



Arkansas Medicaid Program Overview SFY 2010



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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

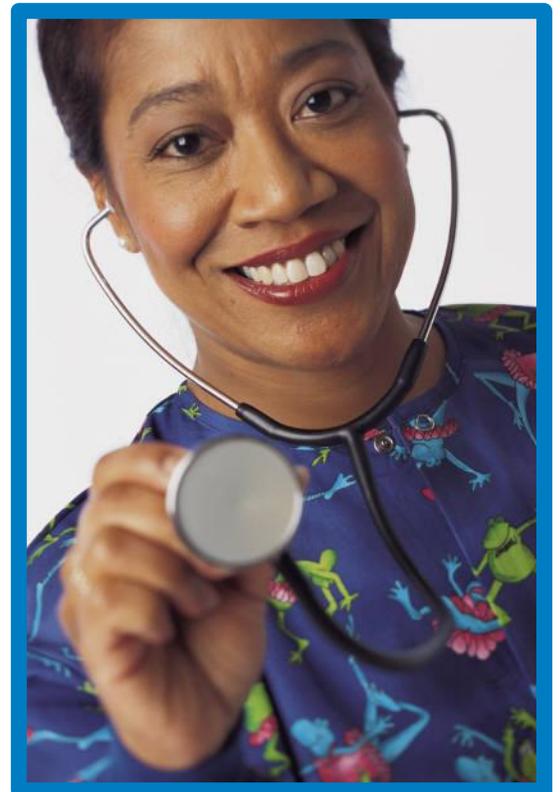
- Compassion
- Courage
- Respect
- Integrity
- Trust

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 to the 2010 overview of the Arkansas Medicaid Program. Designed to offer a high-level source of information about the Medicaid program, this overview provides a general understanding of the program including how it is funded and where tax resources are spent.

This year has been an exciting one, as I am settling into my role as director of the Arkansas Medicaid Program. I have learned that our program faces many demands in these tough economic times as we strive to continue providing better health for the state of Arkansas and quality healthcare providers for the Medicaid Program. It has been a challenge to provide the best possible value with limited resources. We have worked to contain administrative costs as much as possible and spend the maximum amount of Medicaid funding where it should be spent—on the people of Arkansas. We are looking toward the future and gathering input from the many Medicaid stakeholders, including providers, provider networks and associations, hospitals, clinics and insurance companies. We are giving them a voice in the direction of our program; their guidance will help us deliver health, safety and a higher quality of life to the people of Arkansas. We aim to achieve the best results while utilizing all available resources.

As the Department of Human Services mission states, protecting the vulnerable, fostering independence and promoting better health for Arkansas are what make the Medicaid program worthwhile. We believe in the importance of our work and hope that this resource will assist you in understanding the Arkansas Medicaid program.

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

Eugene I. Gessow
Director,
Division of Medical Services

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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. In 1965, Title XIX of the Social Security Act created grant programs popularly called “Medicaid”. Medicaid furnishes medical assistance to those who have insufficient incomes and resources to meet the costs of necessary medical services. Medicaid provides rehabilitation and other services to help families and individuals become or remain independent and able to care for themselves.

Each state has created a Medicaid type program to meet the federal mandates and requirements as laid out in Title XIX. Arkansas, however, established a medical care program requiring health care for the needy 26 years before passage of the federal laws; 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 (DHS) 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
- 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



Current Federal Poverty Levels

Monthly Levels

(April 1, 2009, until superseded)

Family Medicaid Categories

| Family size | ARKids A Children 6 and over and AR Health Care Access 100% | ARKids A Children under age 6 133% | Transitional Medicaid 185% | SOBRA Pregnant Women, Family Planning, and ARKids First B 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

| | ARSeniors Equal to or below 80% | QMB Equal To or Below 100% | SMB Between 100% & 120% | QI-1 At least 120% but less than 135% | QDWI & TB Equal To or Below 200% | Working Disabled 250% |
|---|--|-------------------------------------|-------------------------------|--|---|--------------------------|
| Individual | \$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 for Medicaid is shared between the federal government and the states with the federal government matching the state share at an authorized rate between 50 and 90 percent, depending on the program. The federal participation rate is adjusted each year to compensate for changes in the per capita income of each state relative to the nation as a whole.

- Arkansas 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.

SFY 2010 Medicaid Operating Budget

| | (millions) |
|-----------------------|------------|
| General Revenue | \$648.4 |
| Other Revenue | \$195.3 |
| Quality Assurance Fee | \$63.0 |
| Trust Fund | \$0.0 |
| Federal Revenue | \$3,391.6 |
| Total Program | \$4,298.3 |

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) administer the Medicaid Program for the U.S. Department of Health and Human Services. CMS authorizes federal funding levels and approves each state's State Plan to ensure compliance with human services federal regulations.

Administration Statistics

In SFY 2010, DMS Program Development and Quality Assurance processed

- 9 State Plan amendments
- 35 provider manual updates
- 6 official notices
- 1 provider memorandum
- 4 pharmacy memorandums

Arkansas Medicaid's fiscal agent, Hewlett-Packard (HP), held 63 workshops around the state presented by their provider representatives in SFY 2010. The provider representatives also conducted 1,478 provider visits and responded to 290,159 voice and automated calls.

In 2010, MMCS Provider Relations Representatives contacted a quarterly average of

- 82 hospitals
- 1,152 clinics
- 2,248 physicians



What Programs are Provided by Arkansas Medicaid?

Medicaid pays for a wide range of medical services. The Medical Assistance (Medicaid) Office assists in determining if Medicaid pays for a specific service. Many benefits have limits, especially for adults, which 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.
- Optional services that the state has elected to provide.
- Additional covered services for individuals under age 21.

NOTE: In addition to the services shown in the 3 groups described below, the State complies with federal requirements regulating the EPSDT program. "Early and periodic screening and diagnosis and treatment" means:

1. Screening and diagnostic services to determine physical or mental defect in beneficiaries under age 21; and
2. Health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered.

Mandatory Services

Clinics and Programs

FQHC Core Services

Rural Health Clinics

Maternity Clinic

Dental Services

Oral Surgery Dentist (ADA Codes)

Oral Surgery Physicians

FQHC Dental

EPSDT

EPSDT Screening

EPSDT Immunizations

Family Planning (Not Prescription Drugs)

FP All Aid Cat, 90/10 Match

Family Planning Physician

Family Planning Clinics

FP Not Aid Cat 69 90/10 Match

Family Planning FQHC

Family Planning RHC

Family Planning Nurse Practitioner

Output Hospital Family Planning

Inpatient Hospital

Inpatient Acute Care

Pediatric Inpatient

Inpatient AR Teaching

Critical Access Hospitals INP MED

Rural Inpatient

Lab and X-Ray

Radiologist

Independent Lab

Independent X-ray

Pathologist

Note:

Long Term Care – Nursing Facility services for age 21 and older are mandatory; Nursing Facility services for individuals under age 21 are optional.

Long Term Care (See note below.)

ICF/INF/E.S.

Private SNF

Public ICF Mentally Retarded

Public SNF

Other Care Services

Home Health Services

Other Practitioners

Nurse Practitioner

Nurse Midwife

Outpatient Hospital

Outpatient Hospital

Pediatric Outpatient Hospital

Outpatient Teaching Hospital

Critical Access Hospitals OUT MED

Physician Services

Physician Services

Surgery

Maternity/physician program cost

Ophthalmologist medical

Ophthalmologist

Prof Inpatient AR Teaching Hospital

Prescription Drugs

Family Planning Drugs

Transportation

Ambulance

Non-Public Transportation

Nonprofit Transportation

FQHC Transportation

Optional Services

Aging and Disability Services

ElderChoices Waiver
 APD Attendant Care
 APD-Environmental Adaptations
 APD Agency Attendant Care, Co Employer
 APD Counseling Case Management
 IndependentChoices Treatment Elderly
 IndependentChoices Treatment Young Disabled
 IndependentChoices New Treatment Elderly
 IndependentChoices New Treatment Young Disabled
 IndependentChoices New Control Elderly
 IndependentChoices FMS Services
 IndependentChoices C/FI
 DDS Alternative Com Service Waiver
 PACE

Behavioral Health

Mental Hospital Services - aged
 Community Mental Health (RSPMI)

Case Management

CSMT Age 60 and Older
 CSMT Age 21-59 with Developmental Disability

Clinics and Programs

Health Dept Communicable Disease
 ARKIDS - Immunology
 Ambulatory Surgical Centers

Family Planning (Not Prescription Drugs)

Family Planning Waiver
 FP Aid Cat 69, 75/25 Prof
 OP FP, All Aid Cat
 FP Aid Cat 69, 75/25 OP
 Family Planning Waiver RHC
 Family Planning Waiver Other Facilities

Inpatient Hospital

Inpatient Transplant
 Inpatient Rehab

Long Term Care (See note below.)

