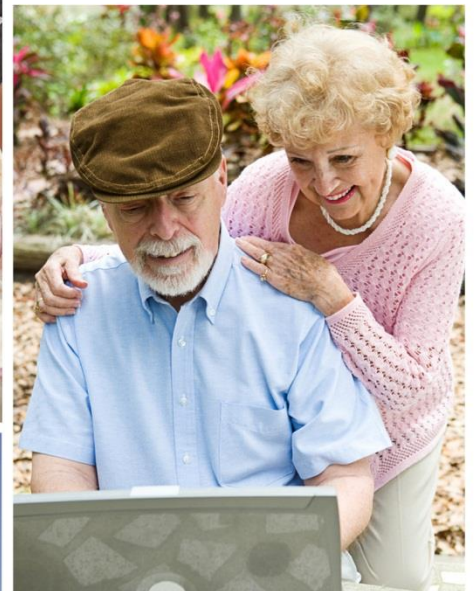




Arkansas Medicaid Program Overview

SFY 2014



ARKANSAS
DEPARTMENT OF
 **HUMAN**
SERVICES

Dawn Stehle, Director
DHS - Division of Medical Services
Donaghey Plaza South
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Department of Human Services (DHS) Mission Statement

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

DHS Vision

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

Division of Medical Services Mission Statement

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

Our Core Values

- Compassion
- Courage
- Respect
- Integrity
- Trust

Our Beliefs

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

Physical Address

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



Division of Medical Services

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501-682-8292 · Fax: 501-682-1197



Welcome to the 2014 overview of the Arkansas Medicaid Program. This booklet provides a general understanding of how Medicaid works in our state, including the health care services covered, who depends on these services, how DMS pays for them, and the new directions DMS is taking to improve our overall health care system in Arkansas.

During 2014, Arkansas continued to take center stage in the national debate on health care improvement by becoming the first state to offer an alternative to Medicaid expansion. The Arkansas Health Care Independence Act of 2013 allows our state to pay for private insurance instead of traditional Medicaid coverage for Arkansans with incomes up to 138 percent of the Federal Poverty Level. To date, more than 220,000 Arkansans have become eligible to take advantage of the Arkansas Private Option and are now able to visit the doctor or receive needed medication thanks to this innovative new program.

Arkansas Medicaid enjoyed a strong year of innovation and cost management in 2014. DMS continues to advance this groundbreaking initiative by creating new episodes of care, and our biggest endeavor yet, the Patient-Centered Medical Home (PCMH) program. PCMH is a key component of the Arkansas Payment Improvement Initiative that rewards team-based care and promotes early intervention to reduce complications and associated health care costs.

As Arkansas continues to lead the nation in key health care initiatives, the state is also in the process of implementing new systems to expedite processing information for both providers and beneficiaries. Major initiatives include a new Medicaid Management Information System and a new Eligibility & Enrollment Framework. Additionally, DMS is assisting Arkansas Medicaid providers in converting beneficiaries' records from paper to electronic form and helping them prepare to comply with new International Classification of Diseases (10th Edition, Clinical Modification/Procedure Coding System) billing requirements that take effect in 2015.

Through all of our initiatives, the Division of Medical Services maintains focus on the core mission of Arkansas Medicaid: protecting the vulnerable, fostering independence and promoting better health for all Arkansans. I hope this overview of the program will help you understand the steps DMS is taking to achieve these goals.

A handwritten signature in black ink that reads "Dawn Stehle".

Dawn Stehle
Director, Division of Medical Services

humanservices.arkansas.gov

Protecting the vulnerable, fostering independence and promoting better health

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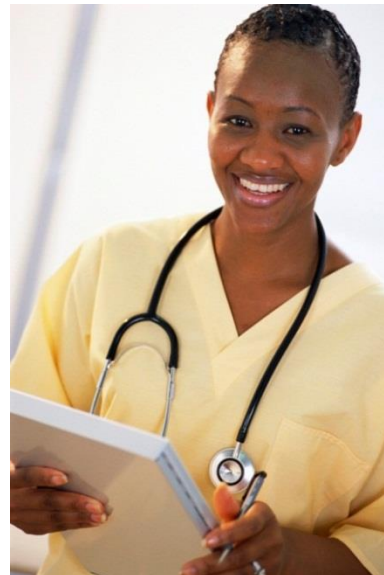
About the Arkansas Medicaid Program Overview Booklet

The Arkansas Medicaid overview booklet is produced annually by the Division of Medical Services (DMS) and Hewlett-Packard (HP). This overview is designed to give a high-level understanding of the Arkansas Medicaid program, its funding, covered services and how the program is administered. Statistics included in this overview come from many sources including the Department of Human Services Statistical Report, reports from the Decision Support System, the University of Arkansas at Little Rock website and other reports from units at DMS, HP and Arkansas Foundation for Medical Care.

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

If you have questions, comments or suggestions about the Arkansas Medicaid Program Overview booklet, please contact us at

OverviewFeedback@arkansas.gov to share your thoughts and let us know how you use the overview booklet. We value your feedback about this publication!



What is Medicaid?

Medicaid is a joint federal and state program that provides necessary medical services to eligible persons based on financial need and/or health status. In 1965, Title XIX of the Social Security Act created grant programs to provide federal grants to the states for medical assistance programs. Title XIX, popularly known as Medicaid, enables states to furnish:

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

Each state has a Medicaid program to meet the federal mandates and requirements as laid out in Title XIX. Arkansas, however, established a medical care program 26 years before passage of the federal laws requiring health care for the needy; Section 7 of Act 280 of 1939 and Act 416 of 1977 authorized the State of Arkansas to establish and maintain a medical care program for the indigent. The Medicaid program was implemented in Arkansas on January 1, 1970.

The Department of Human Services (DHS) is the single Arkansas state agency authorized and responsible for regulating and administering the Medicaid program. DHS administers the Arkansas Medicaid Program through the Department of Medical Services. The Centers for Medicare and Medicaid Services (CMS) administer the Medicaid Program for the U.S. Department of Health and Human Services. CMS authorizes federal funding levels and approves each state's State Plan, ensuring compliance with federal regulations. Individuals are certified as eligible for Arkansas Medicaid services by DHS Field Staff located in DHS County Offices or by District Social Security Offices.

Who Qualifies for Arkansas Medicaid?

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

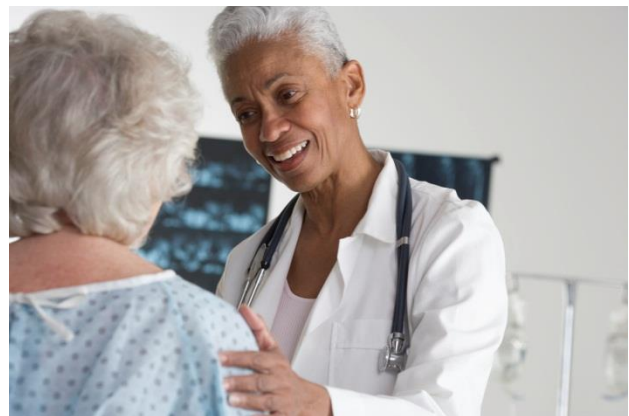
- Age 65 and older;
- Under age 19;
- Age 19 to 64 not receiving Medicare (the new Health Care Independence Program);
- Blind;
- Pregnant;
- The parent or the relative who is the caretaker of a child;
- Living in a nursing home;
- Under age 21 and in foster care;
- A former foster care recipient between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

Current Federal Poverty Levels

Monthly Levels* for Families and Individuals Medicaid Categories

(Effective April 1, 2014 through March 31, 2015)

Family size	Health Care Independence 133%	Health Care Independence with 5% Disregard 138%	ARKids First-A 142%	ARKids First-A with 5% Disregard 147%	ARKids First-B 211%	ARKids First-B with 5% Disregard 216%
1	\$1,293.43	\$1,342.05	\$1,380.95	\$1,429.58	\$2,051.98	\$2,100.60
2	\$1,743.41	\$1,808.95	\$1,861.39	\$1,926.93	\$2,765.86	\$2,831.40
3	\$2,193.39	\$2,275.85	\$2,341.82	\$2,424.28	\$3,479.75	\$3,562.20
4	\$2,643.38	\$2,742.75	\$2,822.25	\$2,921.63	\$4,193.63	\$4,293.00
5	\$3,093.36	\$3,209.65	\$3,302.69	\$3,418.98	\$4,907.51	\$5,023.80
6	\$3,543.34	\$3,676.55	\$3,783.12	\$3,916.33	\$5,621.40	\$5,754.60
7	\$3,993.33	\$4,143.45	\$4,263.55	\$4,413.68	\$6,335.28	\$6,485.40
8	\$4,443.31	\$4,610.35	\$4,743.99	\$4,911.03	\$7,049.16	\$7,216.20
9	\$4,893.29	\$5,077.25	\$5,224.42	\$5,408.38	\$7,763.05	\$7,947.00
10	\$5,343.27	\$5,544.15	\$5,704.85	\$5,905.73	\$8,476.93	\$8,677.80
For each additional member add:	\$449.98	\$466.90	\$480.43	\$497.35	\$713.88	\$730.80



Monthly Levels (continued)

Family size	Arkansas Health Care Access 150%	Full Pregnant Women & Parent Caretaker Relative (monthly dollar amount)	Transitional Medicaid 185%	Limited Pregnant Women / Unborn Child 209%	Limited Pregnant Women / Unborn Child with 5% Disregard 214%
1	\$1,458.75	\$124.00	\$1,799.13	\$2,032.53	\$2,081.15
2	\$1,966.25	\$220.00	\$2,425.04	\$2,739.65	\$2,805.19
3	\$2,473.75	\$276.00	\$3,050.96	\$3,446.76	\$3,529.22
4	\$2,981.25	\$334.00	\$3,676.88	\$4,153.88	\$4,253.25
5	\$3,488.75	\$388.00	\$4,302.79	\$4,861.00	\$4,977.29
6	\$3,996.25	\$448.00	\$4,928.71	\$5,568.11	\$5,701.32
7	\$4,503.75	\$505.00	\$5,554.63	\$6,275.23	\$6,425.35
8	\$5,011.25	\$561.00	\$6,180.54	\$6,982.35	\$7,149.39
9	\$5,518.75	\$618.00	\$6,806.45	\$7,689.46	\$7,873.42
10	\$6,026.25	\$618.00	\$7,432.36	\$8,396.58	\$8,597.45
For each additional member add:	\$507.50	9 and greater \$618.00	\$625.91	\$707.12	\$724.03

Aid to the Aged, Blind and Disabled Medicaid Categories

	ARSeniors Equal to or below 80%	Qualified Medicaid Beneficiary Equal to or below 100%	Specified Low-Income Medicare Beneficiary Between 100% and 120%	Qualifying Individuals-1 Group At least 120% but less than 135%	Qualified Disabled and Working Individuals Equal to or below 200%
Individual	\$778.00	\$972.50	\$1,167.00	\$1,312.88	\$1,945.00
Couple	\$1,048.67	\$1,310.83	\$1,573.00	\$1,769.63	\$2,621.67

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

How is Medicaid Funded?

Funding for Medicaid is shared between the federal government and the states with the federal government matching the state share at an authorized rate between 50 and 90 percent, depending on the program. The federal participation rate is adjusted each year to compensate for changes in the per capita income of each state relative to the nation as a whole.

- Arkansas funded approximately 29.88% of Arkansas Medicaid Program-related costs in State Fiscal Year 2014; the federal government funded approximately 70.12%. State funds are drawn directly from appropriated state general revenues, license fees, drug rebates, recoveries and the Arkansas Medicaid Trust Fund.
- Administrative costs for Arkansas Medicaid are generally funded 50% by Arkansas and 50% by the federal government; some specialized enhancements are funded 75% or 90% by the federal government.

