



Arkansas Medicaid Program Overview

SFY 2016



Division of Medical Services
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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 (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 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.

Our Core Values

- Compassion
- Courage
- Respect
- Integrity
- Trust

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Division of Medical Services

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The Division of Medical Services is a large, encompassing area that provides medically necessary services to needy and low-income Arkansans through Medicaid. The Arkansas Medicaid booklet offers a general look at the program's beneficiaries and how the program has changed, while more specifically highlighting the greatest challenges and accomplishments from the past fiscal year.

When Governor Asa Hutchinson came into office in early 2015, he promised to take a clear, unbiased look at the Health Care Independence Program, commonly known as the private option, and selected a task force to review and make recommendations for how to best serve Arkansans. Over the last year, they have met with stakeholders across the state and developed a program that is before the Centers for Medicare and Medicaid Services awaiting approval – Arkansas Works.

Along with improving health insurance services, Arkansas Works provides beneficiaries with workforce development training and an opportunity to move up the economic ladder. Additionally, healthier people make better employees, which is a win-win for everyone in the workplace.

Staff in the areas of behavioral health, developmental disabilities, and aging and adult services have worked closely this last year with providers and clinicians to develop new rules changes that more effectively serve our clients while ensuring the agency is a good steward of the financial resources we are given by state general revenue and federal funds. Those proposed changes will go before the legislature in early spring with a target implementation date no earlier than July 1, 2017.

It takes a lot of work to serve nearly one million Arkansans each year through Medicaid and its many services, and we appreciate the trust placed in DMS. We will continue to maintain focus on the core mission of Arkansas DHS: protecting the vulnerable, fostering independence and promoting better health for all Arkansans.

A handwritten signature in black ink, reading "Dawn Stehle".

Dawn Stehle

Director, Division of Medical Services

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About this Booklet

The Arkansas Medicaid overview booklet is produced annually by the Division of Medical Services (DMS) and Hewlett Packard Enterprise. 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, Hewlett Packard Enterprise and Arkansas Foundation for Medical Care.

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

Some information in this publication will differ from the Financial Outlook due to data pulls and systems.

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) administers the Medicaid Program for the U.S. Department of Health and Human Services. CMS authorizes federal funding levels and approves each state's State Plan, ensuring compliance with federal regulations. Individuals are certified as eligible for Arkansas Medicaid services by DHS County Staff located in DHS County Offices or by District Social Security Offices.

Who Qualifies?

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

- Age 65 and older;
- Under age 19;
- Age 19 to 64 not receiving Medicare (the new 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, 2016 through March 31, 2017)

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	\$1,316.70	\$1,366.20	\$1,405.80	\$1,455.30	\$2,088.90	\$2,138.40
2	\$1,775.55	\$1,842.30	\$1,895.70	\$1,962.45	\$2,816.85	\$2,883.60
3	\$2,234.40	\$2,318.40	\$2,385.60	\$2,469.60	\$3,544.80	\$3,628.80
4	\$2,693.25	\$2,794.50	\$2,875.50	\$2,976.75	\$4,272.75	\$4,374.00
5	\$3,152.10	\$3,270.60	\$3,365.40	\$3,483.90	\$5,000.70	\$5,119.20
6	\$3,610.95	\$3,746.70	\$3,855.30	\$3,991.05	\$5,728.65	\$5,864.40
7	\$4,070.91	\$4,223.95	\$4,346.38	\$4,499.42	\$6,458.35	\$6,611.39
8	\$4,531.98	\$4,702.35	\$4,838.65	\$5,009.03	\$7,189.83	\$7,360.20
9	\$4,993.05	\$5,180.75	\$5,330.92	\$5,518.63	\$7,921.30	\$8,109.01
10	\$5,454.12	\$5,659.15	\$5,823.19	\$6,028.22	\$8,652.75	\$8,857.79
For each additional member add:	\$461.05	\$478.39	\$492.25	\$509.59	\$731.45	\$748.78



Monthly Levels (continued)

Family size	Full Pregnant Women & Parent Caretaker Relative (monthly dollar amount)	Transitional Medicaid 185%	Limited Pregnant Women / Unborn Child 209%	Limited Pregnant Women/ Unborn Child with 5% Disregard 214%
1	\$124.00	\$1,831.50	\$2,069.10	\$2,118.60
2	\$220.00	\$2,469.75	\$2,790.15	\$2,856.90
3	\$276.00	\$3,108.00	\$3,511.20	\$3,595.20
4	\$334.00	\$3,746.25	\$4,232.25	\$4,333.50
5	\$388.00	\$4,384.50	\$4,953.30	\$5,071.80
6	\$448.00	\$5,022.75	\$5,674.35	\$5,810.10
7	\$505.00	\$5,662.54	\$6,397.13	\$6,550.18
8	\$561.00	\$6,303.88	\$7,121.68	\$7,292.05
9	\$618.00	\$6,945.21	\$7,846.22	\$8,033.92
10	\$618.00	\$7,586.54	\$8,570.73	\$8,775.78
For each additional member add:	9 and greater \$618.00	\$641.32	\$724.51	\$741.85

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	\$792.00	\$990.00	\$1,188.00	\$1,336.50	\$1,980.00
Couple	\$1,068.00	\$1,335.00	\$1,602.00	\$1,802.25	\$2,670.00