Assisted Living Agency
 Assisted Living Facility
 Assisted Living Pharmacy Consultant

Other Care Services

Durable Medical Equipment/Oxygen
 Eyeglasses
 Hemodialysis
 Hyperalimentation
 Ventilator
 Tuberculosis
 Vaccine administered in pharmacy
 Personal Care Services
 Nursing Home Hospice
 Hospice
 Private Duty Nursing Services

Other Practitioners

Optometrist/ Ocularist
 CRNA
 Chiropractor

Outpatient Hospital

Outpatient Rehab
 Outpatient Transplant Services

Physician Services

Physician Transplant Services
 Managed Care Fees

Prescription Drugs

Prescription Services
 Family Planning Waiver
 Prescription Services

Transportation

Net Managed Care Waiver



Note:

Long Term Care – Nursing Facility services for age 21 and older are mandatory; Nursing Facility services for individuals under age 21 are optional.

Additional Covered Services for Individuals Under Age 21

Aging and Disability Services

RSPD Residential Rehab Center
RSPD Extended Rehab Services
Developmental Rehab Services

Behavioral Health

Inpatient Psychiatric for Under Age 21
School-Based Mental Health Services
DYS Rehab Services

Sexual Offender Program

Case Management

Case Management CMS
TCM/DYS
Targeted Case Management

Case Management DCFS

Clinics and Programs

Therapy Individual/Regular Group
Therapy School District/Esc Group
Developmental Day Treatment Clinic Svc (See note below.)
EPSDT CHMS

CMS

CMS/RESPITE CARE/MR/DD (W9)
CMS/RESPITE CARE/PD (W8)

Dental Services

Dental Services (See note below.)
Dental Services EPSDT

EPSDT

EPSDT Prosthetic Device
EPSDT Orthotic Appliances
EPSDT DMS Expansion
EPSDT Podiatry
EPSDT Psychology Services

Other Care Services

Hearing Aid
Private Duty Nursing EPSDT

Other Practitioners

Audiologist
Psychologist

Note:

Dental – Medical and surgical services of a dentist are mandatory; Dental services for individuals age 21 and older are optional.

DDTCS program is an optional program that includes services available to both pre-school age individuals and adults.

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 (SFY).
- A total of twelve office visits allowed per SFY for any combination of the following: certified nurse midwife, nurse practitioner, physician, medical services provided by a dentist, medical services furnished by an optometrist and rural health clinics.
- One basic family planning visit and three periodic family planning visits per SFY. Family planning visits are not counted toward other service limitations.
- Lab and x-ray services limited to total benefit payment of \$500 per SFY, 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 SFY, except for EPSDT beneficiaries and certain organ transplant patients.

- Co-insurance
 - Some beneficiaries must pay 10% of the first Medicaid covered day of a hospital stay.
 - Beneficiaries in the Working Disabled Aid Category must pay 25% of the charges for the first Medicaid covered day of inpatient hospital services and must also pay co-insurance for some additional services.
 - Some beneficiaries must pay \$0.50 - \$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.
 - ARKids B beneficiaries must pay co-insurance of 20% of the charges for the first Medicaid covered day of inpatient hospital services, a higher co-payment for inpatient services and co-insurance/co-payment 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.



SFY 2010 in Review

State Fiscal Year (SFY) 2010 has been a busy year in Arkansas Medicaid. Growth in the Arkansas Medicaid program in terms of expenditures and number of beneficiaries served continues to outpace growth in staffing. Changes at the national level from health care reform and other federal programs will continue to demand more from the program over the next several years. Arkansas Medicaid is able to meet these challenges through better program management, increased use of technology and continued process improvements.

Arkansas Medicaid is in the early stages of several new projects based on new federal programs. In 2011, Arkansas Medicaid will implement a six-year program to provide federally-funded incentive payments to Medicaid health care providers for their adoption and use of electronic health record systems (EHR). Arkansas Medicaid is working with the Arkansas Office of Health Information Technology to plan a state-wide health information exchange to improve health care through electronic connection and exchange of information between individuals (patients, physicians, pharmacists) and places (hospitals, doctor's offices, clinics). The process of replacing our aging Medicaid claims processing system with a modern, robust system capable of supporting and interfacing with new information exchanges has also begun.

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

Medicaid Operations

In SFY 2010, Medicaid's fiscal agent, Hewlett-Packard (HP), processed more than 37 million claims for 12,500 providers on behalf of more than 771,000 Arkansans. They responded to 80,717 voice calls, 209,442 automated calls and 37,059 written inquiries and conducted 1,478 provider visits and 63 workshops around the state.

Medicaid processed 99% of claims within 30 days with the average claim being processed in under 2.5 days. On average, providers received their payments within a week of claim submission.

Medicaid is a critical component of health care financing for children and pregnant women. Through ARKids First and other programs, Medicaid insures approximately 791,000 children. According to recent data, Medicaid paid for approximately 64% of all births in Arkansas.

e-Prescribe Arkansas

To support the physicians of Arkansas in implementing e-prescribing, Arkansas Medicaid created e-Prescribe Arkansas in December 2008. E-prescribing uses bi-directional electronic delivery of prescriptions between prescribers and pharmacies to connect patients, providers, pharmacists and payers within a network. The connectivity and real-time access to information allows e-prescribing to significantly improve patient safety. As part of the program, Medicaid actively encouraged providers to implement e-prescribing by providing on-site assessments and assistance in procuring e-prescribing software.

Since the project's "going live" in December 2008, over 3,300 providers within the state were contacted regarding e-Prescribe Arkansas and over 500 have received assistance in implementing e-prescribing in their offices. In December 2008, there were 345 prescribers actively routing electronic prescriptions. Today, there are almost 700 prescribers e-prescribing with a pharmacy participation rate of 88%. The number of e-prescription transactions in Arkansas has grown 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 responsible for auditing approximately 60 DMS contracts for quality and compliance. The Unit currently has a staff of three, including a supervisor. The Unit officially began in May 2009. As the Unit has grown and developed it has taken on other responsibilities, such as writing and reviewing RFP's and contracts.

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 which utilizes 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. Currently there are three Green House® facilities in Arkansas— Legacy Village Assisted Living in Bentonville; The Green House® Cottages of Wentworth in Magnolia; and The Green House® Cottages of Southern Hills in Rison. The project required the cooperation of CMS and the endorsement and assistance of the Governor and the General Assembly and is limited to the development of 1000 facility beds.

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. It is assisting with the launch and implementation of the mandated outcomes measurement and tracking system for children and adolescents (Y-OQ®) promulgated for use by all Rehabilitative Services for Persons with Mental Illness (RSPMI) providers September 1, 2010. 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 RSPMI policy revisions to define services and their delivery on a more individualized, family-driven basis. This unit has led the successful launch of a new utilization and peer review contractor and is initiating new measures to improve performance and accountability within the current system. The unit continues to participate in provider forums throughout the state with the utilization and peer review contractor to ensure a continuing positive relationship with stakeholders and the transition process. The unit also collaborates with DHS divisions and serves on committees, task forces and workgroups to provide support and have a positive impact on the continual progression of the System of Care.

Third Party Liability

Third Party Liability (TPL) collections and cost avoidance totals have more than doubled from 2007 to 2010 (\$28 million to \$60 million). TPL collections refer to the recovery of funds when Medicaid has erroneously paid part or all of a bill that should have been paid by a third party. Cost avoidance refers to the identification of third party resources that are available to Medicaid beneficiaries. Once these resources are identified, they are loaded into the Medicaid Management Information System (MMIS) to avoid automatic payment by Medicaid for services for which another party is liable.

In order to enhance cost avoidance and collection of valuable state and federal funds on behalf of Arkansas Medicaid, the TPL Unit has contracted with Health Management Systems, Inc. (HMS). HMS performs services for TPL Units in thirty-nine states around the nation and has helped Arkansas Medicaid consistently increase its collection and cost avoidance activities.

The TPL Unit is looking forward to new projects in SFY 2011 that will allow Arkansas Medicaid to save and collect even more. Starting in the fall of 2010, TPL will implement a Health Insurance Premium Payment (HIPP) program. The HIPP program will allow Arkansas Medicaid to purchase available insurance coverage on behalf of Medicaid beneficiaries when doing so is cost effective for Arkansas Medicaid. The program will save Arkansas money while providing families with increased access to health care at no cost or loss of benefits.

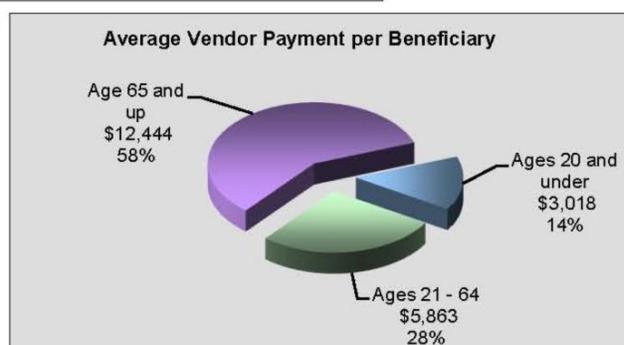
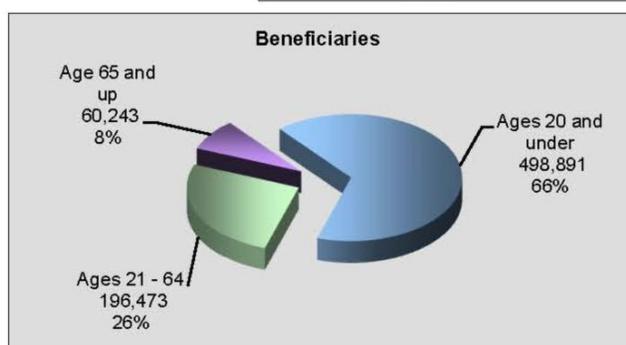
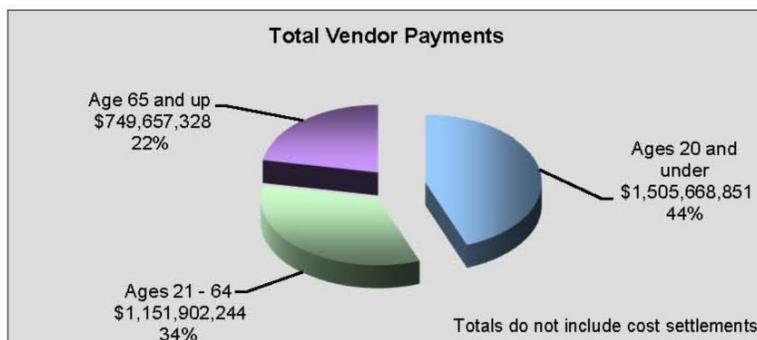
The TPL Unit will also assume responsibility of the Estate Recovery program beginning October 1, 2010. Federal and state law requires Arkansas Medicaid to pursue claims against the estates of Medicaid beneficiaries who receive certain services after the age of 55 years. TPL will use its resources to identify and pursue potential claims against estates.