SFY 2014 Arkansas Medicaid Operating Budget*

	(Millions)
General Revenue	\$879.9
Other Revenue	\$305.1
Quality Assurance Fee	\$77
Hospital Provider Tax	\$67.2
Intermediate Care Facilities for Individuals with Intellectual Disabilities Provider Tax	\$10
Trust Fund	\$75.1
Federal Revenue	\$3,877.2
Total Program	\$5,291.5

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

How is Arkansas Medicaid Administered?

The Arkansas Department of Human Services administers the Arkansas Medicaid program through the Division of Medical Services. Arkansas Medicaid is detailed in the Arkansas Medicaid State Plan, Arkansas Medicaid Waiver Programs and through provider manuals. The Centers for Medicare and Medicaid Services (CMS) administers the Medicaid Program for the U.S. Department of Health and Human Services. CMS authorizes federal funding levels and approves each state's State Plan and Waivers to ensure compliance with human services federal regulations.

Administration Statistics

In State Fiscal Year (SFY) 2014, the Division of Medical Services Program Development and Quality Assurance Unit processed:

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

In SFY 2014, our fiscal agent, Hewlett-Packard, had provider representatives attend and conduct 60 workshops around the state and 41 virtual training sessions. The provider representatives also conducted 2,803 provider visits. The Provider Assistance Center responded to 89,324 voice calls and 134,581 automated calls.

In SFY 2014, Medicaid Managed Care Services Provider Relations Representatives contacted a quarterly average of 34 hospitals and 1,031 physicians.

What Services are Covered by Arkansas Medicaid?

Mandatory Services

Certified Nurse-Midwife Services	All ages
Child Health Services Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	Under age 21
Family Planning Services and Supplies	All ages
Federally Qualified Health Center	All ages
Home Health Services	All ages
Hospital Services – Inpatient and Outpatient	All ages
Laboratory and X-Ray	All ages
Medical and Surgical Services of a Dentist	All ages
Nurse Practitioner	All ages
Nursing Facility Services	Age 21 and older
Physician Services	All ages
Rural Health Clinic	All ages
Transportation (to and from medical providers when medically necessary)	All ages

Optional Services

Ambulatory Surgical Center Services	All ages
Audiological Services	Under age 21
Certified Registered Nurse Anesthetist Services	All ages
Child Health Management Services	Under age 21
Chiropractic Services	All ages
Dental Services	All ages
Developmental Day Treatment Clinic Services	Pre-school and age 18 and older
Developmental Rehabilitation Services	Under age 3
Domiciliary Care Services	All ages
Durable Medical Equipment	All ages
End-Stage Renal Disease Facility Services	All ages
Hearing Aid Services	Under age 21
Hospice Services	All ages
Hyperalimentation Services	All ages
IndependentChoices	Age 18 and older
Inpatient Psychiatric Services	Under age 21
Intermediate Care Facilities for Individuals with Intellectual Disabilities	All ages
Licensed Mental Health Practitioner Services	Under age 21
Medical Supplies	All ages
Medicare Crossovers	All ages
Nursing Facility Services	Under age 21
Occupational, Physical and Speech Therapy Services	Under age 21
Orthotic Appliances	All ages
Personal Care Services	All ages
Podiatrist Services	All ages
Portable X-Ray	All ages
Prescription Drugs	All ages
Private Duty Nursing Services	All ages
Program of All-Inclusive Care for the Elderly	Age 55 and older
Prosthetic Devices	All ages
Rehabilitative Hospital Services	All ages

Rehabilitative Services for:

- Persons with Mental Illness All ages
- Persons with Physical Disabilities, and Youth and Children Under age 21

Respiratory Care Services Under age 21

School-Based Mental Health Services Under age 21

Targeted Case Management for:

- Children's Services (Title V), Supplemental Security Income, Tax Equity Fiscal Responsibility Act (TEFRA) of 1982, EPSDT, Division of Children and Family Services, and Division of Youth Services Under age 21
- Developmentally Disabled Adults All ages
- Adults Age 60 and older
- Pregnant Women All ages

Ventilator Equipment All ages

Visual Care Services All ages

Waivers Approved by the Centers for Medicare and Medicaid Services

Alternatives for Adults with Physical Disabilities Age 21 through 64

ARKids First-B Age 18 and under

Autism Waiver Age 18 months through 6 years

Developmental Disabilities Services/Alternative Community Services All ages

ElderChoices Age 65 and older

Living Choices Assisted Living Age 21 and older

Non-Emergency Transportation All ages

TEFRA Under age 19

Benefit Limitations on Services

The Arkansas Medicaid Program does have limitations on the services that are provided. The major benefit limitations on services for adults (age 21 and older) are as follows:

- 12 visits to hospital outpatient departments allowed per State Fiscal Year (SFY).
- A total of 12 office visits allowed per SFY for any combination of the following: certified nurse-midwife, nurse practitioner, physician, medical services provided by a dentist, medical services furnished by an optometrist and Rural Health Clinics.

- 1 basic family planning visit and 3 periodic family planning visits per SFY. Family planning visits are not counted toward other service limitations.
- Lab and X-Ray services limited to total benefit payment of \$500 per SFY for outpatient services, except for Magnetic Resonance Imaging and cardiac catheterization and for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) beneficiaries.
- 3 pharmaceutical prescriptions are allowed per month. (Family planning and tobacco cessation prescriptions are not counted against benefit limit.) Extensions are considered up to a maximum of 6 prescriptions per month for beneficiaries at risk of institutionalization. Unlimited prescriptions for nursing facility beneficiaries and EPSDT beneficiaries under age 21. Beneficiaries receiving services through the Living Choices Assisted Living waiver may receive up to 9 medically necessary prescriptions per month. Medicare-Medicaid beneficiaries (dual eligible) receive their drugs through the Medicare Part D program as of January 1, 2006.
- Inpatient hospital days limited to 24 per SFY, except for EPSDT beneficiaries and certain organ transplant patients.
- Co-insurance: Some beneficiaries must pay 10% of the first Medicaid-covered day of a hospital stay.
- Beneficiaries in the “Working Disabled” aid category must pay 25% of the charges for the first Medicaid-covered day of inpatient hospital services and must also pay co-insurance for some additional services.
- Beneficiaries 18 years old and older (except long term care) must pay \$.50 – \$3 of every prescription drug, and \$2 on the dispensing fee for prescription services for eyeglasses. Beneficiaries in the Working Disabled aid category must pay a higher co-payment for these services and also must pay co-payments for some additional services.

Additional Information for Limitations Relating to Children

The families of some children with Medicaid coverage are responsible for co-insurance, co-payments, or premiums.

- Co-insurance: ARKids First-B beneficiaries must pay 10% of the charges for the first Medicaid-covered day of inpatient hospital services and must also pay \$10 per visit co-insurance for outpatient hospital services and 10% of Medicaid allowed cost per Durable Medical Equipment item.
- Co-payments: ARKids First-B beneficiaries must pay a co-payment for most services, such as \$10 for most office visits and \$5 per prescription (and must use generic drugs). ARKids First-B beneficiaries’ annual cost-sharing is capped at 5% of the family’s gross annual income after State allowable income disregards.
- Premiums: Based on family income, certain Tax Equity Fiscal Responsibility Act (TEFRA) beneficiaries whose custodial parent(s)’ income is in excess of 150% of the Federal Poverty level must pay a premium. TEFRA beneficiaries whose custodial parent(s)’ income is at or below 150% of the Federal Poverty level cannot be assessed a premium.

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

State Fiscal Year 2014 in Review

State Fiscal Year 2014 ushered in a significant decline in the number of Arkansans who are uninsured. With the implementation of the Health Care Independence Program (HCIP), over 190,000 individuals in the State were able to secure insurance coverage when they otherwise would not have been able to do so. This increase put Arkansas ahead of all other states in ensuring that its citizens had health care coverage.

Insurance coverage began on January 1, 2014, for eligible citizens as part of the Affordable Care Act. The HCIP covers individuals with incomes from 100 to 138 percent of the Federal Poverty Level. Under the HCIP, Federal aid that would normally cover the cost of Medicaid coverage will instead help pay for private insurance plans for eligible beneficiaries.

In addition, the Arkansas Health Care Payment Improvement Initiative (AHCPII) continued to fulfill its objective of rewarding providers for offering cost-effective, team-based, quality care for defined conditions and procedures.

The "Triple Aim" of AHCPII is (1) improving the health of the population; (2) enhancing the patient experience of care, including quality, access, and reliability; and (3) reducing, or at least controlling, the cost of health care. These objectives create the core values surrounding the implementation of the Patient-Centered Medical Homes (PCMH) and the Retrospective Episodes of Care.

Arkansas continued its work on the Electronic Health Record Payment Initiative, created by the American Recovery and Reinvestment Act of 2009. One component of the program was developed to insure "Meaningful Use" with Electronic Health Records (EHRs). The three main components of Meaningful Use are: (1) the use of certified EHR technology for electronic exchange of health information to improve quality of health care; (2) the use of certified EHR technology to submit clinical quality and other measures; and (3) the use of a certified EHR in a meaningful manner, such as e-prescribing.

Simply put, "meaningful use" means providers need to show they're using certified EHR technology in ways that can be measured significantly in quality and in quantity.

To qualify and receive Meaningful Use incentives, participating providers and facilitates must meet various operational and public health criteria established by Centers for Medicaid and Medicare Services (CMS) with the Office of National Coordinator for Health Information technology (ONC).

As noted last year, Medicaid's work continues with the upcoming conversion to International Classification of Diseases (10th Edition, Clinical Modification/Procedure Coding System) billing codes. In the coming year, we will continue enhancing our programs and initiatives to cultivate a better, healthier Arkansas.

Arkansas Medicaid Operations

In State Fiscal Year 2014, our fiscal agent, Hewlett-Packard, processed more than 41 million provider-submitted claims for 11,785 providers on behalf of more than 902,378 Arkansans. They responded to 89,324 voice calls, 134,581 automated calls and 46,983 written inquiries and conducted 2,803 provider visits, 41 virtual training sessions and 60 workshops around the state. Of claims processed, 99% were

done within 30 days, with the average receipt-to-adjudication time of approximately 3.4 days. On average, providers received their payments within a week of claim adjudication.

Arkansas Medicaid is a critical component of health care financing for children and pregnant women. Through ARKids First and other programs, Arkansas Medicaid insures approximately 496,121 children and, according to recent data, paid for approximately 66.5%* of all births in Arkansas.

