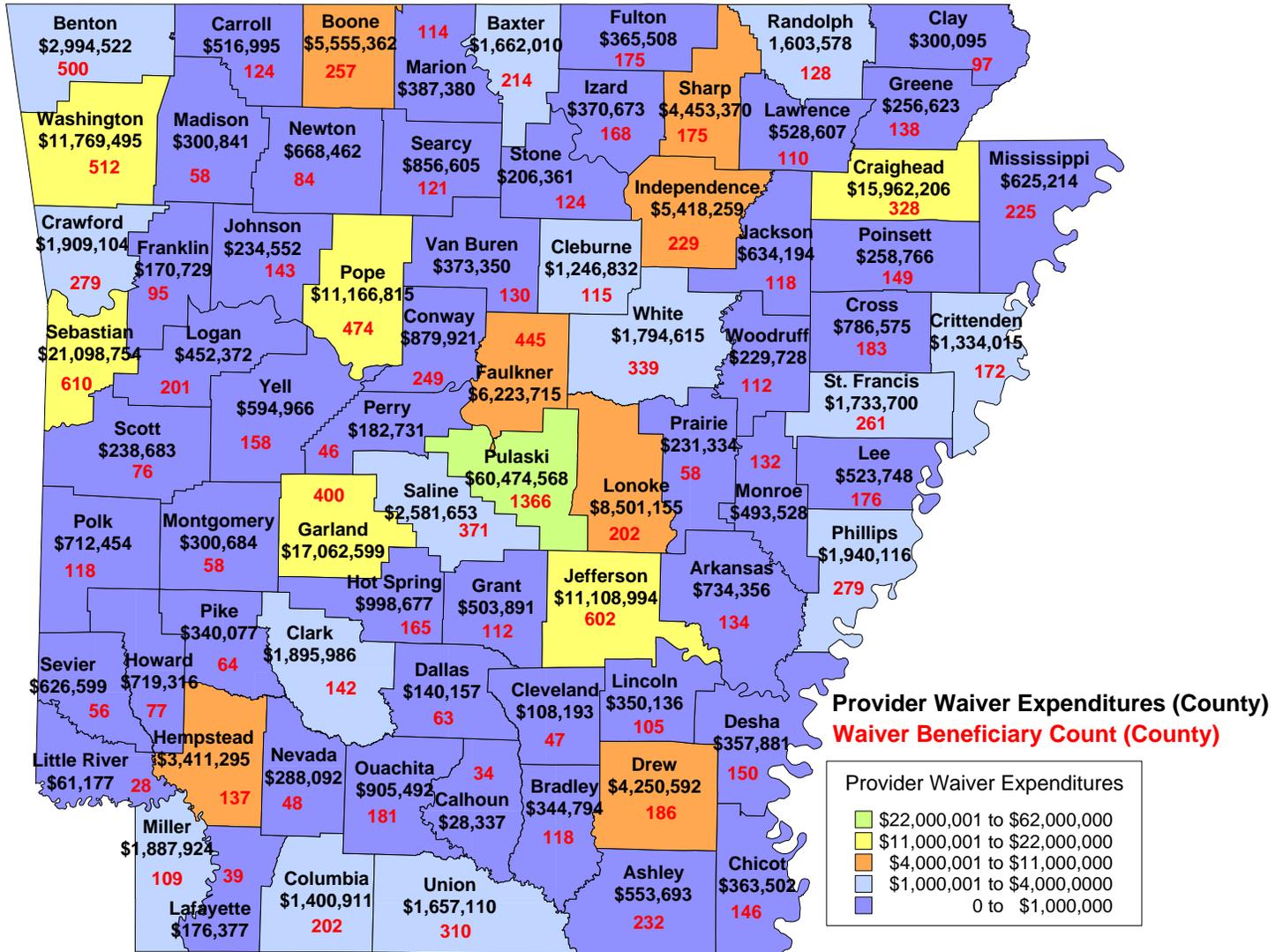
## Medicaid Expenditures by County SFY 2009

<i>Beneficiary County Description</i>	<i>Total Across Claim Types</i>	<i>Beneficiary County Description</i>	<i>Total Across Claim Types</i>	<i>Beneficiary County Description</i>	<i>Total Across Claim Types</i>
01 - Arkansas	22,936,900.00	26 - Garland	103,987,899.00	51 - Newton	8,547,702.00
02 - Ashley	29,391,263.00	27 - Grant	11,789,426.00	52 - Ouachita	31,757,501.00
03 - Baxter	34,093,169.00	28 - Greene	47,957,021.00	53 - Perry	9,533,782.00
04 - Benton	101,909,645.00	29 - Hempstead	29,432,414.00	54 - Phillips	45,715,117.00
05 - Boone	33,465,592.00	30 - Hot Spring	35,446,812.00	55 - Pike	11,680,103.00
06 - Bradley	22,267,223.00	31 - Howard	15,921,946.00	56 - Poinsett	38,364,924.00
07 - Calhoun	4,317,697.00	32 - Independence	42,575,492.00	57 - Polk	16,915,706.00
08 - Carroll	18,288,324.00	33 - Izard	16,042,756.00	58 - Pope	58,988,019.00
09 - Chicot	22,808,667.00	34 - Jackson	25,297,140.00	59 - Prairie	11,164,861.00
10 - Clark	34,712,664.00	35 - Jefferson	86,017,761.00	60 - Pulaski	410,292,305.00
11 - Clay	20,316,543.00	36 - Johnson	24,394,874.00	61 - Randolph	26,190,972.00
12 - Cleburne	22,611,389.00	37 - Lafayette	9,639,594.00	62 - Saline	118,253,796.00
13 - Cleveland	8,797,758.00	38 - Lawrence	28,383,079.00	63 - Scott	11,100,567.00
14 - Columbia	29,965,727.00	39 - Lee	17,867,279.00	64 - Searcy	13,025,798.00
15 - Conway	27,619,800.00	40 - Lincoln	14,728,015.00	65 - Sebastian	120,187,502.00
16 - Craighead	115,909,255.00	41 - Little River	11,891,306.00	66 - Sevier	15,219,083.00
17 - Crawford	54,025,807.00	42 - Logan	36,817,156.00	67 - Sharp	22,364,950.00
18 - Crittenden	65,195,504.00	43 - Lonoke	56,690,571.00	68 - St. Francis	39,261,529.00
19 - Cross	24,305,807.00	44 - Madison	12,897,517.00	69 - Stone	15,448,213.00
20 - Dallas	22,403,394.00	45 - Marion	15,856,727.00	70 - Union	52,091,195.00
21 - Desha	21,933,767.00	46 - Miller	40,580,237.00	71 - Van Buren	17,203,914.00
22 - Drew	26,923,215.00	47 - Mississippi	60,411,777.00	72 - Washington	127,070,681.00
23 - Faulkner	131,535,271.00	48 - Monroe	14,706,552.00	73 - White	65,951,631.00
24 - Franklin	17,462,226.00	49 - Montgomery	8,765,593.00	74 - Woodruff	13,183,224.00
25 - Fulton	16,205,483.00	50 - Nevada	18,253,758.00	75 - Yell	24,098,910.00

## ARKids First-B Expenditures by County SFY 2009

<i>Beneficiary County Description</i>	<i>Total Across Claim Types</i>	<i>Beneficiary County Description</i>	<i>Total Across Claim Types</i>	<i>Beneficiary County Description</i>	<i>Total Across Claim Types</i>
01 - Arkansas	639,606.00	26 - Garland	4,410,064.00	51 - Newton	312,304.00
02 - Ashley	794,182.00	27 - Grant	622,185.00	52 - Ouachita	664,761.00
03 - Baxter	1,172,123.00	28 - Greene	1,698,591.00	53 - Perry	334,303.00
04 - Benton	5,133,310.00	29 - Hempstead	839,021.00	54 - Phillips	737,521.00
05 - Boone	1,262,407.00	30 - Hot Spring	1,764,794.00	55 - Pike	459,584.00
06 - Bradley	336,356.00	31 - Howard	383,269.00	56 - Poinsett	1,353,223.00
07 - Calhoun	235,173.00	32 - Independence	1,371,970.00	57 - Polk	836,033.00
08 - Carroll	773,480.00	33 - Izard	340,237.00	58 - Pope	1,910,856.00
09 - Chicot	443,021.00	34 - Jackson	622,341.00	59 - Prairie	266,473.00
10 - Clark	907,092.00	35 - Jefferson	1,839,305.00	60 - Pulaski	10,975,465.00
11 - Clay	680,175.00	36 - Johnson	1,271,813.00	61 - Randolph	754,910.00
12 - Cleburne	962,953.00	37 - Lafayette	248,419.00	62 - Saline	3,541,572.00
13 - Cleveland	326,342.00	38 - Lawrence	792,279.00	63 - Scott	384,168.00
14 - Columbia	717,428.00	39 - Lee	272,046.00	64 - Searcy	461,201.00
15 - Conway	766,190.00	40 - Lincoln	342,403.00	65 - Sebastian	3,112,019.00
16 - Craighead	3,576,912.00	41 - Little River	447,697.00	66 - Sevier	551,138.00
17 - Crawford	1,770,130.00	42 - Logan	666,064.00	67 - Sharp	652,822.00
18 - Crittenden	1,603,790.00	43 - Lonoke	2,165,677.00	68 - St. Francis	751,938.00
19 - Cross	880,286.00	44 - Madison	485,758.00	69 - Stone	467,764.00
20 - Dallas	261,569.00	45 - Marion	382,352.00	70 - Union	1,298,346.00
21 - Desha	618,363.00	46 - Miller	1,028,755.00	71 - Van Buren	574,305.00
22 - Drew	732,187.00	47 - Mississippi	1,812,770.00	72 - Washington	4,528,601.00
23 - Faulkner	2,952,578.00	48 - Monroe	317,224.00	73 - White	2,705,438.00
24 - Franklin	476,178.00	49 - Montgomery	362,651.00	74 - Woodruff	255,725.00
25 - Fulton	300,469.00	50 - Nevada	420,725.00	75 - Yell	695,835.00

## Provider Waiver Expenditures & Waiver Beneficiary Count By County SFY 2009



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

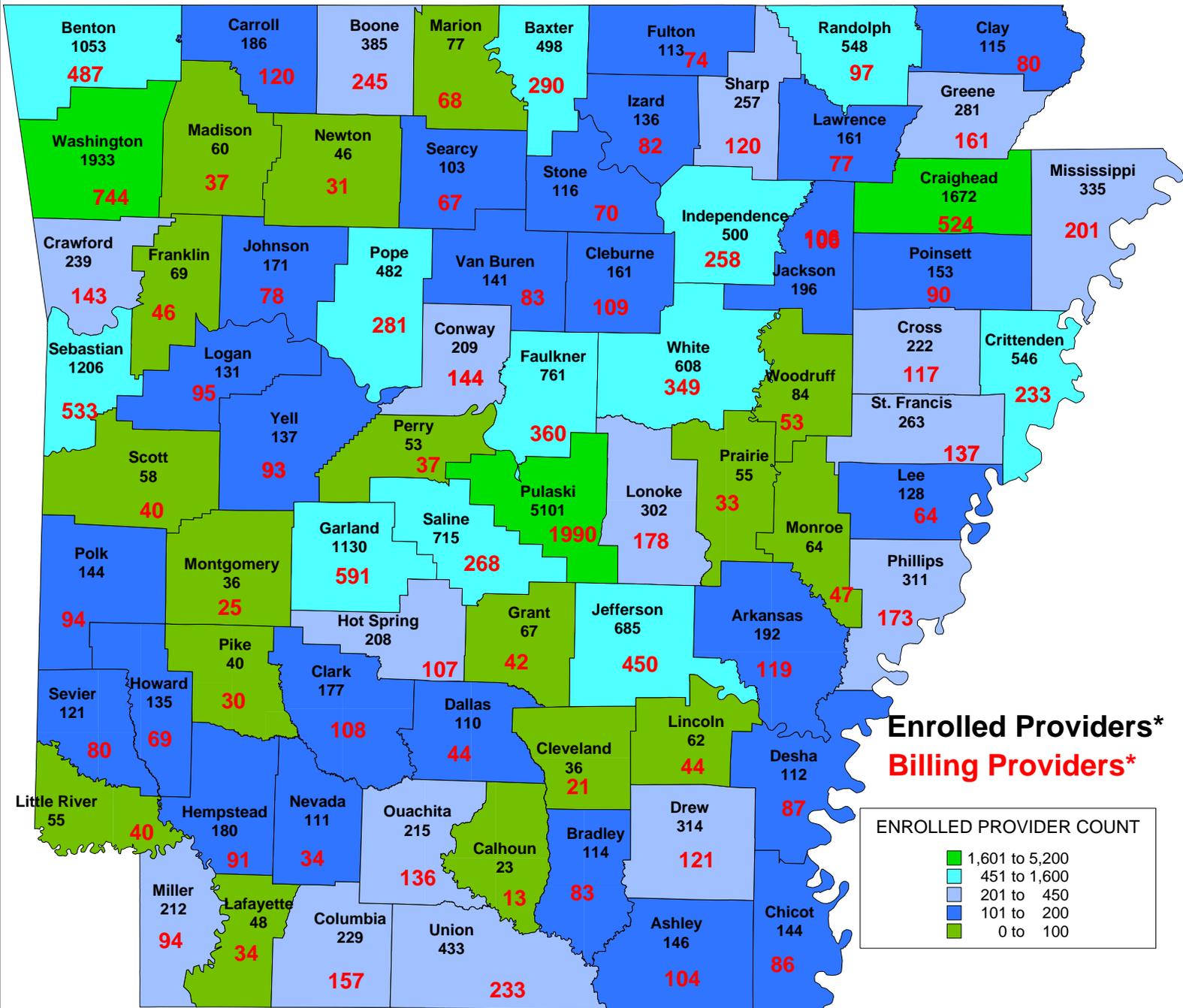
Waivers Include:  
 Alternatives for Persons with Disabilities (APD)  
 DDS - Alternative Community Services Waiver (ACS)  
 ElderChoices Waiver  
 Living Choices/ Assisted Living

## Provider Waiver Expenditures and Waiver Beneficiary Count by County SFY 2009

<i>Beneficiary County</i>	<i>Expenditures</i>	<i>Bene- ficiary Count</i>	<i>Beneficiary County</i>	<i>Expenditures</i>	<i>Bene- ficiary Count</i>	<i>Beneficiary County</i>	<i>Expenditures</i>	<i>Bene- ficiary Count</i>
Arkansas	\$734,356.00	134	Garland	\$17,062,599.00	400	Newton	\$668,462.00	84
Ashley	\$553,693.00	232	Grant	\$503,891.00	112	Ouachita	\$905,492.00	181
Baxter	\$1,662,010.00	214	Greene	\$256,623.00	138	Perry	\$182,731.00	46
Benton	\$2,994,522.00	500	Hempstead	\$3,411,295.00	137	Phillips	\$1,940,116.00	279
Boone	\$5,555,362.00	257	Hot Spring	\$998,677.00	165	55 - Pike	\$340,077.00	64
Bradley	\$344,794.00	118	Howard	\$719,316.00	77	Poinsett	\$258,766.00	149
Calhoun	\$28,337.00	34	Independence	\$5,418,259.00	229	Polk	\$712,454.00	118
Carroll	\$516,995.00	124	Izard	\$370,673.00	168	Pope	\$11,166,815.00	474
Chicot	\$363,502.00	146	Jackson	\$634,194.00	118	Prairie	\$231,334.00	58
Clark	\$1,895,986.00	142	Jefferson	\$11,108,994.00	602	Pulaski	\$60,474,568.00	1,366
Clay	\$300,095.00	97	Johnson	\$234,552.00	143	Randolph	\$1,603,578.00	128
Cleburne	\$1,246,832.00	115	Lafayette	\$176,377.00	39	Saline	\$2,581,653.00	371
Cleveland	\$108,193.00	47	Lawrence	\$528,607.00	110	Scott	\$238,683.00	76
Columbia	\$1,400,911.00	202	Lee	\$523,748.00	176	Searcy	\$856,605.00	121
Conway	\$879,921.00	249	Lincoln	\$350,136.00	105	Sebastian	\$21,098,754.00	610
Craighead	\$15,962,206.00	328	Little River	\$61,177.00	28	Sevier	\$626,599.00	56
Crawford	\$1,909,104.00	279	Logan	\$452,372.00	201	Sharp	\$4,453,370.00	175
Crittenden	\$1,334,015.00	172	Lonoke	\$8,501,155.00	202	St. Francis	\$1,733,700.00	261
Cross	\$786,575.00	183	Madison	\$300,841.00	58	69 - Stone	\$206,361.00	124
Dallas	\$140,157.00	63	Marion	\$387,380.00	114	Union	\$1,657,110.00	310
Desha	\$357,881.00	150	Miller	\$1,887,924.00	109	Van Buren	\$373,350.00	130
Drew	\$4,250,592.00	186	Mississippi	\$625,214.00	225	Washington	\$11,769,495.00	521
Faulkner	\$6,223,715.00	445	Monroe	\$493,528.00	132	White	\$1,794,615.00	339
Franklin	\$170,729.00	95	Montgomery	\$300,684.00	58	Woodruff	\$229,728.00	112
Fulton	\$365,508.00	175	Nevada	\$288,092.00	48	Yell	\$594,966.00	158



# Number of Providers by County SFY 2009



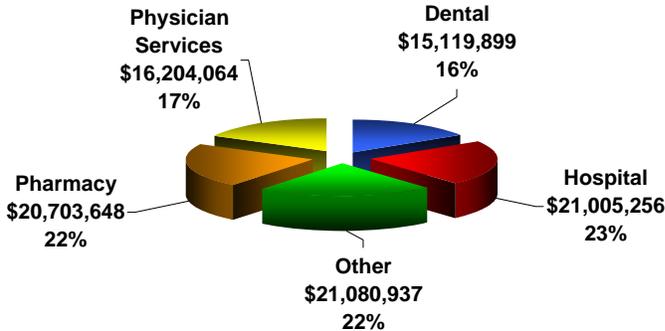
## Enrolled and Billing Providers by County

<i>Beneficiary County</i>	<i>Enrolled Providers</i>	<i>Billing Providers</i>	<i>Beneficiary County</i>	<i>Enrolled Providers</i>	<i>Billing Providers</i>	<i>Beneficiary County</i>	<i>Enrolled Providers</i>	<i>Billing Providers</i>
Arkansas	192	119	Garland	1,130	591	Newton	46	31
Ashley	146	104	Grant	67	42	Ouachita	215	136
Baxter	498	290	Greene	281	161	Perry	53	37
Benton	1,053	487	Hempstead	180	91	Phillips	311	173
Boone	385	245	Hot Spring	208	107	55 - Pike	40	30
Bradley	114	83	Howard	135	69	Poinsett	153	90
Calhoun	23	13	Independence	500	258	Polk	144	94
Carroll	186	120	Izard	136	82	Pope	482	281
Chicot	144	86	Jackson	196	106	Prairie	55	33
Clark	177	108	Jefferson	685	450	Pulaski	5,101	1,990
Clay	115	80	Johnson	171	78	Randolph	548	97
Cleburne	161	109	Lafayette	48	34	Saline	715	268
Cleveland	36	21	Lawrence	161	77	Scott	58	40
Columbia	229	157	Lee	128	64	Searcy	103	67
Conway	209	144	Lincoln	62	44	Sebastian	1,206	533
Craighead	1,672	524	Little River	55	40	Sevier	121	80
Crawford	239	143	Logan	131	95	Sharp	257	120
Crittenden	546	233	Lonoke	302	178	St. Francis	263	137
Cross	222	117	Madison	60	37	69 - Stone	116	70
Dallas	110	44	Marion	77	68	Union	433	233
Desha	112	87	Miller	212	94	Van Buren	141	83
Drew	314	121	Mississippi	335	201	Washington	1,933	744
Faulkner	761	360	Monroe	64	47	White	608	349
Franklin	69	46	Montgomery	36	25	Woodruff	84	53
Fulton	113	74	Nevada	111	34	Yell	137	93