*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 30.00% of Arkansas Medicaid Program-related costs in State Fiscal Year 2016; the federal government funded approximately 70.00%. 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 2016 Arkansas Medicaid Operating Budget*

	(Millions)
General Revenue	\$968.7
Other Revenue	\$278.5
Quality Assurance Fee	\$85.1
Hospital Provider Tax	\$61.0
Intermediate Care Facilities for Individuals with Intellectual Disabilities Provider Tax	\$11.0
Trust Fund	\$44.9
Federal Revenue	\$5,077
Total Program	\$6,526



*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) 2016, the Division of Medical Services Program Development and Quality Assurance Unit processed:

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

In SFY 2016, our fiscal agent, Hewlett Packard Enterprise, responded to 84,427 voice calls, more than *123,861 automated calls and 55,774 written inquiries. HPE Provider Enrollment responded to 38,270 calls, received 12,413 applications, and worked 12,825 applications for prospective or reenrolling providers. HPE provider representatives conducted 1,659 provider visits, 32 workshops around the state and 20 virtual training sessions reaching 243 providers.

*This information is unavailable for June 2016.

In SFY 2016, Medicaid Managed Care Services (MMCS) Provider Relations Outreach Specialists contacted a quarterly average of 51 hospitals and 1,194 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 (Emergency ambulance transportation and Non-Emergency Transportation [NET waiver] to and from medical providers when medically necessary)	All ages

Optional Services

Ambulatory Surgical Center Services	All ages
Audiological Services	Under age 21
Certified Registered Nurse Anesthetist Services	All ages
Child Health Management Services	Under age 21
Chiropractic Services	All ages
Dental Services	All ages
Developmental Day Treatment Clinic Services	Pre-school and age 18 and older
Developmental Rehabilitation Services	Under age 3
Domiciliary Care Services	All ages
Durable Medical Equipment	All ages
End-Stage Renal Disease Facility Services	All ages
Hearing Aid Services	Under age 21
Hospice Services	All ages
Hyperalimentation Services	All ages
IndependentChoices	Age 18 and older
Inpatient Psychiatric Services	Under age 21
Intermediate Care Facilities for Individuals with Intellectual Disabilities	All ages
Licensed Mental Health Practitioner Services	Under age 21
Medical Supplies	All ages
Medicare Crossovers (not a medical service)	All ages
Nursing Facility Services	Under age 21
Occupational, Physical and Speech Therapy Services	Under age 21
Orthotic Appliances	All ages
Personal Care Services	All ages
Podiatrist Services	All ages
Portable X-Ray	All ages
Prescription Drugs	All ages
Private Duty Nursing Services	All ages
Program of All-Inclusive Care for the Elderly	Age 55 and older
Prosthetic Devices	All ages
Rehabilitative Hospital Services	All ages

Rehabilitative Services for:

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

Respiratory Care Services	Under age 21
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School-Based Mental Health Services	Under age 21
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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
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Visual Care Services	All ages
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Waivers Approved by the Centers for Medicare and Medicaid Services

ARChoices	Age 21 and older
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ARKids First-B (Beginning August 1, 2015, with approval of CHIP SPA #6, ARKids-B is transitioning to a separate child health program through the CHIP state plan. After this date, ARKids-B will no longer be a waiver but a separate child health program under the authority of the CHIP state plan.)	Under age 19
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Autism Waiver	Age 18 months through 7 years
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Developmental Disabilities Services/Alternative Community Services	All ages
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Health Care Independence (Private Option)	Childless Adults Age 19-64 and Parent/Caretakers 19-64
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Living Choices Assisted Living	Age 21 and older
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Non-Emergency Transportation	All ages
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TEFRA	Under age 19
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Benefit Limitations on Services

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

- 12 visits to hospital outpatient departments allowed per State Fiscal Year (SFY).
- A total of 12 office visits allowed per SFY for any combination of the following: certified nurse-midwife, nurse practitioner, physician, medical services provided by a dentist, medical services furnished by an optometrist and Rural Health Clinics.
- 1 basic family planning visit and 3 periodic family planning visits per SFY. Family planning visits are not counted toward other service limitations.
- Lab and X-Ray services limited to total benefit payment of \$500 per SFY for outpatient services, except for Magnetic Resonance Imaging and cardiac catheterization and for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) beneficiaries.
- 3 pharmaceutical prescriptions are allowed per month. (Family planning and tobacco cessation prescriptions are not counted against benefit limit.) Extensions are considered up to a maximum of 6 prescriptions per month for beneficiaries at risk of institutionalization. Unlimited prescriptions for nursing facility beneficiaries and EPSDT beneficiaries under age 21. Beneficiaries receiving services through the Living Choices Assisted Living waiver may receive up to 9 medically necessary prescriptions per month. Medicare-Medicaid beneficiaries (dual eligible) receive their drugs through the Medicare Part D program as of January 1, 2006.
- Inpatient hospital days limited to 24 per SFY, except for EPSDT beneficiaries and certain organ transplant patients.
- Co-insurance: Some beneficiaries must pay 10% of the first Medicaid-covered day of a hospital stay.
- Beneficiaries in the “Working Disabled” aid category must pay 25% of the charges for the first Medicaid-covered day of inpatient hospital services and must also pay co-insurance for some additional services.
- Beneficiaries age 18 and older (except long term care) must pay \$.50 – \$3 of every prescription drug, and \$2 on the dispensing fee for prescription services for eyeglasses. Beneficiaries in the Working Disabled aid category must pay a higher co-payment for these services and also must pay co-payments for some additional services.