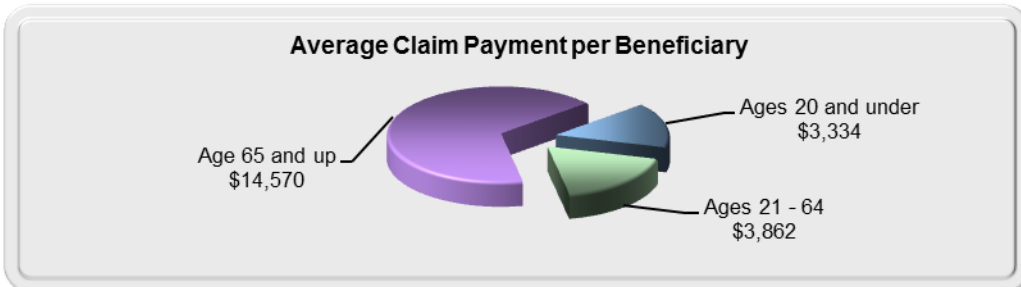
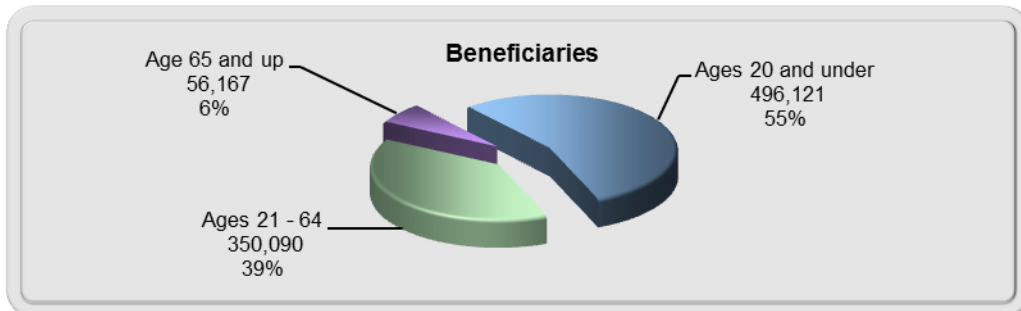
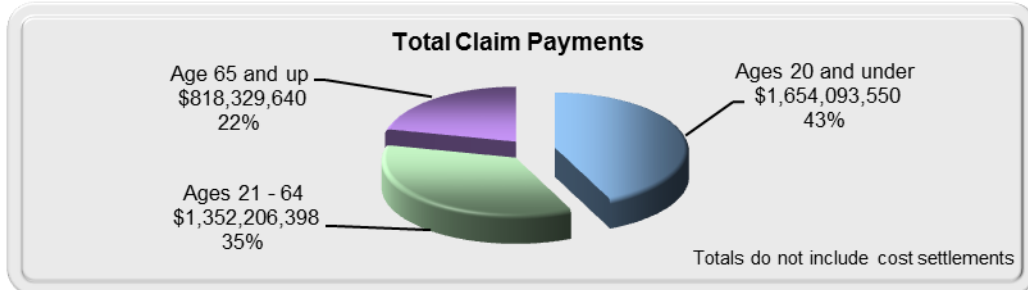
*This calculation is based on SFY13 data, which is the most recent available.



State Fiscal Year (SFY) 2014 Statistics

Beneficiary Information

Unduplicated Beneficiary Counts and Claim Payments by Age



Source: OnDemand HMGR580J

Percentage of Change in Enrollees and Beneficiaries from SFY 2013 to SFY 2014

	SFY13	SFY14	% Change
Medicaid enrollees	798,188	969,699	21.5%
Medicaid beneficiaries	777,922	902,378	16.0%



Newborns Paid for by Arkansas Medicaid

	SFY12	SFY13	% Change
Newborns paid for by Arkansas Medicaid	24,970	24,619	-1.41%



The medical cost for 66.5%* of all babies born to Arkansas residents during SFY 2013 was paid for by Medicaid.

Source: Department of Human Services (DHS) – Division of Medical Services and the Arkansas Department of Health

*This calculation is based on SFY13 data, which is the most recent available.

Percentage of Population Served by Arkansas Medicaid

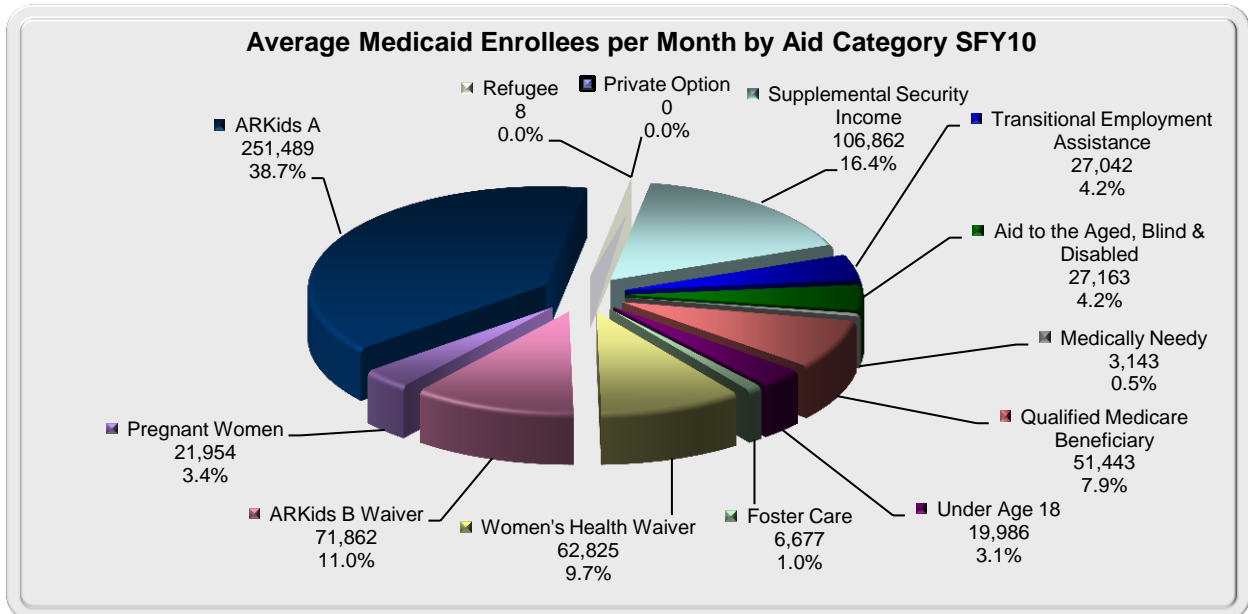
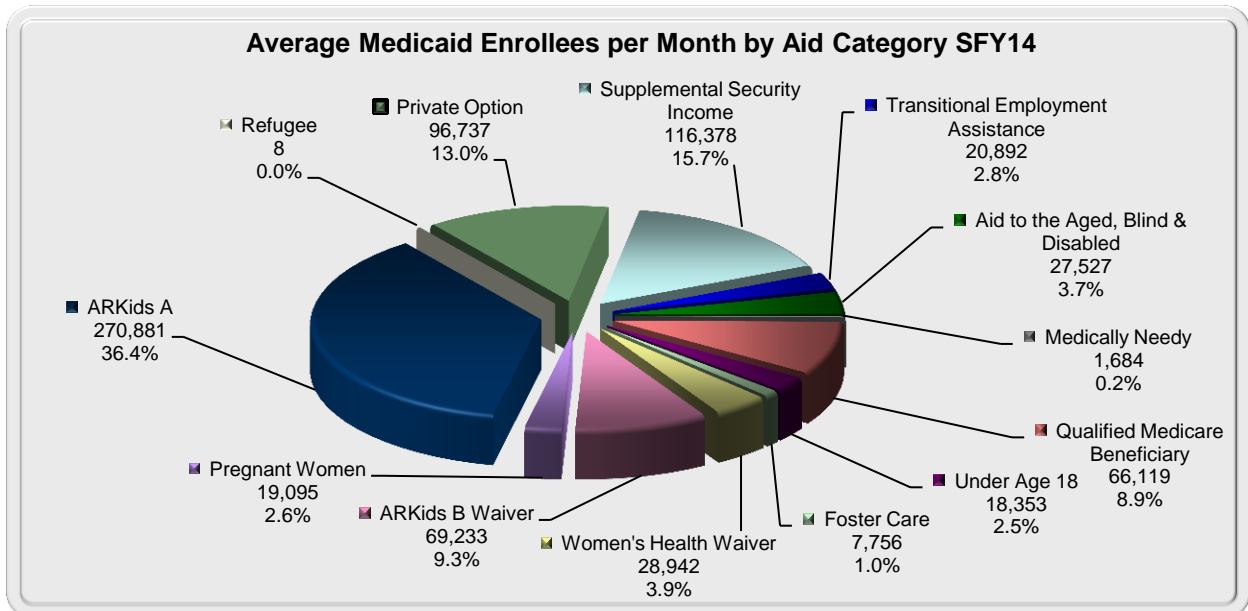
Age group	Arkansas Population	% of Population Served by Arkansas Medicaid**
All ages	3,011,207	30%
Elderly (65 and older)	435,713	13%
Adults (21 through 64)	1,721,684	20%
Children (20 and under)	853,811	58%

** This calculation is based on the Arkansas population for 2013, which is the most recent available.

Source: University of Arkansas at Little Rock, OnDemand HMGR580J



Arkansas Medicaid Enrollees by Aid Category – 5 year Comparison

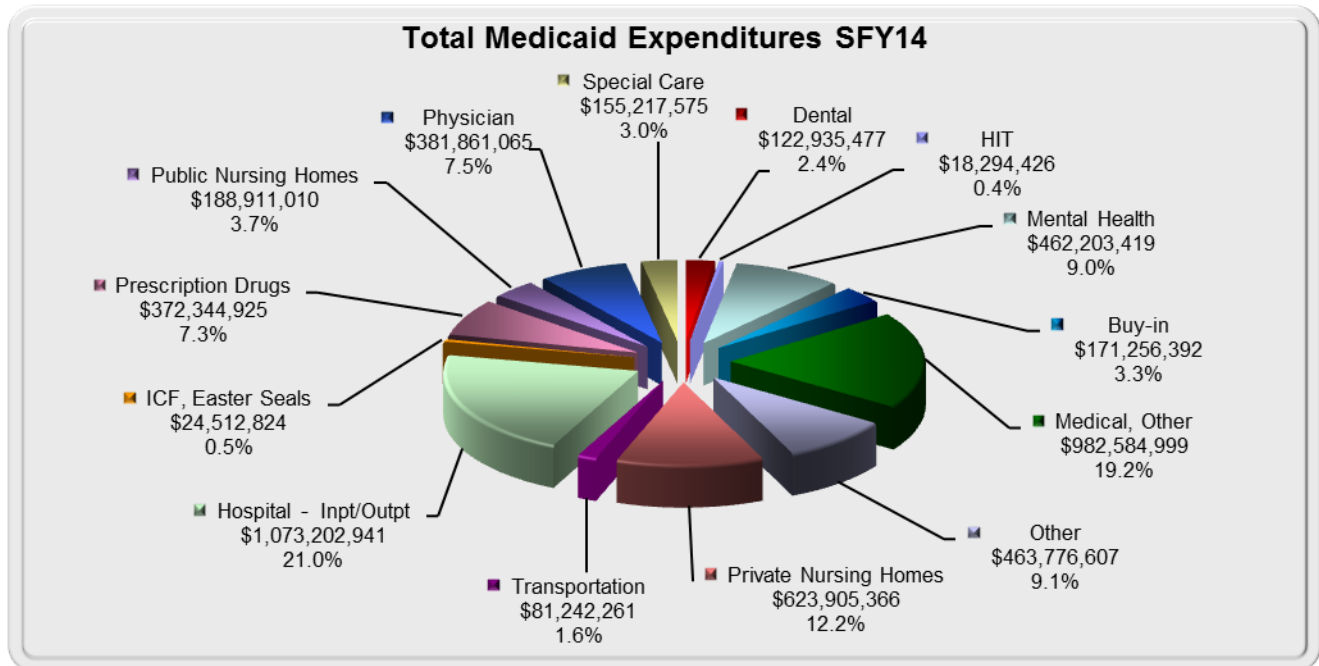


NOTE: These are individuals who have enrolled in the program and may or may not have received services. Enrollees may have multiple aid categories and are therefore counted in each of those categories.