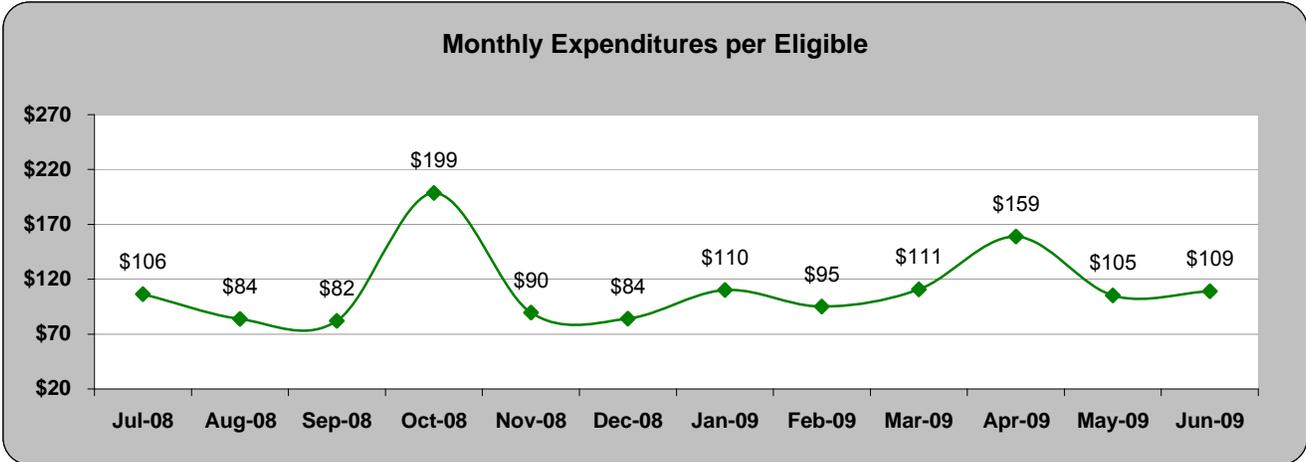
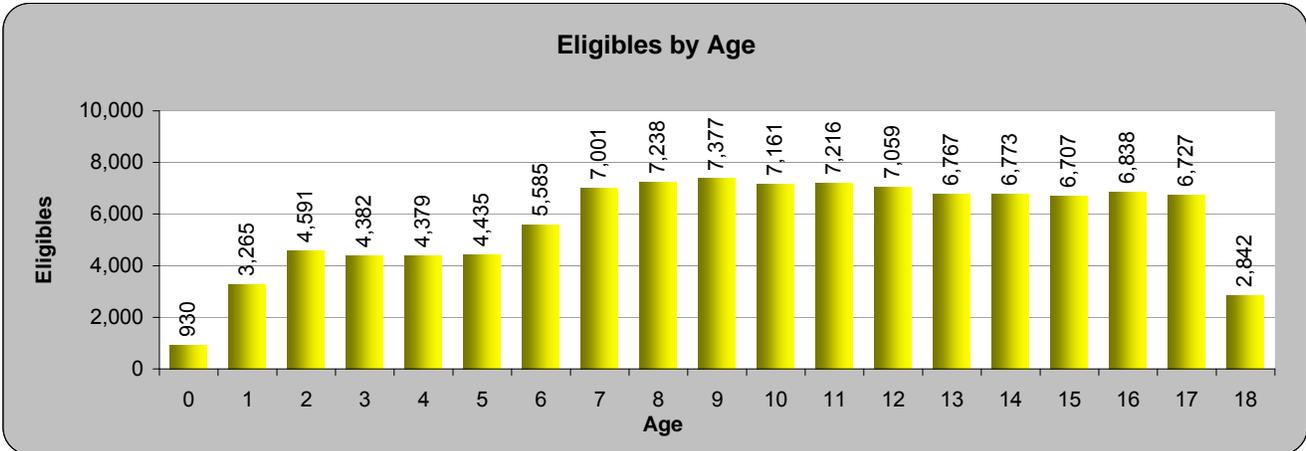


## STATE OF ARKANSAS SFY 2009

**Expenditures based upon  
Categories of Service**



**Median Age for  
ARKids B Eligibles  
was  
9 years 7 months**



Source: Category of Service Report, DSS Reports

Department of Human Services / Division of Medical Services

Reports and Analysis 06/30/2009

# MEDICAID FACTSHEET AAPD WAIVER

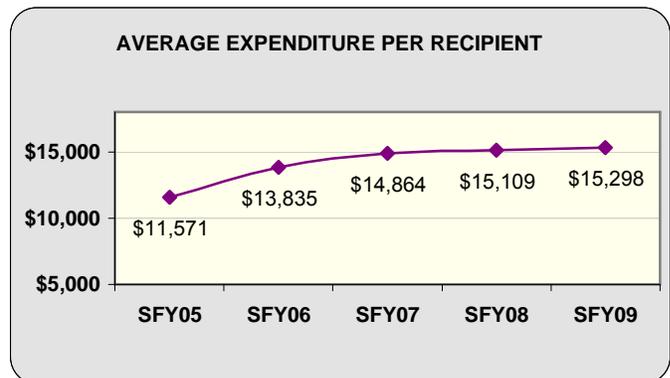
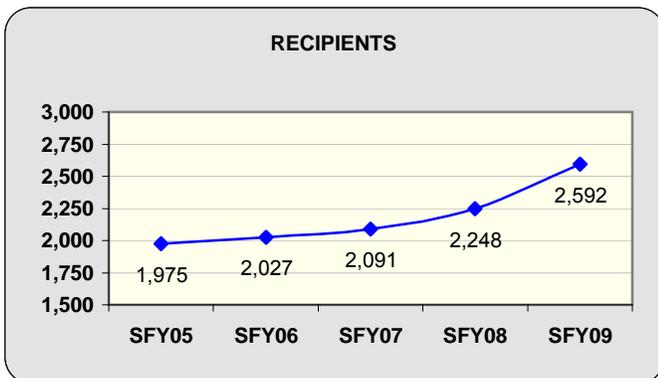
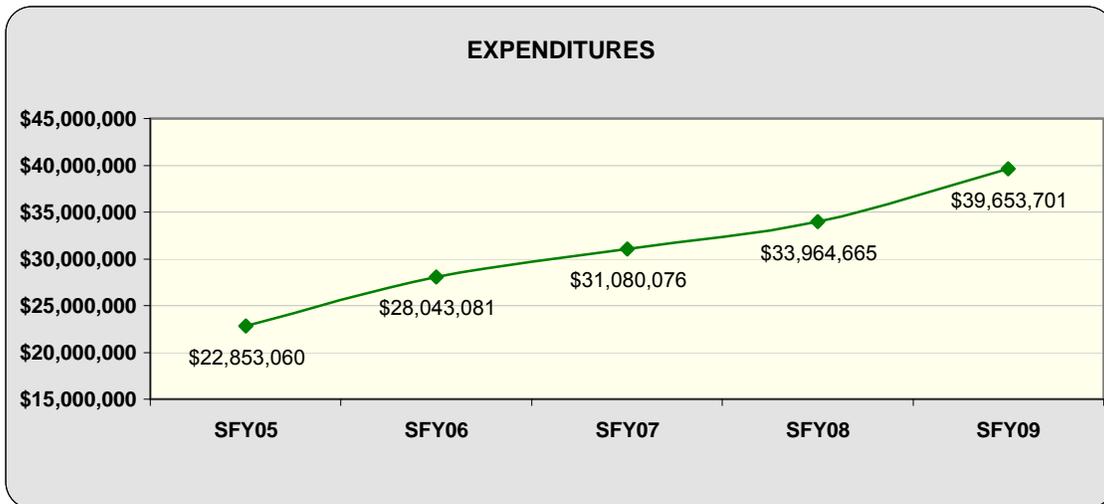
APD Waiver Expenditures  
as % of Total Hosp/Med Exp:  
SFY05: 1.17%  
SFY06: 1.34%  
SFY07: 1.36%  
SFY08: 1.38%  
SFY09: 1.51%

Alternatives for Adults with Physical Disabilities (AAPD) is a Medicaid Waiver program that provides home and community-based services to a limited number of adults with physical disabilities who meet the intermediate level of care in a nursing facility.

Home and community based waiver services are available to individuals who are not inpatients (residents) of a hospital, nursing facility (NF), or intermediate care facility for the mentally retarded (ICF/MR).

### The Alternatives program offers three consumer-directed services

- ◆ Attendant Care (Both traditional agency services and self-directed services): Assistance given to accomplish tasks of daily living, based on need and approved by the physician. Based on need, the client may receive up to 8 hours a day, 7 days a week of attendant care. The client shall recruit, hire, supervise and approve payment of the attendant. Although the attendant may be a family member, it may NOT be a spouse or other legally responsible person.
- ◆ Environmental Adaptations: Modifications to the environment that increase independence or accessibility.
- ◆ Counseling Support Management: Case Management services to assist with access to services and support for consumer direction.



Source: DSS Reports; Category of Service Report; Medicaid Provider Manual

# MEDICAID FACTSHEET AMBULANCE SERVICES

Ambulance Expenditures  
as % of Total Hosp/Med Exp:  
SFY05: 0.53%  
SFY06: 0.54%  
SFY07: 0.52%  
SFY08: 0.49%  
SFY09: 0.60%

Ambulance services, including air ambulance, are covered when certified by the physician to be medically necessary. Prior authorization is not required for any air ambulance services. Ground transportation is covered from point of pick-up to point of delivery. Ambulance service to a doctor's office or clinic is excluded.

Prior authorization must be obtained for ambulance trips to a medical facility outside the state of Arkansas unless the facility is within a 50-mile trade area and is the nearest hospital or nursing home from point of pick-up.

## EXPENDITURES



## RECIPIENTS



## AVERAGE EXPENDITURE PER RECIPIENT



Source: DSS Reports; Category of Service Report; Medicaid Provider Manual

# MEDICAID FACTSHEET AMBULATORY SURGICAL CENTERS

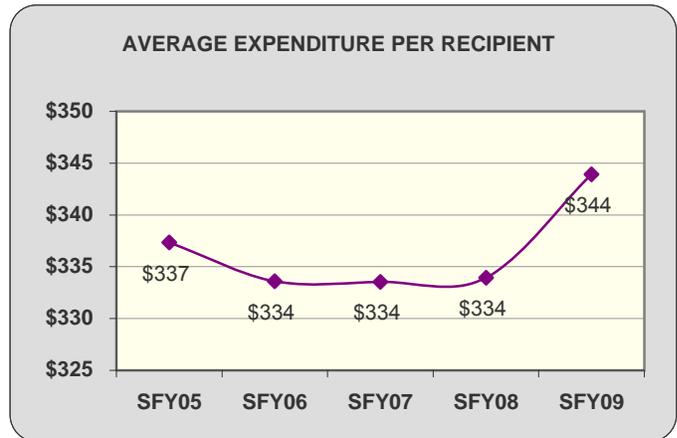
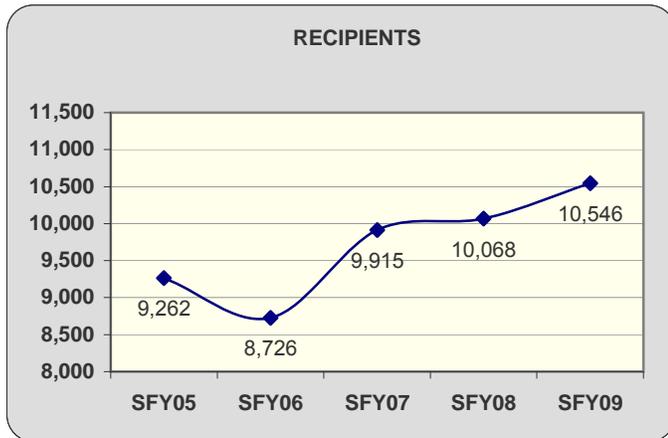
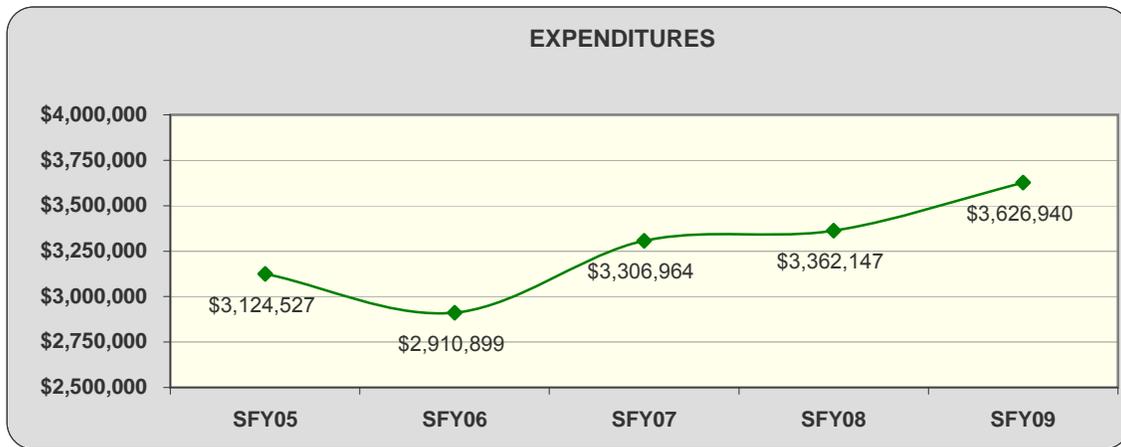
Ambulatory Surg Ctr Expenditures  
as % of Total Hosp/Med Exp:  
SFY05: 0.16%  
SFY06: 0.14%  
SFY07: 0.14%  
SFY08: 0.14%  
SFY09: 0.14%

An Ambulatory Surgical Center (ASC) is a distinct entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization.

All services (except nurse-midwife services) rendered in an Ambulatory Surgical Center must be under the direction of a physician or dentist.

There are no benefit limits on outpatient surgical procedures.

Lab, x-ray and machine test services provided in an Ambulatory Surgical Center are counted against the \$500 annual benefit limit. MRI and cardiac catheterization procedures are exempt from the \$500 outpatient laboratory and X-ray annual benefit limit.



There are 67 ASCs available to Medicaid recipients in 17 Arkansas counties plus the states of Louisiana, Missouri, Tennessee and Texas.

#### Arkansas Counties with Ambulatory Surgical Centers:

Baxter, Benton, Boone, Craighead, Crittenden, Faulkner, Garland, Independence, Jefferson, Miller, Mississippi, Pulaski, Sebastian, Sharp, Union, Washington, and White

Source: DSS Reports; Category of Service Report; Medicaid Provider Manual

# MEDICAID FACTSHEET CHIROPRACTIC SERVICES

Chiropractic Expenditures  
as % of Total Hosp/Med Exp:  
SFY05: 0.0103%  
SFY06: 0.0115%  
SFY07: 0.0099%  
SFY08: 0.0084%  
SFY09: 0.0080%

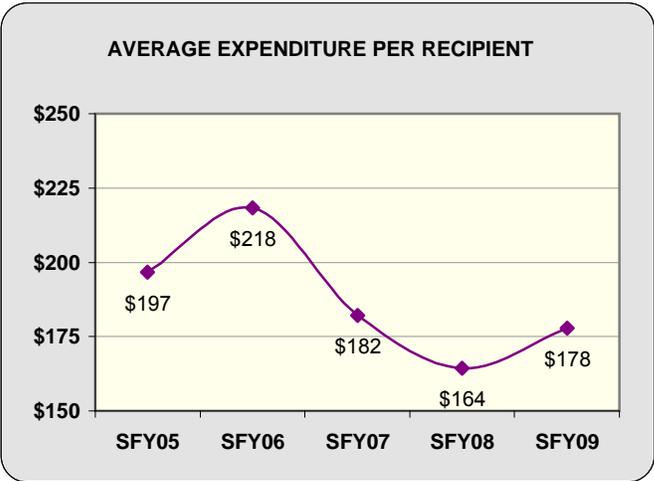
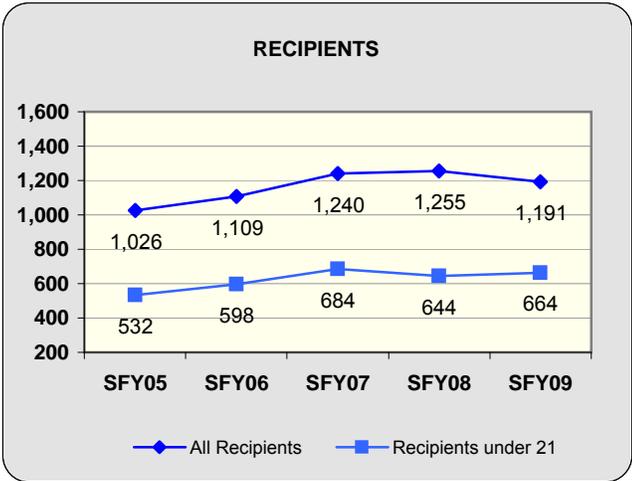
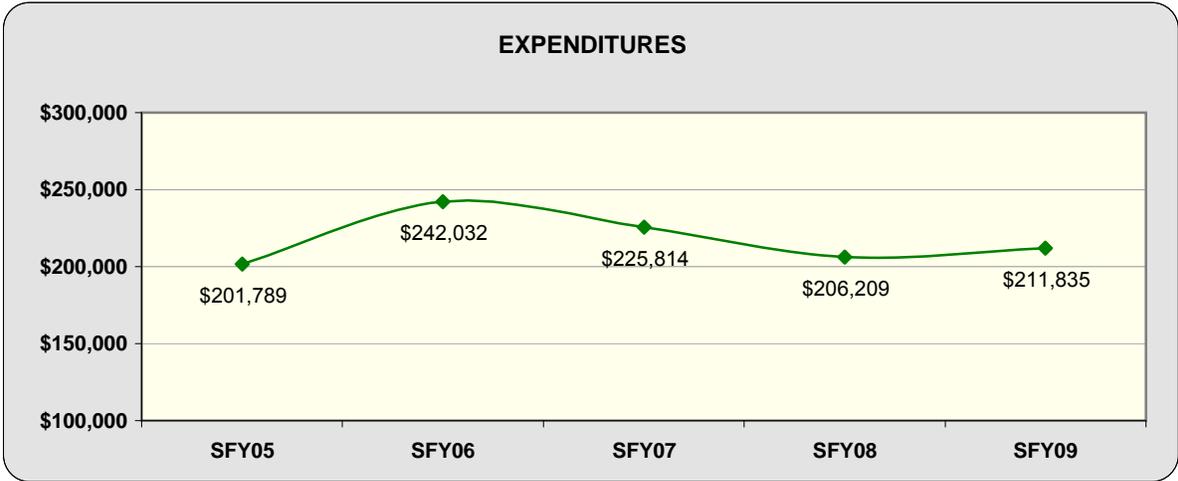
Chiropractic services are covered by Medicaid *only* to correct a subluxation of the spine by manual manipulation.  
Services are covered for all ages.

A referral from the recipient's Primary Care Physician is required.

**Benefit limit for under 21:**  
No Limit

**Benefit limit for 21 and older:**  
12 visits per State Fiscal Year

% of Recipients Under Age 21	
SFY09:	56%
SFY08:	51%
SFY07:	55%
SFY06:	54%
SFY05:	52%



Source: DSS Reports; Category of Service Report; Medicaid Provider Manual

# MEDICAID FACTSHEET

## CHILD HEALTH MANAGEMENT SERVICES

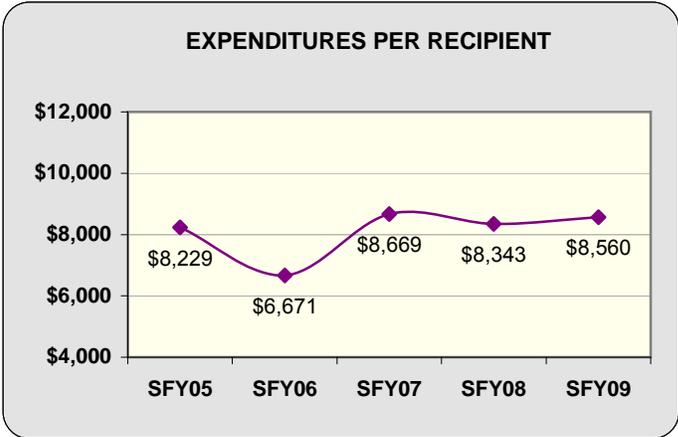
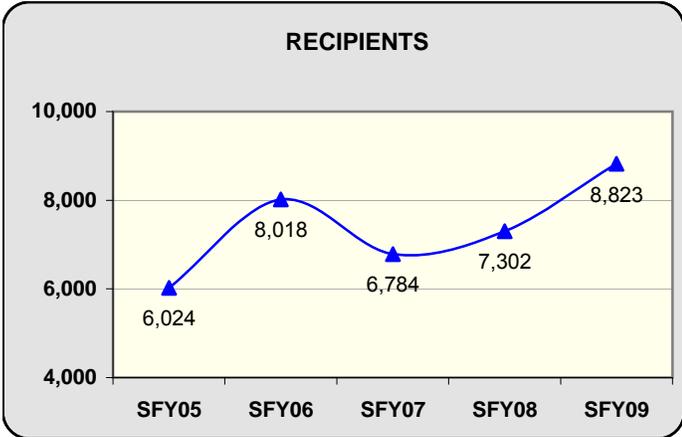
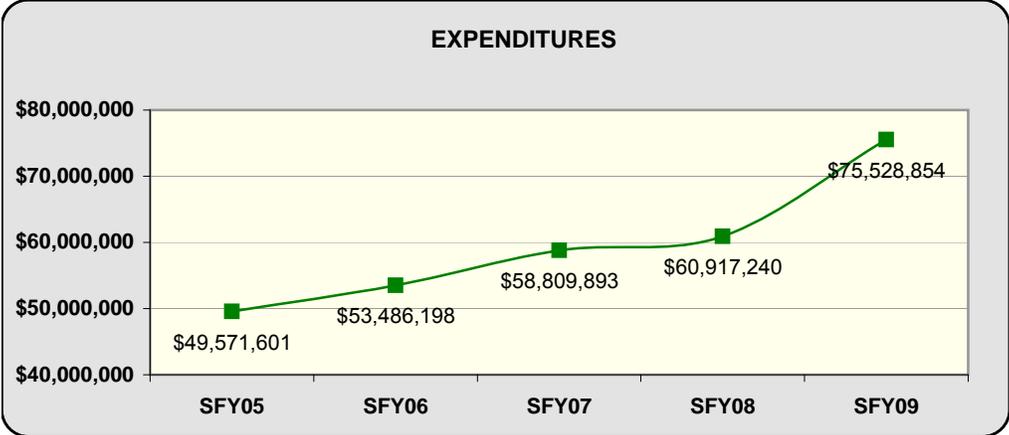
CHMS Expenditures  
as % of Total Hosp/Med Exp:  
SFY05: 2.14%  
SFY06: 2.55%  
SFY07: 2.57%  
SFY08: 2.47%  
SFY09: 2.87%

Child Health Management Services (CHMS) comprises an array of clinic services intended to provide full medical multi-discipline diagnosis, evaluation and treatment for the purpose of intervention, treatment and prevention of long-term disability for Medicaid beneficiaries.

Beneficiaries of CHMS must have a problem-related diagnosis.  
These services are not designed to be used as a well-child check-up.