SFY 2010 Statistics

Beneficiary Information

Unduplicated Beneficiary Counts and Vendor Payments by Age SFY 2010



Sources: HCFA 2082

Percentage of Change in Enrollees and Beneficiaries from SFY 2009 to SFY 2010

| | SFY09 | SFY10 | % Change from Last Year |
|------------------------|---------|---------|-------------------------|
| Medicaid Enrollees | 753,166 | 771,918 | 2.5% |
| Medicaid Beneficiaries | 747,851 | 755,607 | 1.0% |

Percentage of babies paid for by Medicaid

The medical cost for 64% of all babies born to Arkansas residents was paid for by Medicaid. *

*This calculation is based on SFY09 data, which is the most recent available.

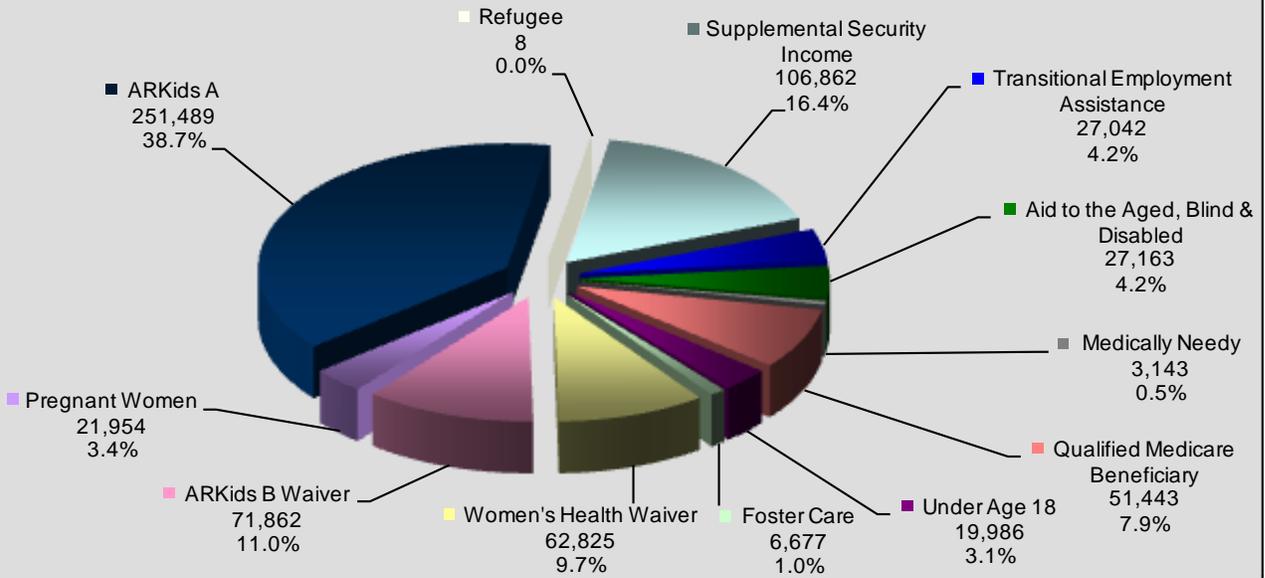
Percentage of Population Served by Medicaid

| Age group | Arkansas Population | % of Population Served by Medicaid** |
|-------------------------|---------------------|--------------------------------------|
| All Ages | 2,889,450 | 26% |
| Elderly (65 and older) | 413,681 | 15% |
| Adults (20-64) | 1,684,428 | 12% |
| Children (19 and under) | 791,341 | 64% |

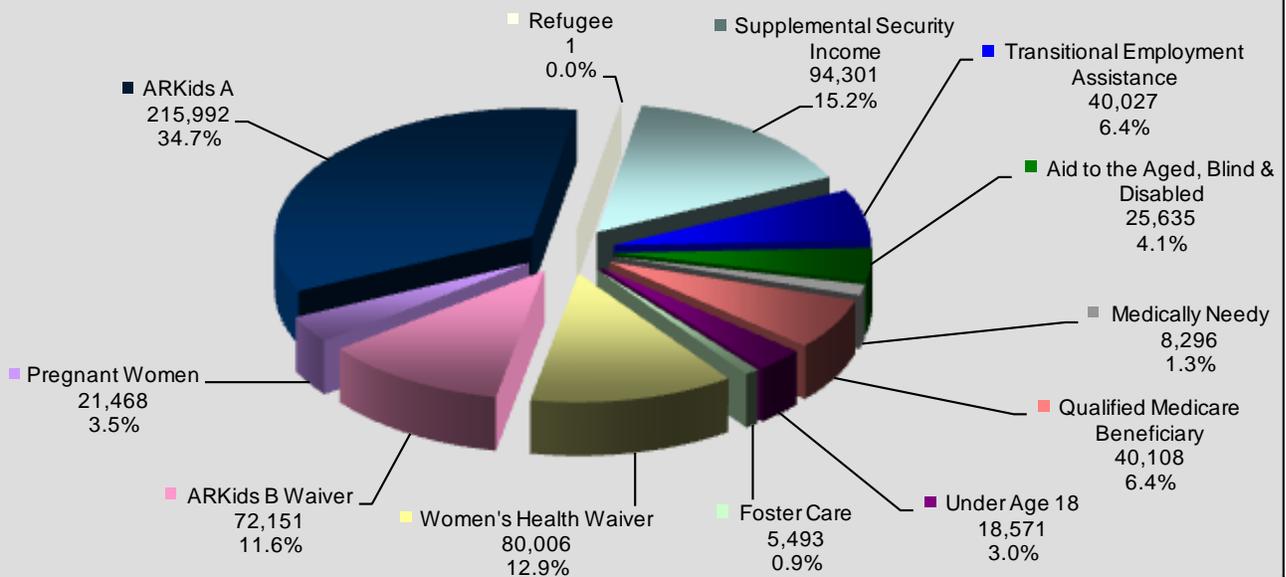
**This calculation is based on the Arkansas population as of July 1, 2009, which is the most recent available.