Source: Arkansas Client Eligibility System IM-2414

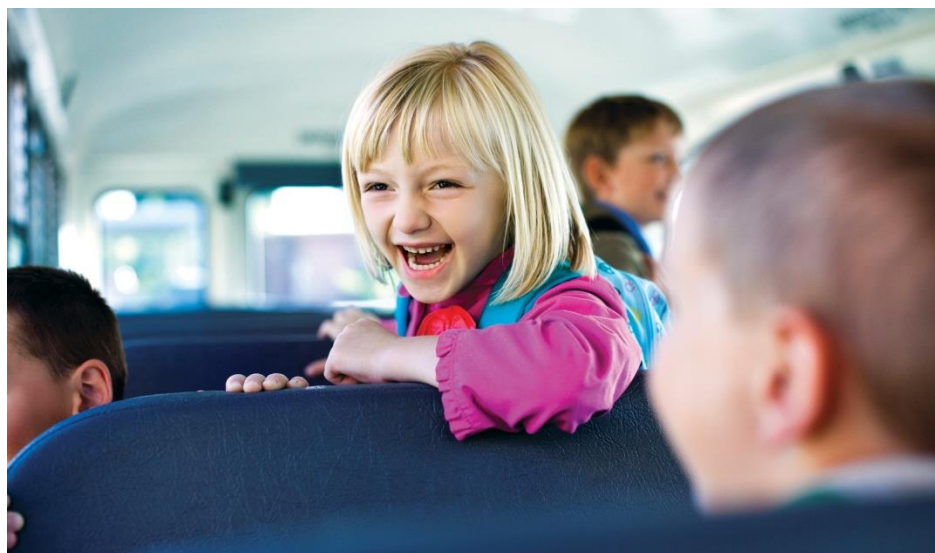
Expenditures

Total Arkansas Medicaid Expenditures

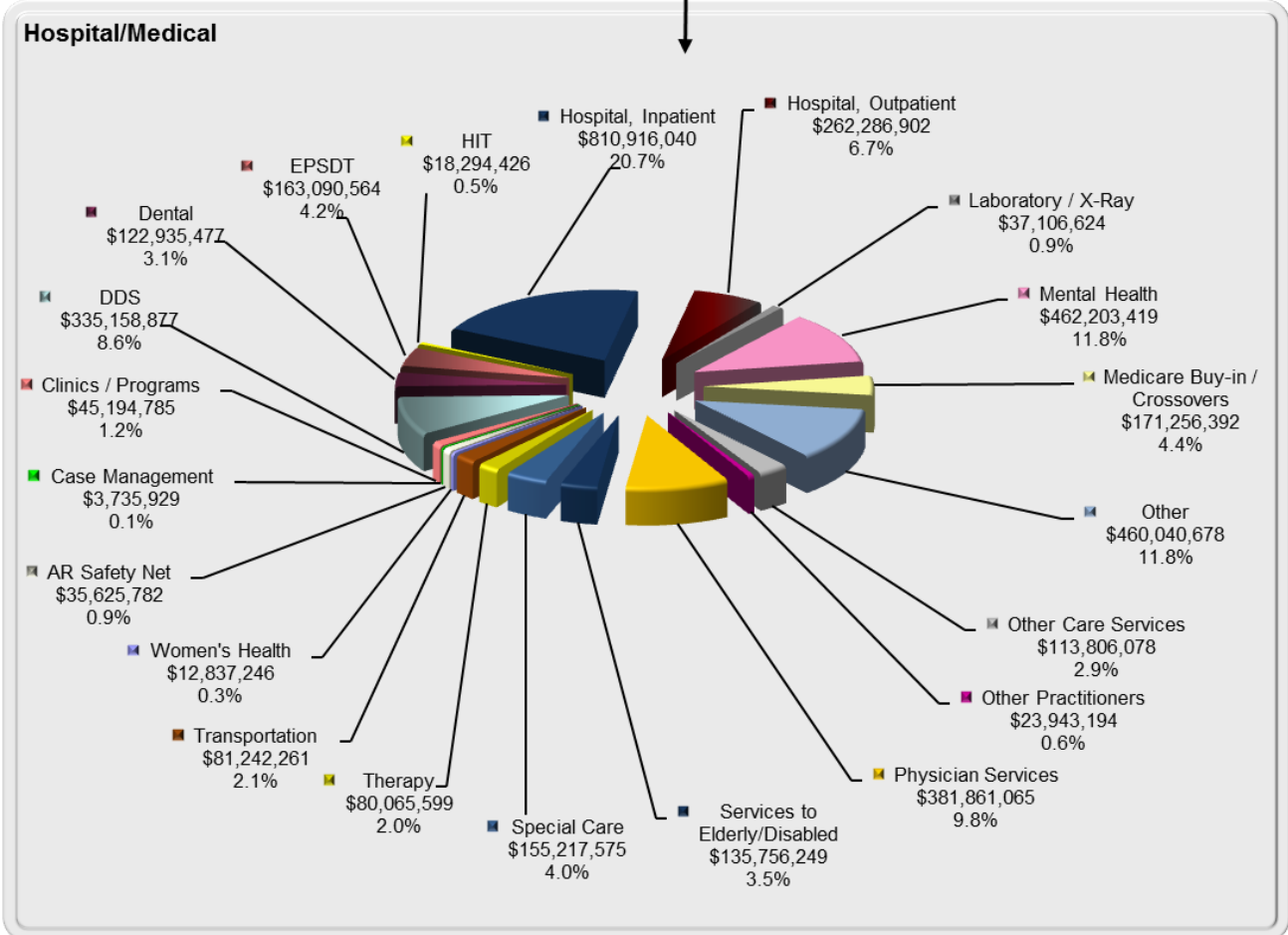
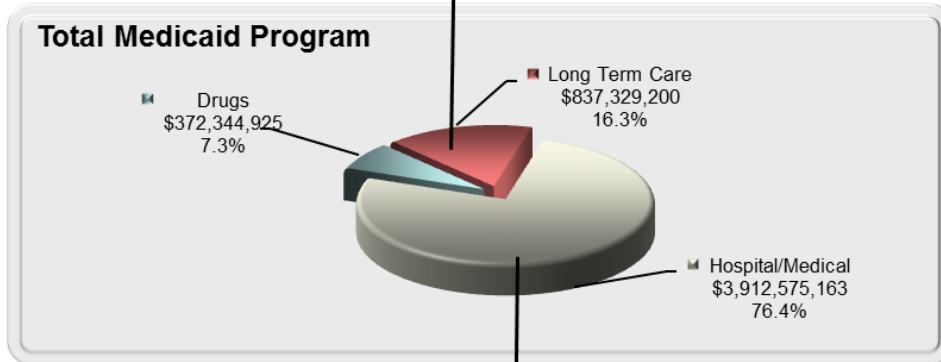
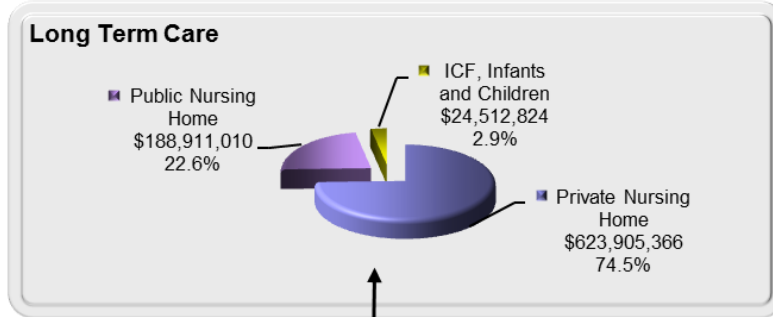


- Special Care includes Home Health, Private Duty Nursing, Personal Care and Hospice Services.
- Transportation includes emergency and non-emergency transportation.
- Other includes vendor contracts for Hospital/Medical, Targeted Case Management, Private Option premium payments and cost sharing and other adjustments.
- Buy-in includes Medicare premiums.
- Prescription Drugs includes regular prescription drugs, Family Planning drugs, Medicare Part D benefit payments, Assisted Living drugs and contracts related to the Prescription Drug Program.

Source: Department of Human Services Annual Statistical Report



Arkansas Medicaid Program Benefit Expenditures



Source: Arkansas Medicaid Category of Service Report

Drug Rebate Collections

The Omnibus Budget Reconciliation Act of 1990 requires manufacturers who want outpatient drugs reimbursed by State Medicaid programs to sign a federal rebate contract with the Centers for Medicare and Medicaid Services (CMS). Until 2008, this only affected those drugs reimbursed through the pharmacy program. The Federal Deficit Reduction Act of 2005 required a January 2008 implementation of the submission of payment codes to include a National Drug Code (NDC) number on professional and institutional outpatient provider claims. The NDC number is used for the capture and payment of rebates. CMS granted an extension for Arkansas Medicaid to allow implementation of institutional outpatient provider claims until June 30, 2008. Each quarter, eligible rebate drugs paid by Arkansas Medicaid are invoiced to the manufacturers. The manufacturers then submit payment to the state. Those payments are then shared with CMS as determined by the respective match rates.

Rebate Dollars Collected	
Total State Fiscal Year 2014	\$163,408,406
State portion	\$45,316,881
*Federal portion	\$118,091,525

*Note: Federal includes Share at regular FMAP and 100% FMAP ACA Offset.

Economic Impact of Arkansas Medicaid

Program Costs			
State Fiscal Year (SFY)	Total (in mil)	Unduplicated Beneficiaries	Average Annual Cost per Beneficiary
2007	\$3,299	742,965	\$4,440
2008	\$3,533	744,269	\$4,747
2009	\$3,716	747,851	\$4,969
2010	\$4,102	755,607	\$5,429
2011	\$4,379	770,792	\$5,681
2012	\$4,590	776,050	\$5,915
2013	\$4,658	777,922	\$5,988
2014	\$5,122	902,378	\$5,678
2015*	\$6,337	955,604	\$6,629

Arkansas Budget and Medicaid percentage		
	SFY 2014	Medicaid Represents
State of Arkansas Budget	\$26.2 billion	20.2%
State General Revenue Funded Budget	\$4.9 billion	17.9%

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

2014 - includes Private Option costs: Private Option alone 196,186 unduplicated beneficiaries

Program costs: includes Premium Payments and Cost sharing and Medically Frail Population, \$362,429,754

*2015 Estimated - 2015 projection includes Private Option costs, savings from Arkansas Payment Improvement Initiative and implementation of other identified efficiencies which impacts the number of unduplicated beneficiaries and program costs.

Arkansas Medicaid Providers

Number of Enrolled Providers

Arkansas Medicaid has approximately 42,378 enrolled providers.

Number of Participating Providers

Approximately 11,785 or 28% are participating providers.

Number of Claims Processed and Approximate Processing Time

More than 41 million provider-submitted claims were processed in State Fiscal Year 2014 with an average processing time of 3.4 days.

Sources: HMDR215J, HMGR526J

NOTE: The count for participating providers includes all providers and provider groups who have submitted claims. It does not include individual providers who may have actually performed services but are part of the provider group that submitted claims for those services.

(See Number of Providers by County in appendices.)



Top 10 Provider Types Enrolled

1	Physicians (8,969)
2	Individual Occupational, Physical and Speech Therapy Services Providers (2,739)
3	Physicians Groups (1,966)
4	Alternatives for Adults with Physical Disabilities Waiver Attendant Care (1,543)
5	Nurse Practitioner (1,236)
6	*Dental Services (1,045)
7	Pharmacy (867)
8	Prosthetic Services/Durable Medical Equipment (672)
9	Visual Care – Optometrist Optician (538)
10	Hospital (437)

*Includes orthodontists, oral surgeons and dental groups

Understanding the Division of Medical Services (Arkansas Medicaid)

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

Under DMS, Arkansas Medicaid Services is organized into seven major Divisions:

- Medicaid Programs
- Office of Long Term Care
- Medicaid Information Management
- Primary Care Initiatives
- Continuity and Coordination of Coverage
- Health Care Innovation
- Program and Administrative Support

These seven Divisions include units that directly support Medicaid and provide support to DMS staff.