Additional Information for Limitations Relating to Children

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

- Co-insurance: ARKids First-B beneficiaries must pay 10% of the charges for the first Medicaid-covered day of inpatient hospital services and must also pay \$10 per visit co-insurance for outpatient hospital services and 10% of Medicaid allowed cost per Durable Medical Equipment item.
- Co-payments: ARKids First-B beneficiaries must pay a co-payment for most services, such as \$10 for most office visits and \$5 per prescription (and must use generic drugs). ARKids First-B beneficiaries’

annual cost-sharing is capped at 5% of the family's gross annual income after State allowable income disregards.

- Premiums: Based on family income, certain Tax Equity Fiscal Responsibility Act (TEFRA) beneficiaries whose custodial parent(s)' income is in excess of 150% of the Federal Poverty level must pay a premium. TEFRA beneficiaries whose custodial parent(s)' income is at or below 150% of the Federal Poverty level cannot be assessed a premium.

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



State Fiscal Year (SFY) 2016 Statistics

Arkansas Medicaid Operations

In State Fiscal Year 2016, our fiscal agent, Hewlett Packard Enterprise, processed more than 45 million provider-submitted claims for 12,363 providers on behalf of more than 1,106,471 Arkansans. The Provider Assistance Center responded to 84,427 voice calls, more than *123,861 automated calls and 55,774 written inquiries. HPE Provider Enrollment responded to 38,270 calls, received 12,413 applications, and worked 12,825 applications for prospective or reenrolling providers. HPE provider representatives conducted 1,659 provider visits, 32 workshops around the state and 20 virtual training sessions reaching 243 providers.

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 538,960 children and, according to recent data, paid for approximately 59.5%** of all births in Arkansas.

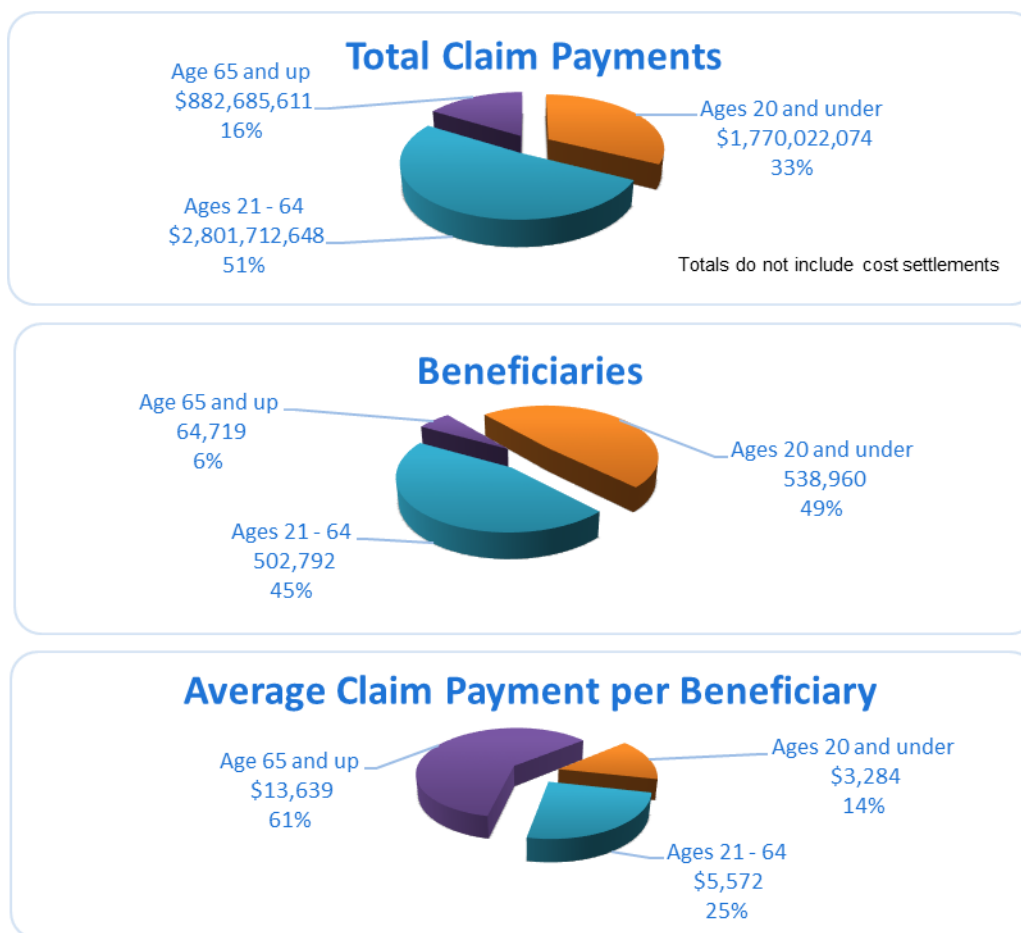
**This information is unavailable for June 2016.

