

# Arkansas Medicaid Program Overview

Eugene I. Gessow, Director  
DHS - Division of Medical Services  
Donaghey Plaza South  
P.O. Box 1437 Slot S401  
Little Rock, AR 72203-1437  
(501) 682-8292  
(800) 482-5431

SFY 2011



## 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.

## Physical Address

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



**Division of Medical Services**  
**Department of Human Services**

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



Welcome to the 2011 overview of the Arkansas Medicaid Program. Designed as 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 has been an exciting year in Arkansas Medicaid as the program undertakes new initiatives to make it sustainable in the long-term and explores opportunities for improvement. Not only is Arkansas Medicaid in the process of purchasing and developing a new Medicaid Management Information System (MMIS), Medicaid is also working with private payers to design and implement a new payment system as part of the Arkansas Payment Improvement Initiative (APII). This initiative will improve the health care delivery system for all Arkansans. Additional reform changes at the national level have required the Medicaid program and the Division to be dynamic and versatile. During this time of transition and change, Arkansas Medicaid will continue delivering quality service. Consumers and providers will already find better program management, process improvements and the use of new technologies.

Arkansas Medicaid management and staff are committed to ensuring that all Medicaid-eligible Arkansans receive the best medical services possible. Our program works with providers and their professional organizations to identify and support the use of evidence-based practices and to secure access to services across the state.

Protecting the vulnerable, fostering independence and promoting better health for Arkansans are the goals that make the Medicaid program worthwhile. We hope that this overview will help you understand the steps we are taking to achieve these goals.

A handwritten signature in black ink, appearing to read "Eugene I. Gessow".

Eugene I. Gessow

Director,

Division of Medical Services



# Contents

What is Medicaid? .....	1
Who Qualifies for Medicaid? .....	1
Current Federal Poverty Levels .....	2
Monthly Levels .....	2
Aid to the Aged, Blind and Disabled Medicaid Categories .....	2
How is Medicaid Funded? .....	3
SFY 2011 Medicaid Operating Budget .....	3
How is Medicaid Administered? .....	3
Administration Statistics .....	4
What Programs are Provided by Arkansas Medicaid? .....	4
Mandatory Services .....	5
Optional Services .....	6
Additional Covered Services for Individuals Under Age 21 .....	7
Major Benefit Limitations on Services for Adults (Age 21 and Older)* .....	7
Additional Information for Children's Services .....	8
SFY 2011 in Review .....	9
Medicaid Operations .....	9
Inpatient Quality Incentive Reaches 5 Year Mark .....	10
Office of Long Term Care .....	10
Substance Abuse Treatment Services (SATS) .....	11
SFY 2011 Statistics .....	12
Beneficiary Information .....	12
Expenditures .....	15
Drug Rebate Collections .....	17
Economic Impact of Arkansas Medicaid .....	17
Arkansas Medicaid Providers .....	18
Understanding DMS and Medicaid .....	19
Medical Services .....	20
Provider and Beneficiary Relations, Dental & Visual Care Unit .....	20
Utilization Review .....	20
Behavioral Health Unit .....	21
Program Integrity .....	21
Long Term Care .....	21
Long Term Care Statistics .....	23
Pharmacy .....	24
Prescription Drug Program .....	24
Program and Administrative Support .....	25
Financial Activities .....	25
Provider Reimbursement .....	25
Third Party Liability .....	26
Program Budgeting and Analysis .....	26
Policy, Program and Contract Oversight .....	27
Program Development and Quality Assurance .....	27
Medicaid Information Management .....	27
Medicaid Data Security Unit .....	27
Systems and Support .....	28
Appendices .....	i
Glossary .....	i
DHS - Division of Medical Services Organizational Chart .....	iv
Map - Enrollees by County SFY 2011 .....	v
Map - Expenditures by County SFY 2011 .....	vi
Map - Waiver Expenditures and Waiver Beneficiaries by County SFY 2011 .....	vii
Map - Providers by County SFY 2011 .....	viii
Division of Medical Services Contacts .....	ix



## What is Medicaid?

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

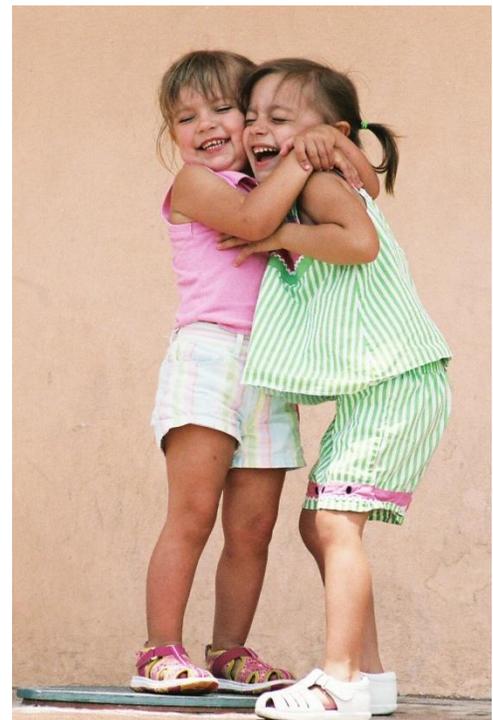
- Medical assistance to those who have insufficient incomes and resources to meet the costs of necessary medical services and
- Rehabilitation and other services to help families and individuals become or remain independent and able to care for themselves.

Each state has some sort 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 (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 qualify for Medicaid are one of the following:

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



## Current Federal Poverty Levels

### Monthly Levels

(Effective April 1, 2011 through March 31, 2012)

#### 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	907.50	1206.98	1678.88	1815.00
2	1225.83	1630.36	2267.79	2451.67
3	1544.17	2053.74	2856.71	3088.33
4	1862.50	2477.13	3445.63	3725.00
5	2180.83	2900.51	4034.54	4361.67
6	2499.17	3323.89	4623.46	4998.33
7	2817.50	3747.28	5212.38	5635.00
8	3135.83	4170.66	5801.29	6271.67
9	3454.16	4594.04	6390.20	6908.34
10	3772.49	5017.42	6979.11	7545.01
For each additional member add:	318.33	423.38	588.91	636.67

### 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	726.00	907.50	1089.00	1225.13	1815.00	2268.75
Couple	980.66	1225.83	1471.00	1654.88	2451.67	3064.58
For each additional family member in the Working Disabled category add:						795.83

\*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 20.74% of Arkansas Medicaid program-related costs in SFY 2011; the federal government funds approximately 79.26%. These rates are due to increased federal share from ARRA. The ARRA funding ended June 30, 2011. 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 2011 Medicaid Operating Budget

	(millions)
General Revenue	\$681.4
Other Revenue	\$211.3
Quality Assurance Fee	\$65.4
Trust Fund	\$13.0
Federal Revenue	\$3,516.4
Total Program	\$4,487.5

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

## 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, Medicaid Waiver Programs 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 and Waivers to ensure compliance with human services federal regulations.



## Administration Statistics

In SFY 2011, DMS Program Development and Quality Assurance processed:

- 10 State Plan amendments.
- 106 provider manual updates.
- 5 official notices.
- 1 provider memorandum and
- 9 pharmacy memorandums.

In SFY 2011, Arkansas Medicaid's fiscal agent, Hewlett-Packard (HP), had provider representatives attend and conduct 56 workshops around the state. The provider representatives also conducted 2,318 provider visits and responded to 91,315 voice calls and 229,153 automated calls.

In 2011, MMCS Provider Relations Representatives contacted a quarterly average of:

- 68 hospitals.
- 905 clinics and
- 2,442 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 above, the State complies with federal requirements regulating the EPSDT program. "Early and periodic screening and diagnosis and treatment" means:

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

## 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

Outpatient 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

### 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

NET Managed Care Waiver

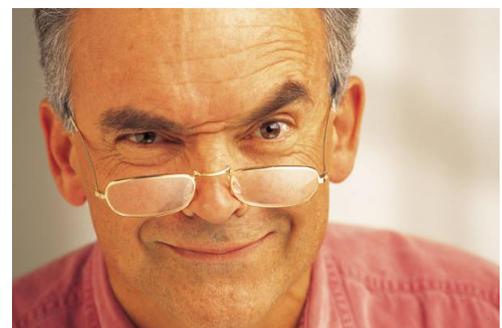
Non-Public Transportation

Nonprofit Transportation

FQHC Transportation

### NOTE:

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



## Optional Services

### Aging and Disability Services

ElderChoices Waiver  
 AAPD Attendant Care  
 AAPD Environmental Adaptations  
 AAPD Agency Attendant Care, Co Employer  
 AAPD Counseling Case Management  
 IndependentChoices  
 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

### 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

Licensed Mental Health Practitioners

### NOTE:

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

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

## 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 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; prescriptions are unlimited for nursing facility beneficiaries and EPSDT beneficiaries under age 21. Extensions of prescriptions will be considered up to a maximum of six (6) prescriptions per month for medically necessary maintenance medications.
- 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 drug and \$2 on the dispensing fee for prescription services for eyeglasses. Beneficiaries in the Working Disabled aid category must pay a higher co-payment for these services and also must pay co-payments for some additional services.