(See the DMS Organizational Chart in the appendices.)

Medicaid Programs

Behavioral Health Programs

The Behavioral Health Unit is responsible for administering the Arkansas Medicaid behavioral health programs. This unit researches and analyzes proposed policy initiatives, encourages stakeholder participation and recommends revisions to policy and programming. Other responsibilities include monitoring the quality of treatment services, prior authorization and benefit extension procedures by performing case reviews, data analysis and procedural activities to identify problems and assure compliance with Arkansas Medicaid rules and regulations. These responsibilities are accomplished through the negotiation, coordination and assessment of the activities of the Behavioral Health utilization and peer review contracts. In addition to its role in auditing behavioral health programs, the peer review contractors develop and implement technical training and educational opportunities to providers. These opportunities are designed to assist providers in evaluating and improving their programs to offer the highest quality of care to Arkansas Medicaid beneficiaries. The Behavioral Health Unit further collaborates and supports other Department of Human Services divisions to design and implement a statewide transformation of the current behavioral health system under the umbrella of the Arkansas Health Care Payment Improvement Initiative. The overarching goal of the Behavioral Health Unit is to be instrumental in the development of a successful, efficient and quality-driven system of care.

Electronic Health Records Unit (EHRU)

The EHRU coordinates oversight for providers statewide by addressing issues that arise for the EHR incentive payment program. The EHRU identifies areas of risk in the eligibility determination, meaningful use, and payment processes and reviews that will mitigate the risk of making an improper

payment. The EHRU conducts audits of provider attestation forms for eligibility, validation of meaningful use, and conducting post and pre-payment reviews.

Prescription Drug Program

The Prescription Drug Program, an optional Arkansas Medicaid benefit, was implemented in Arkansas in 1973. Under this program, eligible beneficiaries may obtain prescription medication through any of the 867 enrolled pharmacies in the state. During State Fiscal Year (SFY) 2014, a total of 464,661 Arkansas Medicaid beneficiaries used their prescription drug benefits. A total of 5.1 million prescriptions were reimbursed by Arkansas Medicaid for a cost of \$326.3 million dollars making the average cost per prescription approximately \$63.98. An average cost for a brand name prescription was \$295 dollars, representing 16% of the claims and accounting for 69% of expenditures. The average cost for a generic prescription was \$25 dollars, representing 84% of claims and accounting for 31% of expenditures.

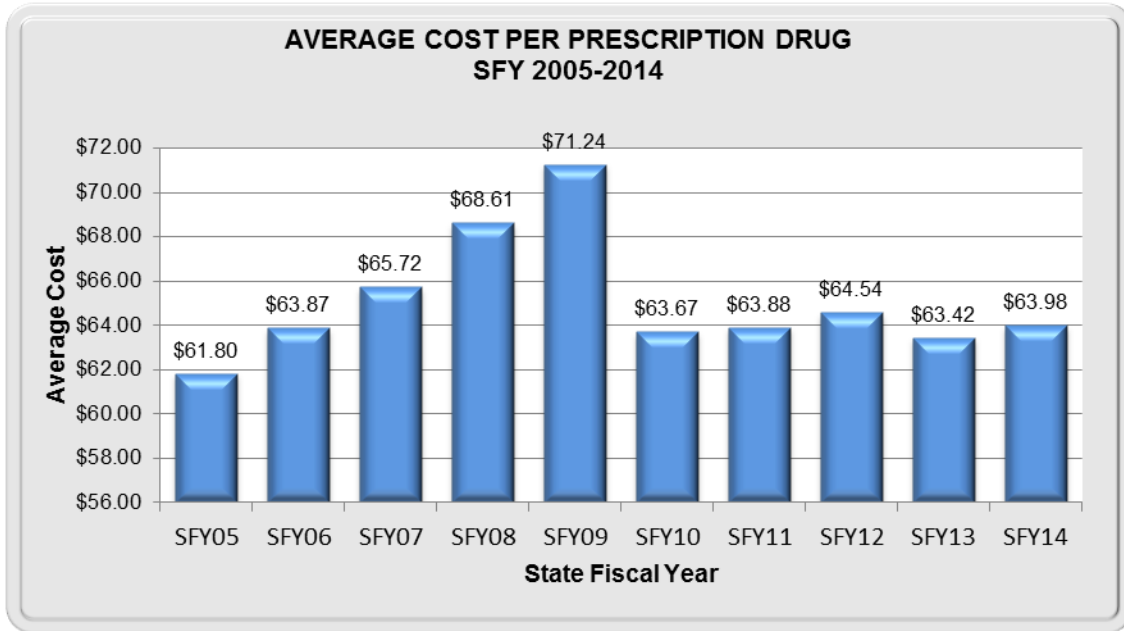
The Prescription Drug Program restricts each beneficiary to a maximum of 3 prescriptions per month, with the capability of receiving up to 6 prescriptions by prior authorization. Beneficiaries under 21 years of age and certified Long Term Care beneficiaries are not restricted to the amount of prescriptions received per month. Persons eligible under the Assisted Living Waiver are allowed up to 9 prescriptions per month.

Beginning January 1, 2006, full benefit, dual-eligible beneficiaries began to receive drug coverage through the Medicare Prescription Drug Benefit (Part D) of the Medicare Modernization Act of 2003, in lieu of coverage through Arkansas Medicaid. Arkansas Medicaid is required to pay the Centers for Medicare and Medicaid Services (CMS) the State Contribution for Prescription Drug Benefit, sometimes referred to as the Medicare Part D Clawback. This Medicare Part D payment for SFY 2014 was \$43,828,997.

Arkansas Medicaid reimbursement for prescription drugs is based on cost and a dispensing fee. Drug costs are established and based upon a pharmacy's Estimated Acquisition Cost (EAC) and the federally-established Generic Upper Limit or State Established Upper Limit. Arkansas Medicaid has a dispensing fee of \$5.51 as established by the Division of Medical Services and approved by CMS. The EAC and dispensing fee are based upon surveys that determine an average cost for dispensing a prescription and the average ingredient cost. In March of 2002, a differential fee of \$2.00 was established and applied to generic prescriptions for which there is not an upper limit. The following table shows the average cost per prescription drug in the Arkansas Medicaid Program.



Average Cost per Prescription Drug, State Fiscal Year (SFY) 2005-2014



Source: Payout Report

Program Development and Quality Assurance (PD/QA)

The PD/QA Unit develops and maintains the Arkansas Medicaid State Plan, leads the development and research of new programs, oversees contractor technical writing of provider policy manuals, coordinates the approval process through both state and federal requirements and coordinates efforts in finalizing covered program services. The PD/QA Unit also leads development of new waiver programs and the resulting provider manuals. Because the Division of Medical Services has administrative and financial authority for all Arkansas Medicaid waiver programs, PD/QA is responsible for monitoring the operation of all Arkansas Medicaid waiver programs operated by other Divisions. PD/QA assures compliance with the Centers for Medicare and Medicaid Services (CMS) requirements for operating waiver programs and monitors for key quality requirements.

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

Quality Assurance (QA) Activities for waiver programs include:

- Leading development of new waiver programs;
- Communicating and coordinating with CMS regarding waiver program activities and requirements, including the required renewal process;

- Providing technical assistance and approval to operating agencies regarding waiver program policies, procedures, requirements and compliance;
- Performing case reviews, data analysis and oversight activities to help identify problems and assure remediation for compliance with CMS requirements;
- Developing QA strategies and interagency agreements for the operation and administration of waiver programs and
- Developing provider manuals for waiver programs.

Provider Management and Vision and Dental Programs

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

Utilization Review and Medical Programs

The Utilization Review (UR) section administers multiple medical programs and services. UR monitors the contracted Quality Improvement Organizations' (QIO) performance for quality assurance. UR administers the following programs and activities:

- Pre- and Post-Payment reviews of medical services;
- Prior authorization for Private Duty Nursing, hearing aids, hearing aid repair and wheelchairs;
- Extension of benefits for Home Health and Personal Care for beneficiaries over the age of 21 and extension of benefits of incontinence products and medical supplies for eligible beneficiaries;
- Prior authorizations and extension of benefits for the following programs: In-patient and Out-patient Hospitalization, Emergency room utilization, Personal Care for beneficiaries under the age of 21, Child Health Management Services, Therapy, Transplants, Durable Medical Equipment and Hyperalimentation services;
- Out-of-state transportation for beneficiaries for medically necessary services/treatment not available in-state;
- Assure compliance of health care coverage benefits as required by regulation, rules, laws and local policy coverage determinations;
- Review of documentation supporting the medical necessity of requested services;
- Analysis of suspended claims requiring manual pricing;
- Review of billing and coding;
- Assist interdepartmental units and other agency divisions regarding health care determinations related to specific rules, laws and policies affecting program coverage;

- Review of evolving medical technological information and contribute to policy changes and program coverage benefits related to specific program responsibility;
- Analysis of information concerning reimbursement issues and assist with resolutions;
- Represent the department in workgroups at the state and local level;
- Conduct continuing evaluations and assessments of performance and effectiveness of various programs;
- Interact with provider groups and levels of federal and state government, including the legislature and governor's office and
- Participate in both beneficiary and provider appeals and hearing process.

Long Term Care

Along with the six major units of Arkansas Medicaid Services, the Division of Medical Services also houses the Office of Long Term Care (OLTC). Most people think of nursing facilities when they think of the OLTC. The OLTC professional surveyors conduct annual Medicare, Medicaid and State Licensure surveys of Arkansas' 227 Nursing Facilities and 42 Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/ID), including five Human Development Centers. Annual and complaint surveys are also conducted in 35 Adult Day Care and Adult Day Health Care facilities and two Post-Acute Head Injury Facilities throughout the state. Semi-annual surveys are conducted in the 61 Residential Care Facilities, 82 Assisted Living Facilities and 14 Alzheimer's Special Care Units. Additionally, annual Civil Rights surveys are conducted in 109 hospitals. In SFY 2014, 29 face-to-face medical need determination visits were made throughout the state.

In addition to its role inspecting long-term care facilities, the OLTC provides training and educational opportunities to various health care providers to help ensure that facilities provide the highest level of care possible to long term care residents. OLTC staff provided approximately 56 hours of continuing education through 25 workshops/seminars to over 1,027 staff members in the nursing home and assisted living industry during SFY 2014. Furthermore, there were 253 agendas submitted from outside sources for review to determine 1,313 contact hours for nursing home administrators.

The Nursing Home Administrator Licensure Unit processed renewals for 667 licensed administrators, and 92 license applications, and issued 47 new licenses and 14 temporary licenses. Additionally, OLTC administered the state nursing home administrator examination to 75 individuals.

The Criminal Record Check Program applies to all categories of licensed long-term care facilities consisting of over 516 affected facilities. During SFY 2014, there were 34,556 "state" record checks processed through OLTC and 20,819 "federal" record checks processed with a total of 833 disqualifications under both categories combined.