Services are limited to the following components:	
Audiology	Occupational/Physical Therapy
Behavior	Psychiatry
Intervention/Treatment Services	Psychological
Medical (to include nursing)	Social work
Neuropsychology	Speech/Language Pathology
Nutrition	Therapy

A patient's entry into the CHMS clinic system begins with a referral from the patient's Primary Care Physician (PCP).  
The PCP's approval of the plan for treatment must be in place to initiate care.



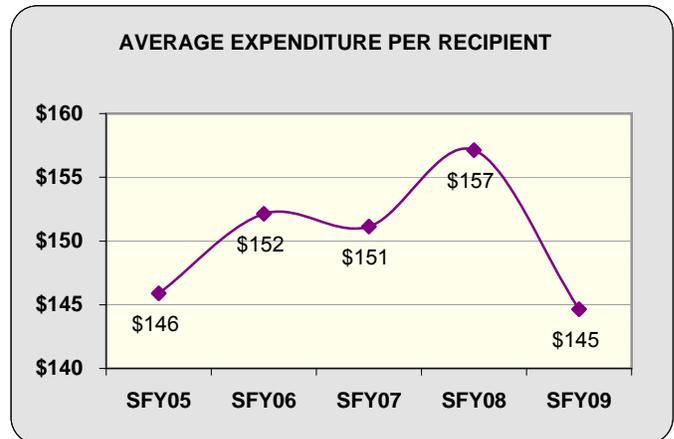
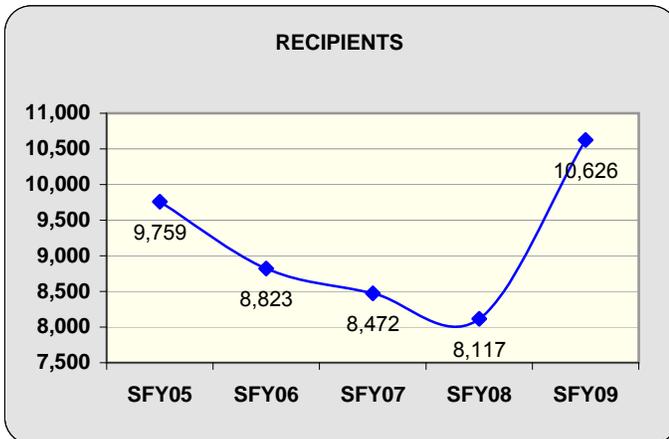
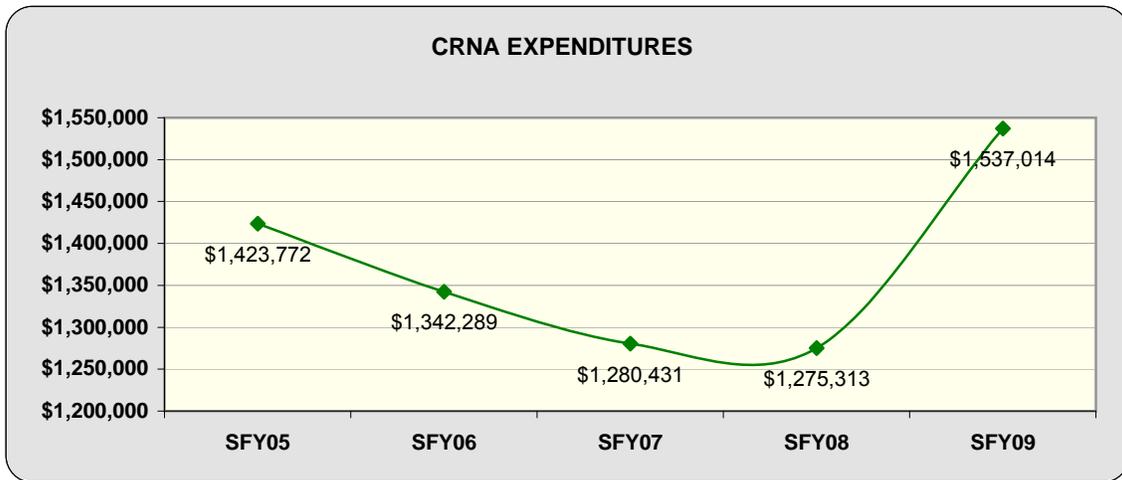
Source: DSS Reports; Category of Service Report; Medicaid Provider Manual

# MEDICAID FACTSHEET CRNA

CRNA Expenditures  
as % of Total Hosp/Med Exp:  
SFY05: 0.07%  
SFY06: 0.06%  
SFY07: 0.06%  
SFY08: 0.05%  
SFY09: 0.06%

## CRNA (Certified Registered Nurse Anesthetist)

Arkansas Medicaid will reimburse either the Anesthesiologist (MD) or the CRNA for anesthesia services provided to eligible Medicaid recipients during surgery and/or medical treatment within the limits of the Medicaid Program.



Source: DSS Reports; Category of Service Report; Medicaid Provider Manual

# MEDICAID FACTSHEET DDS ACS WAIVER

DDS ACS Waiver Expenditures  
as % of Total Hosp/Med Exp:  
SFY05: 4.32%  
SFY06: 4.44%  
SFY07: 4.58%  
SFY08: 4.53%  
SFY09: 4.87%

Medicaid offers certain home and community based services as an alternative to institutionalization. These services are available for a limited number of eligible individuals with a developmental disability who would otherwise require an ICF/MR level of Care

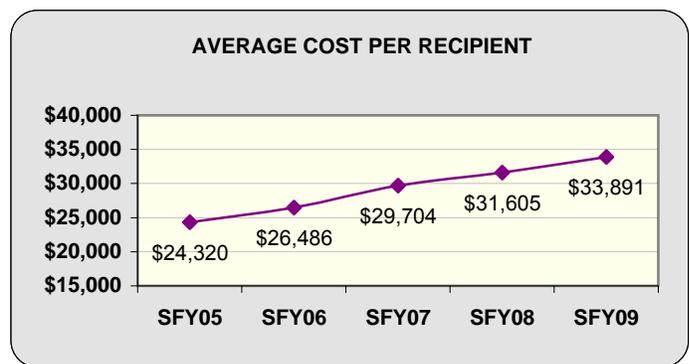
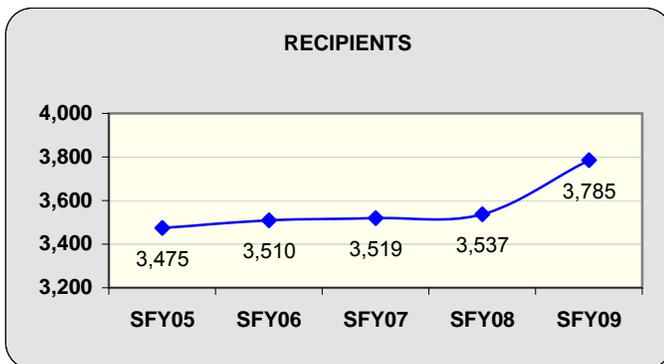
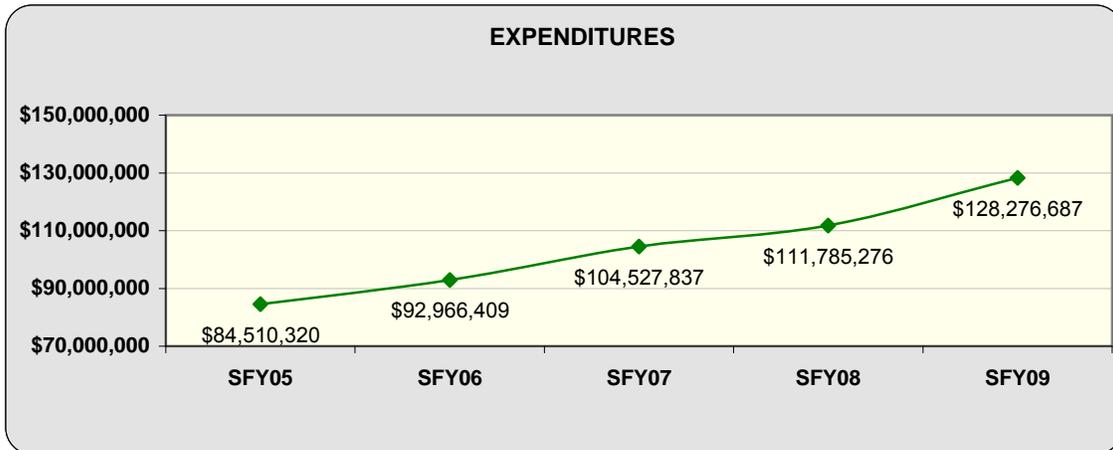
***The DDS ACS Waiver is administered by the Division of Developmental Disabilities.***

### Services provided under this program

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li>* ACS Respite Care Services</li> <li>* Supplemental Support Services</li> <li>* Supported Employment Services</li> <li>* Adaptive Equipment</li> <li>* ACS Specialized Medical Supplies</li> <li>* Case Management Services</li> <li>* Consultation Services</li> </ul> | <ul style="list-style-type: none"> <li>* Crisis Center/Intervention Services</li> <li>* ACS Supportive Living</li> <li>* Community Experiences</li> <li>* ACS Non-medical Transportation</li> <li>* Environmental Modifications</li> </ul> |
|--|--|

Waiver services are not available to individuals who are inpatients (residents) of a hospital, nursing facility (NF), or intermediate care facility for the mentally retarded (ICF/MR) unless payment is made to the facility through private pay or private insurance.

**ACS Waiver Program services require prior authorization.**



Note: The DDS figures do not include APD data.

Source: DSS Reports; Category of Service Report; Medicaid Provider Manual

# MEDICAID FACTSHEET DDTCS

DDTCS Expenditures  
as % of Total Hosp/Med Exp:  
SFY05: 4.06%  
SFY06: 4.51%  
SFY07: 4.69%  
SFY08: 4.57%  
SFY09: 4.76%

**Developmental Day Treatment Clinics Services (DDTCS) in qualified facilities may be covered only when:**

- \* they are provided to outpatients
- \* they are determined medically necessary
- \* provided according to written prescription by a physician
- \* provided according to individualized written plan of care

**Services must be rendered at a DDS licensed Comprehensive Day Treatment Center, offering:**

- \* diagnosis and evaluation
- \* habilitative training
- \* provision of noon meal

**Administered by the Division of Development Disabilities**

**Levels of Care:**

1. Early Intervention: facility-based provision of one-to-one staff/client training in conjunction with services to parents/care-givers of the client
2. Pre-school: facility-based program for children up to 5 years of age
3. Adult Development: facility-based program for adults

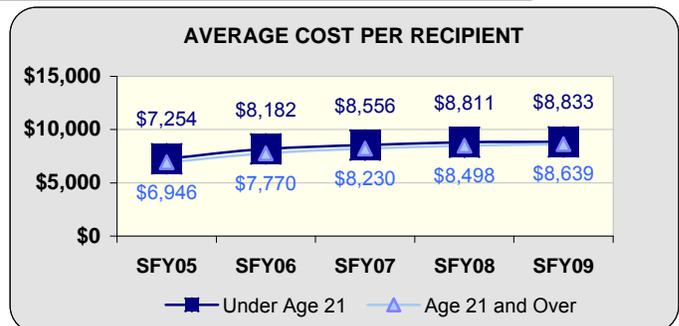
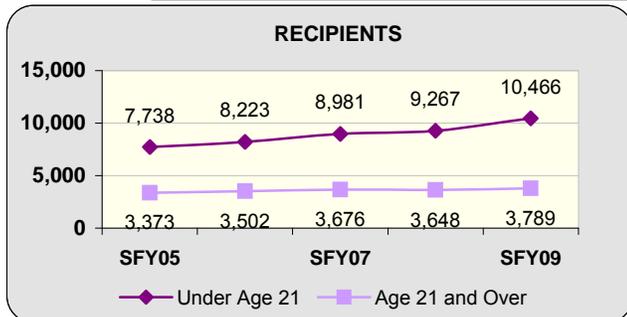
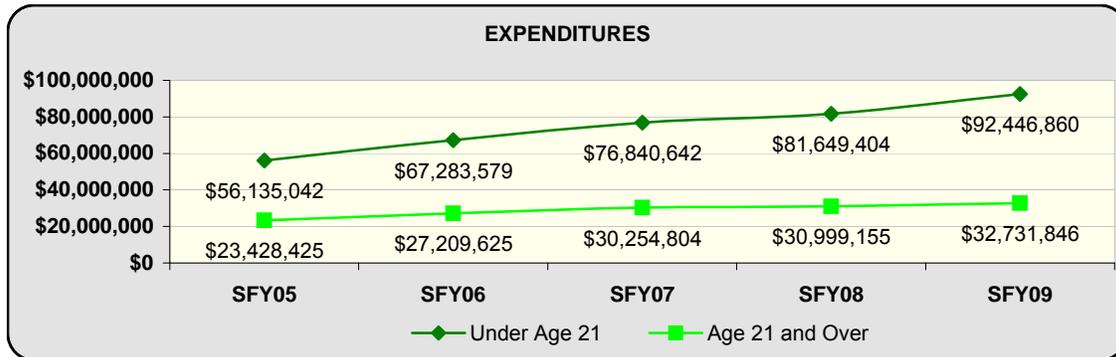
**Optional Services available through DDTCS are as follows:**

(Must be in conjunction with a core service)

- \* physical therapy
- \* speech therapy
- \* occupational therapy
- \* therapy evaluations (PT, OT, and ST)

**Non-covered Services (not limited to):**

- \* Adult Development Services, Pre-school Services, Diagnosis and Evaluation Services less than 1 hour
- \* Early Intervention Services less than 2 hours
- \* Supervised Living Services
- \* Educational Services
- \* Services to Inpatients



Source: DSS Reports; Category of Service Report; Medicaid Provider Manual

# MEDICAID FACTSHEET DENTAL SERVICES

Dental Services Expenditures  
as % of Total Hosp/Med Exp:  
SFY05: 1.49%  
SFY06: 1.65%  
SFY07: 2.81%  
SFY08: 2.89%  
SFY09: 3.17%

Under the Dental Program, Medicaid covers recipients under the age of 21 for many common dental procedures, including orthodontia on a very selective basis.  
Extensions are allowed if treatment is determined to be medically necessary.

Coverage for adults age 21 and over is limited to medically necessary treatment.

Dental prophylaxis and fluoride treatment for under age 21 are covered by Medicaid.

Orthodontic treatment for beneficiaries under age 21 is approved when a handicapping malocclusion is affecting the patient's physical and/or psychological health.  
Prior Authorization is required.

Hospitalization for dental treatment may be approved when the patient's age, medical or mental problems and/or extensiveness of treatment necessitates hospitalization.  
Prior Authorization is required for inpatient/outpatient hospital dental services.

**UNDER AGE 21 - EXPENDITURES**



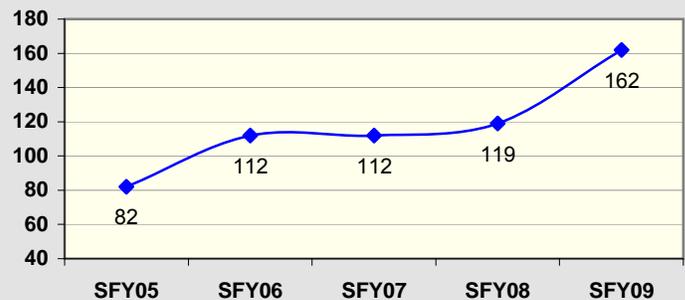
**UNDER AGE 21 - RECIPIENTS**



**AGE 21 AND OVER - EXPENDITURES**



**AGE 21 AND OVER - RECIPIENTS**



Source: DSS Reports; Category of Service Report; Medicaid Provider Manual

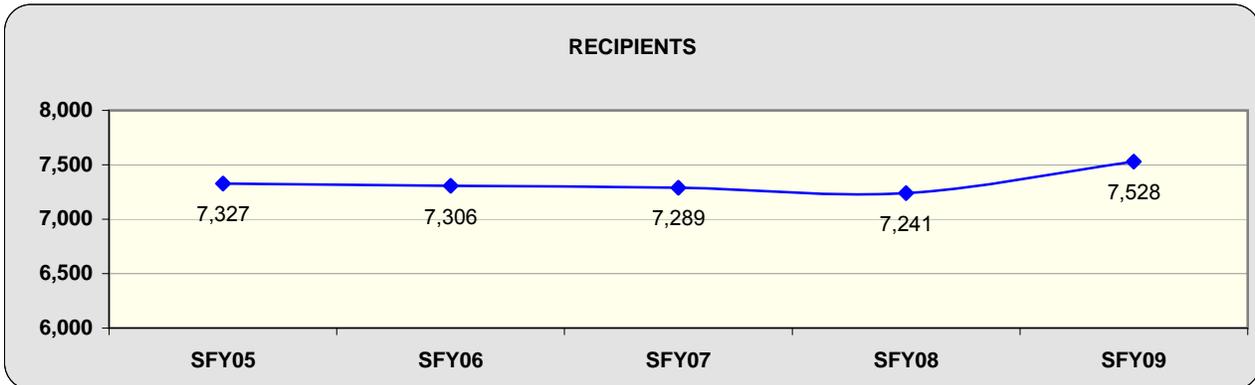
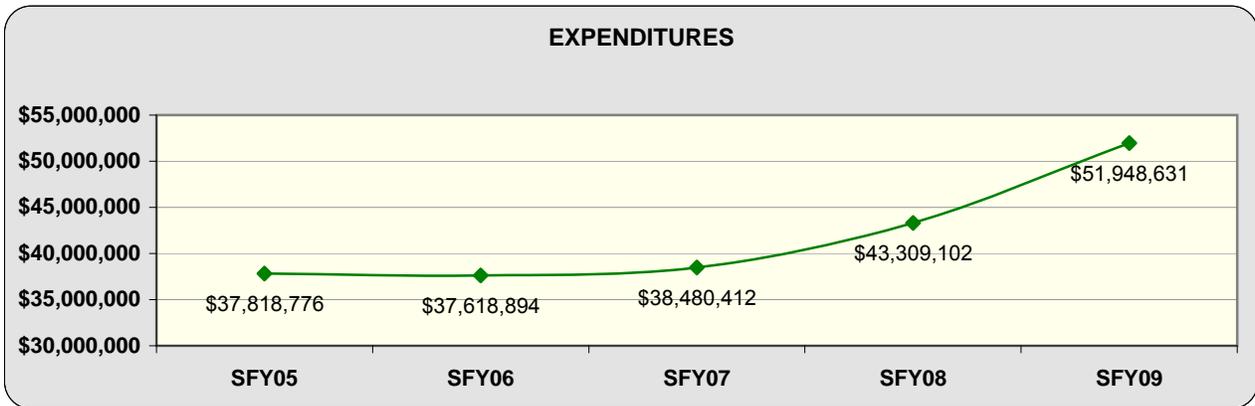
# MEDICAID FACTSHEET ELDERCHOICES

ElderChoices Expenditures  
as % of Total Hosp/Med Exp:  
 SFY05: 1.93%  
 SFY06: 1.80%  
 SFY07: 1.68%  
 SFY08: 1.76%  
 SFY09: 1.97%

ElderChoices is a home and community-based waiver program available to a limited number of individuals ages 65 and older who require an intermediate level of nursing facility care.

ElderChoices services are tailored to the social and medical needs of the recipient through a comprehensive assessment by a registered nurse. ElderChoices services are provided in the patient's home to preclude or delay institutionalization.

- Provided Services**
- Adult Family Home
  - Chore services
  - Home-delivered meals
  - Homemaker services
  - Personal Emergency Response System
    - Adult day care
    - Adult day health care
    - Respite care



AVERAGE COST PER RECIPIENT					
	SFY05	SFY06	SFY07	SFY08	SFY09
<b>Number of Recipients</b>	7,327	7,306	7,289	7,241	7,528
<b>State Share</b>	\$9,617,315	\$9,773,389	\$10,247,334	\$11,671,803	\$11,657,273
<b>Federal Share</b>	\$28,201,461	\$27,845,506	\$28,233,078	\$31,637,299	\$40,291,358
<b>Total Expenditures</b>	\$37,818,776	\$37,618,894	\$38,480,412	\$43,309,102	\$51,948,631
<b>Cost per Recipient</b>	\$5,162	\$5,149	\$5,279	\$5,981	\$6,901

Source: DSS Reports; Category of Service Report; Medicaid Provider Manual

# MEDICAID FACTSHEET

## EPSDT

EPSDT Expenditures  
as % of Total Hosp/Med Exp:  
SFY05: 3.07%  
SFY06: 3.50%  
SFY07: 3.55%  
SFY08: 3.51%  
SFY09: 3.99%

### Child Health Services Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program

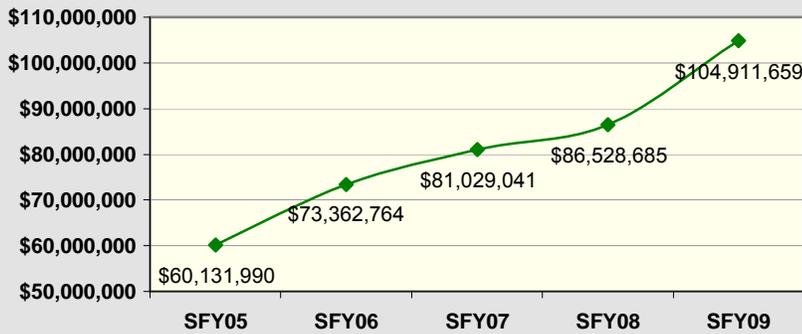
EPSDT is a federally mandated child health component of Medicaid. EPSDT is designed to ensure comprehensive health care for individuals under the age of 21 (even if individual is a parent) who are eligible for Medicaid.

Arkansas's Medicaid periodic screening schedule follows the American Academy of Pediatrics recommendations. Health professionals who do EPSDT screenings may diagnose and treat health problems identified during the screening, or may refer the child to other sources of care. Treatment for conditions discovered during a screen may exceed the limits of the Medical Program.