Medicaid Enrollees by Aid Category – 5 year comparison

Average Medicaid Enrollees per Month by Aid Category SFY10



Average Medicaid Enrollees per Month by Aid Category SFY06

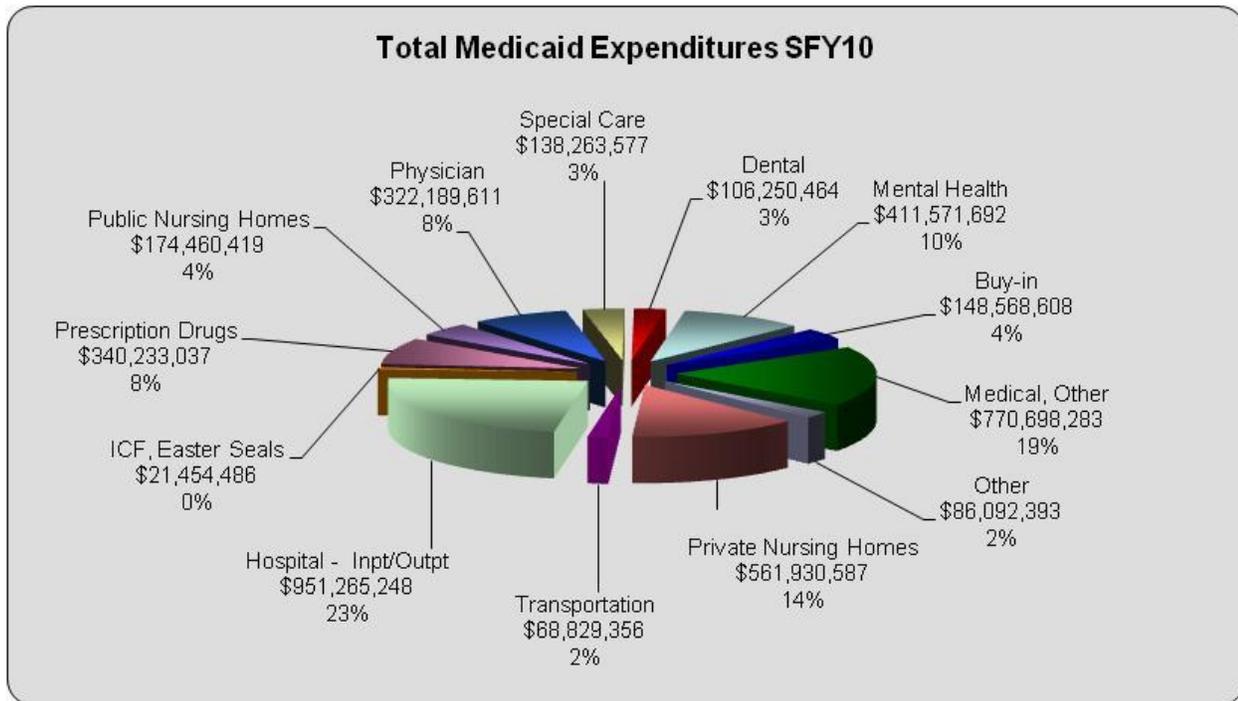


Source: Division of County Operations
ACES IM 2414

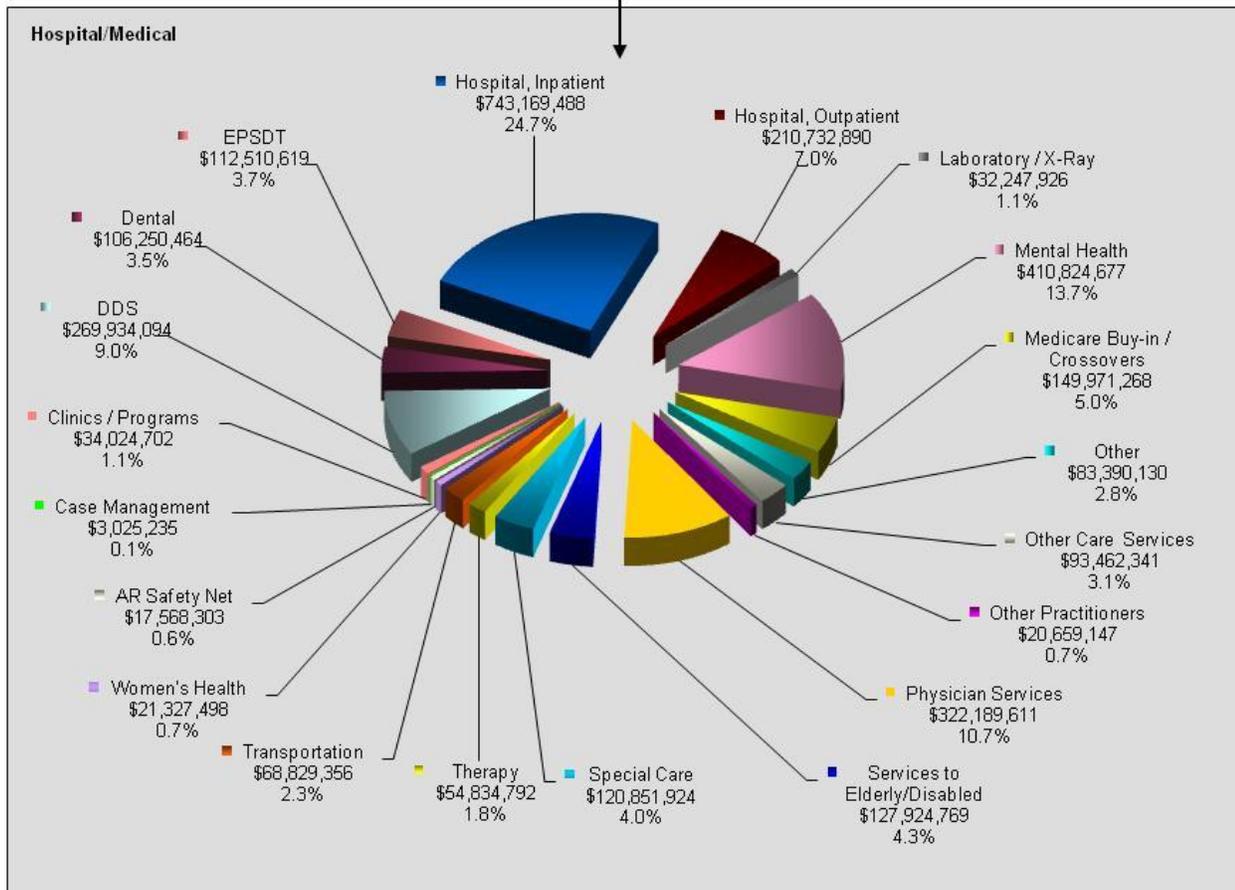
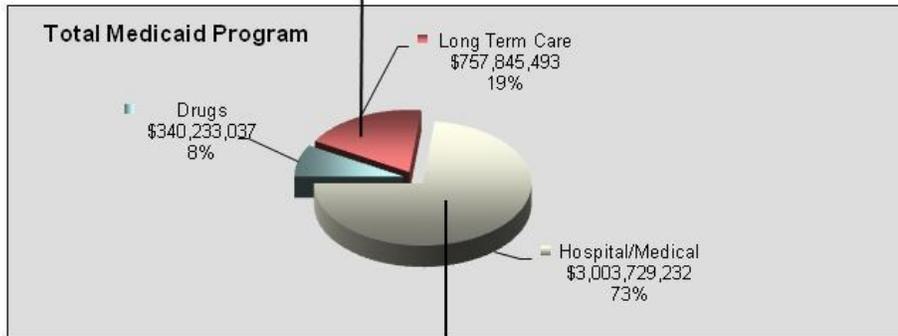
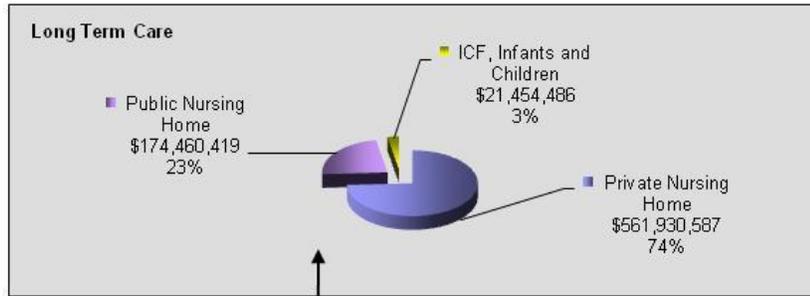
NOTE: Beneficiaries may have multiple aid categories and therefore, are counted in each of those categories.

Expenditures

Total Medicaid Expenditures SFY 2010



Arkansas Medicaid Program Benefit Expenditures SFY 2010



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.

| Rebate Dollars Collected | |
|--------------------------|------------------|
| Total SFY 2010 | \$125,547,932.40 |
| State portion | \$24,090,541.40 |
| Federal portion | \$101,484,081.00 |



Economic Impact of Arkansas Medicaid

| Program Costs | | | |
|-------------------------|----------------|----------------------------|--------------|
| State Fiscal Year (SFY) | Total (in mil) | Unduplicated Beneficiaries | Average Cost |
| 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 | \$4,102 | 755,607 | \$5,429 |
| 2011* | \$4,518 | 770,040 | \$5,867 |

*Projected

| Arkansas Budget and Medicaid percentage SFY10 | | |
|---|----------------|---------------------|
| | SFY 2010 | Medicaid Represents |
| State of Arkansas Budget | \$24.7 billion | 20.4% |
| State General Revenue Funded Budget | \$4.3 billion | 15.1% |

Arkansas Medicaid Providers

Number of enrolled providers

Medicaid has approximately 35,039 enrolled providers.

Number of participating providers

Approximately 12,577 (36%) are participating providers.

Number of claims processed and approximate processing time

37,681,967 claims were processed in SFY 2010 with an average processing time of 2.6 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 enrolled

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

Understanding DMS and Medicaid

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

Medicaid

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

The Department of Human Services (DHS) is the single state agency authorized and responsible for regulating and administering the program. DHS administers the 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 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 and 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 Behavioral Health Unit is responsible for monitoring the Medicaid behavioral health programs. This unit researches and analyzes proposed policy initiatives, encourages stakeholder participation and recommends revisions to policy and programming. The behavioral health unit maintains an outcome measurement method to establish more accountability related to the provision of behavioral health services for children and adolescents. Other responsibilities include the monitoring of the quality of treatment services and benefit extension procedures and performing case reviews, data analysis and oversight activities to help identify problems and assure compliance with Medicaid requirements. These responsibilities are accomplished through the negotiation, coordination and assessment of the activities of the Behavioral Health utilization and peer review contracts. In addition to its role in auditing behavioral health programs, the peer review contractors provide training and educational opportunities to providers to help ensure that all programs provide the highest level of care possible to Arkansas Medicaid beneficiaries. The unit collaborates with other DHS divisions to establish goals and objectives for designing a Children's System of Care and an Adult Recovery Model for mental health care and 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. The Financial Activities unit is also responsible for Human Resource functions in DMS.