At the end of SFY 2014, the Registry for Certified Nursing Assistants (CNAs) contained 30,525 active and 76,379 inactive names. In addition to maintaining the Registry for CNA's, 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 1,266 Arkansas Medicaid nursing facility applications per month while maintaining approximately 12,384 active cases. The unit also processed 10,384 assessments, 1,995 changes of condition requests, 502 transfers, 1,928 utilization review requests and 2,307 applications/reviews for ICF/ID, which includes 377 new assessments and 16 transfers during the year. The unit completed 3,570 TEFRA applications and 105 autism waiver applications. Additionally, the unit completed 15,308 applications/reviews/waivers for other medical programs within the Department of Human Services during SFY 2014.

The OLTC Complaint Unit staffs a registered nurse and licensed social worker who record the initial intake of complaints against long-term care facilities. When this occurs, the OLTC performs an on-site complaint investigation. They are often able to resolve the issues with the immediate satisfaction of the involved parties. The OLTC received 865 nursing home complaints during SFY 2014 regarding the care or conditions in facilities.

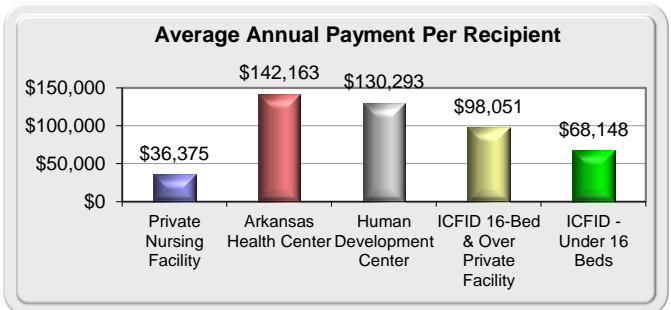
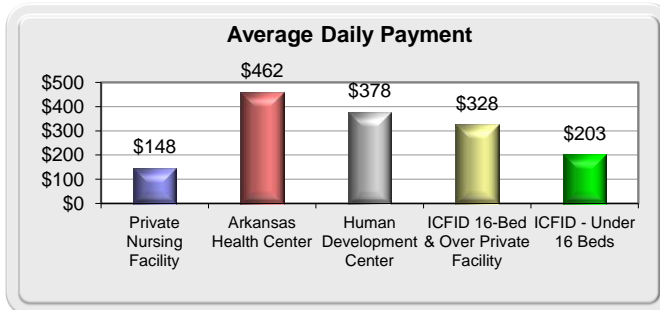
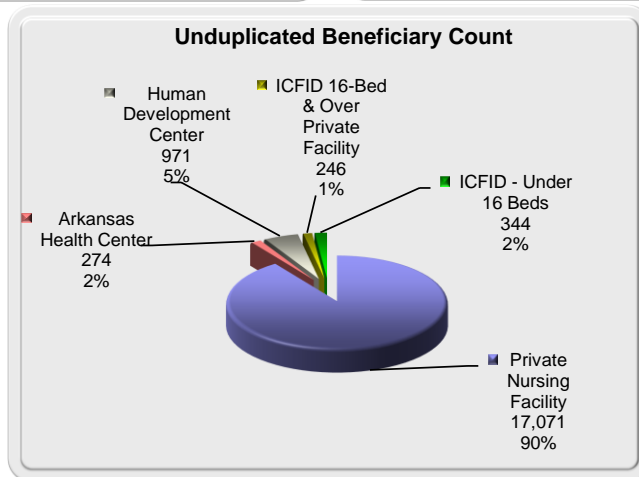
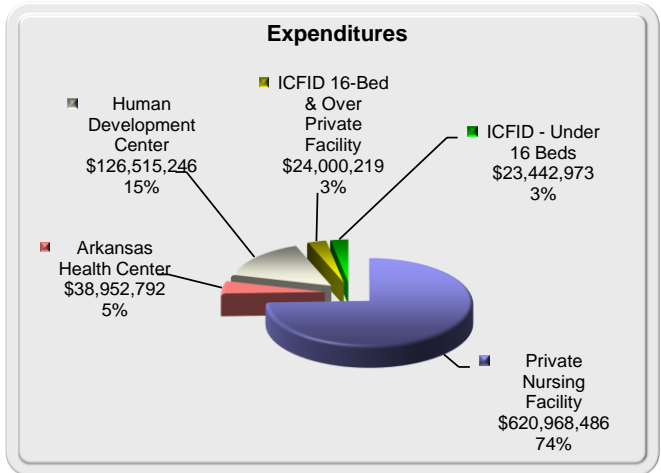
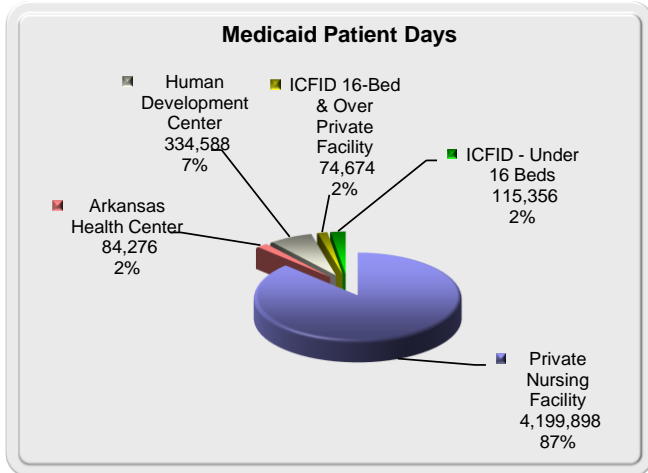
Since 1990, the federal long-term care program has had two levels of facility care under Medicaid. These levels of care are nursing facility services and intermediate care facility services for the intellectually disabled (ICF/ID). Arkansas classifies state-owned facilities as public and all others as private. Arkansas Health Center is a public nursing facility. The ICF/ID population is divided into the five state-owned Human Development Centers, four private pediatric facilities of which three are for profit, one private nonprofit pediatric facility, and 33 fifteen-bed or less facilities serving adults. The nursing facilities include one public and 224 private under Medicaid.

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

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



Long Term Care Statistics



Source: Department of Human Services Annual Statistical Report



Medicaid Information Management

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

Arkansas Medicaid Enterprise (AME) Project Management Office

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

- Develop, Design, and Implement (DDI) activities with Optum Government Solutions, Inc., as the newly awarded Decision Support System (DSS) vendor,
- Develop, Design, and Implement (DDI) activities with Magellan Health as the newly awarded Pharmacy System vendor,
- Managing all MMIS-related procurement and implementation project plans, and
- Coordinating the award and start of the new MMIS Core contract awarded to HP.

Data Analytics

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

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

Medicaid Data Reporting Unit

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

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

In addition, this unit supports Office of Policy and Legal Services and Office of Systems & Technology personnel to ensure compliance with federal and state data privacy and data security regulations as data and report requests are processed.

Systems and Support

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

- Developing Advance Planning Documents related to MMIS;
- Developing, tracking and documenting customer service requests for modifications to MMIS;
- Approving production system modifications to MMIS and monitoring the fiscal agent contractor's performance;
- Managing the Division of Medical Services (DMS) SharePoint and DocuShare sites and portals and
- Coordinating computer technical support for the DMS division.

Primary Care Initiatives

Patient-Centered Medical Home and Transportation Programs

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

Surveillance Utilization Review Subsystem (SURS)

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

Continuity of Care and Coordination of Coverage

The Continuity of Care and Coordination of Coverage unit is responsible for coordinating DMS efforts in the implementation of the Health Care Independence Program and assisting with coordination of coverage for enrollees as they move in and out of Medicaid and transition to private health insurance programs. The unit is also responsible for the administration and oversight of the Balancing Incentive Program (BIP), which implements required structural changes to enhance Medicaid-funded Home and Community Based Services (HCBS). Additionally, this unit supports other Medicaid initiatives and coordinates with all areas within DMS, several other DHS Divisions, and other State agencies.

Health Care Innovation

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

Now in its third year of work, HCI continues in its mission to improve the health of the population, enhance the patient experience of care, including quality, access, and reliability; and reduce, or at least control, the cost of health care. The main goal is to move the Arkansas health system from a payment model that rewards volume to one that rewards high-quality, efficient outcomes for patients by aligning financial incentives for how care is delivered.

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

Today, visits to primary care doctors often focus on acute illnesses with much less attention to managing chronic conditions. PCMHs can change that by actively promoting prevention services, such as vaccines, and empowering patients with the education they need to stay healthy.

Since its inception, 658 Primary Care Physicians (PCPs) have enrolled in PCMHs (includes those enrolled in both PCMH and CPCi, the Comprehensive Primary Care Initiative.) To date, there are 310,446 Medicaid beneficiaries enrolled in PCMHs and/or CPCi. The enrollment is twice the anticipated volume and speaks to the success of the program.

Another segment of Health Care Innovation that has already been implemented is the Retrospective Episodes of Care. To date, thirteen (13) Episodes have gone live (including Perinatal, Congestive Heart Failure, Total Joint Replacement, Colonoscopy, Cholecystectomy, Tonsillectomy and three types of Upper Respiratory Infections.)

With Episodes of Care, providers are rewarded for providing high quality, cost efficient care. And those providers whose costs exceed the performance of their peers must make payments to the Medicaid program.

Through July 2014, Retrospective Episodes of Care has produced over 15,600 reports to almost 2,000 individual providers responsible for a patient's care. In order to create these detailed reports, approximately 226.5 million Medicaid claims have been processed to format just under 2.67 million individual episodes (before exclusions).

Arkansas Blue Cross Blue Shield and QualChoice continue to participate and launch selected episodes of care and in the creation of PCMHs.

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

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

Program and Administrative Support

Contract Oversight

The Contract Monitoring Unit oversees all contracts involving the Division of Medical Services and Arkansas Medicaid. The unit reviews both the Request for Proposals and the resulting contracts to ensure the requirements for each contract are capable of being met and measured. The unit makes on-site visits to contractors to establish relationships with the contractors, to review required documentation and to ensure the contractor is providing the services directed under the contract.



Financial Activities

The Financial Activities Unit of the Division of Medical Services (DMS) is responsible for the Division's budgeting and financial reporting, including the preparation of internal management reports and reports to federal and state agencies. This unit also handles division-level activities related to accounts payable, accounts receivable and purchasing, as well as activities to secure and renew administrative and professional services contracts. The Financial Activities unit is also responsible for Human Resource functions in DMS.

Program Budgeting and Analysis

Program Budgeting and Analysis develops the budgets for all of Arkansas' Medicaid waiver renewals and newly proposed Arkansas Medicaid waiver programs. Depending on the type of waiver that is being renewed or proposed budget neutrality, cost effectiveness or cost neutrality is determined.

In addition to waiver budgeting, Program Budgeting and Analysis analyzes Arkansas Medicaid programs to determine whether each program is operating within their budget and if program changes should be considered. This unit also performs trend and other financial analysis by type of service, provider, aid category, age of beneficiary, etc.

Provider Reimbursement

Provider Reimbursement develops reimbursement methodologies and rates, identifies budget impacts for changes in reimbursement methodologies, coordinates payments with the Arkansas Medicaid Fiscal Agent and provides reimbursement technical assistance for the following Arkansas Medicaid providers:

- Institutional – The Institutional Section is responsible for processing: all necessary cost settlements for in-state and border city Hospitals, Residential Treatment Units and Federally Qualified Health Clinics; calculating and reimbursing annual hospital Upper Payment Limit

amounts, hospital quality incentive payments and hospital Disproportionate Share payments; calculating per diem reimbursement rates for Residential Treatment Centers; processing and implementing all necessary rate changes within Medicaid Management Information System for the above named providers and processing all necessary retroactive reimbursement rate change mass adjustments for these providers.