## Additional Information for 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.
- Based on family income, certain TEFRA beneficiaries must pay a premium.

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



## SFY 2011 in Review

State Fiscal Year (SFY) 2011 brought many new opportunities for Arkansas Medicaid. First, Arkansas Medicaid has placed an emphasis on development of its information technology systems. As part of the American Reinvestment and Recovery Act (ARRA), Arkansas Medicaid was able to partner with other organizations and agencies to invest in Health Information Technologies (HIT). Over the past year, Arkansas Medicaid designed and will soon implement its HIT Provider Incentive Program which provides federally-funded incentive payments to Medicaid health care providers for their adoption of Electronic Health Record systems (EHR). In addition, Arkansas Medicaid is actively working with the Office of Health Information Technology (OHIT) to plan a state-wide Health Information Exchange to improve health care through real time exchange of health information. Also in SFY 2011, Arkansas Medicaid initiated the procurement process to replace the current Medicaid Management Information System (MMIS). The new MMIS will be very different from the current system and will improve operations and processes across the Medicaid program.

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

Finally, in 2011 Arkansas Medicaid began a series of stakeholder meetings to discuss concerns regarding upcoming budget challenges and begin a dialogue about moving away from the fee-for-service payment model to episodes of care. As a result of these discussions, Arkansas Medicaid and other payers are partnering to design and implement the Arkansas Payment Improvement Initiative (APII). The goal of APII is to provide coordinated care to achieve better health outcomes for all Arkansans.

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

## Medicaid Operations

In SFY 2011, Medicaid's fiscal agent, Hewlett-Packard (HP), processed more than 39 million provider-submitted claims for 12,300 providers on behalf of more than 770,000 Arkansans. They responded to 91,315 voice calls, 229,153 automated calls and 29,712 written inquiries and conducted 2,318 provider visits and 56 workshops around the state.

Medicaid processed 99.5% of provider-submitted claims within 30 days, with the average receipt-to-adjudication time approximately 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 489,000 children. According to recent data, Medicaid paid for approximately 66% of all births in Arkansas.

## Inpatient Quality Incentive Reaches 5 Year Mark

The Medicaid Inpatient Quality Incentive (IQI) Program grew out of a collaboration between Arkansas Medicaid, the Arkansas Hospital Association and the Arkansas Foundation for Medical Care (AFMC). It was conceived as a way to update the existing Medicaid hospital per diem rate and reward facilities for providing high-quality care, and was the first pay-for-performance program for hospitals in the nation that included a validation component.

The program awards bonus payments to hospitals for significant improvement and/or high performance on a list of care measures that is adjusted each year. For instance, the SFY 2012 measures target obstetrics, care transitions, surgical care, VTE prophylaxis and exclusive breastfeeding. Several of the original measures have been retired as participating hospitals reached the maximum level of achievement.

In the first five years of the program (SFYs 2007-2011) Arkansas hospitals received a total of \$22.45 million in bonus payments from Arkansas Medicaid. Just as importantly, these hospitals significantly raised their performance on care measures that directly affect patient outcomes. The number of participating hospitals has ranged from 53 to 76, with the number receiving bonus payments each year ranging from 24 to 37. In the 2011 IQI program, 53 hospitals participated and 31 received bonus payments.

The IQI program has positioned Arkansas as a leader in national Medicaid pay-for-performance efforts. The initiative represents a growing national movement toward rewarding hospitals for their commitment to providing quality, evidence-based care to their patients.

## Office of Long Term Care

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

Additionally, the Office of Long Term Care has provided extensive training to nursing facilities and facility staff to implement the Minimum Data Set (MDS) 3.0. MDS 3.0 represents a significant redesign of the information collected by facilities concerning residents' social, cognitive, emotional and medical conditions. MDS 3.0 now includes a significant emphasis on identifying residents for whom home- and community-based services may be an alternative to facility placement. This emphasis, referred to as Section Q, directly supports the State of Arkansas' Options Counseling program, which attempts to identify, at the time of admission, those individuals that express a desire to return home or to the community. For those individuals, the State of Arkansas assesses the possibility of return and the services necessary for return.

## Substance Abuse Treatment Services (SATS)

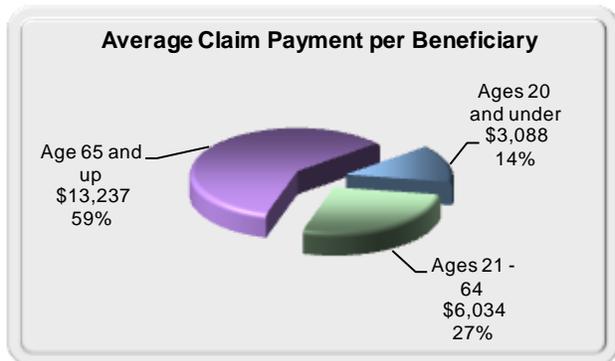
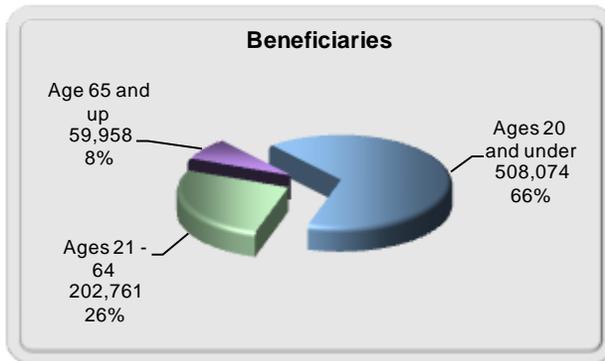
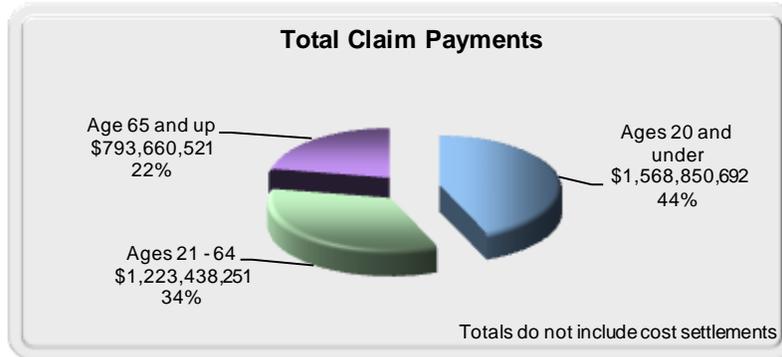
The Division of Medical Services received approval and promulgated a new outpatient Substance Abuse Treatment Services (SATS) program for pregnant women through their 60 days post-partum and for adolescents. The new program became effective July 1, 2011 and was the culmination of a two year DHS departmental planning process which included representatives across all DHS divisions and a broad array of interested stakeholders. The DMS Behavioral Health Unit is assisting with the launch and implementation of the program to supply outreach and information to interested providers and beneficiaries regarding the new regulations.



## SFY 2011 Statistics

### Beneficiary Information

#### Unduplicated Beneficiary Counts and Claim Payments by Age



#### Percentage of Change in Enrollees and Beneficiaries from SFY 2010 to SFY 2011

	SFY10	SFY11	% Change
Medicaid Enrollees	771,918	785,446	1.8%
Medicaid Beneficiaries	755,607	770,792	2.0%

#### Newborns paid for by Medicaid

	SFY09	SFY10	% Change
Newborns paid for by Medicaid	25,337	25,659	1.27%

The medical cost for 66% of all babies born to Arkansas residents during SFY 2010 was paid for by Medicaid. \*

Source: DHS- DMS

\*This calculation is based on SFY10 data, which is the most recent available.

### Percentage of Population Served by Medicaid

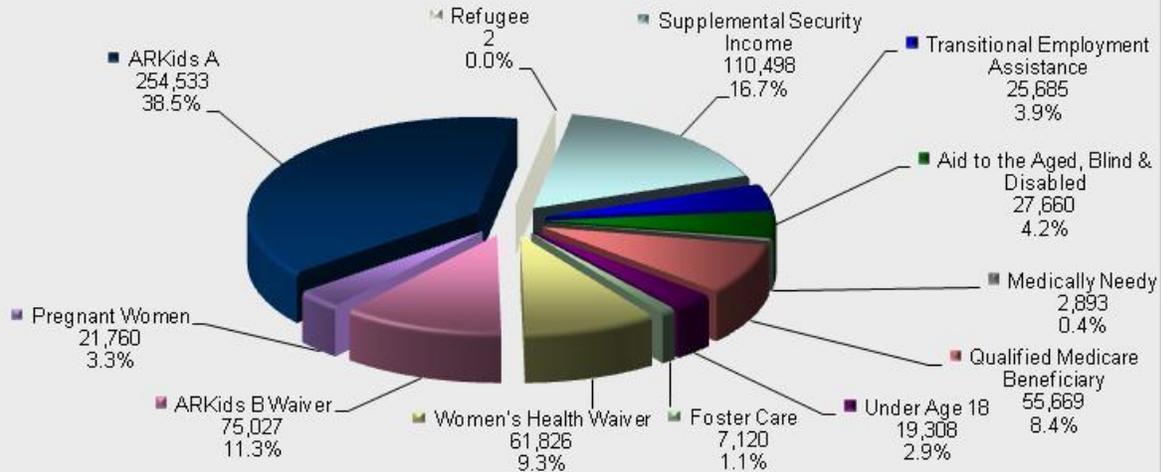
Age group	Arkansas Population	% of Population Served by Medicaid**
All Ages	2,915,918	26%
Elderly (65 and older)	419,981	14%
Adults (20-64)	1,700,007	12%
Children (19 and under)	795,930	64%

\*\*This calculation is based on the Arkansas population as of July 1, 2010, which is the most recent available.