Medical Assistance Unit

The Medical Assistance Unit contracts with Hewlett-Packard (HP) to enroll providers in Medicaid and the ARKids First Program. At the end of SFY 2010, there were more than 28,895 enrolled providers in the above programs. More than 9,612 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 2010, 91,008 telephone inquiries were handled in all Assistance Sections including 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, Connect Care and the Primary Care Case Management programs.

| | SFY 2010 | SFY 2009 | SFY 2008 |
|------------------------|----------|----------|----------|
| Telephone Inquiries | 91,008 | 76,266 | 73,608 |
| Written Correspondence | 3,032 | 663 | 1,056 |
| Fair Hearings | 435 | 453 | 418 |

Source: DMS Statistical Report

Medicaid Data Security Unit

The Medicaid Data Security Unit provides Health Insurance Portability and Accountability Act (HIPAA) enforcement and monitoring of the privacy and security of patient's information along with guiding contractors in adhering to DHS Information Technology security policies and procedures. The Security unit also monitors and performs technical audits on contractors and researchers who use Medicaid data. A Data Security Committee evaluates requests for Medicaid data for research projects and publication requests to ensure HIPAA compliance.

Office of Long Term Care

The Office of Long Term Care (OLTC) professional surveyors conduct annual Medicare and Medicaid and State Licensure surveys of Arkansas' 227 Nursing Facilities and in the state's 41 Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) including 6 Human Development Centers. Annual and complaint surveys are also conducted in 39 Adult Day Care and Adult Day Health Care facilities and one Post Acute Head Injury Facility throughout the state. Semi-annual surveys are conducted in the 77 Residential Care Facilities, 55 Assisted Living Facilities and 22 Alzheimer's Special Care Units. In addition, annual Civil Rights surveys were conducted in 111 hospitals and 91 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. OLTC staff provided approximately 256 hours of continuing education through 95 workshops/seminars to over 3,863 staff members in the nursing home and assisted living industry during SFY 2010. In addition, there were 403 agendas submitted from outside sources for review to determine 1,990 contact hours for nursing home administrators.

The Nursing Home Administrator Licensure Unit processed renewals for 650 licensed administrators, processed 83 license applications and issued 74 new licenses and 8 temporary licenses. In addition, OLTC administered the state nursing home administrator examination to 79 individuals.

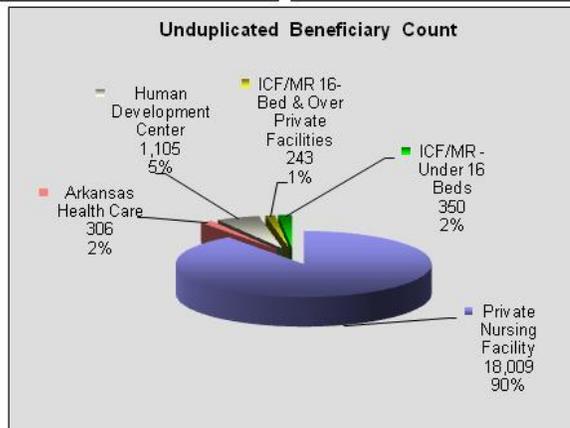
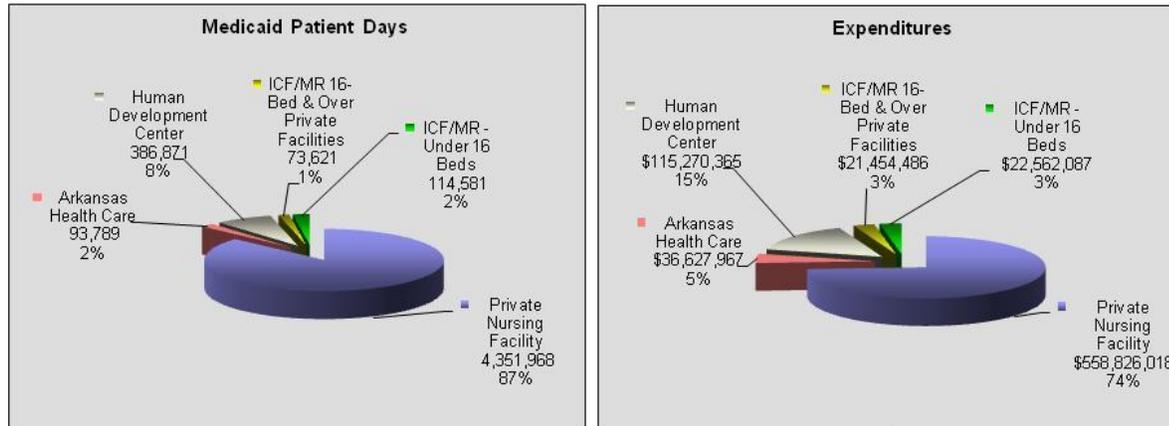
The Criminal Record Check Program applies to all categories of licensed long-term care facilities consisting of over 511 affected facilities. During SFY 2010, there were 35,137 state record checks processed through OLTC with 957 disqualifications (2.7%) and 18,232 federal record checks processed with 192 disqualifications (1.6%).

At the end of SFY 2010, the Registry for Certified Nursing Assistants (CNAs) contained 28,840 active and 60,685 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 1,238 Medicaid nursing facility applications per month while maintaining approximately 12,692 active cases which includes processing 10,602 assessments, 1,833 changes of condition requests, 564 transfers, 1,861 utilization review requests and 3,328 applications/reviews for ICFs/MR during the year. In addition, over 13,800 applications/reviews/waivers for other medical programs within DHS were made during SFY 2010.

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 881 nursing home complaints during SFY 2010 regarding the care or conditions in long-term care facilities.

Office of Long Term Care Statistics



Prescription Drug Program

The Prescription Drug Program, which is an optional Medicaid benefit, was implemented in Arkansas in 1973. Under this program, eligible beneficiaries may obtain prescription medication through any of the 838 enrolled pharmacies in the state. During SFY 2010, a total of 449,381 Medicaid beneficiaries used their prescription drug benefits. A total of 4.9 million prescriptions were reimbursed by Arkansas Medicaid for cost of \$316.2 million dollars thus making the average cost per prescription approximately \$64.50. An average cost for a brand name prescription was \$186 dollars, which accounts for 25% of the claims and 72% of expenditures. The average cost for a generic prescription was \$24 dollars, which accounts for 75% of the claims and 28% of expenditures.

The Prescription Drug Program restricts each beneficiary to a maximum of three prescriptions per month and up to six prescriptions by prior authorization, except for beneficiaries under 21 and certified long-term care beneficiaries 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 Medicare Part D payment for SFY 2010 was \$25,977,235.22. This lower payment was due to recalculation as a result of the American Recovery and Reinvestment Act of 2009 (ARRA.)

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 the Centers for Medicare and Medicaid (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 Budgeting and Analysis

Program Budgeting and Analysis develops the budgets for all of Arkansas' Medicaid waiver renewals and 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 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.

Program Development and Quality Assurance

The Program Planning and Development (PPD) Section and the Waiver Quality Assurance units, formerly two separate units, have been combined. The new Program Development and Quality Assurance (PD/QA) Unit develops and maintains the Medicaid State Plan and the State's Child Health Insurance Program Plan, leads the development and research of new programs, oversees contractor technical writing of provider policy manuals, coordinates the approval process through both State and Federal requirements and coordinates efforts in finalizing covered program services, benefit extension procedures and claims processing. The PD/QA Unit also leads development of new waiver and demonstration programs and the resulting provider manuals. Because 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 and approval to operating agencies regarding waiver and demonstration policies, procedures, requirements and compliance.

- Performing case reviews, data analysis and oversight activities to help identify problems and assure remediation for compliance with CMS requirements.
- Developing QA strategies and interagency agreements for the operation and administration of waivers and demonstrations.

Program Integrity

In 2010, Program Integrity (PI) audited 159 providers and identified \$4.8 million in questioned cost and \$29 million in cost avoidance. The unit also reviewed 988 questionable enrollment applications, denied 66 questionable applications and terminated 79 providers. 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 state employee coder certification this year. 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. Arkansas was one of three states selected to participate in Medicaid Integrity Group supplemental audits based on active involvement with CMS and state PI groups. The purpose is to conduct joint audits with CMS focusing on hospice, durable medical equipment and pharmacy providers.

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) payments for institutional providers. The Institutional Section is also responsible for processing all necessary cost settlements for the following providers: Hospital, Residential Treatment Unit (RTU), Rural Health Clinic (RHC), Federally Qualified Health Center (FQHC), Residential Treatment Center (RTC), Other.
- Non-Institutional –The Non-Institutional Section is also responsible for the maintenance of reimbursement rates and assignment of all billing codes for both institutional and non-institutional per diems, services, supplies, equipment purchases and equipment rental for the following providers: Physician, Dental, Durable Medical Equipment, ARKids, Nurse Practitioner, Nurse Midwife, CHMS, DDTCS, Other.
- 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 desk 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

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

- Developing all Request for Proposals (RFPs) and Advance Planning Documents (APDs) related to MMIS.
- Developing the contract for the fiscal agent to operate MMIS and monitoring the contractor's performance.
- Maintaining system documentation from the contractor.