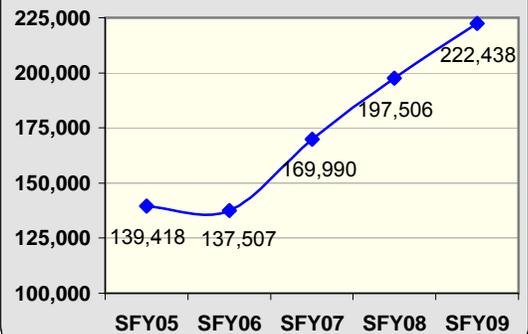
### Screening Components

- \* Health and developmental history
- \* Unclothed physical examination
- \* Developmental assessment
- \* Health education
- \* Visual and hearing evaluations
- \* Dental health assessment
- \* Laboratory tests including blood lead testing
- \* Nutritional assessment
- \* Appropriate immunizations

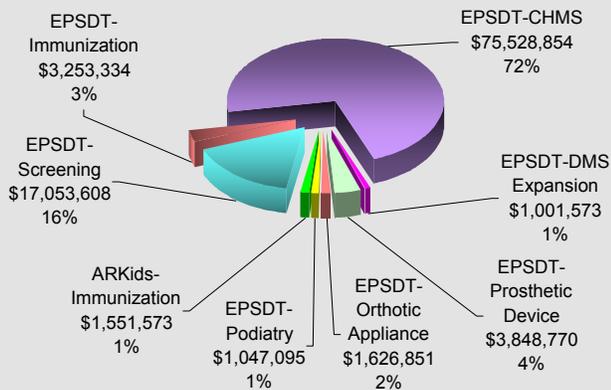
### EXPENDITURES



### RECIPIENTS



### EXPENDITURE BREAKDOWN



### AVERAGE EXPENDITURE PER RECIPIENT



Source: DSS Reports; Category of Service Report; Medicaid Provider Manual

# MEDICAID FACTSHEET FAMILY PLANNING SERVICES / WOMEN'S HEALTH WAIVER

Family Planning Expenditures  
as % of Total Hosp/Med Exp:  
SFY05: 1.05%  
SFY06: 0.97%  
SFY07: 0.76%  
SFY08: 0.74%  
SFY09: 0.80%

## FAMILY PLANNING - Who Is eligible? What services are provided?

- \* Family planning services are for women of childbearing age.
- \* Services include one basic family planning examination and three follow-up visits per recipient per State Fiscal Year (extension of benefits not available).
- \* Services may be provided by physicians or nurse practitioners.
- \* Sterilization procedures are included in family planning services.
- \* Prescriptions are covered.

## WOMEN'S HEALTH WAIVER - Effective September 1, 1997

Participants are eligible for family planning services only, including sterilization.  
There is no requirement for PCP election.

## Who provides the services?

- \* Local County Health Department Offices
- \* Physicians, Nurse Practitioners, Certified Nurse Midwives
- \* Hospitals
- \* Rural Health Clinics (FQHCs)

### TOTAL RECIPIENTS

Age -->	Under 21	21 - 44	45 - 64	65+	Total
SFY05	32,238	62,195	1,369	41	95,843
SFY06	35,736	49,479	914	1	86,130
SFY07	28,750	45,857	808	0	75,415
SFY08	23,580	50,648	1,025	7	75,260
SFY09	24,187	50,587	1,081	2	75,857

### RECIPIENTS BY CATEGORY

	Family Planning Services	Family Planning Crossovers	Family Planning Physician Services	Women's Health Waiver Services	Women's Health Wvr Crossovers	Women's Health Wvr Physician Services
SFY05	18,131	130	18,682	70,965	39	0
SFY06	17,241	132	18,364	64,027	51	0
SFY07	20,054	135	18,357	62,903	162	39
SFY08	29,284	143	16,020	78,032	262	141
SFY09	31,802	138	12,808	82,532	307	193

Note: Recipients can be reported in multiple categories, depending upon the service(s) received, so each recipient may be counted more than once above.

### EXPENDITURES



\* NOTE: SFYs 05 and 06 include Family Planning Prescriptions

### AVERAGE COST PER RECIPIENT



Source: DSS Reports; Category of Service Report; Medicaid Provider Manual

# MEDICAID FACTSHEET FEDERALLY QUALIFIED HEALTH CENTERS

FQHC Expenditures  
as % of Total Hosp/Med Exp:  
SFY05: 0.32%  
SFY06: 0.31%  
SFY07: 0.33%  
SFY08: 0.37%  
SFY09: 0.44%

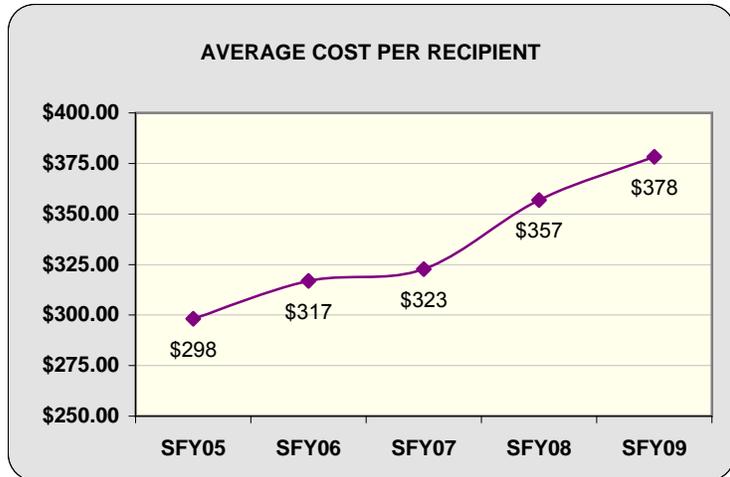
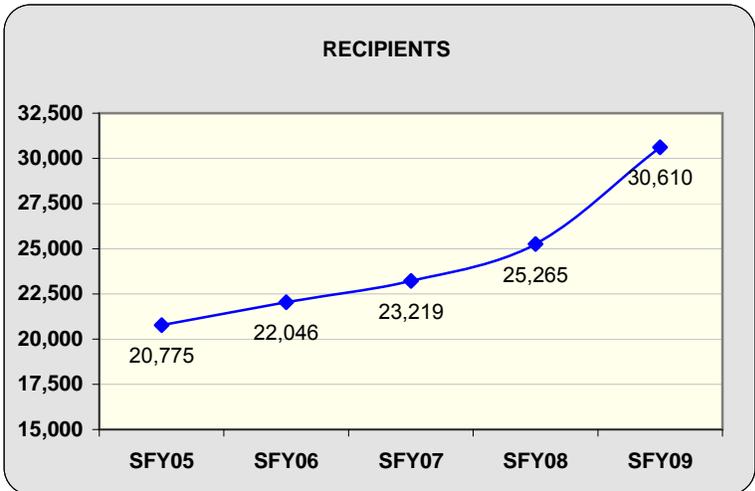
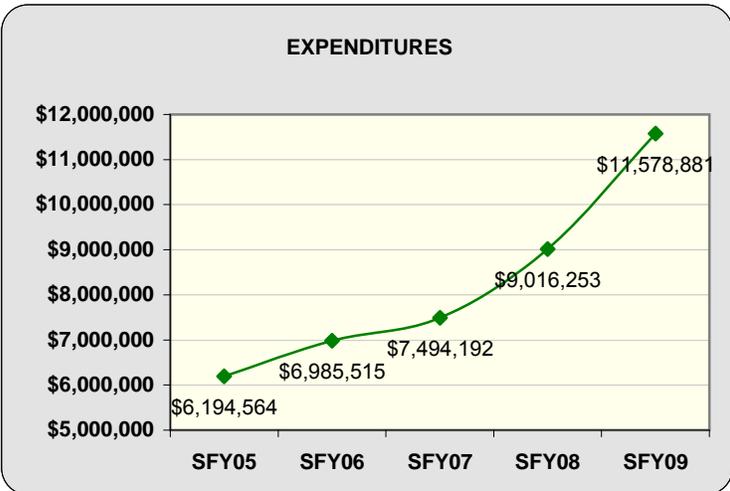
**Federally Qualified Health Centers (FQHC) receive Public Health Services grant funds under authority of one of the following:**

- Section 329 - Migrant Health Centers
- Section 330 - Community Health Centers
- Section 340 - Services to Homeless Individuals

**Covered Core Services**

- Physician services
- Services provided by physician assistants, nurse practitioners, clinical psychologists, clinical social workers
- Services and supplies incidental to services rendered by above named professionals
- Pneumococcal vaccine, influenza vaccine

**No benefit limit for Medicaid recipients under the age of 21 in the Child Health Services (EPSDT) Program  
Limit of 12 encounters per state fiscal year for recipients age 21 and older**



**Counties with FQHC(s)**

Ashley, Benton, Calhoun, Chicot, Clark, Clay, Cleburne, Craighead, Crittenden, Cross, Hempstead, Independence, Jackson, Jefferson, Lafayette, Lawrence, Lee, Logan, Lonoke, Madison, Monroe, Montgomery, Newton, Ouachita, Phillips, Poinsett, Polk, Prairie, Pulaski, Randolph, Searcy, Sebastian, St. Francis, Union, Van Buren, Washington, White, and Woodruff

**Counties with more than one FQHC**

Ashley, Benton, Chicot, Craighead, Crittenden, Cross, Jackson, Jefferson, Lee, Lonoke, Monroe, Prairie, Pulaski, Sebastian, St. Francis, Van Buren, White, and Woodruff

Source: DSS Reports; Category of Service Report; Medicaid Provider Manual

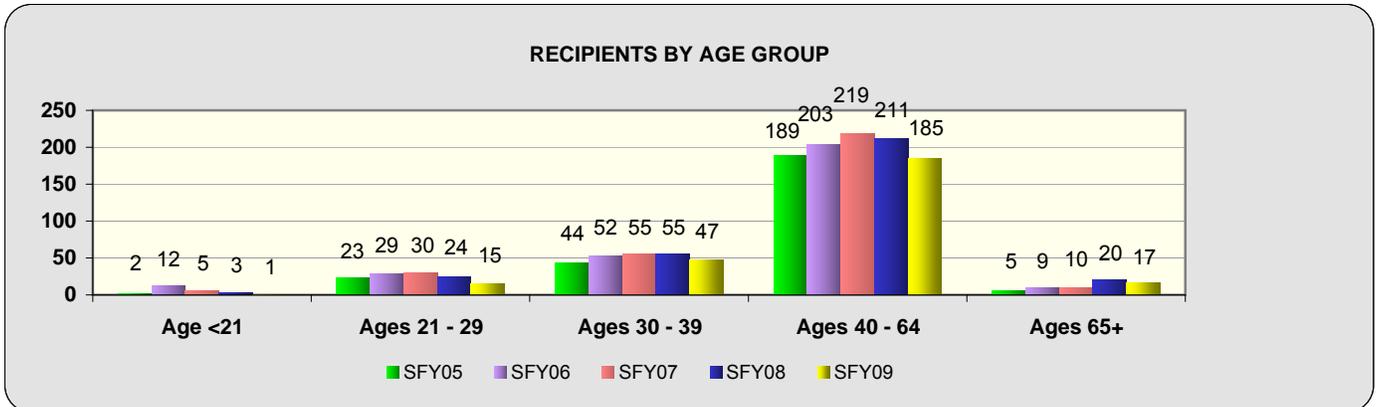
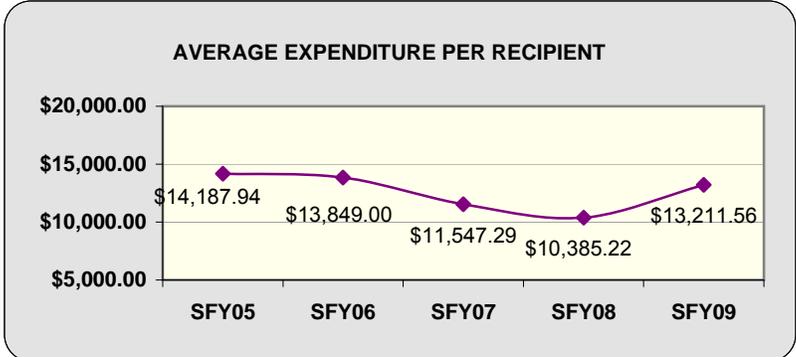
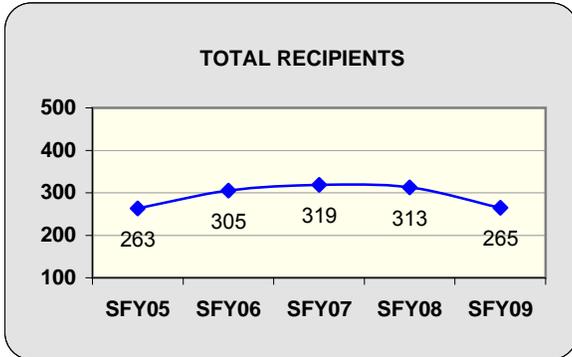
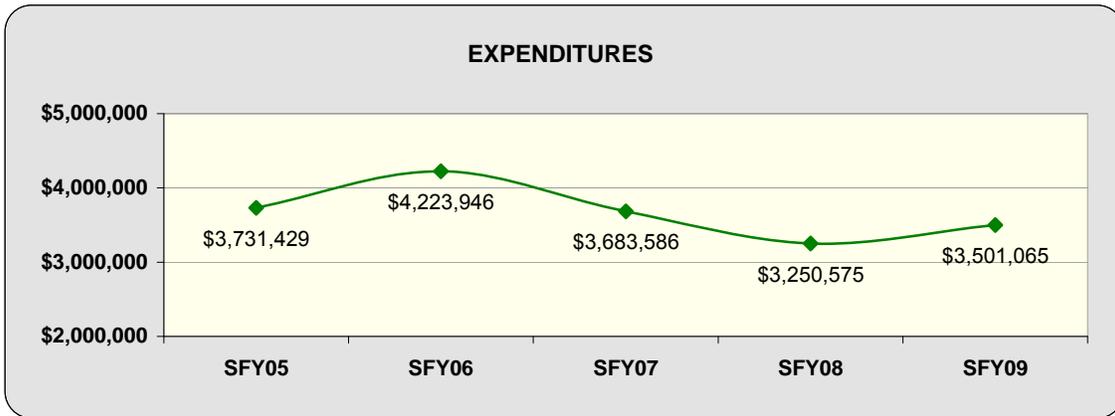
# MEDICAID FACTSHEET HEMODIALYSIS

Hemodialysis Expenditures  
as % of Total Hosp/Med Exp:  
SFY05: 0.19%  
SFY06: 0.20%  
SFY07: 0.16%  
SFY08: 0.13%  
SFY09: 0.13%

Hemodialysis services are available to Arkansas Medicaid recipients  
from 80 hemodialysis providers in 37 counties plus the states of  
Missouri, Mississippi, Oklahoma, Tennessee, and Texas

### Counties with Hemodialysis Facilities

Arkansas, Ashley, Baxter, Benton, Boone, Bradley, Chicot, Clark, Columbia, Craighead, Crittendon, Desha, Drew, Faulkner, Garland, Greene, Hempstead, Hot Spring, Independence, Jackson, Jefferson, Lafayette, Miller, Mississippi, Nevada, Quachita, Phillips, Pope, Pulaski, Saline, Sebastian, St. Francis, Union, Washington, White and Woodruff.



Source: DSS Reports; Category of Service Report; Medicaid Provider Manual

# MEDICAID FACTSHEET HOME HEALTH SERVICES

Home Health Expenditures  
as % of Total Hosp/Med Exp:  
SFY05: 0.68%  
SFY06: 0.62%  
SFY07: 0.55%  
SFY08: 0.57%  
SFY09: 0.54%

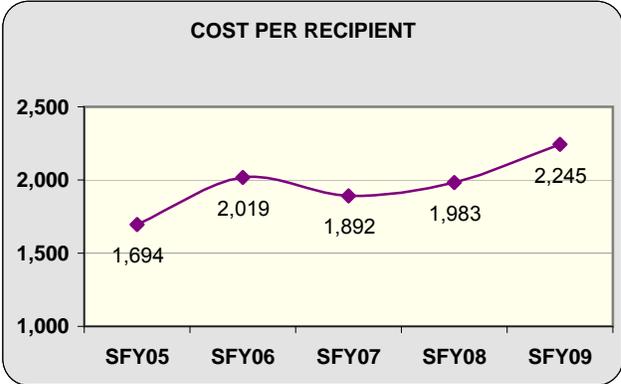
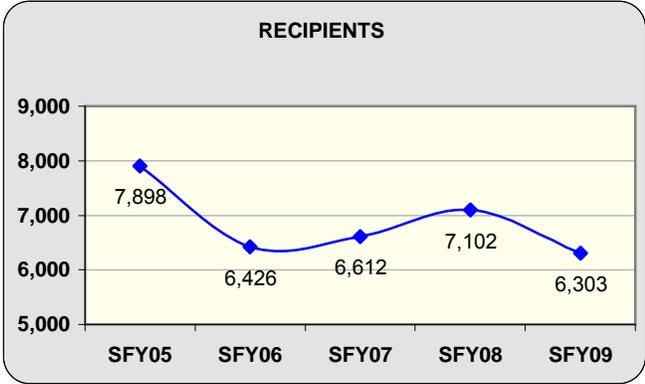
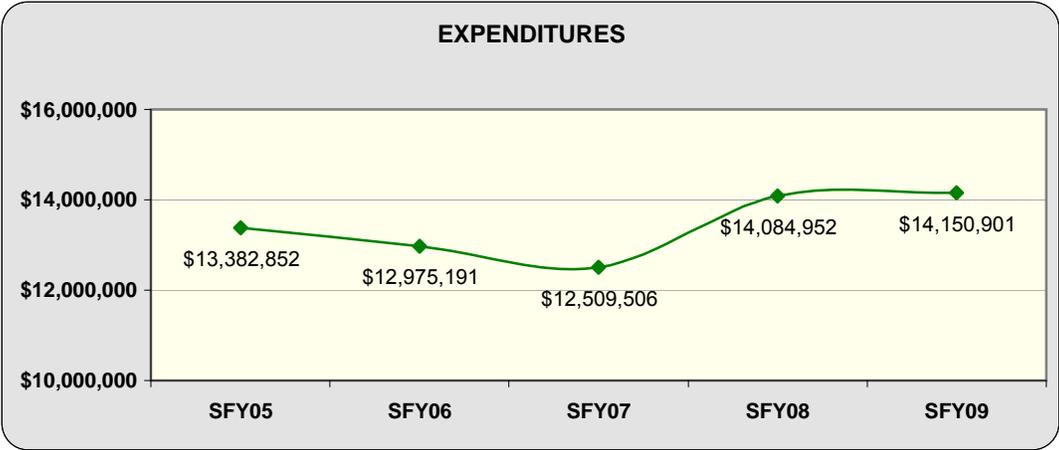
Home Health Services provides skilled nursing, home health aide and physical therapy services in the home. Services are for part-time, intermittent care, for a few hours a day, one or more times a week. Services are provided in the patient's residence.

All home health services are at the direction of the patient's attending physician.

*Home Health Services is a federally mandated program administered by the Arkansas Department of Health and private providers.*

**Benefit limit:** 50 visits per State Fiscal Year (extensions may be granted)

Home Health Services enables individuals to remain in their homes, thereby reducing the need for costly institutional care. PCP referral is required.



Source: DSS Reports; Category of Service Report; Medicaid Provider Manual

# MEDICAID FACTSHEET HOSPICE SERVICES

Hospice Expenditures  
as % of Total Hosp/Med Exp:  
SFY05: 0.67%  
SFY06: 0.86%  
SFY07: 0.96%  
SFY08: 0.82%  
SFY09: 0.83%

### DEFINITION

Hospice is a continuum of care directed by professionals, designed to meet the needs & desires of those who are terminally ill, and for whom curative medicine has exhausted its possibilities.

Hospice services are reasonable & medically necessary services.

### ELIGIBILITY

- \* Patients of all ages are eligible
- \* Dual eligibles must reside in a nursing facility
- \* Patient must have terminal illness with life expectancy of six months or less
- \* Patients elect to receive hospice service instead of certain other Medicaid benefits
- \* Hospice services must be provided primarily in patient's residence

A patient may elect to receive hospice services in a nursing facility under specific agreement; or in a hospital or nursing facility if the facility is an enrolled Medicaid Hospice provider.

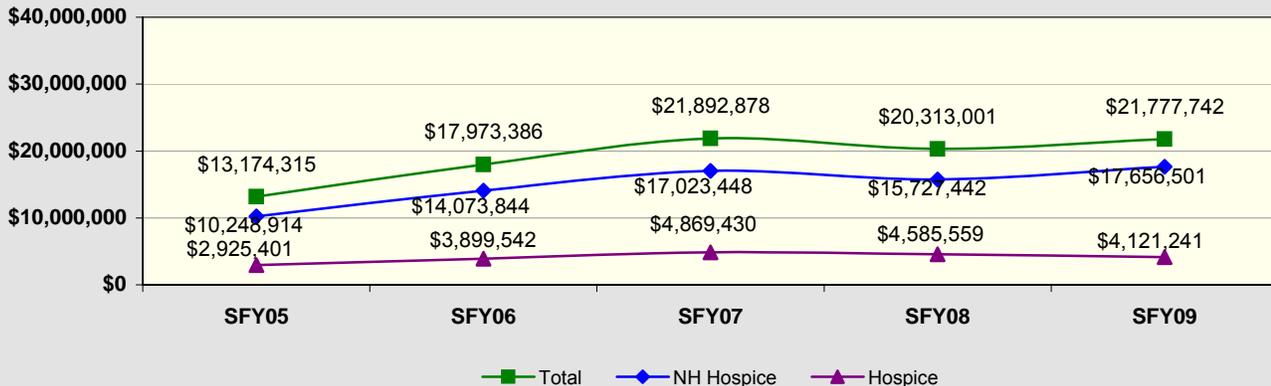
Hospice providers must have an interdisciplinary staff and volunteer assistants.