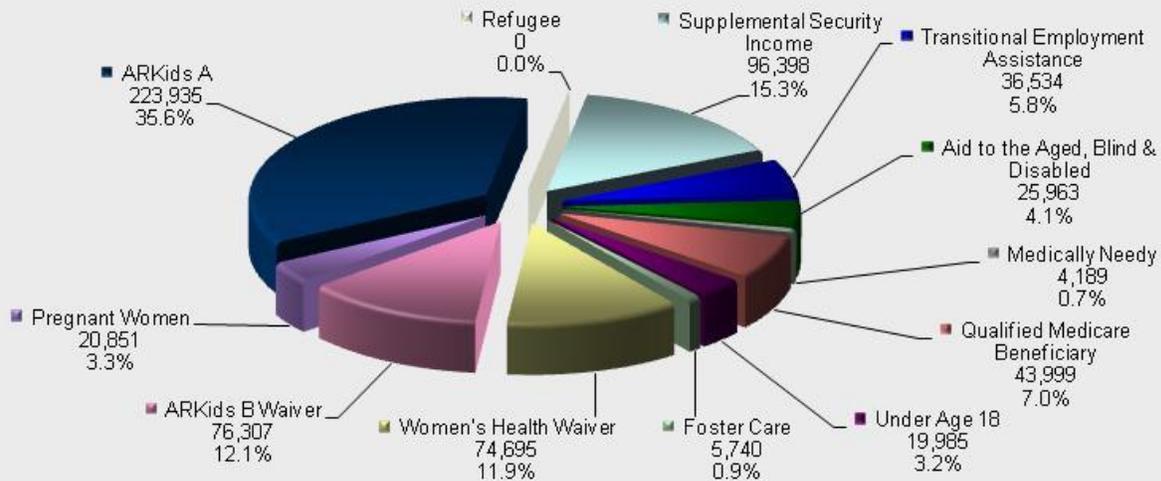


Medicaid Enrollees by Aid Category - 5 year comparison

Average Medicaid Enrollees per Month by Aid Category SFY11



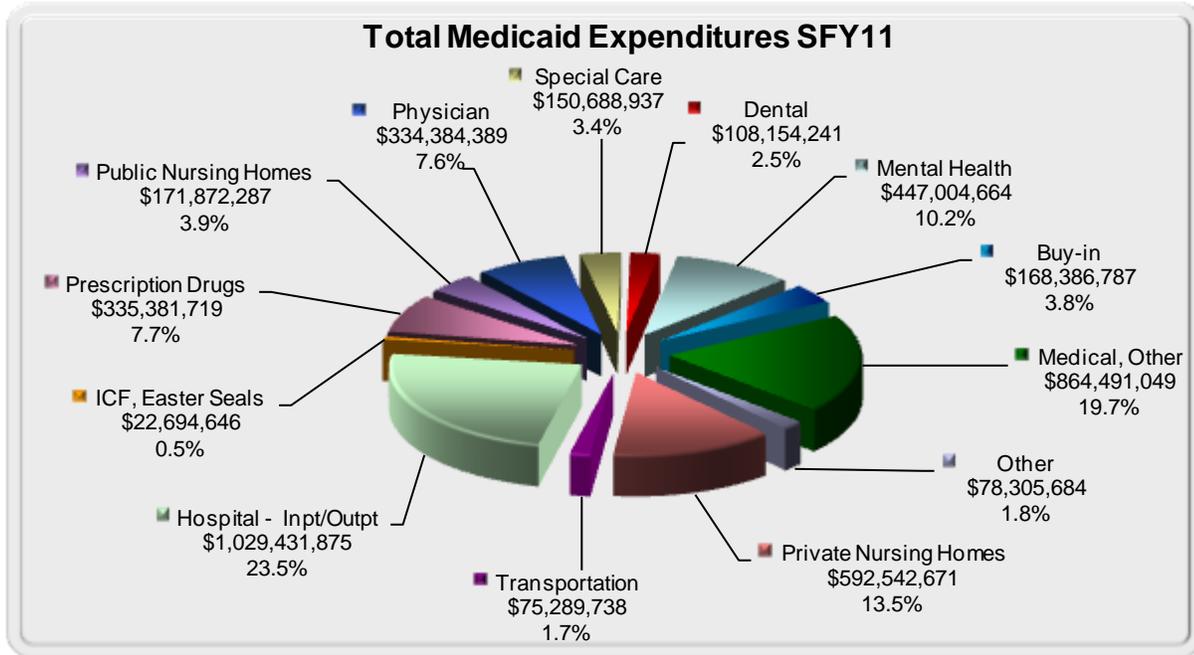
Average Medicaid Enrollees per Month by Aid Category SFY07



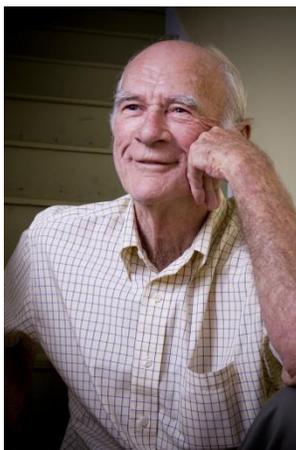
NOTE: Beneficiaries may have multiple aid categories and therefore, are counted in each of those categories.

# Expenditures

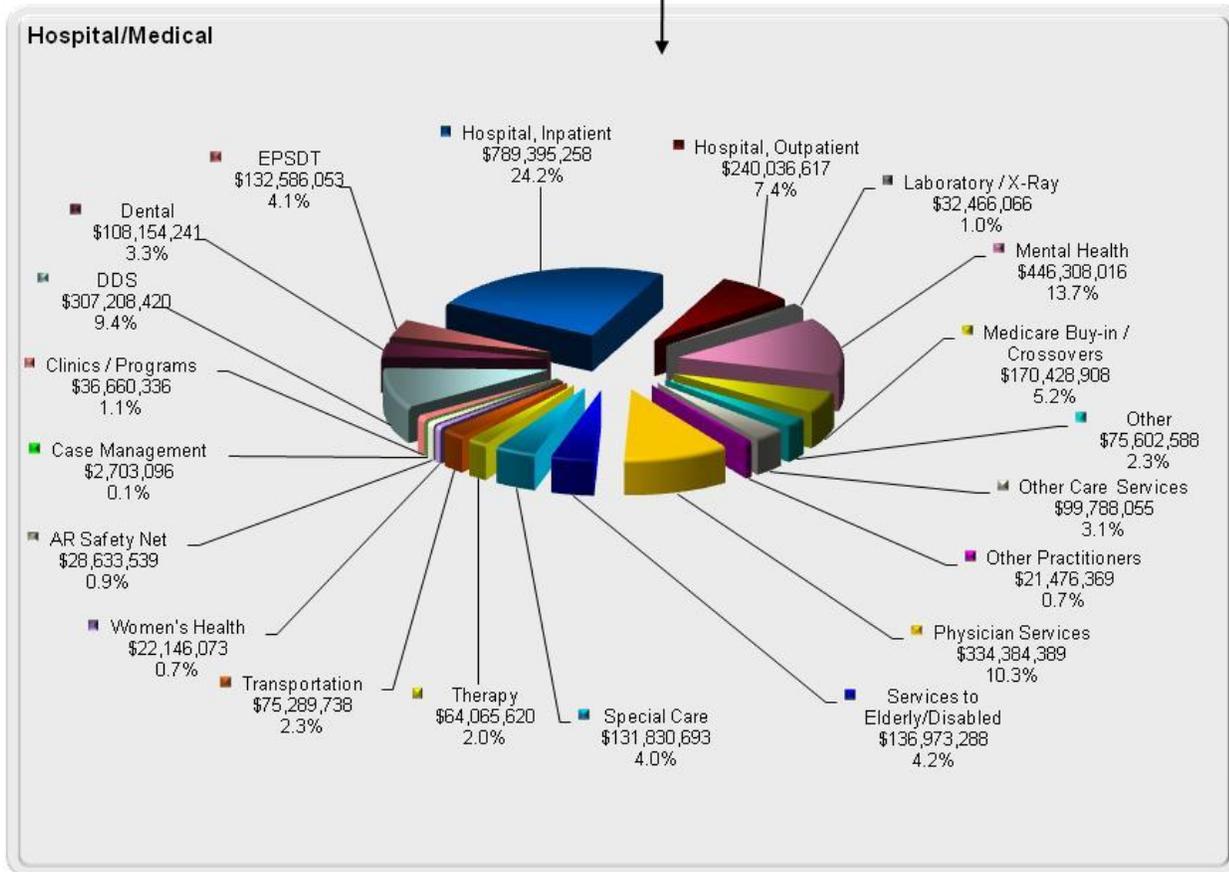
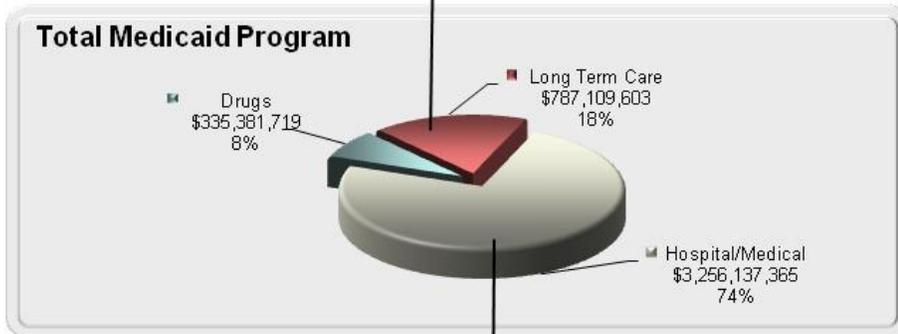
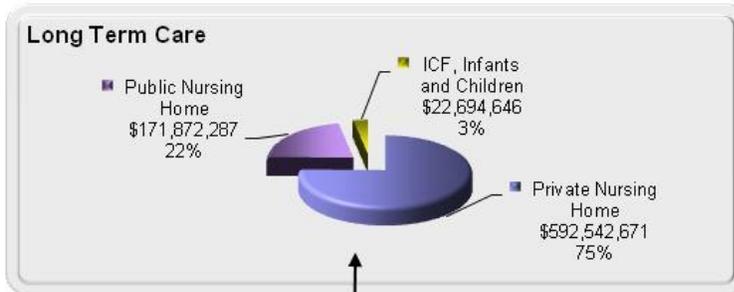
## Total Medicaid Expenditures