**This calculation is based on SFY15 data, which is the most recent available.



Beneficiary Information

Unduplicated Beneficiary Counts and Claim Payments by Age



Source: DMS/DSS Lab

Percentage of Change in Enrollees and Beneficiaries from SFY 2015 to SFY 2016

	SFY15	SFY16	% Change
Medicaid enrollees	1,009,856	1,132,517	12.0%
Medicaid beneficiaries	998,530	1,106,471	11.0%

Source: DMS

Newborns Paid for by Arkansas Medicaid

	SFY14	SFY15	% Change
Newborns paid for by Arkansas Medicaid	18,837	23,035	22.29%

The medical cost for 59.5%* of all babies born to Arkansas residents during SFY 2015 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 SFY15 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	3,107,353	36%
Elderly (65 and older)	451,521	14%
Adults (21 through 64)	1,786,926	28%
Children (20 and under)	868,906	62%

** This calculation is based on the Arkansas population for 2015, which is the most recent available.

Source: University of Arkansas at Little Rock, DMS, DSS Lab

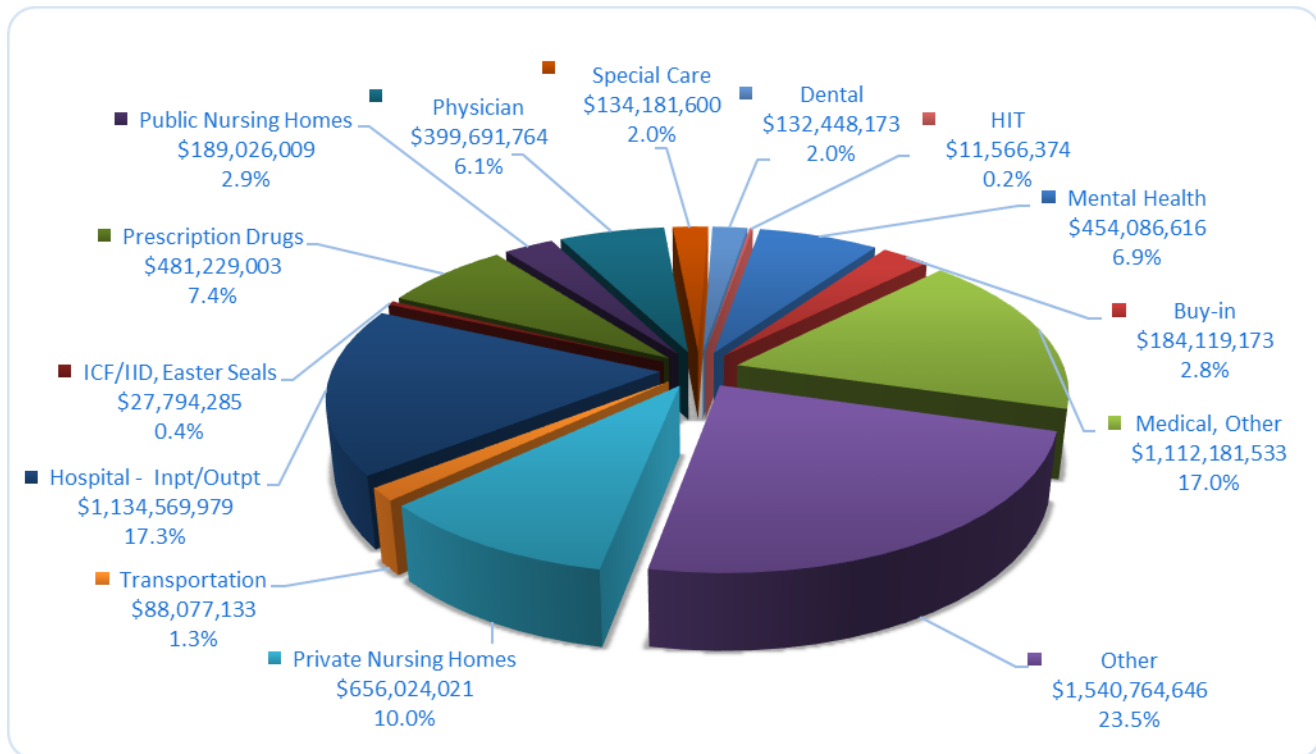
Arkansas Medicaid Enrollees by Aid Category - 5 year Comparison