- Non-Institutional –The Non-Institutional Section is responsible for the maintenance of reimbursement rates and assignment of all billing codes for both institutional and non-institutional per diems, services, supplies, equipment purchases and equipment rental for the following providers: Physician, Dental, Durable Medical Equipment, ARKids, Nurse Practitioner, Certified Nurse-Midwife, Child Health Management Services, Developmental Day Treatment Clinic Services, Other.
- Long Term Care (LTC) – The LTC Section reviews annual and semi-annual cost reports submitted by Nursing Facilities and Intermediate Care Facilities for Individuals with Intellectual Disabilities. The cost reports are reviewed for compliance with applicable state and federal requirements and regulations, including desk and on-site reviews. The LTC Section maintains a database of the cost report information, which is used to evaluate cost and develop reimbursement methodologies and rates. The LTC Section is also responsible for processing all necessary retroactive reimbursement rate change mass adjustments for these providers.

Third Party Liability and Estate Recovery

As the payer of last resort, federal and state statutes require Medicaid agencies to pursue third party resources to reduce Medicaid payments. One aspect of Arkansas Medicaid cost containment is the Third Party Liability Unit of Administrative Support. This unit pursues third party resources (other than Arkansas Medicaid) responsible for health care payments to Arkansas Medicaid beneficiaries. These sources include health and liability insurance, court settlements and absent parents. The savings for State Fiscal Year (SFY) 2014 were as follows:

	SFY 2014
Other Collections (Health & Casualty Insurance)	\$28,718,880.83
Cost Avoidance (Health Insurance)	\$29,104,335.84
Total Savings	\$57,823,216.67

Source: Division of Medical Services Statistical Report



Appendices

Glossary of Acronyms

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

Maps

- Enrollees by County State Fiscal Year (SFY) 2014
- Expenditures by County SFY 2014
- Waiver Expenditures and Waiver Beneficiaries by County SFY 2014
- Providers by County SFY 2014

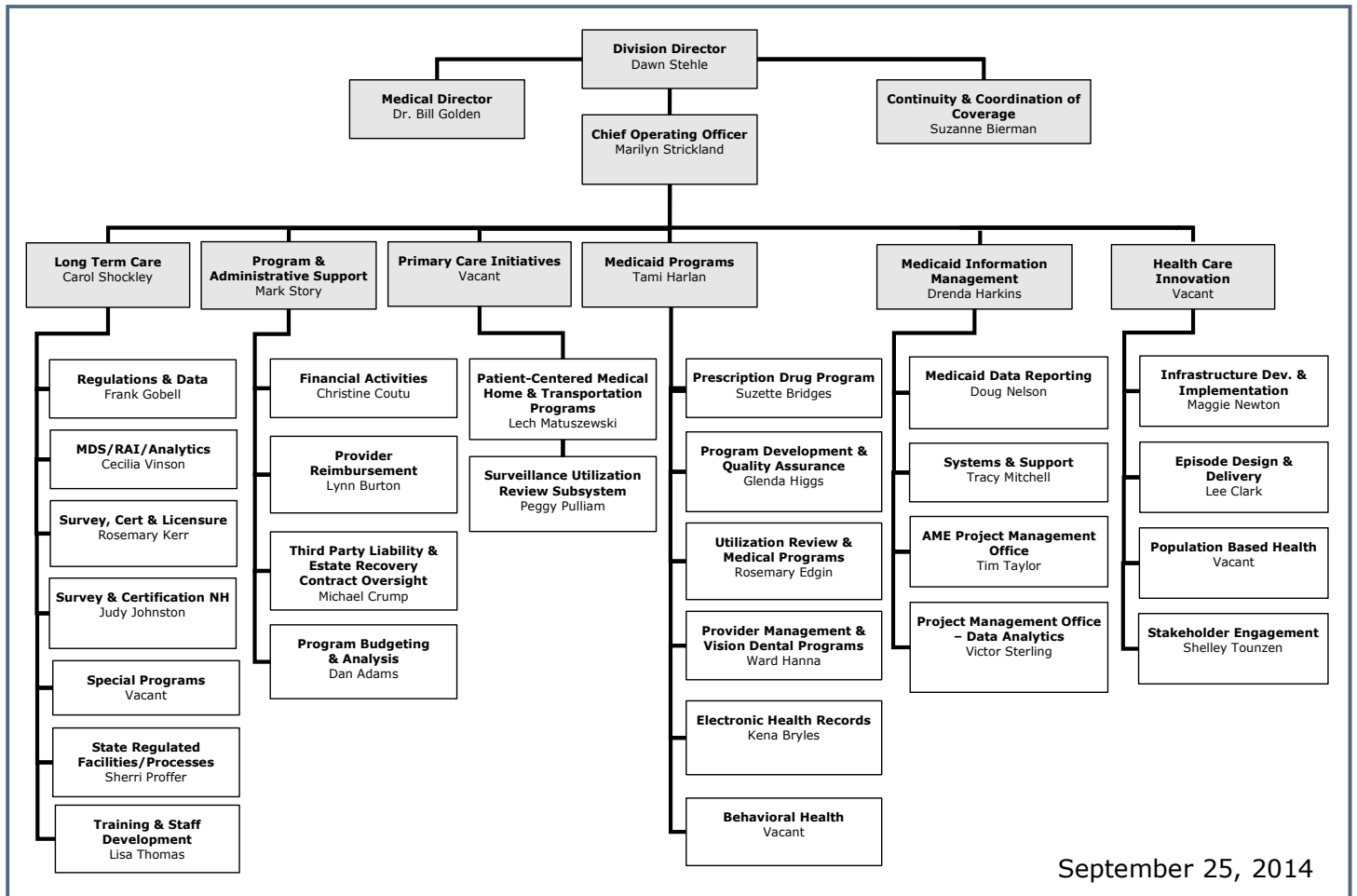
DMS Contacts



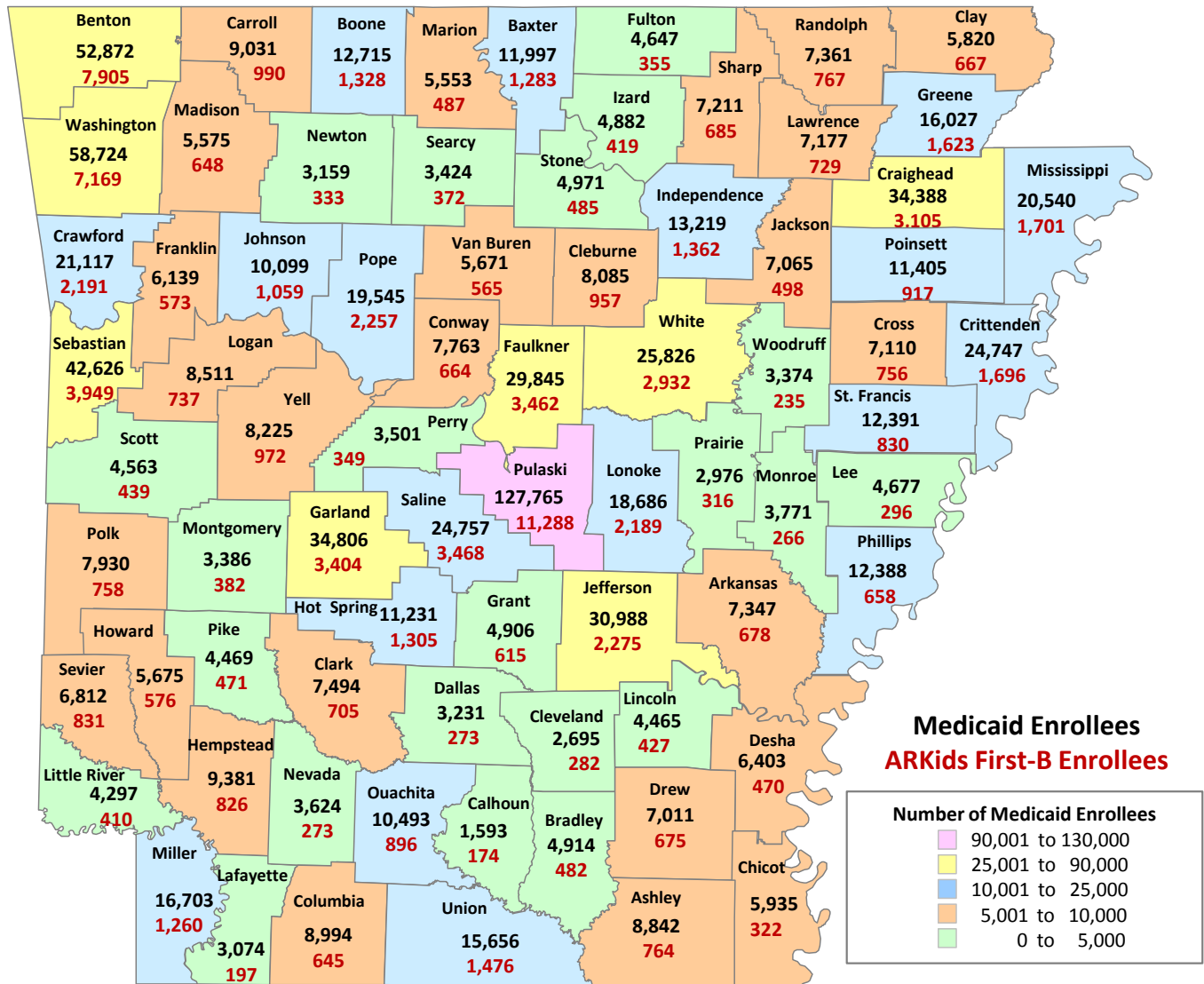
Glossary of Acronyms

ACA Affordable Care Act	EAC Estimated Acquisition Cost	PCMH Patient-Centered Medical Home
ADHD Attention Deficit Hyperactivity Disorder	EHRU Electronic Health Records Unit	PD/QA Program Development and Quality Assurance
AFMC Arkansas Foundation for Medical Care	EPSDT Early and Periodic Screening, Diagnosis and Treatment	PI Program Integrity
AIPP Arkansas Innovative Performance Program	HCIP Health Care Independence Program	QA Quality Assurance
AME Arkansas Medicaid Enterprise	HP Hewlett-Packard	QIO Quality Improvement Organization
APII Arkansas Health Care Payment Improvement Initiative	ICF/ID Intermediate Care Facilities for Individuals with Intellectual Disabilities	RAC Recovery Audit Contractor
CMS Centers for Medicare and Medicaid Services	LTC Long Term Care	RFP Request for Proposals
CNA Certified Nursing Assistant	MIM Medicaid Information Management	SFY State Fiscal Year – July 1 to June 30
DHS Department of Human Services	MMIS Medicaid Management Information System	SURS Surveillance and Utilization Review Subsystem
DMS Division of Medical Services (Medicaid)	NDC National Drug Code	TEFRA Tax Equity and Financial Responsibility Act
DSS Decision Support System/Data Warehouse	OLTC Office of Long Term Care	UR Utilization Review