Volunteer hours must be equivalent to at least five percent of the total compensated patient care hours.

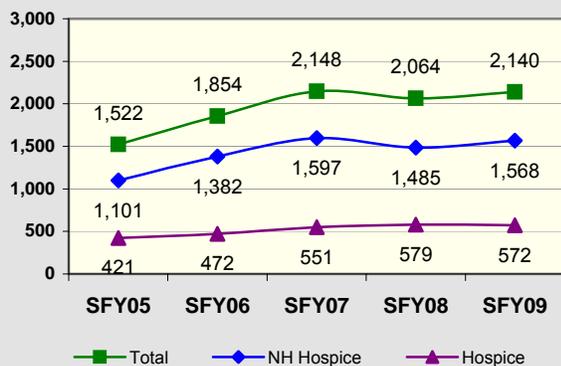
### REIMBURSABLE HOSPICE SERVICES

Nursing care; social workers; physician services; counseling services to patient/family/care givers; medical appliances & supplies including drugs; home health aide services; certain physical, occupational & speech therapy services; continuous home care during crisis period; inpatient respite care; general inpatient care.

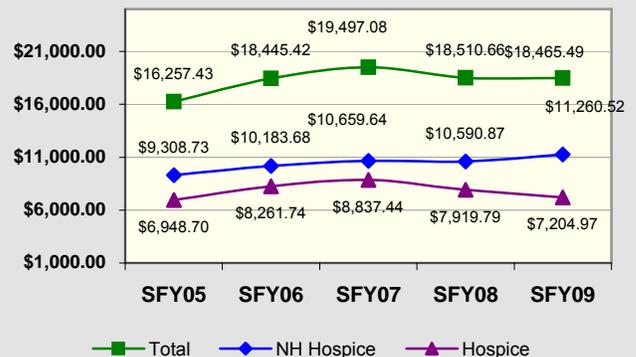
### EXPENDITURES



### RECIPIENTS



### AVERAGE EXPENDITURE PER RECIPIENT



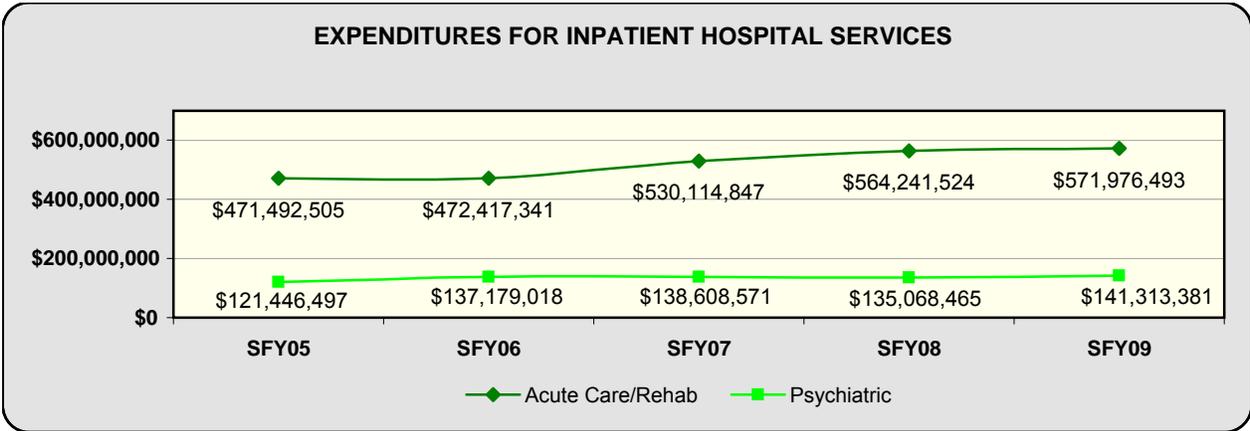
Source: DSS Reports; Category of Service Report; Medicaid Provider Manual

# MEDICAID FACTSHEET HOSPITALS

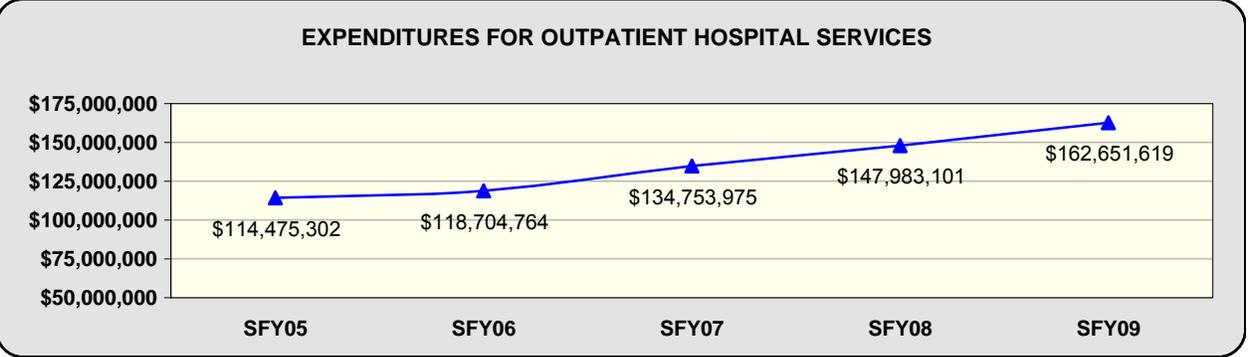
Hospital Expenditures  
as % of Total Hosp/Med Exp  
SFY05: 36.14%  
SFY06: 34.75%  
SFY07: 35.14%  
SFY08: 34.34%  
SFY09: 33.28%

RECIPIENTS - INPATIENT ACUTE CARE & REHAB HOSPITAL SERVICES					
Age	SFY05	SFY06	SFY07	SFY08	SFY09
Under 1	27,255	26,951	28,035	28,867	29,185
1 thru 20	17,442	16,501	17,191	18,112	17,605
21 thru 64	42,723	38,253	39,079	40,430	41,294
65+	<u>18,378</u>	<u>14,961</u>	<u>15,400</u>	<u>15,077</u>	<u>13,902</u>
<b>Total</b>	<b>105,798</b>	<b>96,666</b>	<b>99,705</b>	<b>102,486</b>	<b>101,986</b>

RECIPIENTS - INPATIENT PSYCHIATRIC HOSPITAL SERVICES					
Age	SFY05	SFY06	SFY07	SFY08	SFY09
Under 21	6,313	5,491	5,415	5,182	5,342
21+	<u>506</u>	<u>607</u>	<u>752</u>	<u>598</u>	<u>523</u>
<b>Total</b>	<b>6,819</b>	<b>6,098</b>	<b>6,167</b>	<b>5,780</b>	<b>5,865</b>



RECIPIENTS - OUTPATIENT ACUTE CARE & REHAB SERVICES					
Age	SFY05	SFY06	SFY07	SFY08	SFY09
Under 1	27,425	25,498	26,215	26,871	26,886
1 thru 20	202,196	160,296	166,884	169,752	176,565
21 thru 64	115,435	83,804	85,533	86,393	88,648
65+	<u>38,429</u>	<u>27,588</u>	<u>28,198</u>	<u>27,507</u>	<u>26,195</u>
<b>Total</b>	<b>383,485</b>	<b>297,186</b>	<b>306,830</b>	<b>310,523</b>	<b>318,294</b>



Source: DSS Reports; Category of Service Report; Medicaid Provider Manual

# MEDICAID FACTSHEET HYPERALIMENTATION

Hyperalimentation Expenditures  
as % of Total Hosp/Med Exp:  
SFY05: 0.04%  
SFY06: 0.05%  
SFY07: 0.06%  
SFY08: 0.09%  
SFY09: 0.08%

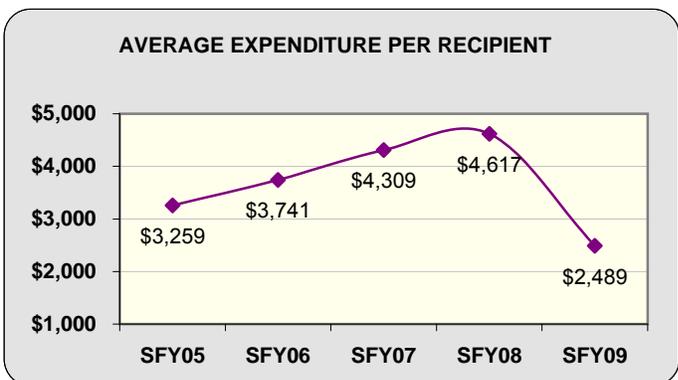
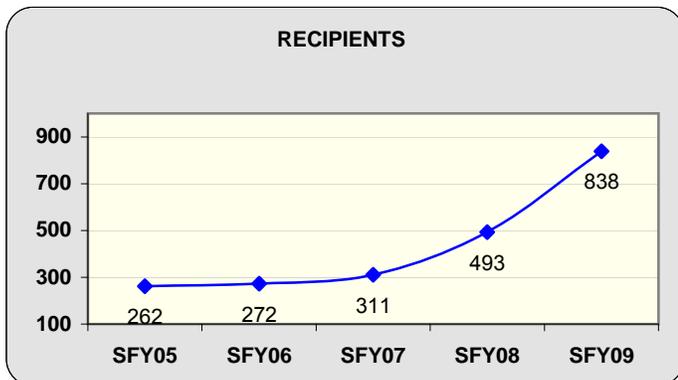
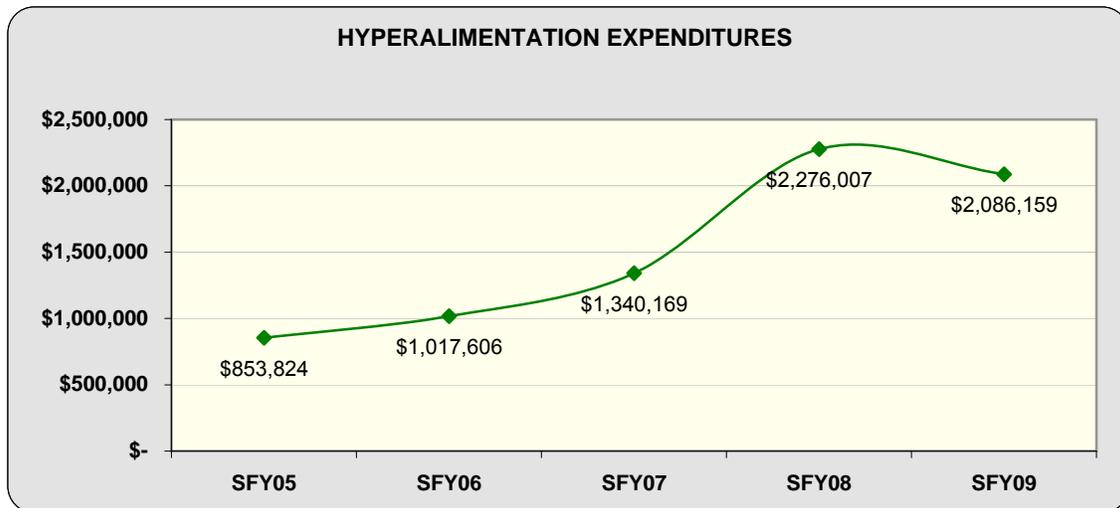
Hyperalimentation services in the beneficiary's place of residence are covered when medically necessary and prescribed by a physician following a period of hospitalization.

Enteral nutrition therapy for long term care facility residents *is not* covered.  
(*Enteral nutrition therapy services are included in long term care facility per diem.*)  
Parenteral nutrition therapy for long term care facility residents *is* covered.

Enteral nutrition therapy is considered medically necessary for a patient with a functioning gastrointestinal tract but who due to pathology or nonfunction of the structures that normally permit food to reach the digestive tract, cannot maintain weight and strength.

Parenteral nutrition therapy is considered reasonable and necessary for a patient with severe pathology of the alimentary tract which does not allow absorption of sufficient nutrients to maintain weight and strength.

**Nutritional supplementation is not covered under the Hyperalimentation Program.**



Source: DSS Reports; Category of Service Report; Medicaid Provider Manual

# MEDICAID FACTSHEET INDEPENDENTCHOICES

Independent Choices Expenditures  
as % of Total Hosp/Med Exp:  
SFY05: 0.31%  
SFY06: 0.36%  
SFY07: 0.37%  
SFY08: 0.43%  
SFY09: 0.59%

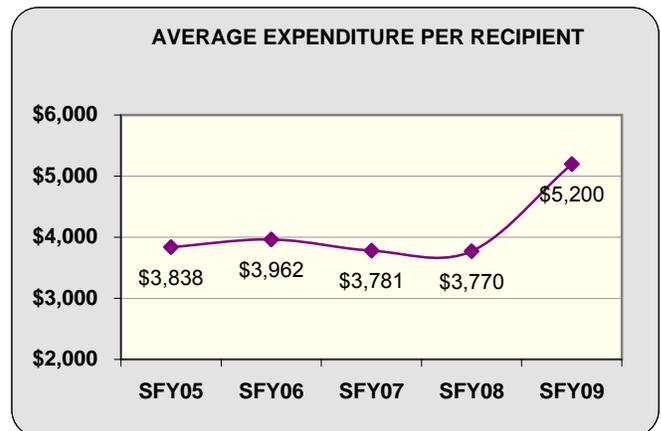
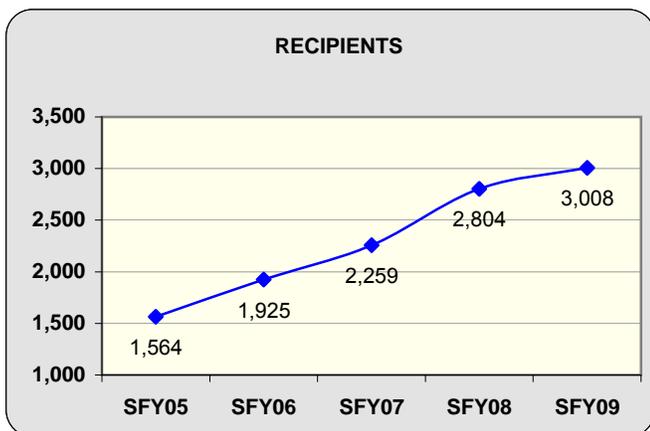
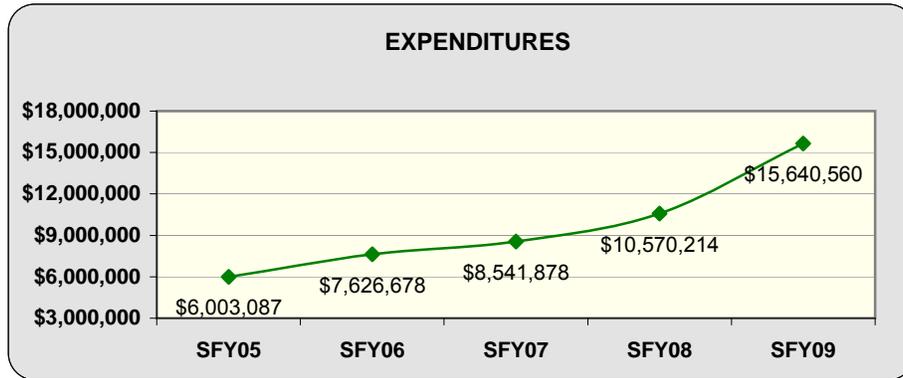
IndependentChoices offers an opportunity to Medicaid-eligible adults with disabilities (age 18 and older) and the elderly who qualify for personal care, to self-direct their care.

This program provides qualifying clients with counseling and training to assist them in administering their own personal care.

Participants also receive a cash allowance with which they may hire an assistant or purchase other services and items related to their personal care.

The goal of the IndependentChoices Program is to evaluate the efficiency and feasibility of a Medicaid personal care program that offers consumer direction with a monthly cash allowance.

IndependentChoices is administered by the Division of Aging and Adult Services (DAAS).



Source: DSS Reports; Category of Service Report; Medicaid Provider Manual

# MEDICAID FACTSHEET LABORATORY AND X-RAY

Lab & X-ray Expenditures  
as % of Total Hosp/Med Exp:  
SFY05: 1.26%  
SFY06: 1.27%  
SFY07: 1.24%  
SFY08: 1.16%  
SFY09: 1.16%

Lab and X-ray services rendered outside an inpatient hospital may be provided in a physician's office, outpatient hospital setting, ambulatory surgical center, nursing facility, or a certified independent laboratory.

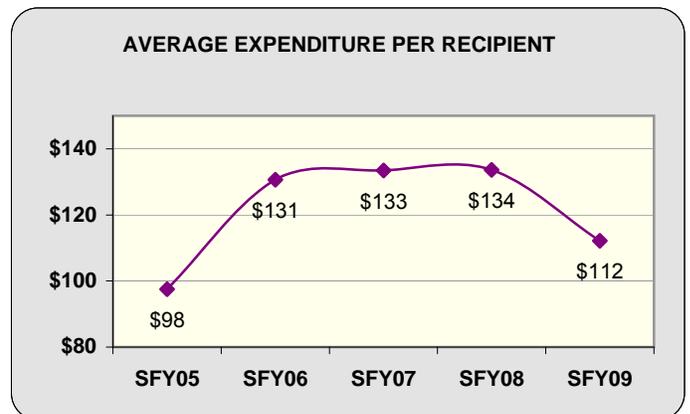
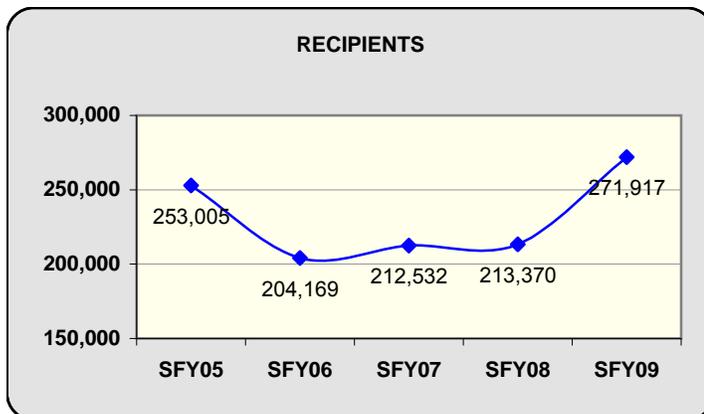
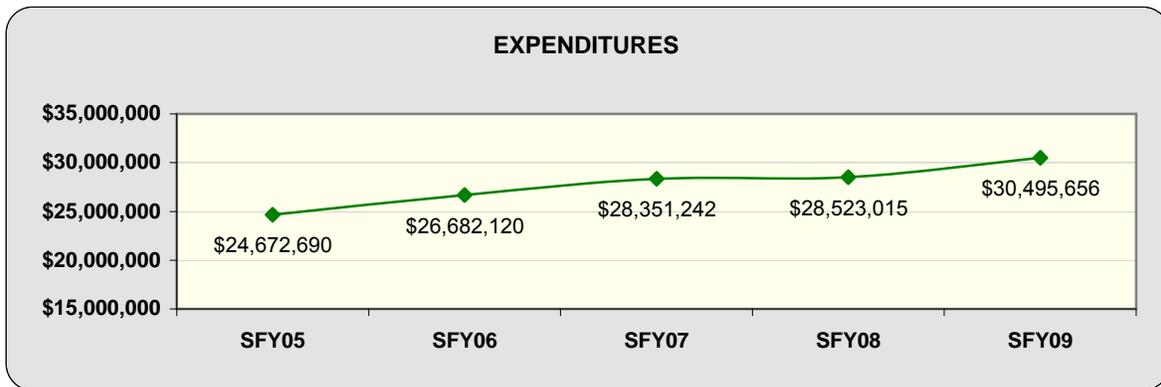
For recipients age 21 and older, there is a benefit limit of \$500 per year for lab and x-ray services with extension considerations for those recipients requiring life-maintaining treatment.

*No benefit limit exists for recipients under age 21.*

Diagnoses exempt from benefit limit include malignant neoplasm, renal failure, HIV infection and AIDS. Procedures exempt from benefit limit include magnetic resonance imaging (MRI) and cardiac catheterization.

Fetal non-stress test limit of two per pregnancy; ultrasound limit of two per pregnancy.  
Extensions may be granted for medical necessities.

Portable x-ray services are included in the lab and x-ray services benefit limit of \$500 per state fiscal year.



Source: DSS Reports; Category of Service Report; Medicaid Provider Manual

# MEDICAID FACTSHEET LICENSED MENTAL HEALTH PRACTITIONER

Licensed Mentl Hlth Pract Expenditures  
as % of Total Hosp/Med Exp:  
SFY05: 0.07%  
SFY06: 0.04%  
SFY07: 0.04%  
SFY08: 0.04%  
SFY09: 0.03%

The Licensed Mental Health Practioner Program consists of a range of mental health diagnostic, therapeutic, rehabilitative or palliative services provided by a licensed psychologist, licensed certified social worker, licenced marital and family therapist or licensed professional counselor to Medicaid eligible beneficiaries under the age of 21 who are diagnosed with psychiatric conditions as described in the American Psychiatric Association Diagnostic and Statistical Manual (DSM IV) and subsequent revisions.

## Psychology Services

- \* referred by a physician
- \* provided to outpatients
- \* provided by licensed psychologist
- \* when applicable, provided according to an individualized Education Plan
- \* provided to both ArKids-A and ARKids-B beneficiaries

- Services are covered when provided in--**
- \* provider's office
  - \* outpatient acute care hospital setting
  - \* public school system setting under authority of Arkansas Department of Education

## Licensed Professional Services

- \* referred by a physician
- \* provided to outpatients
- \* provided by LCSW, LMFT & LPC
- \* provided to ARKids-A beneficiaries

- Services are covered when provided in--**
- \* provider's office

Licensed Mental Health Practioner services are not available to inpatients. Licensed Mental Health Professionals may not bill for services provided in a rehabilitative services for persons with mental illness (RSPMI) clinic or an inpatient psychiatric facility. The individual facility must bill through their respective program.