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



Expenditures

Total Arkansas Medicaid Expenditures SFY16

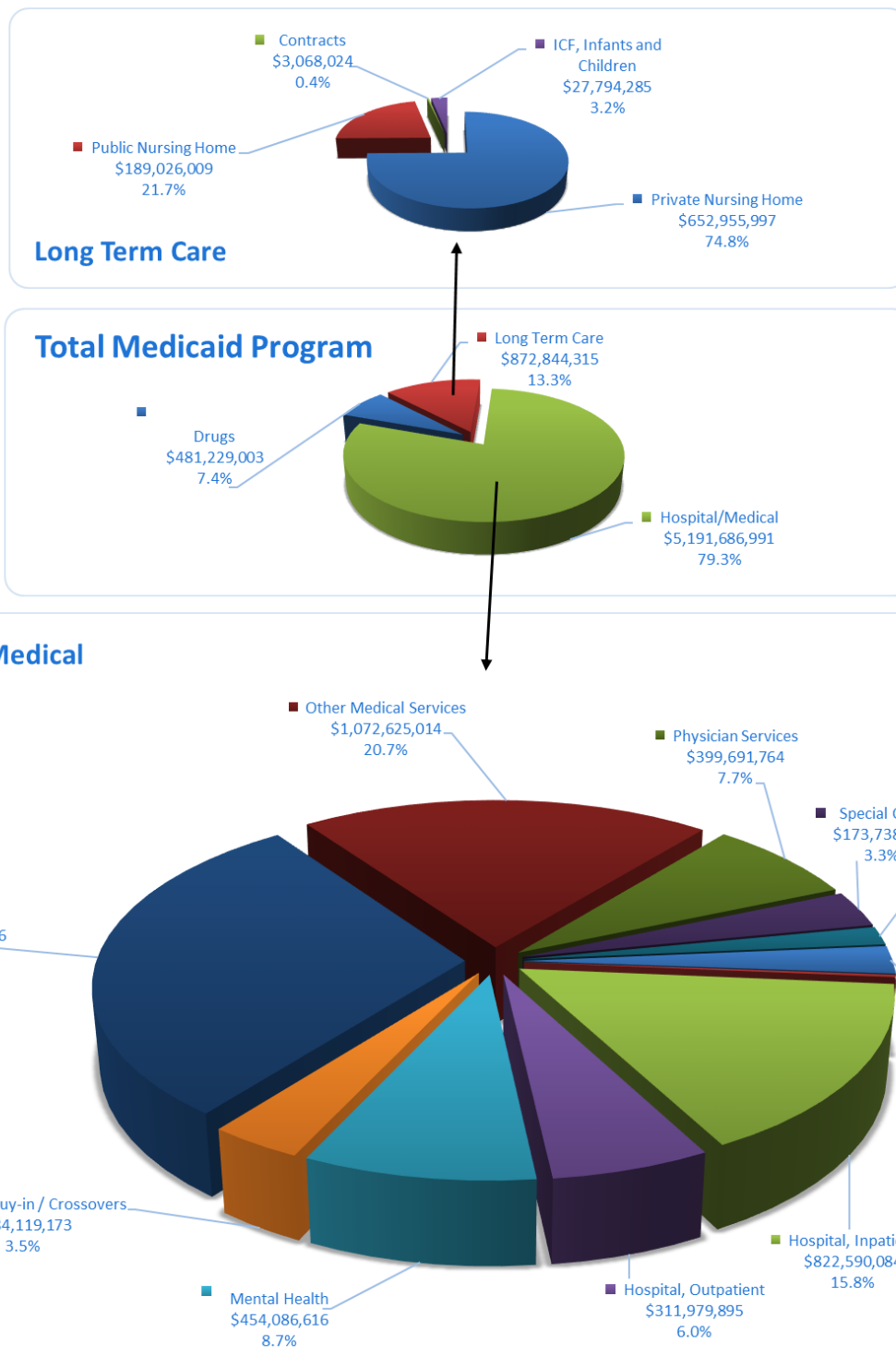


- Special Care includes Home Health, Private Duty Nursing, Personal Care and Hospice Services.
- Transportation includes emergency and non-emergency transportation.
- Other administrative expenditures, Medicare co-pay and deductibles.
- ICF/IID is an abbreviation for Intermediate Care Facility for Individuals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

Source: Department of Human Services Annual Statistical Report



Arkansas Medicaid Program Benefit Expenditures



Source: DMS Financial Activities

Drug Rebate Collections

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

Rebate Dollars Collected	
Total State Fiscal Year 2016	\$246,648,427
State portion	\$57,276,249
*Federal portion	\$189,372,178

*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	\$6,263	1,009,856	\$6,202
2016	\$6,553	1,106,471	\$5,922
**2017	\$7,161	1,106,471	\$6,472

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

** 2017 Estimated - Unduplicated Recipient count 8/23/16 Optumas) ESTIMATE only.

Arkansas Budget and Medicaid percentage		
	SFY 2016	Medicaid Represents
State of Arkansas Budget	\$28.9 billion	22.6%
State General Revenue Funded Budget	\$5.2 billion	18.6%

Arkansas Medicaid Providers

Number of Enrolled Providers

Arkansas Medicaid has approximately 47,154 enrolled providers.

Number of Participating Providers

Approximately 12,363 or 26% are participating providers.

Number of Claims Processed and Approximate Processing Time

More than 45 million provider-submitted claims were processed in State Fiscal Year 2016 with an average processing time of 2.7 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 (9,606)
2	Individual Occupational, Physical and Speech Therapy Services Providers (3,278)
3	Physicians Groups (2,517)
4	Nurse Practitioner (1,884)
5	Alternatives for Adults with Physical Disabilities Waiver Attendant Care (1,329)
6	*Dental Services (1,166)
7	Pharmacy (938)
8	Prosthetic Services/Durable Medical Equipment (621)
9	Visual Care – Optometrist Optician (586)
10	Hospital (466)

*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 units:

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

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

(See the DMS Organizational Chart in the appendices.)

Medicaid Programs

Electronic Health Records Unit

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

Under the direction of the Electronic Health Record Unit (EHRU), classes of Medicaid professionals are eligible to receive Medicaid incentive payments. Eligible professionals (EPs) include physicians, dentists, certified nurse-midwives, nurse practitioners, and physician assistants who are practicing in Federally Qualified Health Centers (FQHCs) or Rural Health Clinics (RHCs). Eligible hospitals (EHs) that may participate are acute care hospitals and children's hospitals. To receive the Medicaid financial incentive, providers must be able to demonstrate certified adoption, implementation, or upgrading of EHR technology, and follow in subsequent years with demonstrated meaningful use. Payments or reimbursements of up to \$63,750 to a participating clinic may be provided to offset the cost associated with implementing an EHR system.