- Developing, tracking and documenting customer service requests for modifications to MMIS.
- Approving production system modifications to MMIS.
- Performing quality assurance reviews on all edits and audits affecting claims processed by MMIS.
- Developing and producing reports from the Medicaid data warehouse.
- Managing and monitoring access to the Medicaid data warehouse.
- Monitoring the use and security of Arkansas Medicaid data used or accessed by DHS business associates and other outside entities.
- Researching IT security issues and coordinating IT security compliance and related issues with the DHS HIPAA Security Officer, HP Privacy Officer and the DHS Office of Systems and Technology.
- Managing DMS SharePoint sites and portals.

Third Party Liability

As the payor of last resort, federal and state statutes require Medicaid agencies to pursue third party resources to reduce Medicaid payments. 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 health care payments to Medicaid beneficiaries. These sources include health and liability insurance, court settlements and absent parents. The savings for SFY 2010 were as follows:

| | SFY 2010 |
|---|------------------------|
| Other Collections (Health & Casualty Insurance) | \$33,137,931.31 |
| Cost Avoidance (Health Insurance) | \$27,034,652.88 |
| Total Savings | \$60,172,584.19 |

Source: DMS Statistical Report

Utilization Review

As a safeguard to inappropriate and medically unnecessary services, Arkansas Medicaid subjects some services to a review process. The Utilization Review (UR) Section of the Arkansas Medicaid Program performs professional medical necessity reviews. The review process assists Medicaid in the development of coverage determinations for health plan benefits and provides monitoring of delivery and appropriateness of care according to clinically based standards of care.

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

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

Appendices

Glossary

DHS – Division of Medical Services Organizational Chart

Third Party Liability Collections, HMS Collections, and Cost Avoidance

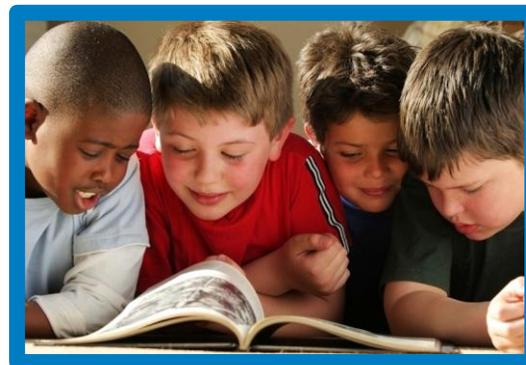
Maps

- Enrollees by County SFY 2010
- Expenditures by County SFY 2010
- Waiver Expenditures and Waiver Beneficiaries by County SFY 2010
- Providers by County SFY 2010

Division of Medical Services Contacts

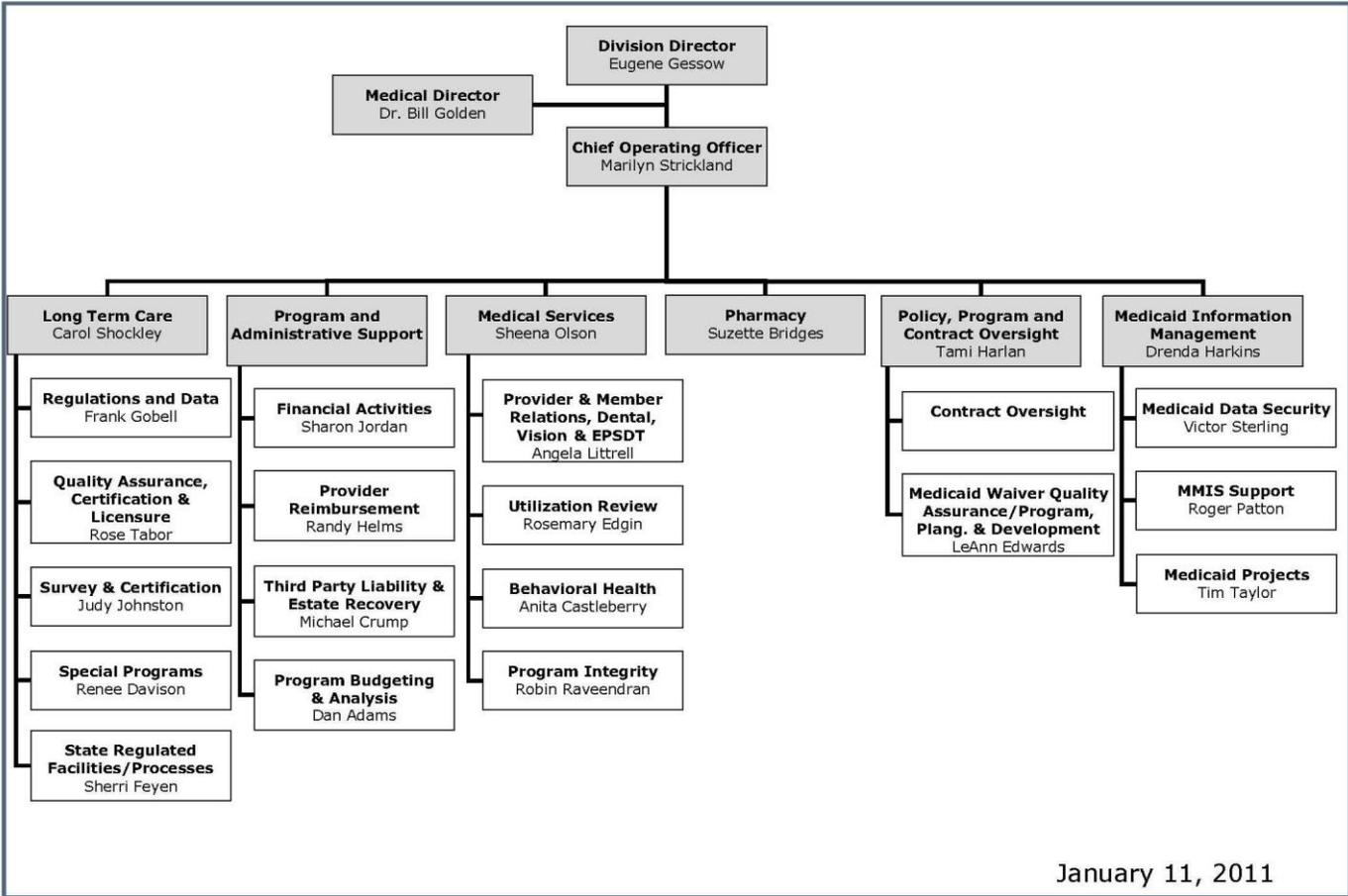
Glossary

| | | |
|--|--|---|
| AAA Area Agency on Aging | BCCDT Breast and Cervical Cancer Diagnosis and Treatment | DIS Department of Information Systems |
| ACES Arkansas Client Eligibility System | BO Business Objects | DME Durable Medical Equipment |
| ACS Alternative Community Services | CHIP Children's Health Insurance Program | DMHS Division of Mental Health Services |
| Adjudicate To determine whether a claim is to be paid or denied | CHMS Child Health Management Services | DMS Division of Medical Services (Medicaid) |
| ADL Activities of Daily Living | CMHC Community Mental Health Center | DSS Decision Support System/Data Warehouse |
| AEVCS Automated Eligibility Verification and Claims Submission | CMS Centers for Medicare and Medicaid Services | DUR Drug Utilization Review |
| On-line system for providers to verify eligibility of beneficiaries and submit claims to fiscal agent | COB Coordination of Benefit | DYS Department of Youth Services |
| AFDC Aid to Families with Dependent Children | COBA Coordination of Benefits Agreement | EBT Electronic Benefit Transfer |
| AFMC Arkansas Foundation for Medical Care | COTS Commercial off-the-shelf software | EFT Electronic Funds Transfer |
| AHA Arkansas Hospital Association | DAAS Division of Aging and Adult Services | EHR Electronic Health Record A subset of a patient's health record in digital format that is capable of being shared electronically across different health care organizations |
| AHQA American Healthcare Quality Association | DBHS Division of Behavioral Health Services | EIN Employer's Identification Number |
| AMA American Medical Association | DBS Division of Blind Services | EMR Electronic Medical Record A record of clinical services for patient encounters in a care delivery organization. |
| ANSI American National Standards Institute (as used here, refers to health care standard transactions) | DCFS Division of Children and Family Services | EOB Explanation of Benefits |
| ANSWER Arkansas' Networked System for Welfare Eligibility and Reporting | DCO Division of County Operations | EOMB Explanation of Medical Benefits |
| ARRA American Recovery and Reinvestment Act of 2009 | DDE Direct Data Entry | EPSDT Early and Periodic Screening, Diagnosis and Treatment |
| AVR Automatic Voice Response | DDI Design, Development and Implementation | ERA Electronic Remittance Advice |
| | DDS Division of Developmental Disabilities Services | |
| | DHS Department of Human Services | |