- Special Care includes Home Health, Private Duty Nursing, Personal Care and Hospice Services.
- Transportation includes emergency and non-emergency transportation.
- Other includes vendor contracts for Hospital/Medical, Targeted Case Management, and other adjustments.
- Buy-in includes Medicare premiums 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.



Arkansas Medicaid Program Benefit Expenditures



## 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 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 2011	\$138,002,121
State portion	\$27,099,097
Federal portion	\$110,903,024

## Economic Impact of Arkansas Medicaid

Program Costs			
State Fiscal Year (SFY)	Total (in mil)	Unduplicated Beneficiaries	Average Annual Cost per Beneficiary
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	\$4.379	770,792	\$5,681
2012*	\$4.793	779,282	\$6,151

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

\*Estimated

Arkansas Budget and Medicaid percentage		
	SFY 2011	Medicaid Represents
State of Arkansas Budget	\$24.8 billion	18.1%
State General Revenue Funded Budget	\$4.5 billion	15.2%



## Arkansas Medicaid Providers

### Number of enrolled providers

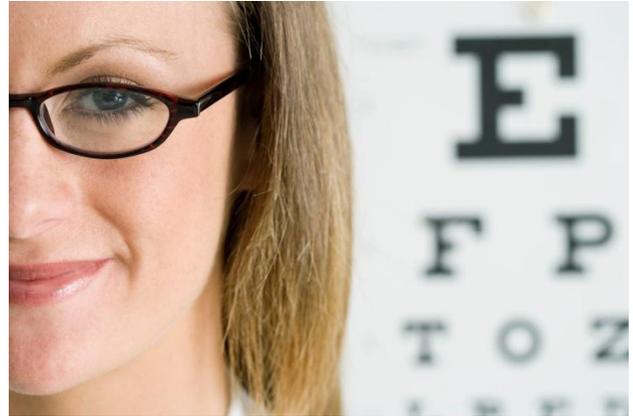
Medicaid has approximately 36,800 enrolled providers.

### Number of participating providers

Approximately 12,300 (34%) are participating providers.

### Number of claims processed and approximate processing time

39 million provider-submitted claims were processed in SFY 2011 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 enrolled

1	Physicians (7718)
2	Alternatives for Adults with Physical Disabilities (APD) Waiver Attendant Care (2559)
3	Individual Occupational, Physical and Speech Therapy Services Providers (2518)
4	Physicians Groups (1710)
5	*Dental Services (858)
6	Pharmacy (852)
7	Prosthetic Services/Durable Medical Equipment (753)
8	Nurse Practitioner (592)
9	Visual Care - Optometrist Optician (440)
10	Hospital (437)

\*Includes orthodontists, oral surgeons and dental groups

## Understanding DMS and Medicaid

The Division of Medical Services houses two major programs under one administration: Medicaid and the Office of Long Term Care. 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.

In addition to Medicaid Services, DMS also houses the Office of 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 450 long-term care facilities licensed to provide long-term care services in Arkansas. These facilities include Nursing Facilities, Intermediate Care Facilities for the Mentally Retarded (ICFs/MR), Adult Day Care, Adult Day Health Care, Post Acute Head Injury Facility, Residential Care Facilities and Assisted Living Facilities. Improving the quality of life for residents and protecting their health and safety through enforcing state and federal standards are primary goals of Arkansas Medicaid's Office of Long Term Care (OLTC). Using qualified health care professionals, OLTC surveys, or inspects, all facilities to ensure residents receive the care they need in a clean, safe environment and are treated with dignity and respect.

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

DMS is divided into six major units:

- Medical Services
- Long Term Care
- Pharmacy
- Program and Administrative Support
- Policy, Program and Contract Oversight
- Medicaid Information Management

(See the DMS Organizational Chart in the appendices.)

## Medical Services

### Provider and Beneficiary Relations, Dental & Visual Care Unit

The Provider and Beneficiary Relations, Dental & Visual Care Unit manages multiple programs and services, many of which are provided through professional services contracts. The Unit contracts with Hewlett-Packard (HP) to enroll, educate and assist Medicaid and ARKids First providers. At the end of SFY 2011, there were more than 36,800 enrolled providers. The Unit also contracts with the Arkansas Foundation for Medical Care (AFMC) for provider and beneficiary outreach and assistance. In addition, a contract with the Arkansas Department of Health provides assistance with primary care physician assignments and dental care coordination. The Provider and Beneficiary Relations, Dental & Visual Care Unit also provides internal staff to respond to concerns and questions of providers and beneficiaries of Medicaid and ARKids services. In SFY 2011, 91,008 telephone inquiries were handled in all sections of the Unit. In addition to the services and programs referenced in the Unit's name, the Unit also manages the EPSDT and ARKids programs, the Primary Care Case Management Program (ConnectCare), Non-emergency Medical Transportation, data analysis and quality improvement activities.

### 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.

## 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 monitoring 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.

## Program Integrity

In 2011, Program Integrity (PI) audited 158 providers and identified \$3.8 million in questioned cost and \$22 million in cost avoidance. The unit also reviewed 1,189 questionable enrollment applications, denied 38 questionable applications and terminated 128 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%. Fourteen PI staff attended various training classes at the MII in 2011. 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. PI has worked closely with Medi/Medi contractors on various projects in 2011. 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. PI and the MIG contractor conducted several joint audits in Hospice and Mental Health programs.

## Long Term Care

The Office of Long Term Care (OLTC) professional surveyors conduct annual Medicare and Medicaid and State Licensure surveys of Arkansas' 229 Nursing Facilities and in the state's 40 Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) including 5 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 75 Residential Care Facilities, 66 Assisted Living Facilities and 19 Alzheimer's Special Care Units. In addition, annual Civil Rights surveys are conducted in 108 hospitals. In SFY 2011, 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 249 hours of continuing education through 84 workshops/seminars to over 3,482 staff members in the nursing

home and assisted living industry during SFY 2011. In addition, there were 354 agendas submitted from outside sources for review to determine 1,881 contact hours for nursing home administrators.

The Nursing Home Administrator Licensure Unit processed renewals for 700 licensed administrators, processed 84 license applications and issued 36 new licenses and 7 temporary licenses. In addition, OLTC administered the state nursing home administrator examination to 72 individuals.

The Criminal Record Check Program applies to all categories of licensed long-term care facilities consisting of over 511 affected facilities. During SFY 2011, there were 35,132 state record checks processed through OLTC with 873 disqualifications (2.5%) and 21,548 federal record checks processed with 192 disqualifications (1.4%).