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

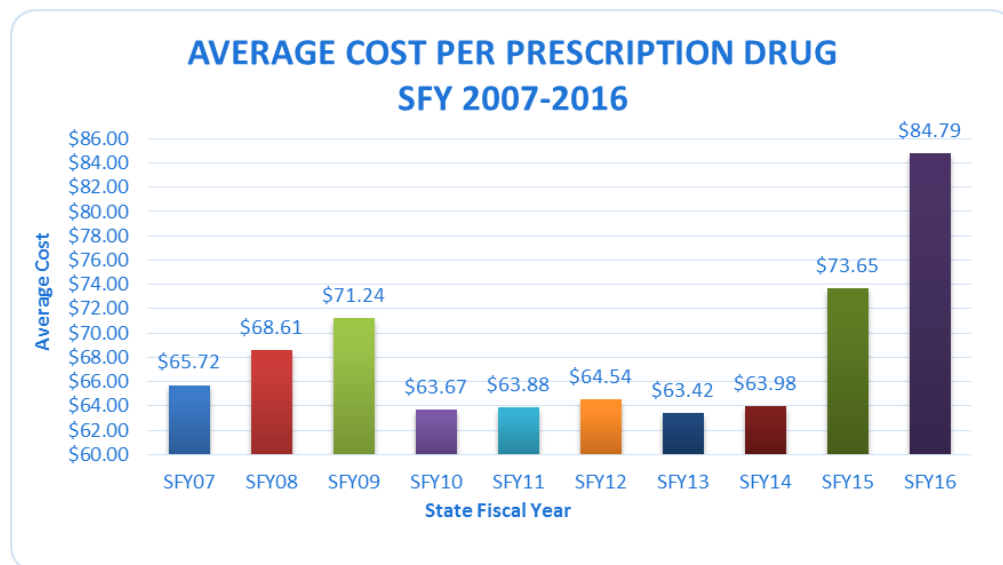
Prescription Drug Program

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 955 enrolled pharmacies in the state. During State Fiscal Year (SFY) 2016, a total of 469,008 Arkansas Medicaid beneficiaries used their prescription drug benefits. A total of 5.3 million prescriptions were reimbursed by Arkansas Medicaid for a cost of \$449.4 million dollars, making the average cost per prescription approximately \$84.79. An average cost for a brand name prescription was \$379.77, representing 14% of the claims and accounting for 68% of expenditures. The average cost for a generic prescription was \$29.74, representing 86% of claims and accounting for 32% 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 2016 was \$44,745,348.

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.



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, and continuous program monitoring through Survey Utilization Review. 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 performance of contracted Quality Improvement Organizations (QIO) for quality assurance. UR administers the following programs and activities:

- Pre- and post-payment reviews of medical services;
- Prior authorization for Private Duty Nursing, hearing aids, hearing aid repair and wheelchairs;
- Extension of benefits for Home Health and Personal Care for beneficiaries age 22 and older and extension of benefits of incontinence products and medical supplies for eligible beneficiaries;
- Prior authorizations and extension of benefits for the following programs: Inpatient and Outpatient Hospitalization, Inpatient Psychiatric under the age of 21, emergency room utilization, Personal Care for beneficiaries under the age of 21, Child Health Management Services, Therapy, Transplants, Rehabilitative Services for Persons with Mental Illness, Licensed Mental Health Practitioner, Substance Abuse Treatment Services, 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 technology information and contribute to policy changes and program coverage benefits related to specific program responsibility;
- Analysis of information concerning reimbursement issues and assist with resolutions;
- Represent the department in workgroups at the state and local level;
- Conduct continuing evaluations and assessments of performance and effectiveness of various programs;
- Interact with provider groups and levels of federal and state government, including the legislature and governor's office and
- Participate in both beneficiary and provider appeals and hearing processes.

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 41 Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), including five Human Development Centers, and 93 Assisted Living Facilities. Annual and complaint surveys are also conducted in 38 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 56 Residential Care Facilities, and 20 Alzheimer's Special Care Units (18 in Assisted Living Facilities and two in nursing homes). Additionally, annual Civil Rights surveys are conducted in 105 hospitals.

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 92 hours of continuing education through 34 workshops/seminars to over 888 staff members in the nursing home and assisted living industry during SFY 2016. Furthermore, there were 279 agendas submitted from outside sources for review to determine 1,523 contact hours for nursing home administrators.

The Nursing Home Administrator Licensure Unit processed renewals for 649 licensed administrators and 79 license applications, and issued 49 new licenses and 5 temporary licenses. Additionally, OLTC administered the state nursing home administrator examination to 72 individuals. During SFY 2016, the Administrator-in-Training program trained 17 participants.

The Criminal Record Check Program applies to all categories of licensed long-term care facilities consisting of over 516 affected facilities. During SFY 2016, there were 40,108 "state" record checks processed through OLTC and 24,483 "federal" record checks processed with a total of 1,428 disqualifications under both categories combined.