Covered services include: diagnosis; psychological evaluation by psychologist; interpretation of diagnosis; crisis management visits; individual outpatient therapy sessions; marital/family therapy; group outpatient therapy.

### EXPENDITURES



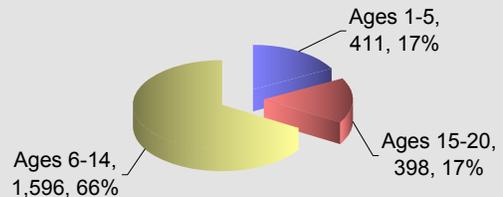
### RECIPIENTS



### AVERAGE EXPENDITURE PER RECIPIENT



### RECIPIENTS BY AGE GROUP - SFY09



Source: DSS Reports; Category of Service Report; Medicaid Provider Manual

# MEDICAID FACTSHEET LONG TERM CARE

Long Term Care Expenditures  
as % of Total Medicaid Program Exp:  
SFY05: 20.70%  
SFY06: 20.94%  
SFY07: 20.48%  
SFY08: 19.97%  
SFY09: 19.33%

## TWO LEVELS OF FACILITY CARE

1. Nursing Facility Services
2. Intermediate Care Facility Services for the Mentally Retarded and Developmentally Disabled (ICF/MR)

<b>Total Nursing Facility Beds:</b>	27,776
<b>Total ICF/MR Beds:</b>	1,695

There are 27,000+ active Certified Nursing Assistants in Arkansas.  
The Office of Long Term Care (OLTC) handles the license renewals, approves training sites and programs and maintains records.

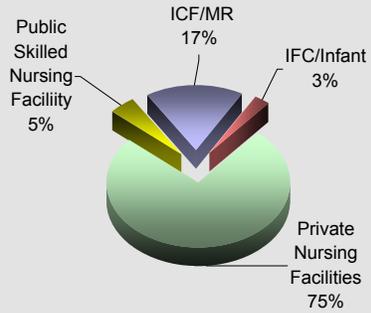
## Arkansas classifies state-owned facilities as public and all others as private.

- 1 public skilled nursing facility - Arkansas Health Care Center Nursing Facility
- 228 private nursing homes
- 6 public ICF/MR (Human Development Centers) - Alexander, Arkadelphia, Booneville, Conway, Jonesboro, and Warren
- 4 private pediatric ICF/MR - Arkansas Pediatric, Brownwood, Millcreek and Easter Seals
- 31 private non-profit fifteen-bed or less ICF/MR facilities for adults

## EXPENDITURES



## EXPENDITURE BREAKDOWN



## RECIPIENTS



## AVERAGE EXPENDITURE PER RECIPIENT



Source: Source: DSS Reports; Category of Service Report; Medicaid Annual Statistical Reports; Medicaid Provider Manual

# MEDICAID FACTSHEET MATERNITY SERVICES

Maternity Services Expenditures  
as % of Total Hosp/Med exp:  
SFY05: 1.36%  
SFY06: 1.33%  
SFY07: 1.24%  
SFY08: 1.19%  
SFY09: 1.07%

## Individuals by age who gave birth in SFY09

Age ->	under 14	14-15	16-17	18-19	20-24	25-29	30-39	40+	Total
	11	231	1,127	3,156	8,559	4,661	2,638	137	20,520
% of Total	0.05%	1.13%	5.49%	15.38%	41.71%	22.71%	12.86%	0.67%	

## Maternity Clinics

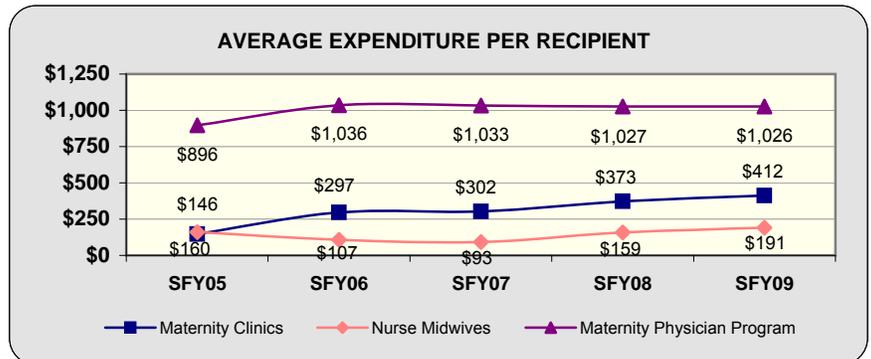
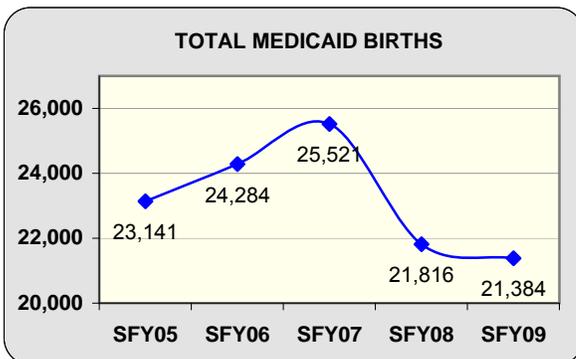
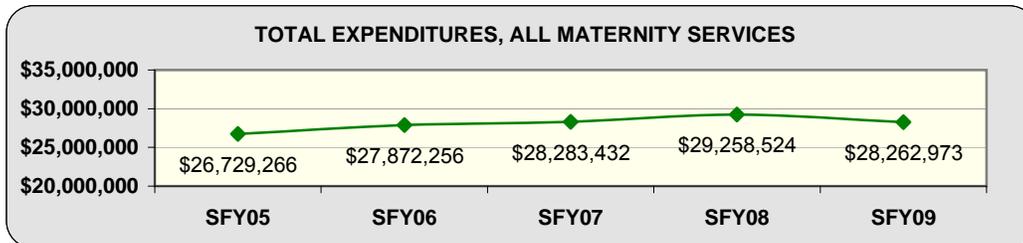
	SFY06	% Change from Prev Yr	SFY07	% Change from Prev Yr	SFY08	% Change from Prev Yr	SFY09
Recipients	14,246	-12.86%	12,414	-9.27%	11,263	-10.22%	10,112
Expenditures	\$4,236,407	-11.64%	\$3,743,257	12.21%	\$4,200,402	-0.86%	\$4,164,417
Exp per Recip	\$297	1.53%	\$302	23.68%	\$373	10.43%	\$412

## Nurse Midwives

	SFY06	% Change from Prev Yr	SFY07	% Change from Prev Yr	SFY08	% Change from Prev Yr	SFY09
Recipients	792	37.75%	1,091	14.39%	1,248	-23.56%	954
Expenditures	\$84,541	20.27%	\$101,677	94.70%	\$197,965	-8.03%	\$182,071
Exp per Recip	\$107	-12.90%	\$93	70.21%	\$159	20.31%	\$191

## Maternity Physician Program

	SFY06	% Change from Prev Yr	SFY07	% Change from Prev Yr	SFY08	% Change from Prev Yr	SFY09
Recipients	22,726	4.11%	23,659	2.32%	24,207	-3.71%	23,309
Expenditures	\$23,551,308	3.77%	\$24,438,499	1.73%	\$24,860,157	-3.80%	\$23,916,486
Exp per Recip	\$1,036	-0.29%	\$1,033	-0.58%	\$1,027	-0.09%	\$1,026



Source: DSS Reports; Category of Service Report; Medicaid Provider Manual

# MEDICAID FACTSHEET MEDICARE BUY-IN

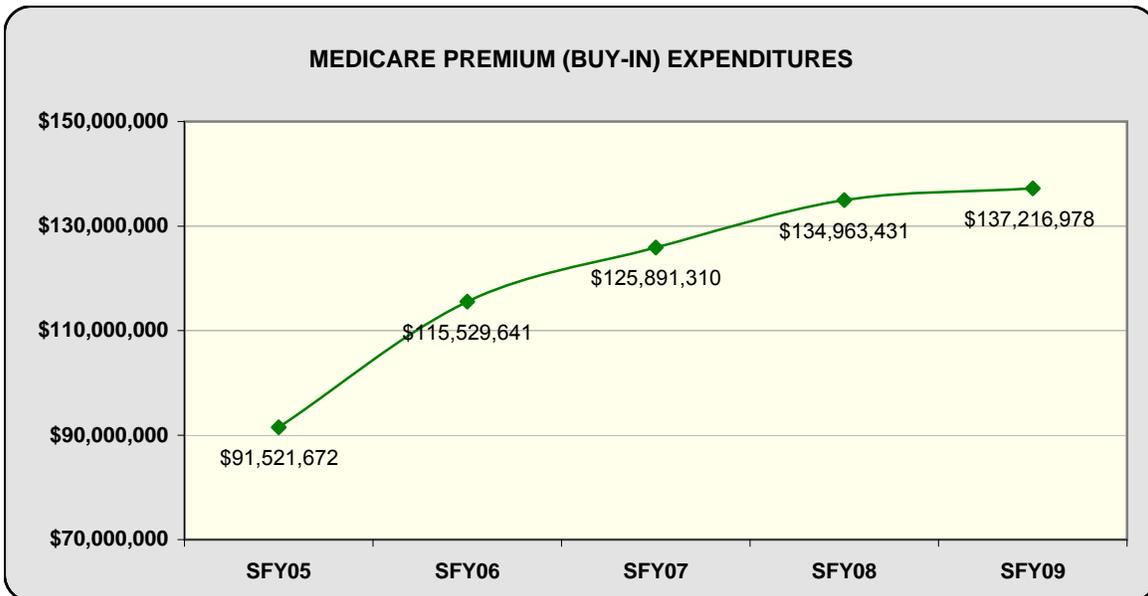
Medicare Buy-in Expenditures  
as % of Total Hosp/Med Exp:  
SFY05: 4.68%  
SFY06: 5.51%  
SFY07: 5.51%  
SFY08: 5.47%  
SFY09: 5.21%

The Qualified Medicare Beneficiary (QMB) Program was created by the Medicare Catastrophic Coverage Act.  
It uses Medicaid funds to assist low income Medicare beneficiaries.

Under the QMB Program, Medicaid pays the Medicare Part B premium, the Medicare Part B deductible and the Medicare Part B coinsurance less any Medicaid cost-sharing for Medicare covered medical services.

Medicaid also pays the Medicare Part A premium, the Medicare Part A hospital deductible and the Medicare Part A coinsurance less any Medicaid cost-sharing.

*For a QMB eligible, Medicaid pays for Medicare-covered services only. If the service provided to the patient is not a Medicare-covered service, Medicaid will not pay for it.*



Source: DSS Reports; Category of Service Report; Medicaid Provider Manual

# MEDICAID FACTSHEET

## MENTAL HEALTH

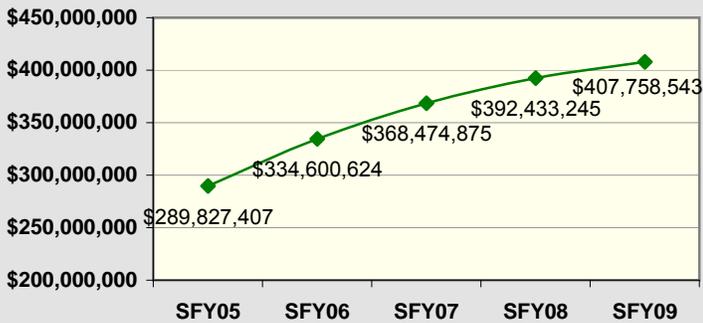
Mental Health Expenditures  
as % of Total Hosp/Med Exp:  
SFY05: 14.61%  
SFY06: 15.97%  
SFY07: 16.13%  
SFY08: 15.91%  
SFY09: 15.49%

Mental Health Services are provided by Rehabilitative Services for Persons with Mental Illness (RSPMI).

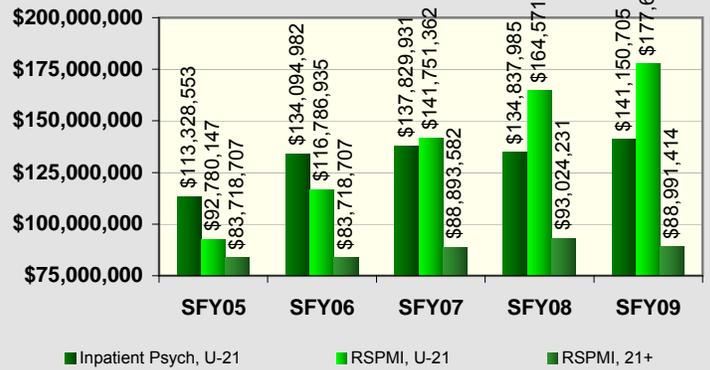
There is no inpatient benefit limit for Medicaid-eligible individuals under age 21. The benefit limit for general and rehabilitative hospital inpatient services is 24 paid inpatient days per state fiscal year (July 1 through June 30) for Medicaid recipients age 21 and older. Extension of this benefit is not available.

Outpatient Services for Rehabilitative Services for Persons with Mental Illness (RSPMI) are provided through facilities licensed by the Division of Behavioral Health Services (DBHS).

**TOTAL EXPENDITURES**



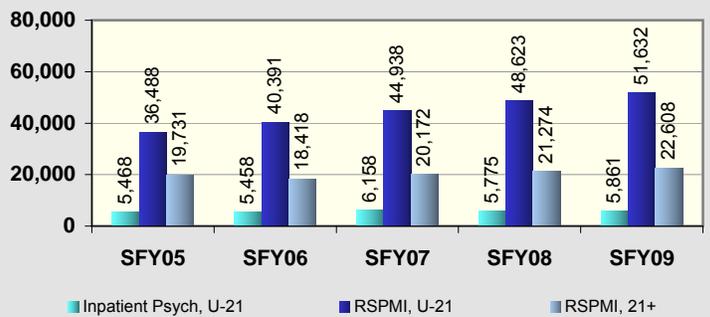
**EXPENDITURES BY GROUP**



**TOTAL RECIPIENTS**



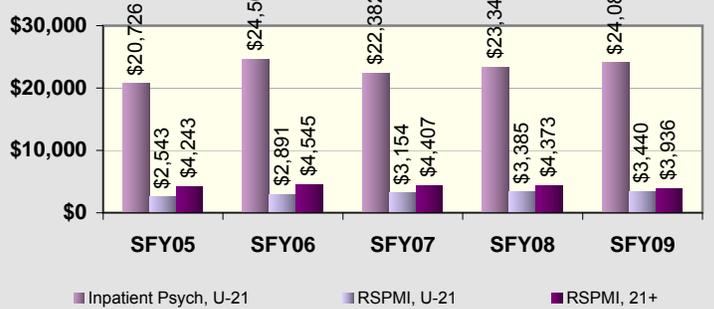
**RECIPIENTS BY GROUP**



**OVERALL AVERAGE EXPENDITURE PER RECIPIENT**



**AVERAGE COST PER RECIPIENT BY GROUP**



Source: DSS Reports; Category of Service Report; Medicaid Provider Manual

# MEDICAID FACTSHEET NON-EMERGENCY TRANSPORTATION

Transportation Expenditures  
as % of Total Hosp/Med Exp:  
SFY05: 0.47%  
SFY06: 0.47%  
SFY07: 0.45%  
SFY08: 0.43%  
SFY09: 0.42%

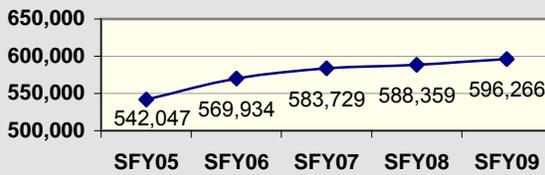
## Arkansas Medicaid Non-emergency Transportation (NET) Program

This program operates under the authority of a Section 1915(b) waiver.  
In the NET program, the state is divided into 11 regions. In each region, a single broker is contracted to provide non-emergency medical transportation for Medicaid beneficiaries. A broker may be contracted to provide service in a single or multiple regions. Reimbursement is by capitation.

### NET EXPENDITURES



### NET RECIPIENTS



### AVERAGE EXPENDITURE PER NET RECIPIENT



The only non-public transportation providers are Developmental Day Treatment Clinic Services (DDTCS) providers who are enrolled in the transportation program to transport their clients to the DDTCS facility and back to their homes from the facility.

Non-public transportation providers are reimbursed on a fee for service, per-loaded-mile basis, in accordance with the Arkansas Medicaid fee schedule. Per covered trip, they may bill for only the Medicaid beneficiary traveling the greatest distance. Medicaid-eligible DDTCS clients must use NET for all other medical transportation.

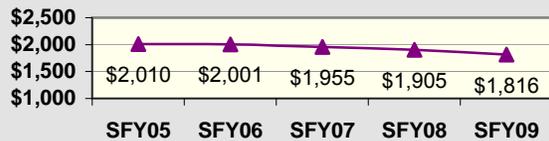
### NON-PUBLIC TRANSPORTATION EXPENDITURES



### NON-PUBLIC TRANSPORTATION RECIPIENTS



### AVERAGE EXPENDITURE PER NON-PUBLIC TRANSPORTATION RECIPIENT



Source: DSS Reports; Category of Service Report; Medicaid Provider Manual

# MEDICAID FACTSHEET PERSONAL CARE

Personal Care Expenditures  
as % of Total Hosp/Med Exp:  
SFY05: 3.10%  
SFY06: 2.76%  
SFY07: 2.54%  
SFY08: 2.37%  
SFY09: 2.29%

Personal care services include medically necessary assistance with defined activities of daily living such as grooming, bathing, food preparation and eating, etc., that are rendered in the home.

For EPSDT recipients under age 21, services may also be provided in the Division of Developmental Disabilities Services (DDS) community provider facilities or in the public schools. The Arkansas Medicaid Personal Care Services Program requires prior authorization (PA) for dates of service on and after December 1, 1977.

### **Personal Care Services is an optional program.**

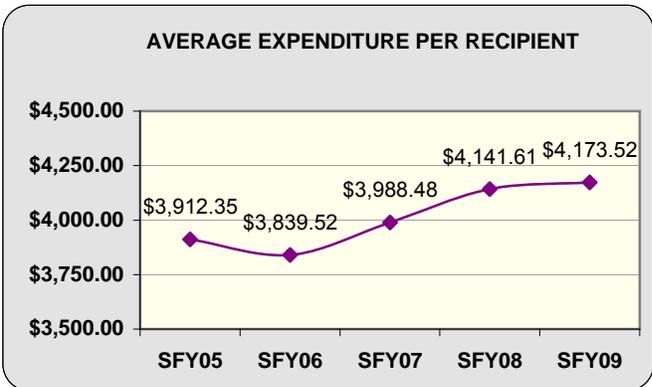
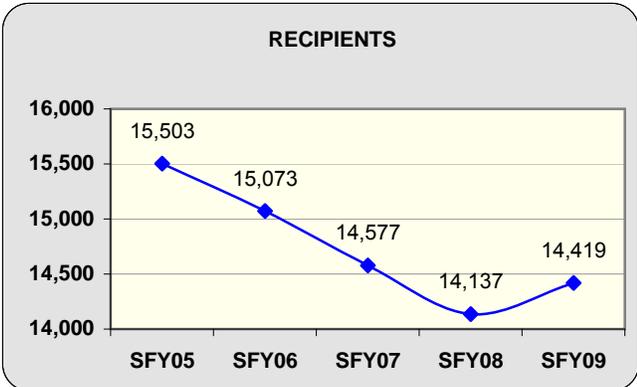
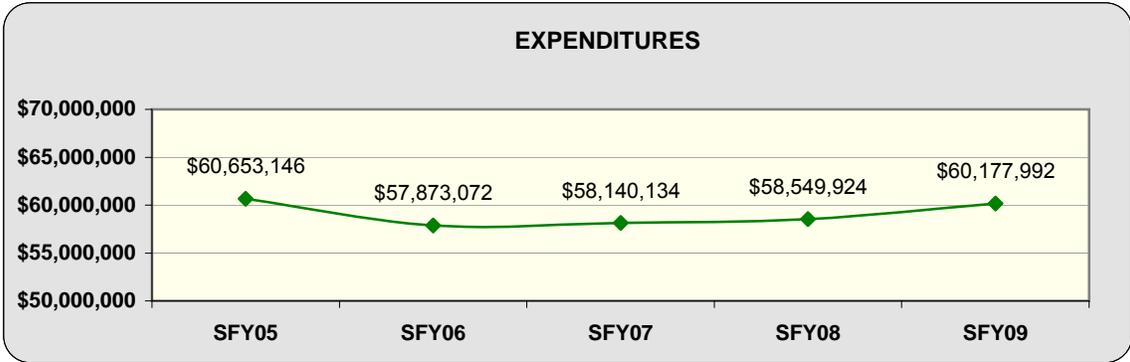
Medicaid imposes a 64-hour benefit limit, per month, per client, on personal care aide services for clients aged 21 and over.

The 64-hour limitation applies to dates of service on and after August 1, 1997. Extension of the benefit limit is available, based on medical necessity.

IndependentChoices offers an opportunity to Medicaid-eligible adults with disabilities (age 18 and older) and the elderly who qualify for personal care, to self-direct their care.

IndependentChoices is a program that provides qualifying clients with counseling and training to assist them in administering their personal care. Participants also receive a cash allowance with which they may hire an assistant or purchase other services and items related to their personal care.

The goal of the IndependentChoices Program is to evaluate the efficiency and feasibility of a Medicaid personal care program that offers consumer direction with a monthly cash allowance.



NOTE: These charts represent state plan Personal Care and do not include IndependentChoices information.