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



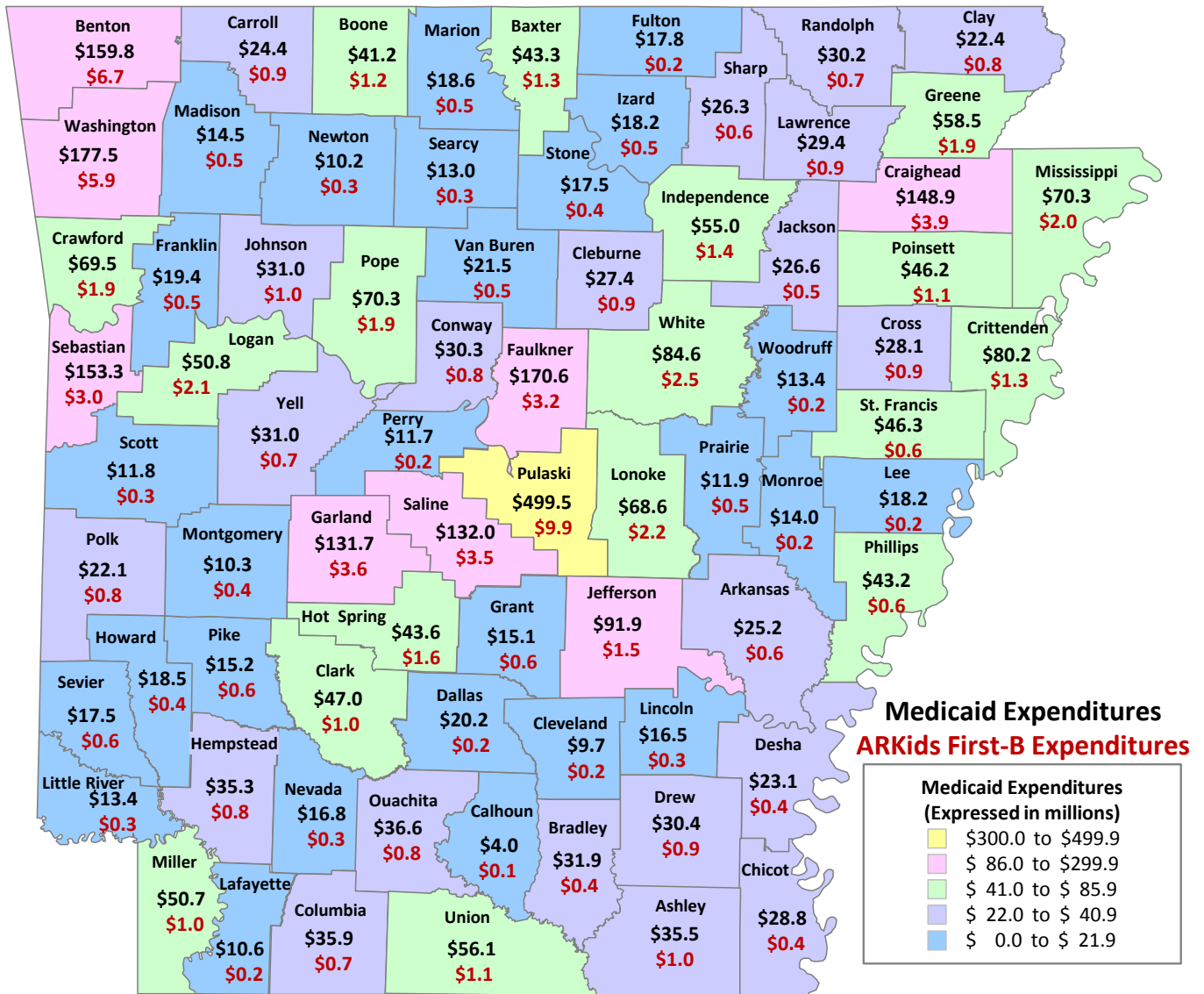
Map – Enrollees by County



Source: Department of Human Services, Division of Medical Services
 Medicaid Decision Support System
 (Medicaid Enrollees includes ARKids First and Private Option)

NOTE: These are individuals who have enrolled in the program, and may or may not have received services.

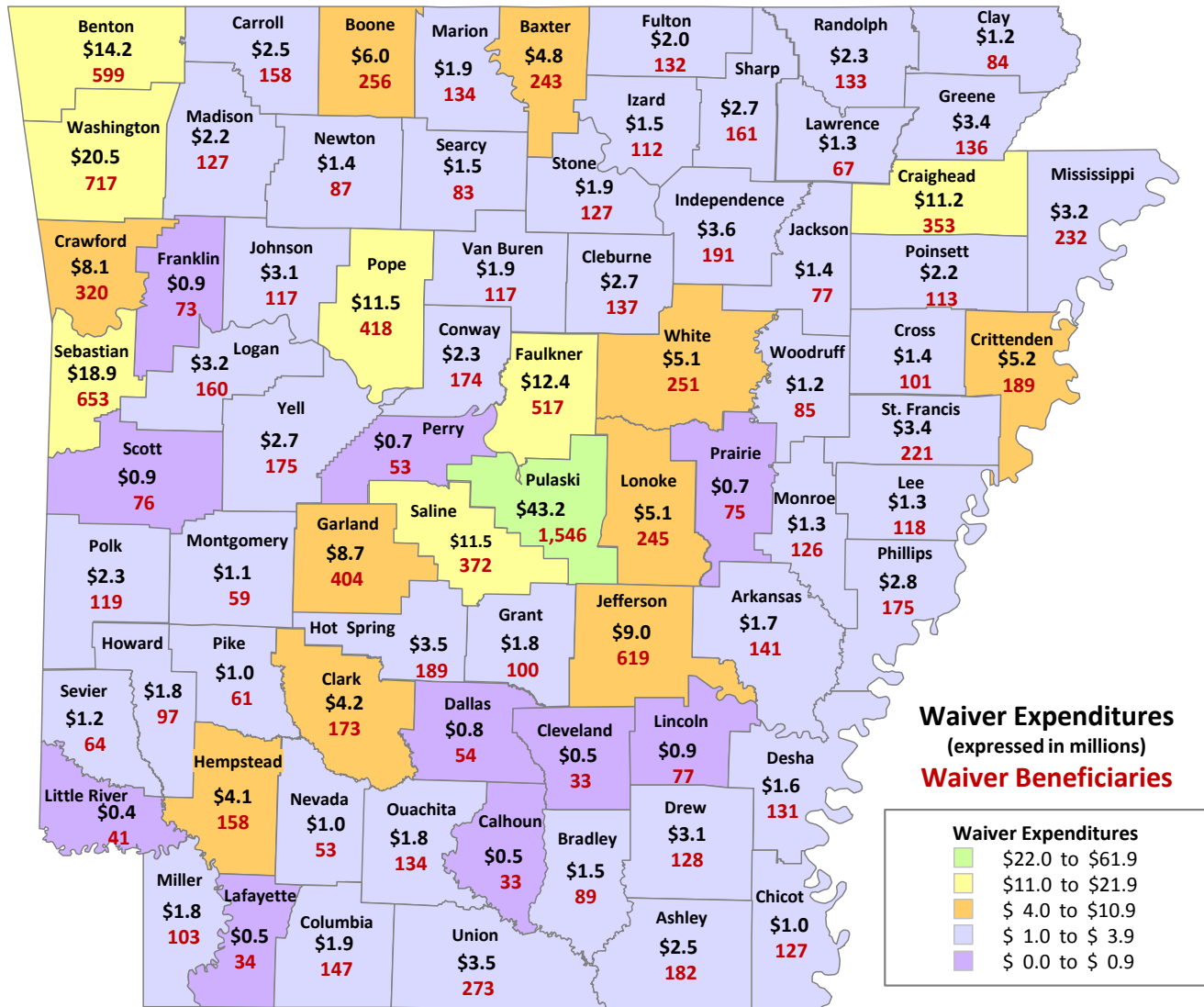
Map – Expenditures by County



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

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

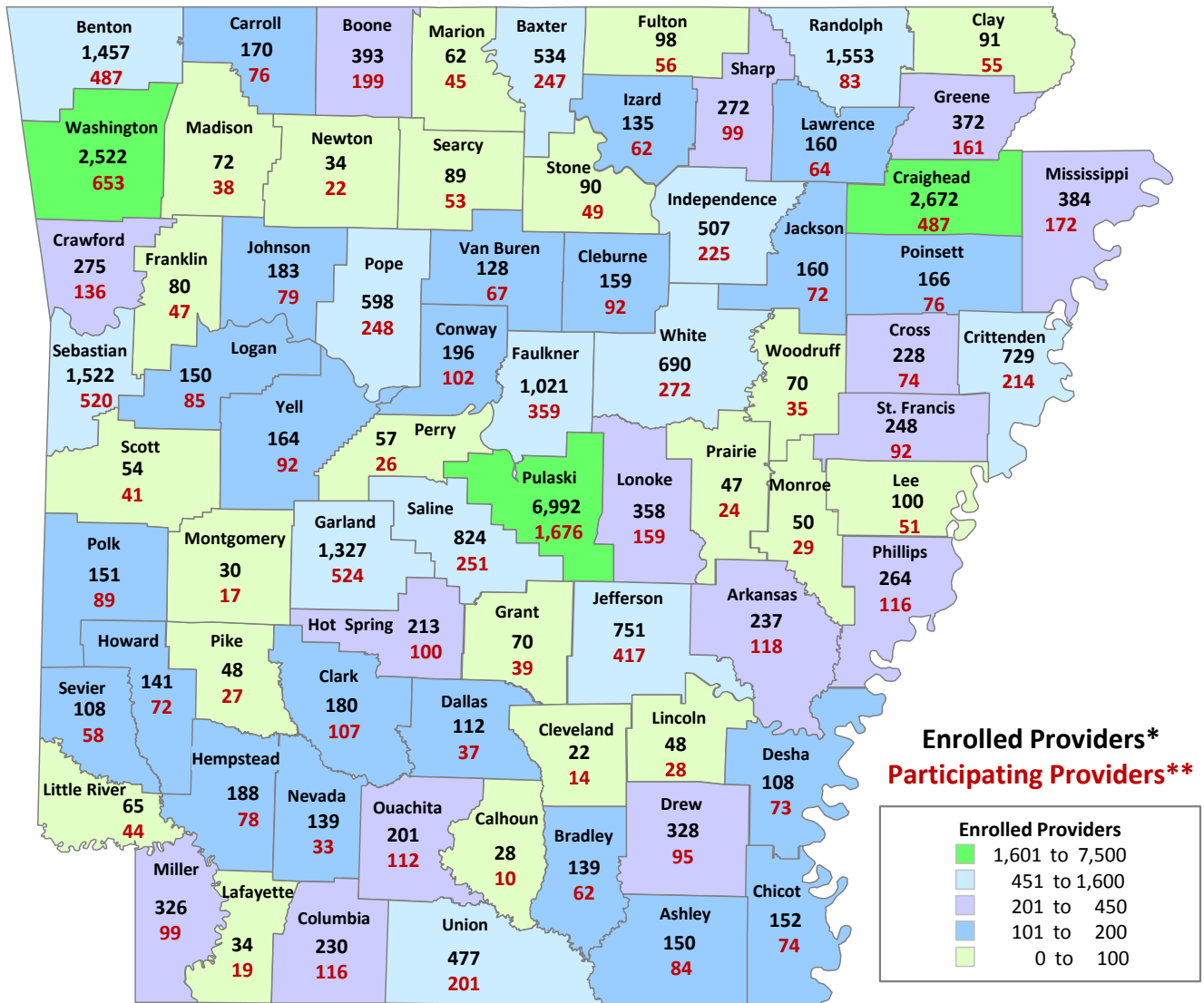
Map – Waiver Expenditures and Waiver Beneficiaries by County



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

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

Map – Providers by County



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

*Enrolled Providers – Providers who have been approved by Medicaid to provide services to Medicaid beneficiaries
**Participating Providers – Providers who billed at least one claim in State Fiscal Year 2014

Division of Medical Services Contacts

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

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Nurse Manager,
Minimum Data Set

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F: 682-6171

S-409



Phone Numbers and Internet Resources

Quick Reference Guide

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

Hotlines

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

Internet Resources

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