At the end of SFY 2016, the Registry for Certified Nursing Assistants (CNAs) contained 30,137 active and 114,605 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 1,416 Arkansas Medicaid nursing facility applications per month while maintaining approximately 13,523 active cases. The unit also processed 11,193 assessments; 3,378 changes of condition requests; 525 transfers; 1,954 utilization review requests and 1,514 applications/reviews for ICF/IID, which includes 189 new assessments and 13 transfers during the year, and 1,312 reassessments. The unit completed 4,550 TEFRA applications and 135 autism waiver applications. Additionally, the unit completed 14,872 applications/reviews/waivers for other medical programs within the Department of Human Services during SFY 2016.

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 696 nursing home complaints during SFY 2016 regarding care or conditions in facilities.

Since 1990, the federal long-term care program has had two levels of facility care under Medicaid. These levels of care are nursing facility services and intermediate care facility services for the intellectually disabled (ICF/IID). Arkansas classifies state-owned facilities as public and all others as private. Arkansas Health Center is a public nursing facility. The ICF/IID population is divided into the five state-owned Human Development Centers, four private pediatric facilities of which three are for profit, one private nonprofit pediatric facility, and 31 fifteen-bed or less facilities serving adults. The nursing facilities include one public and 226 private under Medicaid.

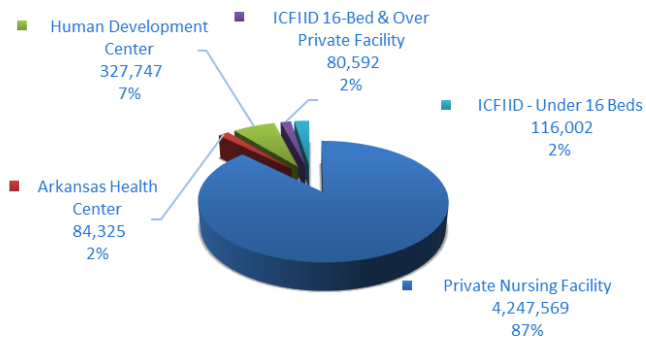
Note: There are two additional private facilities that do not receive Medicaid funding.

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

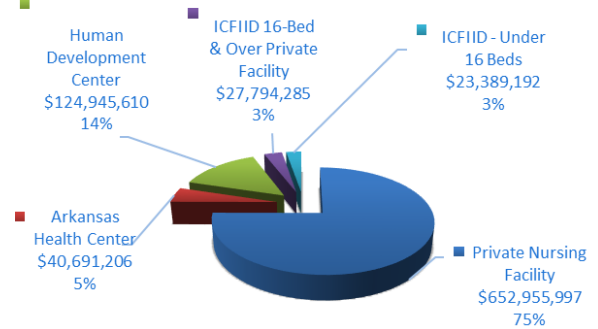


Long Term Care Statistics

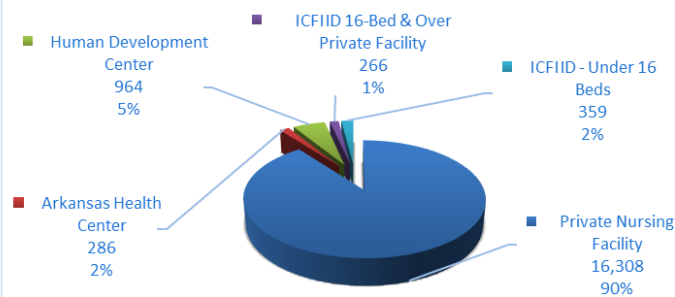
Medicaid Patient Days



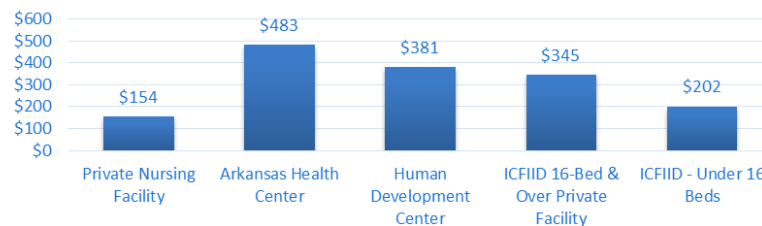
Expenditures



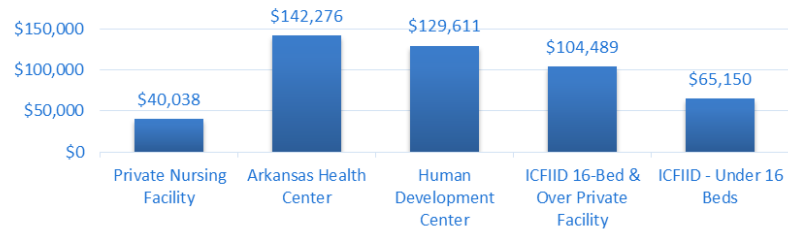
Unduplicated Beneficiary Count



Average Daily Payment



Average Annual Payment Per Recipient



Source: Department of Human Services Annual Statistical Report

Medicaid Information Management

The Medicaid Information Management (MIM) department of the Division of Medical Services is made up of four work units:

1. Arkansas Medicaid Enterprise Project Management Office
2. Data Analytics
3. Operations of the Medicaid Management Information System (MMIS)
4. Professional Services and Support

Arkansas Medicaid Enterprise (AME) Project Management Office

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

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

The Pharmacy system under Magellan Health went into production in March of 2015. The system has paid more than 7.5 million claims since it went live, totaling over \$600 million.

The new Core MMIS design, development, and implementation contract went into effect in December of 2014 with Hewlett Packard Enterprise. The system is targeted to go into production in May of 2017.