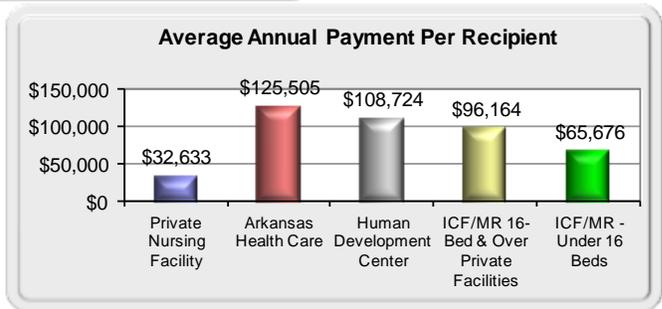
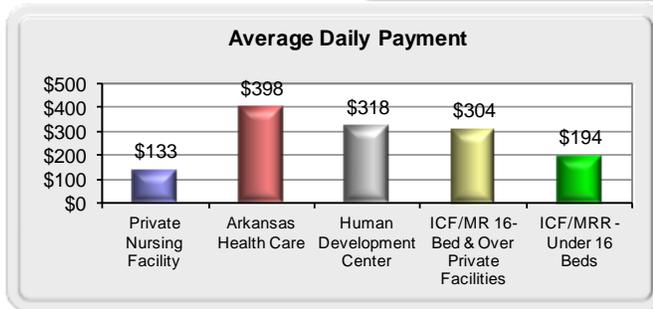
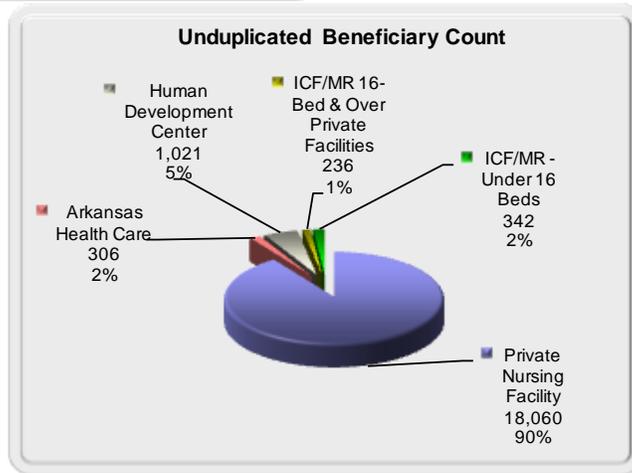
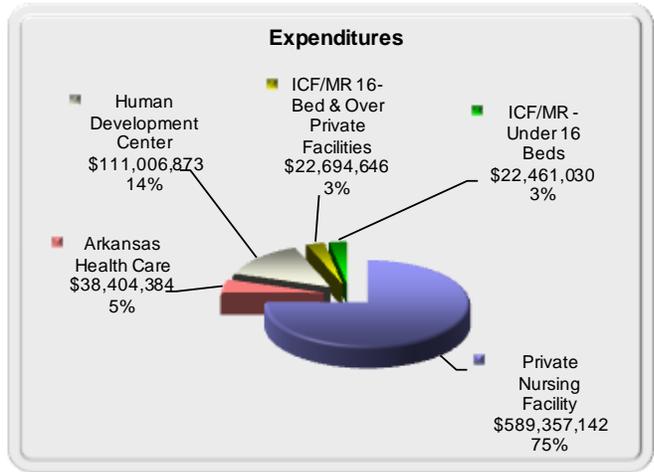
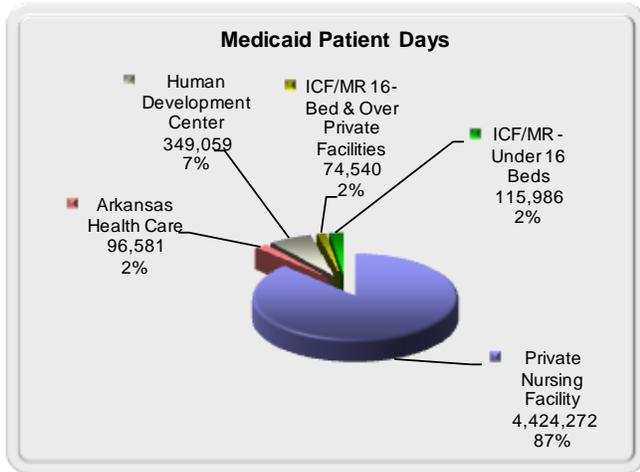
At the end of SFY 2011, the Registry for Certified Nursing Assistants (CNAs) contained 30,126 active and 64,132 inactive names. In addition to maintaining the Registry for CNAs, the OLTC also manages the certification renewal process for CNAs, approves and monitors nursing assistant training programs, manages the statewide competency testing services and processes reciprocity transfers of CNAs coming into and leaving Arkansas.

The Medical Need Determination Unit processed approximately 1,232 Medicaid nursing facility applications per month while maintaining approximately 11,444 active cases. The unit also processed 10,335 assessments, 2,124 changes of condition requests, 519 transfers, 1,811 utilization review requests and 3,288 applications/reviews for ICFs/MR during the year. In addition, the unit completed 13,792 applications/reviews/waivers for other medical programs within DHS during SFY 2011.

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 this occurs, the OLTC performs an on-site complaint investigation. The OLTC received 937 nursing home complaints during SFY 2011 regarding the care or conditions in long-term care facilities.



### Long Term Care Statistics



## Pharmacy

### Prescription Drug Program

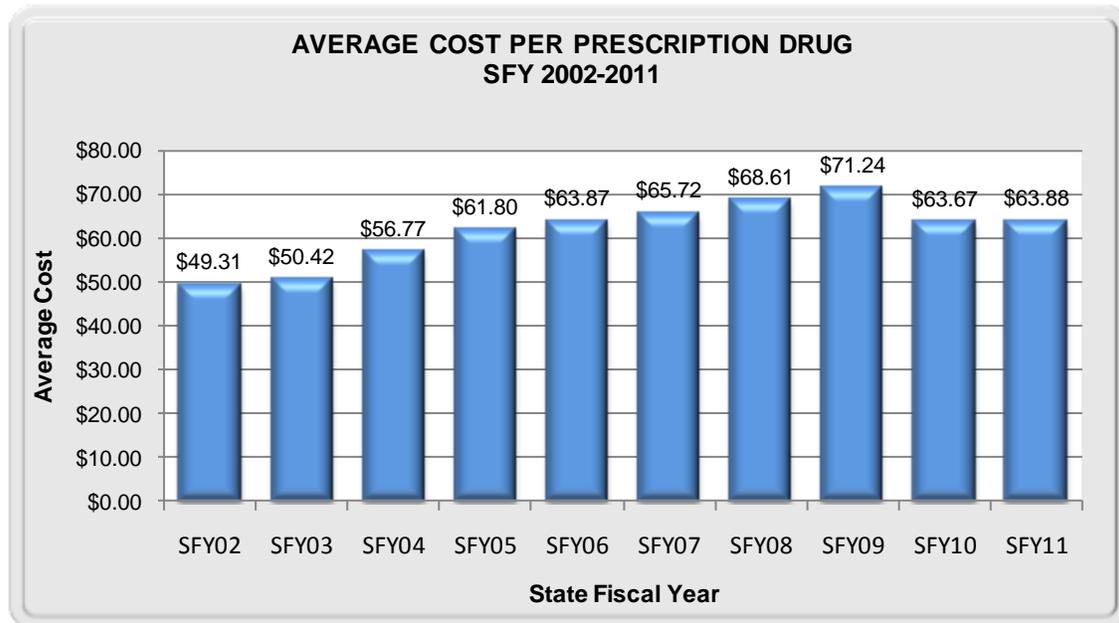
The Prescription Drug Program, which is an optional Medicaid benefit, was implemented in Arkansas in 1973. Under this program, eligible beneficiaries may obtain prescription medication through any of the 852 enrolled pharmacies in the state. During SFY 2011, a total of 451,194 Medicaid beneficiaries used their prescription drug benefits. A total of 4.8 million prescriptions were reimbursed by Arkansas Medicaid for cost of \$307.0 million dollars thus making the average cost per prescription approximately \$63.88. An average cost for a brand name prescription was \$212 dollars, representing 22% of the claims and accounting for 72% of expenditures. The average cost for a generic prescription was \$23 dollars, representing 78% of claims and accounting for 28% of expenditures.

The Prescription Drug Program restricts each beneficiary to a maximum of 3 prescriptions per month, with the capability of getting up to 6 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 9 prescriptions per month.

Beginning January 1, 2006, full benefit, dual-eligible beneficiaries began to receive drug coverage through the Medicare Prescription Drug Benefit (Part D) of the Medicare Modernization Act of 2003 rather than through Arkansas Medicaid. Arkansas Medicaid is required to pay CMS the State Contribution for Prescription Drug Benefit, sometimes referred to as the Medicare Part D Clawback. This Medicare Part D payment for SFY 2011 was \$25,537,036.62. 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 CMS. The EAC and dispensing fee are based upon surveys that determine an average cost for dispensing a prescription and the average ingredient cost. In March of 2002, a differential fee of \$2.00 was established and applied to generic prescriptions for which there is not an upper limit. The following table shows the average cost per prescription drug in the Arkansas Medicaid program.

## Average Cost per Prescription Drug, SFY 2002-2011



## Program and Administrative Support

### 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.

### 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.

## Third Party Liability

As the payer of last resort, federal and state statutes require Medicaid agencies to pursue third party resources to reduce Medicaid payments. One aspect of 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 2011 were as follows:

	SFY 2011
Other Collections (Health & Casualty Insurance)	\$28,963,905.92
Cost Avoidance (Health Insurance)	\$24,246,379.79
<b>Total Savings</b>	<b>\$53,210,285.71</b>

Source: DMS Statistical Report

## 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.

## Policy, Program and Contract Oversight

### Program Development and Quality Assurance

The 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.