Source: DSS Reports; Category of Service Report; Medicaid Provider Manual

# MEDICAID FACTSHEET PHYSICIAN SERVICES

Physician Services Expenditures  
as % of Total Hosp/Med Exp:  
SFY05: 13.51%  
SFY06: 13.68%  
SFY07: 12.10%  
SFY08: 13.14%  
SFY09: 11.92%

## Physician Services Benefit Limitations

- 12 visits per State Fiscal Year for recipients age 21 & older
- No limit for recipients under age 21 in the EPSDT Program
- Extensions are considered when medically necessary
- Two physician consultations per State Fiscal Year
- Extension of benefits not required when primary diagnosis is Malignant Neoplasm, HIV, Renal Failure or Pregnancy

## Physicians and Physician Groups

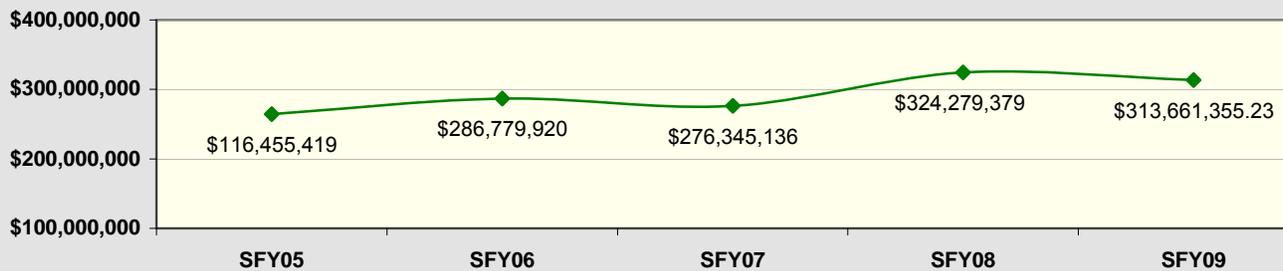
During SFY09, approximately 10,988 were enrolled as Medicaid Providers. Approximately 4,443 were participating.

Physicians enrolled as Medicaid providers are responsible for certifying that services are medically necessary, and that prescribed treatments are in accordance with excellence in medical practice and economic considerations.

The Arkansas Medicaid Primary Care Physician Managed Care Program (ConnectCare) is mandatory for most recipients. The program promotes coordination of care & monitoring of outcomes. A Primary Care Physician (PCP) can be a Family Practitioner, General Practitioner, Internist, Obstetrician/Gynecologist, or Pediatrician.

**All ARKids First participants are required to have a PCP as a condition of eligibility.**

## EXPENDITURES \*



## RECIPIENTS



## AVERAGE EXPENDITURE PER RECIPIENT



Source: DSS Reports; Category of Service Report; Medicaid Provider Manual

# MEDICAID FACTSHEET PRESCRIPTION DRUGS

Prescription Drug Expenditures  
as % of Total Medicaid Program Exp:  
SFY05: 14.20%  
SFY06: 12.25%  
SFY07: 10.18%  
SFY08: 10.20%  
SFY09: 9.85%

## Benefit Limits

Three prescriptions per recipient per month (extensions possible); family planning items do not count against limit.  
No limit for children under 21 (EPSDT) and certified nursing home residents.

## In SFY09 there were 862 participating pharmacies available to Medicaid recipients.

The Medicaid Drug Rebate Program created by OBRA, 1990 - law requires that Medicaid reimburse only for drugs manufactured by pharmaceutical companies that have signed rebate agreements.  
Approximately 639 drug companies currently participate.  
The Rebate Program gives Medicaid the equivalent of large volume purchasing advantages.

## EXPENDITURES



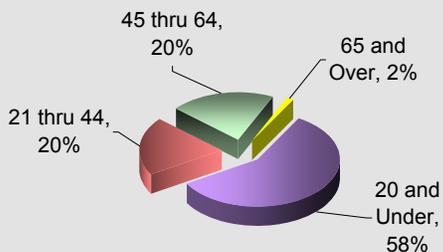
## RECIPIENTS



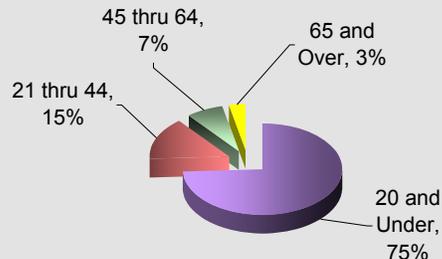
## AVERAGE PRESCRIPTION PRICE



## EXPENDITURES BY AGE GROUP - SFY09



## RECIPIENTS BY AGE GROUP - SFY09



Source: DSS Reports; Category of Service Report; Medicaid Provider Manual

# MEDICAID FACTSHEET PRIVATE DUTY NURSING

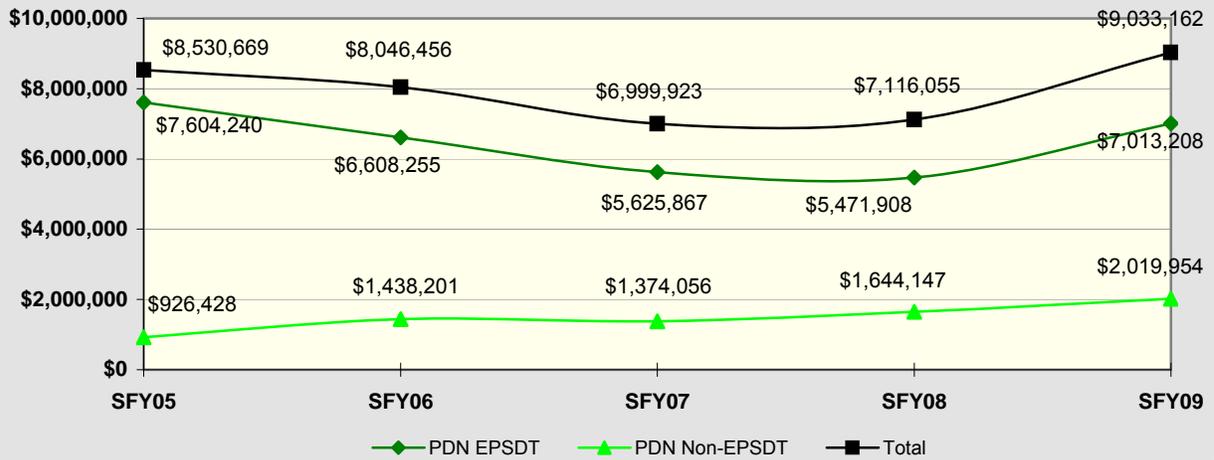
Private Duty Nursing Expenditures  
as % of Total Hosp/Med Exp:  
SFY05: 0.44%  
SFY06: 0.38%  
SFY07: 0.31%  
SFY08: 0.29%  
SFY09: 0.34%

Private Duty Nursing (PDN) Services are provided by a registered nurse and/or licensed practical nurse under the direction of the recipient's physician.  
Services are rendered in the recipient's place of residence.  
PDN Services are not covered in a hospital, boarding home, intermediate care facility, skilled nursing facility or a residential care facility.  
There is an \$80 per month, per recipient benefit limit on Private Duty Nursing medical supplies; limit may be extended.

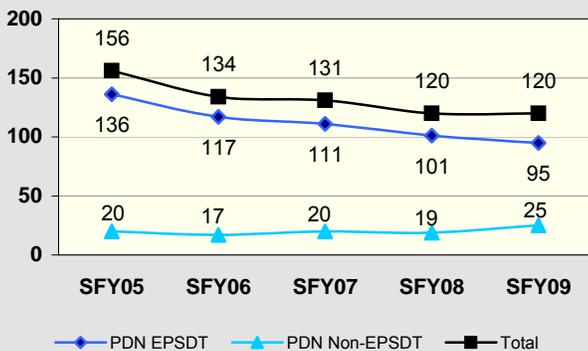
## ELIGIBILITY

PDN services may be covered for Medicaid eligible ventilator-dependent recipients when determined to be medically necessary and prescribed by a physician.  
Coverage may also be available for high technology non-ventilator dependent recipients in the Child Health Services Program (EPSDT) who require:  
Prolonged Intravenous Drugs; Parenteral Nutrition; Oxygen Supplementation; Tube Feeding; and Peritoneal Dialysis.

## EXPENDITURES



## RECIPIENTS



### AVERAGE EXPENDITURE PER RECIPIENT, SFY09

	SFY09	SFY08	SFY07	SFY06	SFY05
<b>EPSDT</b>	\$73,823	\$54,177	\$50,683	\$56,481	\$55,914
<b>Non-EPSDT</b>	\$80,798	\$86,534	\$68,703	\$84,600	\$46,321
<b>Total</b>	\$75,276	\$59,300	\$53,435	\$60,048	\$54,684

Source: DSS Reports; Category of Service Report; Medicaid Provider Manual

# MEDICAID FACTSHEET PROSTHETICS SERVICES/DME

Prosthetics/DME Expenditures  
as % of Total Hosp/Med Exp:  
SFY05: 1.50%  
SFY06: 1.65%  
SFY07: 1.44%  
SFY08: 1.54%  
SFY09: 1.41%

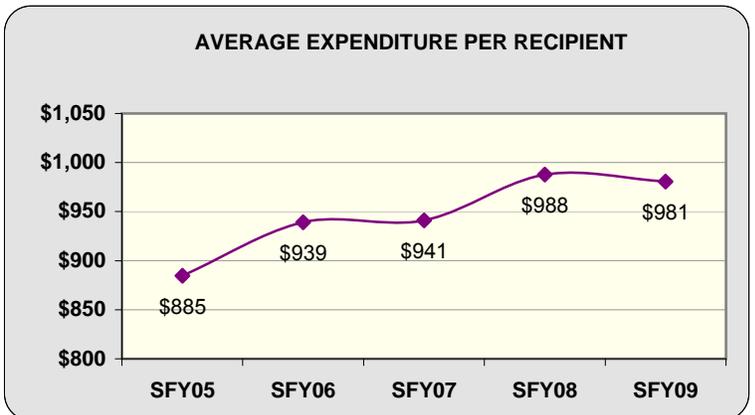
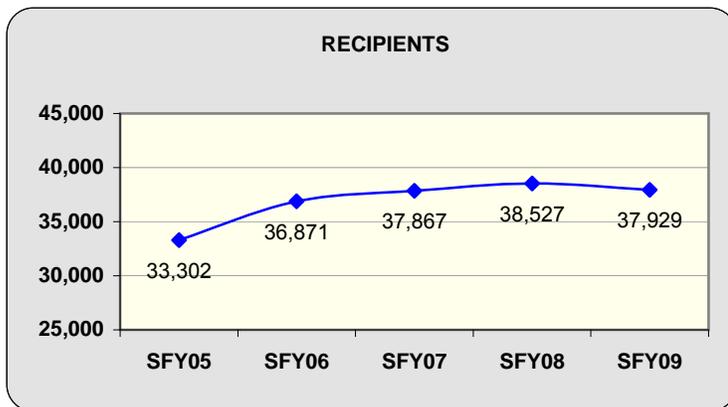
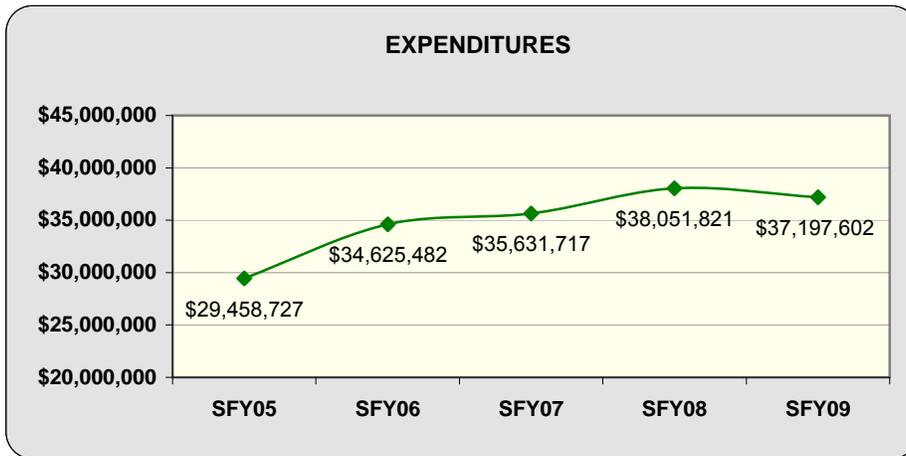
"Prosthetics Services" is defined as durable medical equipment (DME)/oxygen, orthotic appliances, prosthetic devices, augmentative communication devices, specialized wheelchairs, wheelchair seating systems and specialized rehabilitative equipment. Prosthetics Services may include any or all of these services.

Services must be medically necessary and prescribed by the recipient's Primary Care Physician (PCP) unless the recipient is exempt from PCP requirements. Specified services are covered for recipients of all ages. Certain services are covered only for recipients under age 21 in the EPSDT Program. Where applicable, Prior Authorization is required.

***In order to be covered for services, a recipient's place of residence may not include a hospital, a skilled nursing facility, intermediate care facility or any other supervised living setting which is required to provide prosthetic***

- Non-covered Services:**
- \* Orthotic appliances and prosthetic devices for recipients over age 21
  - \* Over-the-counter items provided through the Pharmacy Program
  - \* Over-the-counter drugs
  - \* Specialized wheelchair equipment which has ever been previously purchased for the recipient
  - \* Wheelchairs for recipients under age 21 within two years of the purchase of a specialized wheelchair
  - \* Food stuffs; hyperalimentation

***At least once every 6 months, the Primary Care Physician must certify medical necessity for prosthetics services.***



Source: DSS Reports; Category of Service Report; Medicaid Provider Manual

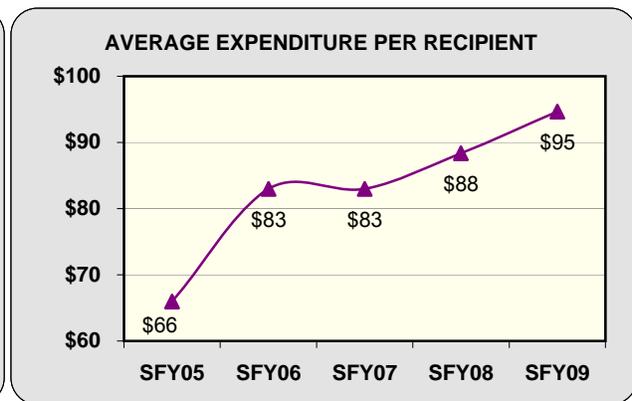
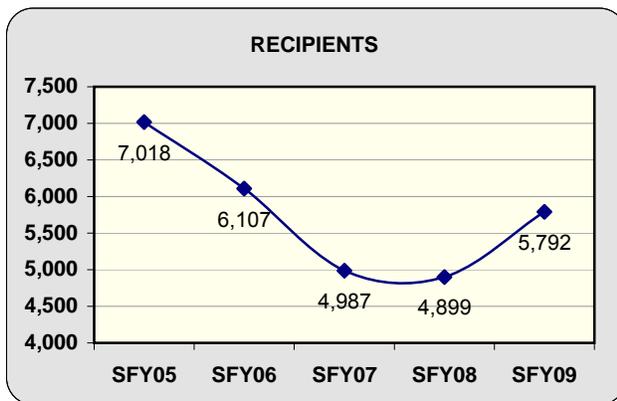
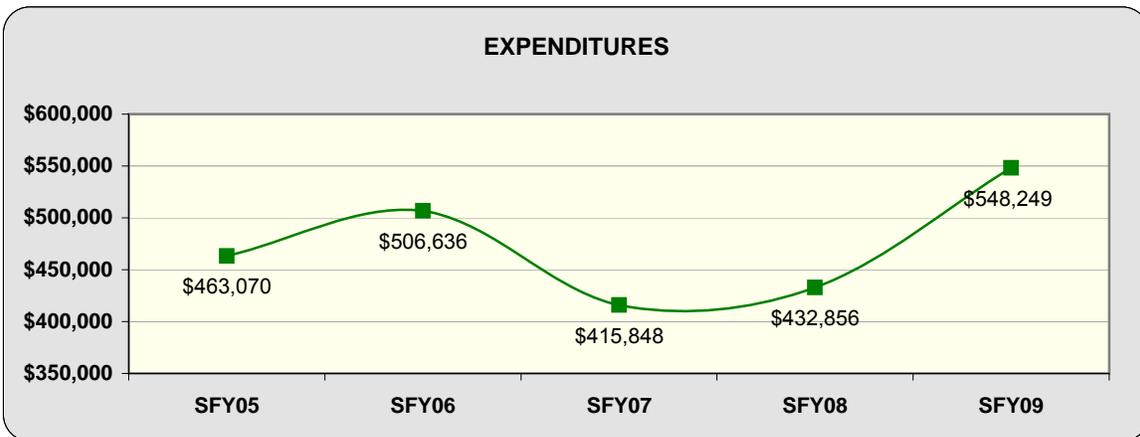
# MEDICAID FACTSHEET REGISTERED NURSE PRACTITIONER

RNP Expenditures  
as % of Total Hosp/Med Exp:  
SFY05: 0.024%  
SFY06: 0.024%  
SFY07: 0.018%  
SFY08: 0.018%  
SFY09: 0.021%

A Registered Nurse Practitioner (RNP) is a licensed professional nurse who specializes in Pediatrics, Family Practice, Gerontological services or OB/GYN and provides direct care to individuals, families and other groups. Settings for care may include private homes, hospitals, offices, industry, schools, nursing homes, and other health care settings.

RNPs plan and initiate health care programs as a member of a health care team; RNPs make independent decisions about nursing care needs of patients; RNPs are directly accountable for quality of care rendered.

RNPs may bill one visit per day for inpatient hospital covered days; Benefit Limit: 12 RNP outpatient visits per State Fiscal Year, Recipients Age 21+; No Benefit Limit for recipients under Age 21 in EPSDT; Extensions of benefit limit are not available.



Source: DSS Reports; Category of Service Report; Medicaid Provider Manual

# MEDICAID FACTSHEET RURAL HEALTH CLINICS

Rural Health Clinic Expenditures  
as % of Total Hosp/Med Exp:  
SFY05: 0.49%  
SFY06: 0.56%  
SFY07: 0.46%  
SFY08: 0.45%  
SFY09: 0.47%

## Counties with Rural Health Clinics

Arkansas, Ashley, Benton, Boone, Chicot, Clay, Cleburne, Columbia, Conway, Crawford, Dallas, Desha, Faulkner, Franklin, Fulton, Greene, Hempstead, Independence, IZard, Lafayette, Lawrence, Lincoln, Logan, Marion, Mississippi, Monroe, Newton, Ouachita, Phillips, Poinsett, Pope, Randolph, Saline, Scott, Searcy, Sharp, Van Buren, and Woodruff

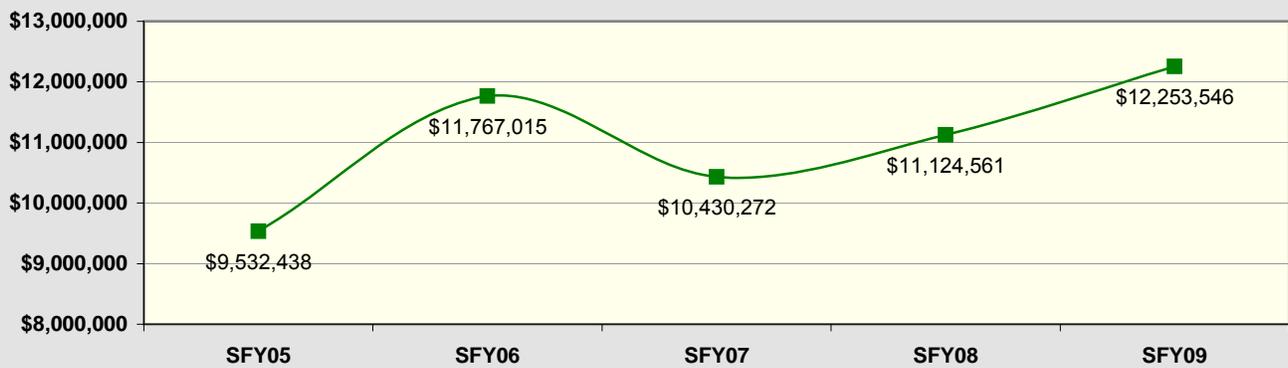
Rural Health Clinics are located in 38 counties throughout Arkansas, as well as in the 4 states of Louisiana, Missouri, Mississippi and Texas.

There are 91 Rural Health Clinics available to Arkansas Medicaid recipients.

## Health Care Challenges Facing Rural Areas

- \* Shortage of primary care providers
- \* Difficult to recruit and retain physicians
- \* Long travel distances to providers
- \* Small rural hospitals often struggle financially

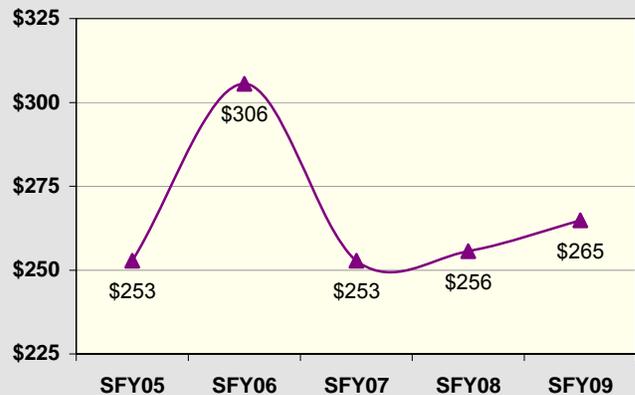
## EXPENDITURES



## RECIPIENTS



## AVERAGE EXPENDITURE PER RECIPIENT



Source: DSS Reports; Category of Service Report; Medicaid Provider Manual

# MEDICAID FACTSHEET TARGETED CASE MANAGEMENT

Targeted Case Management Expenditures  
as % of Total Hosp/Med Exp:  
SFY05: 0.10%  
SFY06: 0.08%  
SFY07: 0.11%  
SFY08: 0.06%  
SFY09: 0.05%

## TARGETED CASE MANAGEMENT

This program is designed to assist individuals in receiving necessary care and to coordinate services for those individuals. Recipients age 21 and older are limited to 104 hours of Targeted Case Management services per state fiscal year. There is no benefit limit for recipients under age 21.