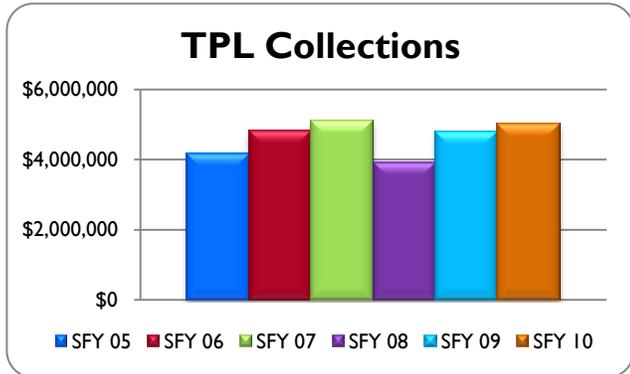


| | | |
|---|--|---|
| EVS Electronic Verification System | MMA Medicare Modernization Act | QDWI Qualified Disabled and Working Individuals |
| FFP Federal Funding Participation | MMCS Medicaid Managed Care Services | QI-1 Qualifying Individuals-I Group |
| FFS Fee For Service | MMIS Medicaid Management Information System | QMB Qualified Medicaid Beneficiary |
| FMAP Federal Medical Assistance Payment | MPAP Medicare Eligible Pharmacy Assistance Program | RSPMI Rehabilitative Services for Persons with Mental Illness |
| F-MAP Federal Medical Assistance Percentage | MSIS Medicaid Statistical Information System | SCHIP State Children's Health Insurance Program |
| HCBS Home Community Based Services | NCPDP National Council for Prescription Drug Programs | SFY State Fiscal Year – July 1 to June 30 |
| HCFA Health Care Financing Administration (former name for Centers for Medicare & Medicaid Services) | NDC National Drug Codes | SLMB Specified Low-Income Medicare Beneficiary |
| HCQIP Health Care Quality Improvement Program | NPDB National Provider Data Bank | SMB Specified Low-Income Medicare Beneficiaries |
| HHS The federal Department of Health and Human Services | NPI National Provider Identifier | SOBRA Sixth Omnibus Budget Reconciliation Act |
| HIE Health Information Exchange | ONC Office of the National Coordinator for Health Information Technology | SSA Social Security Administration |
| HIPAA Health Insurance Portability and Accountability Act | PA Prior Authorization | SSI Supplemental Security Income |
| HIT Health Information Technology | PACE Program for All-Inclusive Care for the Elderly | SSN Social Security Number |
| HITECH Health Information Technology for Economic and Clinical Health | PAM Prior Authorization Management | SUR Surveillance and Utilization Review |
| HITREC Health Information Technology Regional Extension Center | PBM Pharmacy Benefit Manager | TANF Temporary Assistance for Needy Families |
| ICF/MR Intermediate Care Facility/Mental Retardation | PCCM Primary Care Case Management | TB Tuberculosis |
| INS Immigration and Naturalization Services | PCP Primary Care Provider | TEFRA Tax Equity and Financial Responsibility Act |
| IRS Internal Revenue Service | PDA Personal Digital Assistants | TIN Tax Identification Number |
| IT Information Technology | PDF Portable Document Format | TPL Third Party Liability |
| IVR Interactive Voice Response | PDL Preferred Drug List | UR Utilization Review |
| IV&V Independent Validation and Verification | PDP Prescription Drug Plan | US United States |
| LTC Long Term Care | PHI Protected Health Information | USPS United States Postal Service |
| MCO Managed Care Organization | PHR Personal Health Record | VA Veterans Administration |
| MHA Mental Health Administration | PMPM Per-Member-Per-Month | VPN Virtual Private Network |
| MITA Medicaid Information Technology Architecture | POC Plan of care | WIC Women, Infant and Children program |
| | POS Place of service | Y-OQ® Youth Outcome Questionnaire ® |
| | QA Quality Assurance | |

DHS – Division of Medical Services Organizational Chart

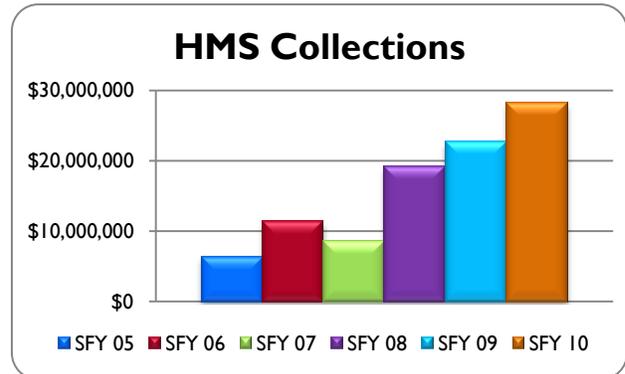


TPL Collections, HMS Collections, and Cost Avoidance



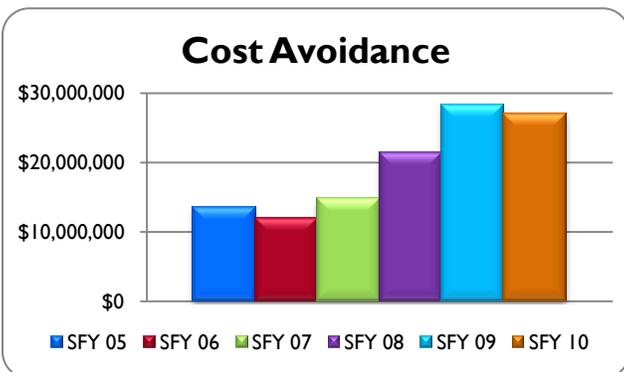
Includes
Manual Credit, Drug, Child Support and Tort Collections

| | |
|--------|----------------|
| SFY 05 | \$4,176,238.14 |
| SFY 06 | \$4,814,711.41 |
| SFY 07 | \$5,084,868.90 |
| SFY 08 | \$3,932,738.43 |
| SFY 09 | \$4,783,152.85 |
| SFY 10 | \$4,996,978.19 |



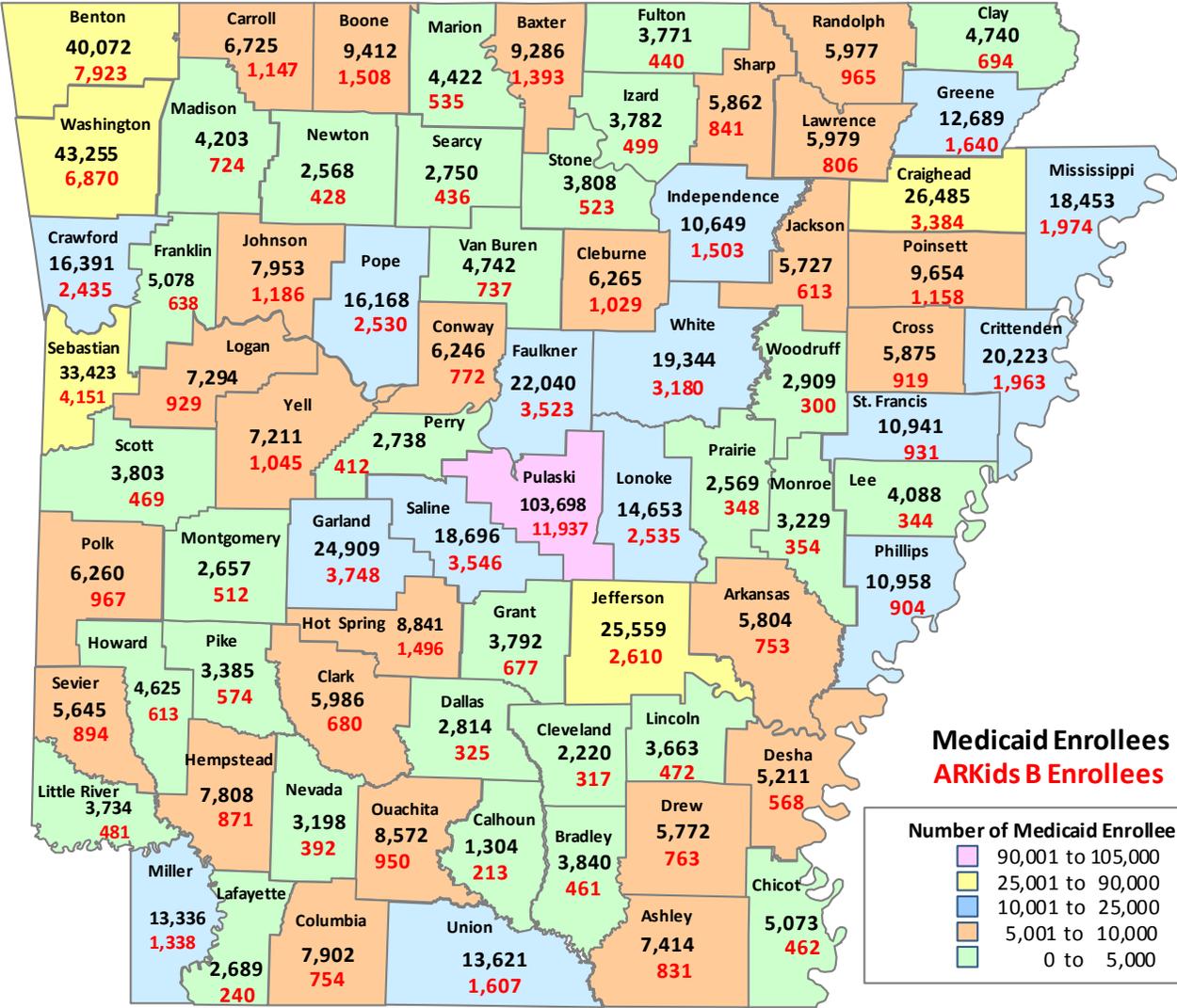
Includes
TPL and Credit Balance Collections

| | |
|--------|-----------------|
| SFY 05 | \$6,363,674.57 |
| SFY 06 | \$11,357,069.59 |
| SFY 07 | \$8,506,576.82 |
| SFY 08 | \$19,042,146.79 |
| SFY 09 | \$22,730,429.41 |
| SFY 10 | \$28,140,953.12 |