Quality Assurance Activities include:

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

## Medicaid Information Management

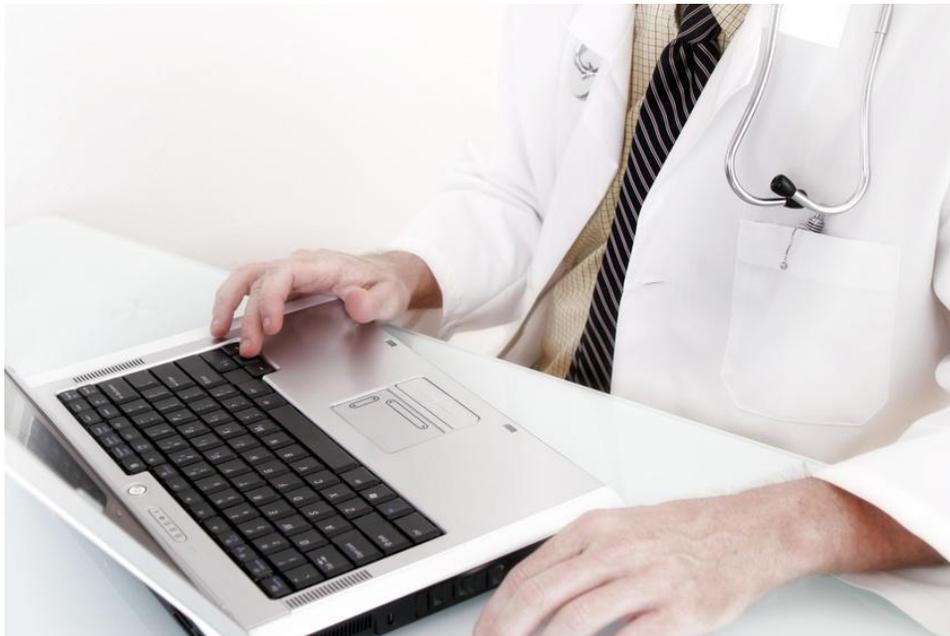
### Medicaid Data Security Unit

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 utilizing Medicaid data for research projects and publication requests to ensure HIPAA compliance.

## 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 Advance Planning Documents (APDs) related to MMIS.
- Maintaining system documentation from the contractor.
- Developing, tracking and documenting customer service requests for modifications to MMIS.
- Approving production system modifications to MMIS and monitoring the fiscal agent contractor's performance.
- Performing quality assurance reviews on all edits and audits affecting claims processed by MMIS.
- Managing DMS SharePoint sites and portals.



## Appendices

### Glossary

DHS - Division of Medical Services Organizational Chart

### Maps

- Enrollees by County SFY 2011
- Expenditures by County SFY 2011
- Waiver Expenditures and Waiver Beneficiaries by County SFY 2011
- Providers by County SFY 2011

Division of Medical Services Contacts



## Glossary

<b>AAA</b> Area Agency on Aging	<b>ANSI</b> American National Standards Institute (as used here, refers to health care standard transactions)	<b>COBA</b> Coordination of Benefits Agreement
<b>ACES</b> Arkansas Client Eligibility System	<b>ANSWER</b> Arkansas' Networked System for Welfare Eligibility and Reporting	<b>COTS</b> Commercial off-the-shelf software
<b>ACS</b> Alternative Community Services	<b>ARRA</b> American Recovery and Reinvestment Act of 2009	<b>DAAS</b> Division of Aging and Adult Services
<b>Adjudicate</b> To determine whether a claim is to be paid or denied	<b>AVR</b> Automatic Voice Response	<b>DBHS</b> Division of Behavioral Health Services
<b>ADL</b> Activities of Daily Living	<b>BCCDT</b> Breast and Cervical Cancer Diagnosis and Treatment	<b>DBS</b> Division of Blind Services
<b>AEVCS</b> Automated Eligibility Verification and Claims Submission On-line system for providers to verify eligibility of beneficiaries and submit claims to fiscal agent	<b>BO</b> Business Objects	<b>DCFS</b> Division of Children and Family Services
<b>AFDC</b> Aid to Families with Dependent Children	<b>CHIP</b> Children's Health Insurance Program	<b>DCO</b> Division of County Operations
<b>AFMC</b> Arkansas Foundation for Medical Care	<b>CHMS</b> Child Health Management Services	<b>DDE</b> Direct Data Entry
<b>AHA</b> Arkansas Hospital Association	<b>CMHC</b> Community Mental Health Center	<b>DDI</b> Design, Development and Implementation
<b>AHQA</b> American Healthcare Quality Association	<b>CMS</b> Centers for Medicare and Medicaid Services	<b>DDS</b> Division of Developmental Disabilities Services
<b>AMA</b> American Medical Association	<b>COB</b> Coordination of Benefit	<b>DHS</b> Department of Human Services
		<b>DIS</b> Department of Information Systems
		<b>DME</b> 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 Record

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

**EIN**

Employer's Identification Number

**EMR**

Electronic Medical Record

A record of clinical services for patient encounters in a care delivery organization.