Services are reimbursable when they are medically necessary, prescribed as the result of an EPSDT screen for recipients under age 21 ineligible for Developmental Disabilities Services, provided to recipients who have no reliable and available supports, and provided by a qualified provider enrolled to serve the recipient's targeted population. Case Management services to inpatients are not covered - inpatient facilities provide discharge planning.

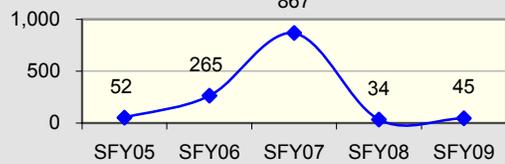
Case Management is also reimbursable for:

- \* individuals age 21 and younger eligible for Developmental Disabilities Services
- \* individuals age 22 and older with a developmental disability
- \* individuals age 60 and older who have limited functional capabilities resulting in the need for multiple services, or who are not of mental capacity to understand their situation poses an imminent danger of death or serious bodily harm.

### EXPENDITURES - CHILDREN



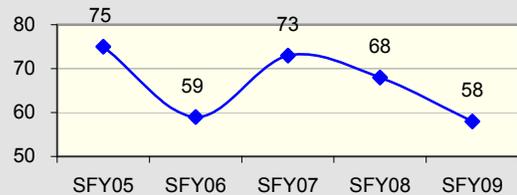
### RECIPIENTS - CHILDREN



### EXPENDITURES - AGE 21-59 DDS



### RECIPIENTS - AGE 21-59 DDS



### EXPENDITURES - AGE 60 & OVER



### RECIPIENTS - AGE 60 & OVER



## SFY09

Total Expenditures	Total Recipients	Overall Average Expenditure per Recipient
\$1,193,261	\$8,295	\$144

Source: DSS Reports; Category of Service Report; Medicaid Provider Manual

# MEDICAID FACTSHEET THERAPY SERVICES

Therapy Services Expenditures  
as % of Total Hosp/Med Exp:  
SFY05: 1.73%  
SFY06: 1.67%  
SFY07: 1.58%  
SFY08: 1.54%  
SFY09: 1.99%

**Therapy Services encompass  
Physical Therapy, Occupational Therapy, and Speech Pathology Services**

Therapy Services are provided according to physician referral to Medicaid eligibles under age 21 under the EPSDT Program

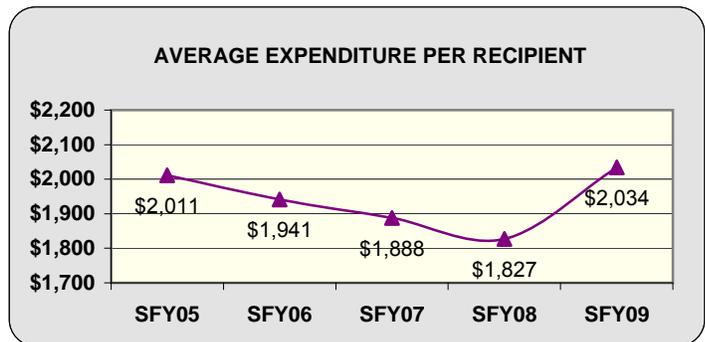
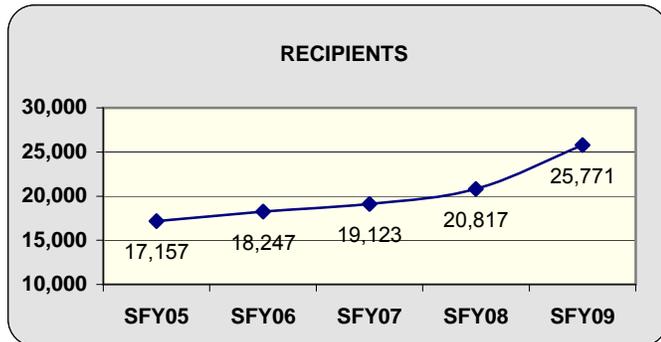
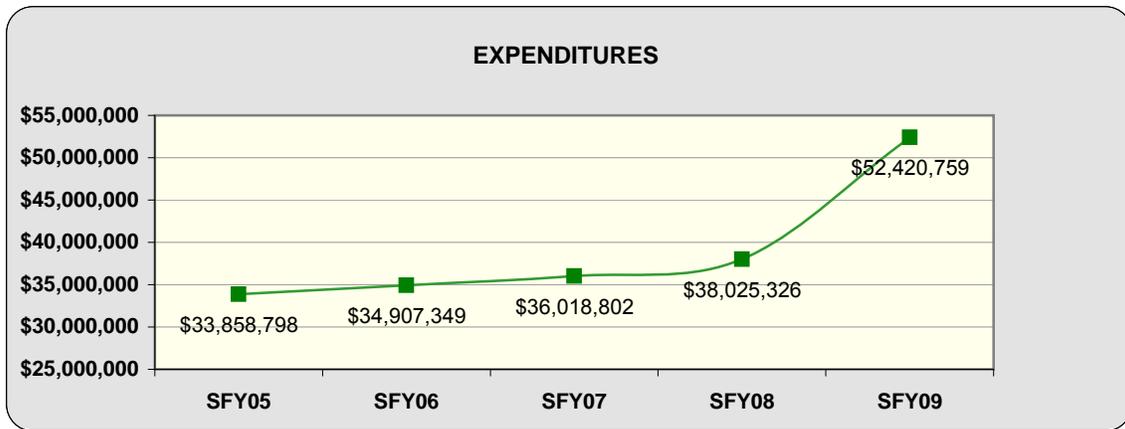
Individuals who have been admitted as an inpatient to a hospital and/or are residing in a nursing care facility are not eligible for occupational therapy, physical therapy, or speech pathology services under this program.

**Scope of Therapy Services:** *Services are covered only when these conditions exist...*

1. Services must be provided by appropriately licensed individuals enrolled as Medicaid providers.
2. Services must be provided as a result of a referral from the recipient's PCP or attending physician.
3. Treatment services must be provided according to a written prescription signed by the recipient's PCP or attending physician.
4. Treatment services must be provided according to a treatment plan or plan of care for the prescribed therapy.

ACTIVE THERAPISTS during SFY09			
	Physical Therapists	Speech Therapists	Occupational Therapists
Individual Therapists	478	1,077	516
Therapy Groups	358	286	311
School Therapy	86	180	80

RECIPIENTS during SFY09	
(Counts are duplicated across categories)	
Physical Therapy	13,039
Speech Therapy	12,555
Occupational Therapy	5,330



Source: DSS Reports; Category of Service Report; Medicaid Provider Manual

# MEDICAID FACTSHEET VENTILATOR EQUIPMENT

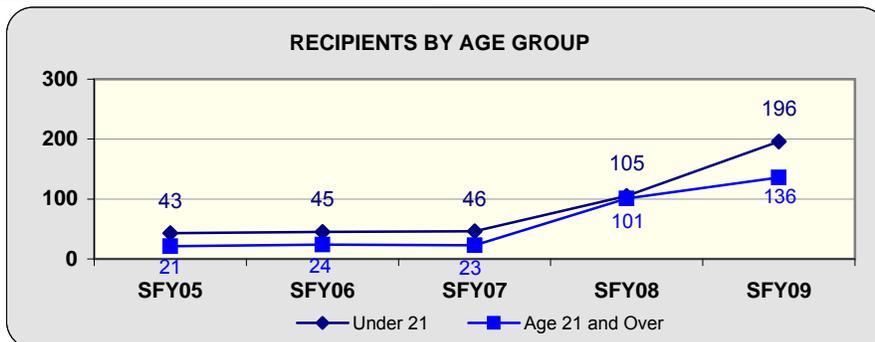
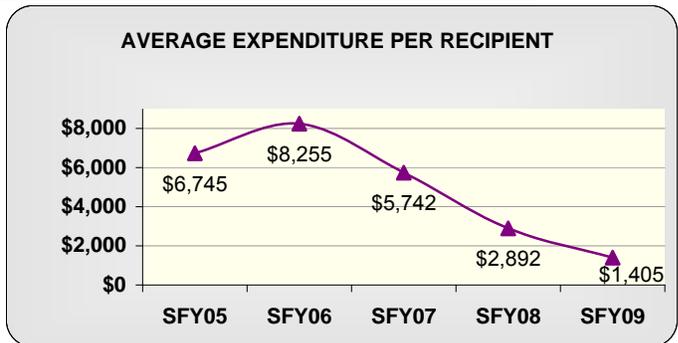
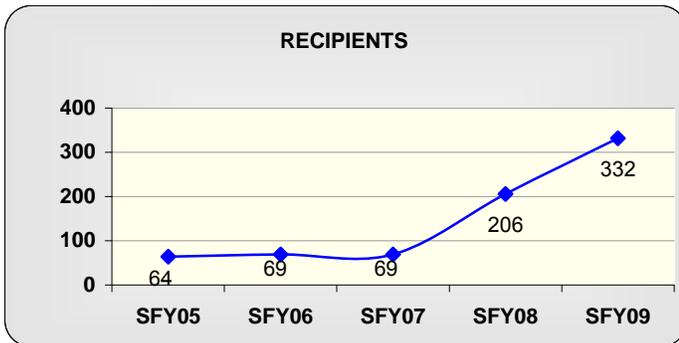
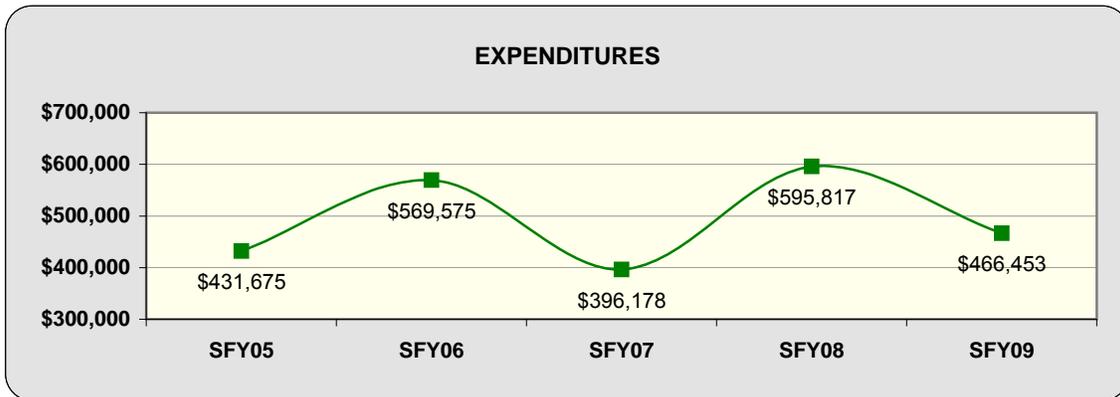
Ventilator Equipment Expenditures  
as % of Total Hosp/Med Exp:  
SFY05: 0.02%  
SFY06: 0.03%  
SFY07: 0.02%  
SFY08: 0.02%  
SFY09: 0.02%

Ventilator equipment in the recipient's residence is covered only when medically necessary and prescribed by a physician.

A nursing home may be considered a place of residence for ventilator equipment.

### To meet eligibility requirements a recipient must:

- be medically dependent on a ventilator for life support at least 6 hours per day.
- have been dependent for 20 consecutive days as inpatient, or requires inpatient respiratory care in absence of ventilator equipment.
- have adequate social support services for at-home care and wish to be cared for at home.
- receive services under the direction of a physician who is familiar with the components of home ventilator support, and who has determined that in-home care is safe and feasible.

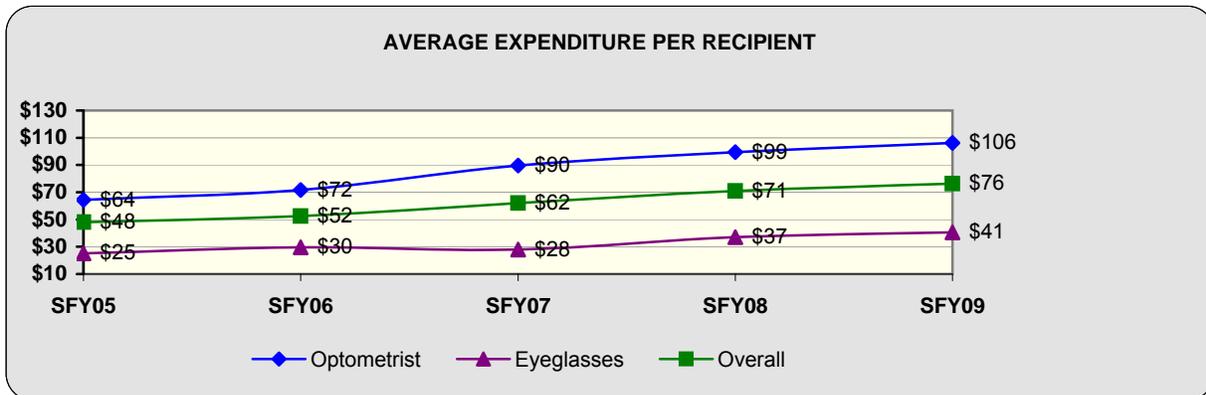
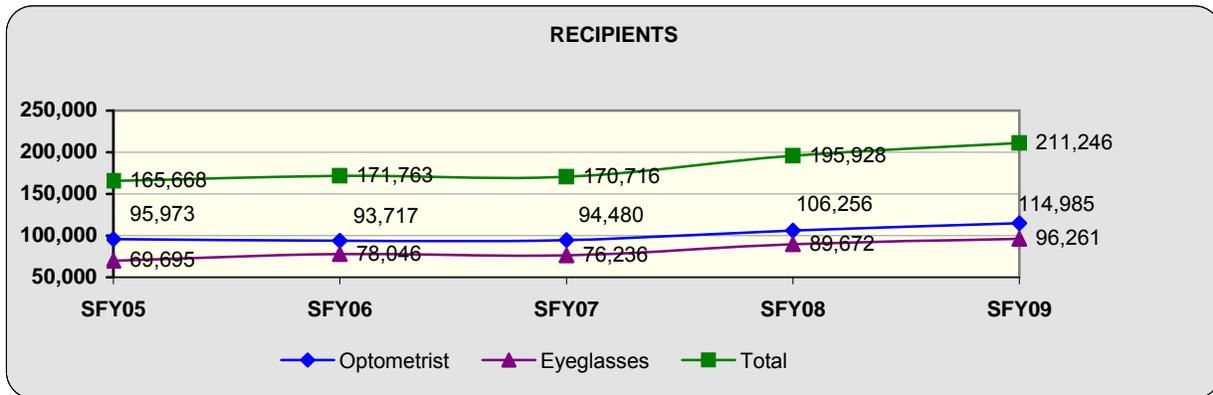
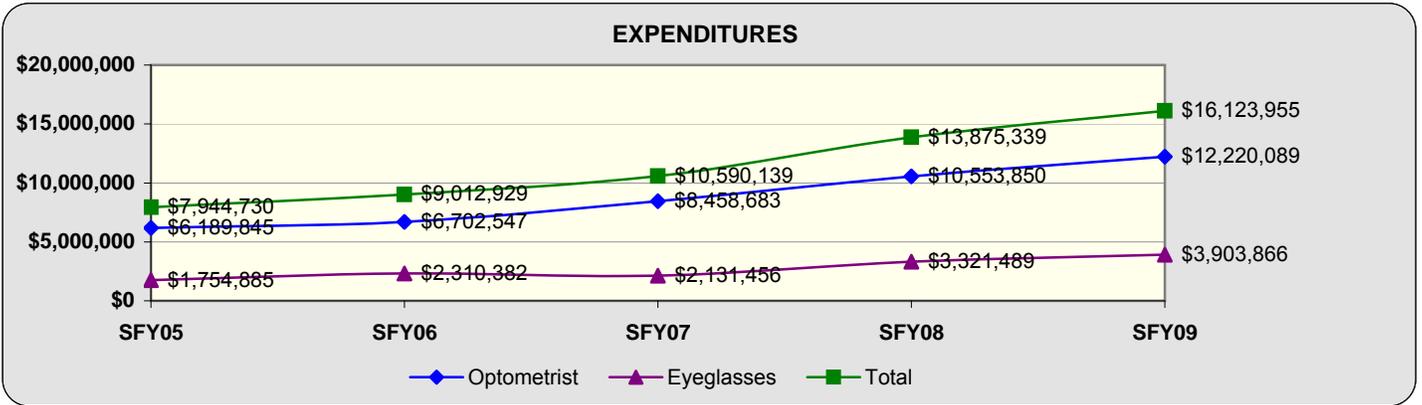


Source: DSS Reports; Category of Service Report; Medicaid Provider Manual

# MEDICAID FACTSHEET VISION SERVICES

Vision Services Expenditures  
as % of Total Hosp/Med Exp:  
SFY05: 0.41%  
SFY06: 0.43%  
SFY07: 0.46%  
SFY08: 0.56%  
SFY09: 0.61%

- Vision Services provide for screening, examination, diagnosis and treatment of eye conditions, prescribing and fitting of eyeglasses, contact lenses and low vision aids for children and adults.
- Adults limited to one visual exam and/or visual prosthetic device per year. Children under 21 limited to one pair of eyeglasses per year.
- Specific eyeglass frames are approved by Medicaid. Recipient desiring non-approved frames is responsible for cost of those frames and the lenses.
- Contact lenses may be covered if medically necessary. Contact lenses are covered for cataract patients.



Source: DSS Reports; Category of Service Report; Medicaid Provider Manual

## Division of Medical Services Contacts

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

<i>Name/e-mail</i>	<i>Title</i>	<i>Voice</i>	<i>Fax</i>	<i>Mail slot</i>
Eugene Gessow Eugene.Gessow@arkansas.gov	Division Director	682-8292	682-1197	S-401
Marilyn Strickland Marilyn.Strickland@arkansas.gov	Assistant Director, Office of Medical Services	682-8330	682-1197	S-401
Suzette Bridges Suzette.Bridges@arkansas.gov	Chief Program Administrator, Prescription Drugs	683-4120	683-4124	S-415
Lynn Burton Lynn.Burton@arkansas.gov	Administrator, Institutional Reimbursement	682-1875	682-3889	S-416
Anita Castleberry Anita.Castleberry@arkansas.gov	Medical Assistance Manager Behavioral Health Unit	682-8154	682-8013	S-413
Michael Crump Michael.Crump@arkansas.gov	Chief Program Administrator, Third Party Liability	683-0596	682-1644	S-296
Rosemary Edgin Rosemary.Edgin@arkansas.gov	Chief Program Administrator, Utilization Review	682-8464	682-8013	S-413
LeAnn Edwards LeAnn.Edwards@arkansas.gov	Chief Program Administrator, Program Development and Quality Assurance	682-8359	682-2480	S-295
Drenda Harkins Drenda.Harkins@arkansas.gov	Reporting and Security Officer Medicaid Management Information System	682-2139	682-5318	S-417
Kyleen Hawkins Kyleen.Hawkins@arkansas.gov	Assistant Director, Administrative Services and Chief Financial Officer	682-0422	682-2263	S-416
Tami Harlan Tami.Harlan@arkansas.gov	Assistant Director Contract Oversight Unit	682-8303	682-8013	S-413
Randy Helms Randy.Helms@arkansas.gov	Chief Program Administrator, Provider Reimbursement	682-1857	682-3889	S-416
Debbie Hopkins Debbie.Hopkins@arkansas.gov	Assistant Director, Medicaid Management, Information, and Performance	682-1473	682-2263	S-416
Sharon Jordan Sharon.Jordan@arkansas.gov	Chief Program Administrator, Financial Activities	682-8489	682-2263	S-416
Judith E. McGhee Judith.McGhee@arkansas.gov	Medical Director Health Reviews	682-9868	682-8013	S-412
Sheena Olson Sheena.Olson@arkansas.gov	Chief Program Administrator, Medical Assistance	683-5287	682-1197	S-410
Roger Patton Roger.Patton@arkansas.gov	Chief Program Administrator, Medicaid Management Information System	683-7987	683-5318	S-417
Robin Raveendran Robin.Raveendran@arkansas.gov	Chief Program Administrator, Program Integrity	682-8173	682-1197	S-414
Carol Shockley Carol.Shockley@arkansas.gov	Assistant Director, Long Term Care	682-8487	682-1197	S-409
Tom Show Tom.Show@arkansas.gov	Administrator, Non-Institutional Reimbursement	682-2483	682-3889	S-416
William Golden William.Golden@arkansas.gov	Medical Director, Health Policy	682-8302	682-1197	S-401



# Phone Numbers and Internet Resources

## Quick Reference Guide

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

## Hotlines

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

## Internet Resources

Department of Human Services (DHS).....	<a href="http://www.arkansas.gov/dhs">http://www.arkansas.gov/dhs</a>
Arkansas Medicaid.....	<a href="http://www.medicaid.state.ar.us">http://www.medicaid.state.ar.us</a>
DHS County Offices .....	<a href="http://www.medicaid.state.ar.us/general/units/cooff.aspx">http://www.medicaid.state.ar.us/general/units/cooff.aspx</a>
ARKids First .....	<a href="http://www.arkidsfirst.com/home.htm">http://www.arkidsfirst.com/home.htm</a>
Arkansas Foundation for Medical Care.....	<a href="http://www.afmc.org">http://www.afmc.org</a>