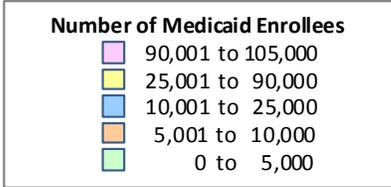


| | |
|--------|-----------------|
| SFY 05 | \$13,484,356.28 |
| SFY 06 | \$12,071,628.46 |
| SFY 07 | \$14,772,749.53 |
| SFY 08 | \$21,373,404.92 |
| SFY 09 | \$28,196,777.06 |
| SFY 10 | \$27,034,652.88 |

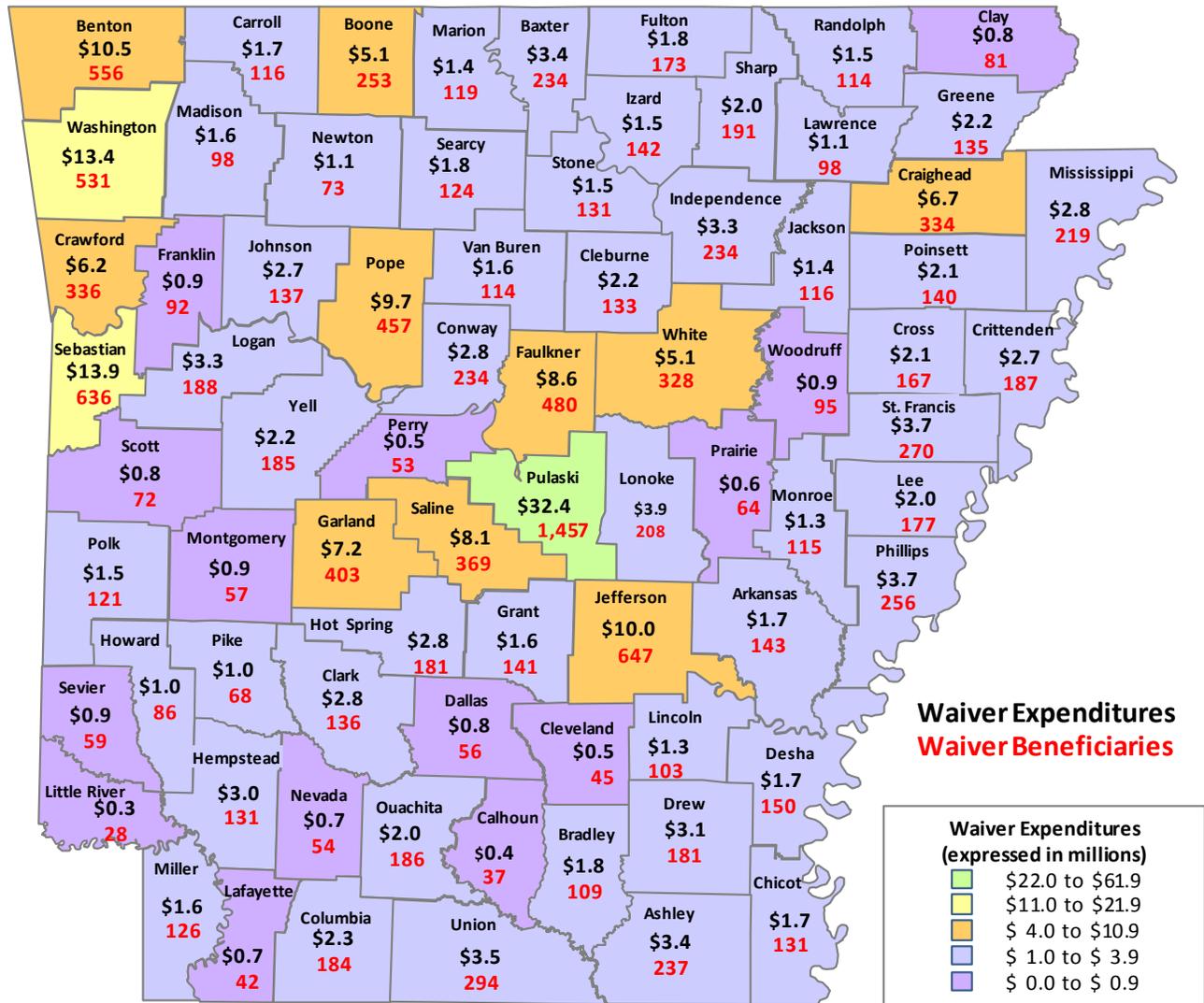
Map - Enrollees by County SFY 2010



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



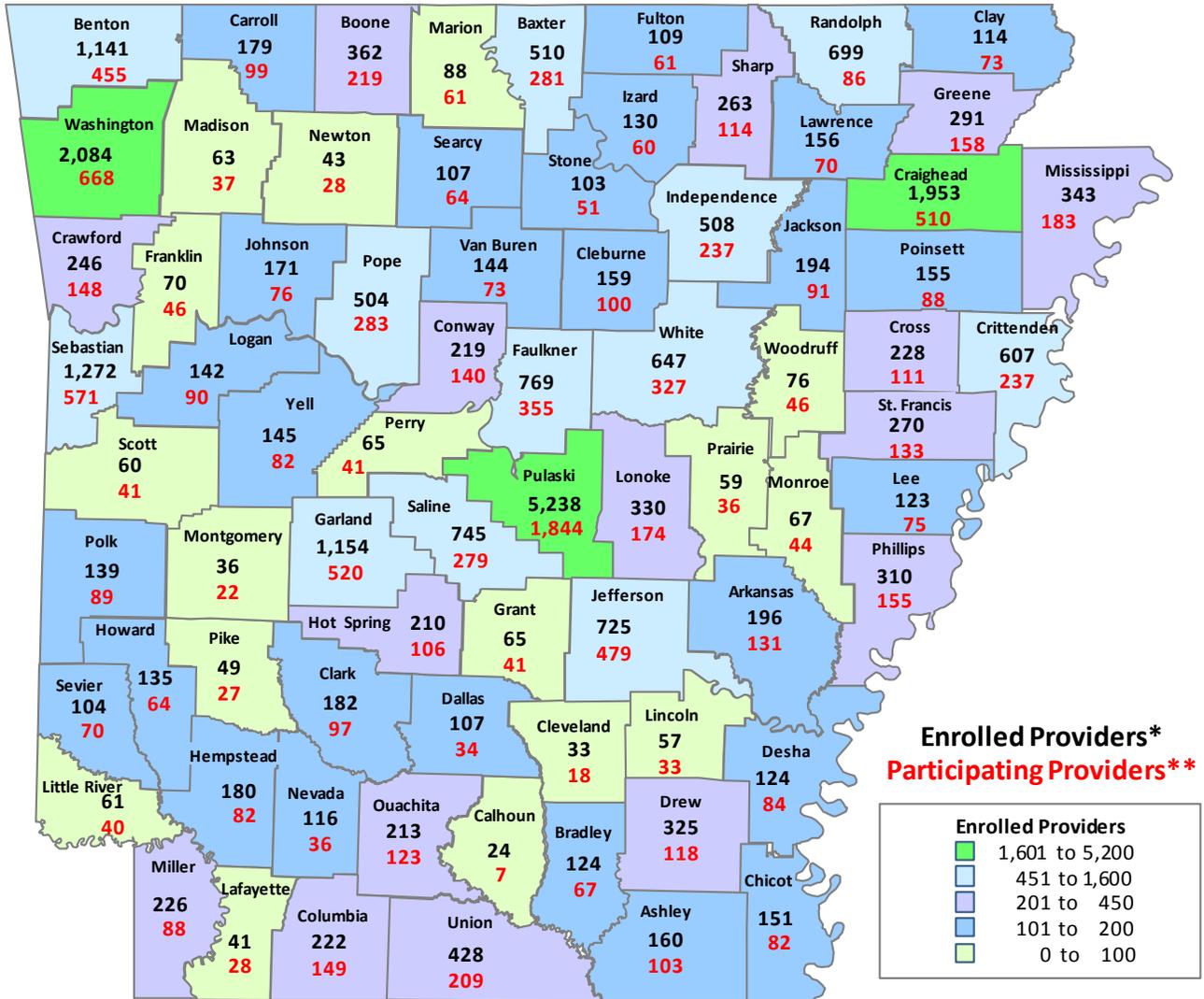
Map - Waiver Expenditures and Waiver Beneficiaries by County SFY 2010



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

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

Map - Providers by County SFY 2010



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

*Enrolled Providers – Providers who have been approved by Medicaid to provide services to Medicaid beneficiaries
 **Participating Providers – Providers who billed at least one claim in State Fiscal Year 2010

Division of Medical Services Contacts

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

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| Sheena Olson Sheena.Olson@arkansas.gov | Assistant Director, Medical Services | 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 |
| Marilyn Strickland Marilyn.Strickland@arkansas.gov | Chief Operating Officer | 682-8330 | 682-1197 | S-401 |
| TBA | Assistant Director, Administrative Services and Chief Financial Officer | 682-0422 | 682-2263 | S-416 |

Phone Numbers and Internet Resources

Quick Reference Guide

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|---|--------------|
| 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

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|---|----------------|
| 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

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