**EOB**

Explanation of Benefits

**EOMB**

Explanation of Medical Benefits

**EPSDT**

Early and Periodic Screening, Diagnosis and Treatment

**ERA**

Electronic Remittance Advice

**EVS**

Electronic Verification System

**FFP**

Federal Funding Participation

**FFS**

Fee For Service

**FMAP**

Federal Medical Assistance Payment

**F-MAP**

Federal Medical Assistance Percentage

**HCBS**

Home Community Based Services

**HCFA**

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

**HCQIP**

Health Care Quality Improvement Program

**HHS**

The federal Department of Health and Human Services

**HIE**

Health Information Exchange

**HIPAA**

Health Insurance Portability and Accountability Act

**HIT**

Health Information Technology

**HITECH**

Health Information Technology for Economic and Clinical Health

**HITREC**

Health Information Technology Regional Extension Center

**ICF/MR**

Intermediate Care Facility/Mental Retardation

**INS**

Immigration and Naturalization Services

**IRS**

Internal Revenue Service

**IT**

Information Technology

**IVR**

Interactive Voice Response

**IV&V**

Independent Validation and Verification

**LTC**

Long Term Care

**MCO**

Managed Care Organization

**MHA**

Mental Health Administration

**MITA**

Medicaid Information Technology Architecture

**MMA**

Medicare Modernization Act

**MMCS**

Medicaid Managed Care Services

**MMIS**

Medicaid Management Information System

**MPAP**

Medicare Eligible Pharmacy Assistance Program

**MSIS**

Medicaid Statistical Information System

**NCPDP**

National Council for Prescription Drug Programs

**NDC**

National Drug Codes

**NPDB**

National Provider Data Bank

**NPI**

National Provider Identifier

**ONC**

Office of the National Coordinator for Health Information Technology

**PA**

Prior Authorization

**PACE**

Program for All-Inclusive Care for the Elderly

**PAM**

Prior Authorization Management

**PBM**

Pharmacy Benefit Manager

**PCCM**

Primary Care Case Management

**PCP**

Primary Care Provider

**PDA**

Personal Digital Assistants

**PDF**

Portable Document Format

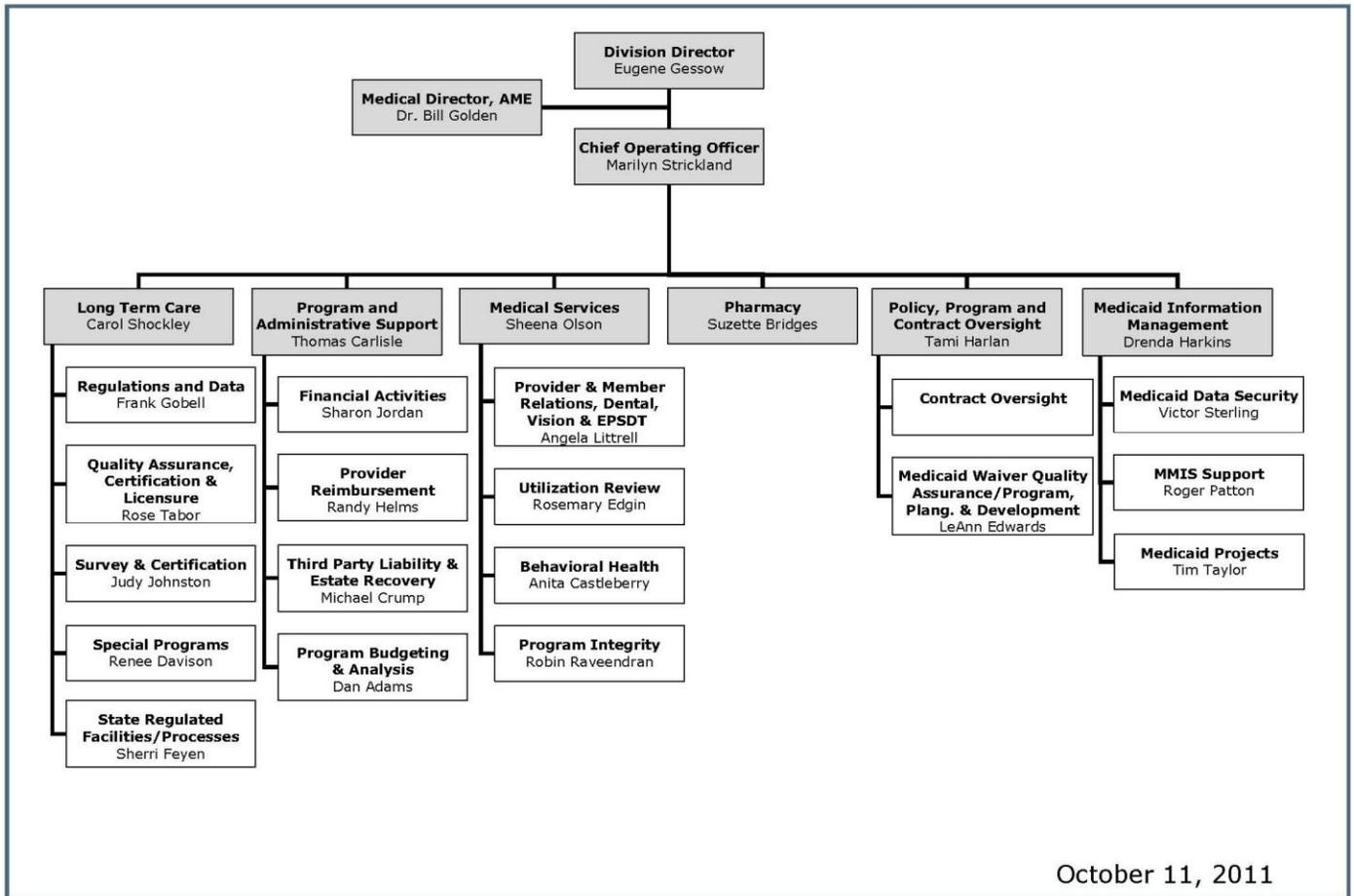
**PDL**

Preferred Drug List

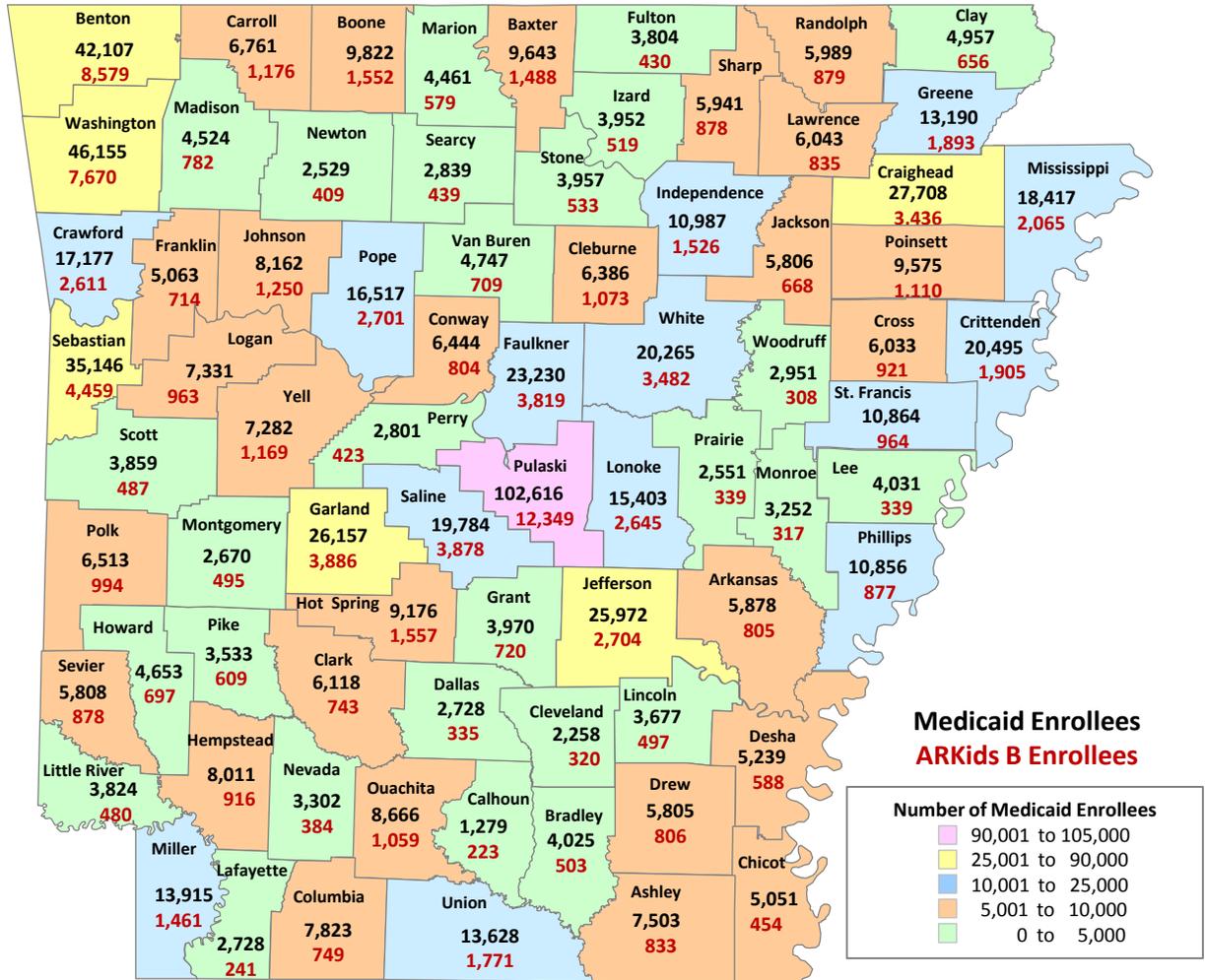
<b>PDP</b> Prescription Drug Plan	<b>SCHIP</b> State Children's Health Insurance Program	<b>TB</b> Tuberculosis
<b>PHI</b> Protected Health Information	<b>SFY</b> State Fiscal Year – July 1 to June 30	<b>TEFRA</b> Tax Equity and Financial Responsibility Act
<b>PHR</b> Personal Health Record	<b>SLMB</b> Specified Low-Income Medicare Beneficiary	<b>TIN</b> Tax Identification Number
<b>PMPM</b> Per-Member-Per-Month	<b>SMB</b> Specified Low-Income Medicare Beneficiaries	<b>TPL</b> Third Party Liability
<b>POC</b> Plan of care	<b>SOBRA</b> Sixth Omnibus Budget Reconciliation Act	<b>UR</b> Utilization Review
<b>POS</b> Place of service	<b>SSA</b> Social Security Administration	<b>US</b> United States
<b>QA</b> Quality Assurance	<b>SSI</b> Supplemental Security Income	<b>USPS</b> United States Postal Service
<b>QDWI</b> Qualified Disabled and Working Individuals	<b>SSN</b> Social Security Number	<b>VA</b> Veterans Administration
<b>QI-I</b> Qualifying Individuals-I Group	<b>SUR</b> Surveillance and Utilization Review	<b>VPN</b> Virtual Private Network
<b>QMB</b> Qualified Medicaid Beneficiary	<b>TANF</b> Temporary Assistance for Needy Families	<b>WIC</b> Women, Infant and Children program
<b>RSPMI</b> Rehabilitative Services for Persons with Mental Illness		<b>Y-OQ®</b> Youth Outcome Questionnaire®



# DHS – Division of Medical Services Organizational Chart



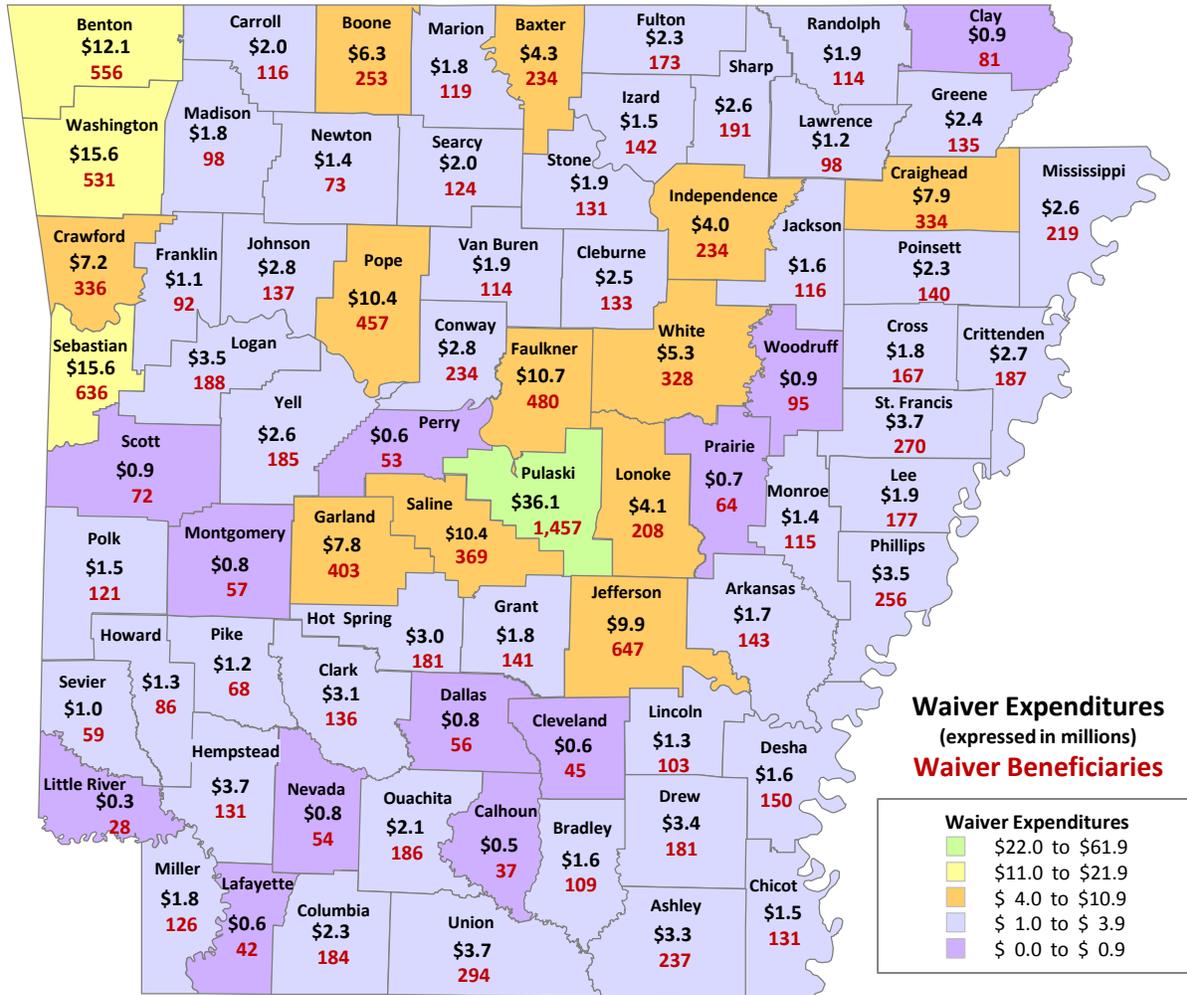
# Map - Enrollees by County SFY 2011



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



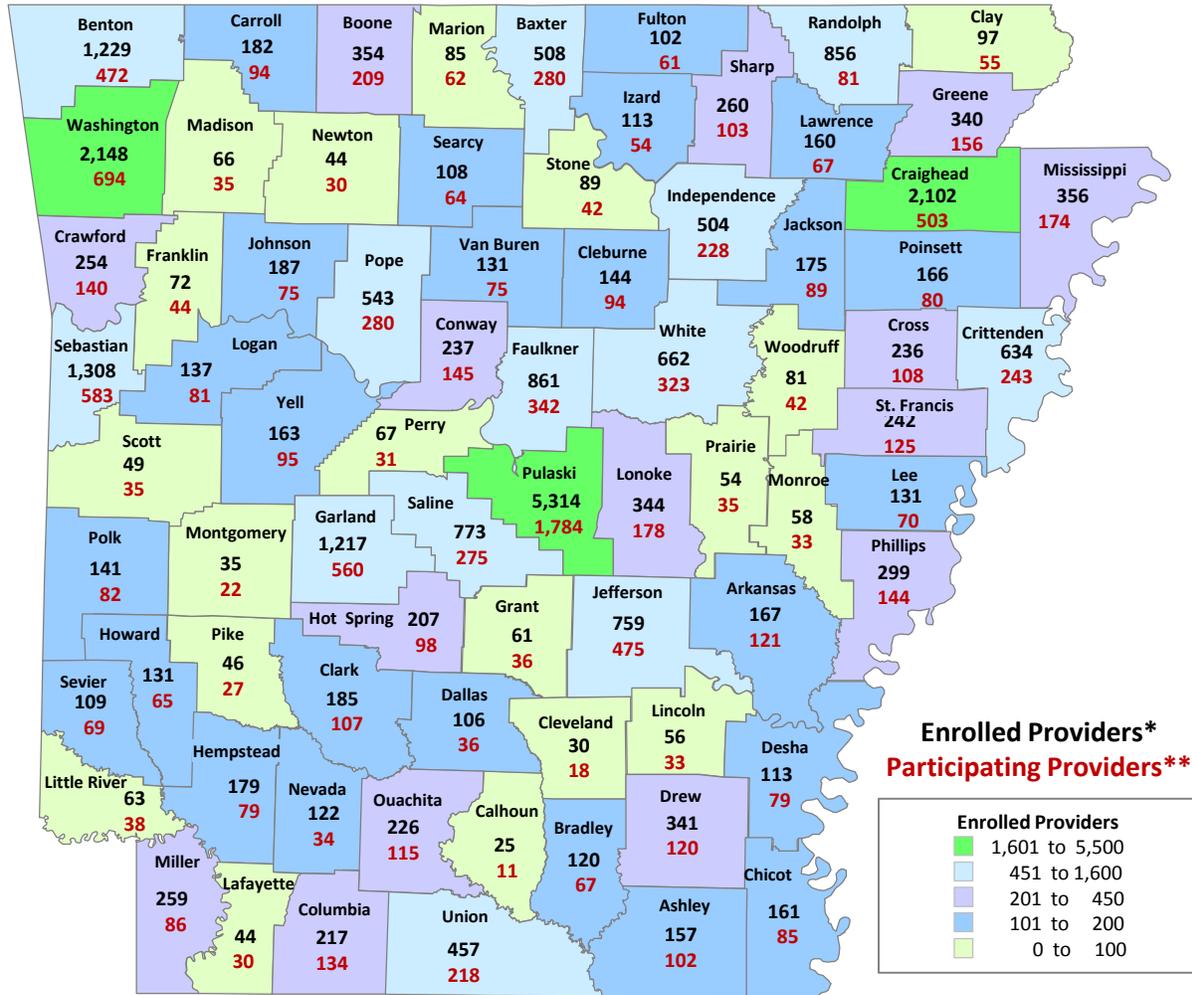
# Map - Waiver Expenditures and Waiver Beneficiaries by County SFY 2011



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 2011



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

\*Enrolled Providers – Providers who have been approved by Medicaid to provider services to Medicaid beneficiaries  
\*\*Participating Providers – Providers who billed at least one claim in State Fiscal Year 2011

## Division of Medical Services Contacts

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

Name/e-mail	Title	Voice	Fax	Mail slot
Eugene Gessow Eugene.Gessow@arkansas.gov	Division Director	682-8292	682-1197	S-401
Suzette Bridges Suzette.Bridges@arkansas.gov	Assistant Director, Pharmacy	683-4120	683-4124	S-415
Lynn Burton Lynn.Burton@arkansas.gov	Administrator, Institutional Reimbursement	682-1875	682-3889	S-416
Thomas Carlisle Thomas.Carlisle@arkansas.gov	Assistant Director, Administrative Services and Chief Financial Officer	682-0422	682-2263	S-416
Anita Castleberry Anita.Castleberry@arkansas.gov	Medical Assistance Manager, Behavioral Health Unit	682-8154	682-8013	S-420
Michael Crump Michael.Crump@arkansas.gov	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
William Golden William.Golden@arkansas.gov	Medical Director, Health Policy	682-8302	682-1197	S-401
Drenda Harkins Drenda.Harkins@arkansas.gov	Assistant Director, Medicaid Management, Information, and Performance	682-2139	682-5318	S-416
Tami Harlan Tami.Harlan@arkansas.gov	Assistant Director, Policy, Programs and Contracts 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
Sharon Jordan Sharon.Jordan@arkansas.gov	Chief Program Administrator, Financial Activities	682-8489	682-2263	S-416
Angela Littrell Angela.Littrell@arkansas.gov	Chief Program Administrator, Provider & Member Relations, Dental, Vision & EPSDT	682-8333	682-8304	S-410
Judith E. McGhee Judith.McGhee@arkansas.gov	Medical Director, Health Reviews	682-9868	682-8013	S-412
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



# Phone Numbers and Internet Resources

## Quick Reference Guide

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

## Hotlines

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

## Internet Resources

ACCESS Arkansas.....	<a href="https://access.arkansas.gov">https://access.arkansas.gov</a>
Arkansas Foundation for Medical Care.....	<a href="http://www.afmc.org">http://www.afmc.org</a>
Arkansas Medicaid.....	<a href="http://www.medicaid.state.ar.us">http://www.medicaid.state.ar.us</a>
ARKids First.....	<a href="http://www.arkidsfirst.com/home.htm">http://www.arkidsfirst.com/home.htm</a>
Connect Care (Primary Care Physicians).....	<a href="http://www.seeyourdoc.org">http://www.seeyourdoc.org</a>
Department of Human Services (DHS).....	<a href="http://www.arkansas.gov/dhs">http://www.arkansas.gov/dhs</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>