Data Analytics

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

Operations of the MMIS

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

For State Fiscal Year 2016, MIM received 21 Security Advisory Committee data requests and the Decision Support Lab output 1,500 reports. The reports produced include information requested by the Arkansas Legislature, Governor's office, press and other private entities seeking Medicaid performance and participation metrics. MIM works diligently to fulfill these requests while respectfully protecting the privacy of our members.

Professional Services and Support

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

Federal funding provided by CMS is approved, allocated and tracked based on the Federal Fiscal Year (FFY) (October 1 – September 30). For FFY-2016 (Oct. 2015 – Sept. 2016), CMS approved over \$167,000,000.00 towards the costs of various DHS Medicaid IT projects.

Primary Care Initiatives

Patient-Centered Medical Homes

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

Surveillance Utilization Review (SUR)

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

Continuity of Care and Coordination of Coverage

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

Health Care Innovation

The Health Care Innovation (HCI) Unit is responsible for coordinating the operations and activities to design the Arkansas Payment Improvement Initiative (APII) and service delivery systems. The 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 and health homes); develop and coordinate improved payment systems infrastructure requirements; and facilitate stakeholder, provider and beneficiary engagement through the APII.

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

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

Nationally, our health system's support for primary care is weak, and it frustrates the general public and Primary Care Providers (PCPs) alike. An individual patient does not have a single provider who is accountable for his or her care. The complexity of the system can be overwhelming. PCPs are underpaid and not well integrated into other stakeholders in the system. The notion of a PCMH has a long history in primary care, and there is an emerging trend to implement PCMH to address these frustrations with the current medical system.

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

Since its inception, 878 PCPs have enrolled in PCMHs, including those enrolled in both PCMH and the Comprehensive Primary Care Initiative (CPCI). To date, there are approximately 330,000 Medicaid beneficiaries enrolled in PCMHs and/or CPCI. Enrollment exceeded expectations and speaks to the success of the programs.

Another segment of Health Care Innovation that has already been implemented is the Retrospective Episodes of Care. To date, 14 Episodes have gone live, which include but are not limited to Perinatal, Heart Failure, Total Joint Replacement, Colonoscopy, Cholecystectomy, Attention Deficit/Hyperactivity Disorder, ODD, Tonsillectomy, CABG, Asthma, COPD, as well as other Upper Respiratory Infections.

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

To date for Episodes of Care, General Dynamics Information Technology (GDIT) has produced 38,381 Principal Accountable Providers (PAP) reports that were delivered to 2,420 distinct PAPs through the June 2016 reporting period. Of those reports, 21,967 are EOC level payment or performance reports and 4,739 are reconciliation reports. Approximately 1.9 billion claims have been processed through the engine for both EOC and PCMH. For EOC, those claims resulted in over 4.6 million episodes (before exclusions).

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

The multi-payer provider portal allows providers to enter quality metric data online and access historical and performance measurement reports. The portal's implementation centers around the quality metric portal design for future episodes and a provider report format based on feedback and lessons learned.

In an effort to improve population-based care for targeted populations, integrated care models are in development to address specific needs for Development Disabilities, Behavioral Health and Long Term Services and Supports 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 many of Arkansas' Medicaid waiver renewals and newly proposed Arkansas Medicaid waiver programs. Depending on the type of waiver that is being renewed or proposed, budget neutrality, cost effectiveness or cost neutrality is determined.

In addition to waiver budgeting, Program Budgeting and Analysis analyzes Arkansas Medicaid programs to determine whether each program is operating within their budget and if program changes should be considered. This unit also performs trend and financial analysis of Medicaid expenditures by category of service, provider type and aid category, and provides any ad hoc managerial reports as requested by DMS leadership.

Provider 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, absent parents and estate recovery. The savings for State Fiscal Year 2016 were as follows:

	SFY 2016
Other Collections (Health, Casualty Insurance, Estate Recovery, Miller Trusts, and Small Estates)	\$24,925,179.49
Cost Avoidance (Health Insurance)	\$27,600,717.29
Total Savings	\$52,525,896.78

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) 2016
- Expenditures by County SFY 2016
- Waiver Expenditures and Waiver Beneficiaries by County SFY 2016
- Providers by County SFY 2016

DMS Contacts

Glossary of Acronyms

ACA

Affordable Care Act

AFMC

Arkansas Foundation for Medical Care

AME

Arkansas Medicaid Enterprise

APII

Arkansas Health Care Payment Improvement Initiative

CHIP

Child Health Insurance Program

CMS

Centers for Medicare and Medicaid Services

CNA

Certified Nursing Assistant

CPCI

Comprehensive Primary Care Initiative

DHS

Department of Human Services

DMS

Division of Medical Services (Medicaid)

DSS

Decision Support System/Data Warehouse

EAC

Estimated Acquisition Cost

EHRU

Electronic Health Records Unit

EPSDT

Early and Periodic Screening, Diagnosis and Treatment

HCI

Health Care Innovation

HCIP

Health Care Independence Program

ICF/IID

Intermediate Care Facilities for Individuals with Intellectual Disabilities

LTC

Long Term Care

MIM

Medicaid Information Management

MMIS

Medicaid Management Information System

NDC

National Drug Code

OLTC

Office of Long Term Care

PCMH

Patient-Centered Medical Home

PCP

Primary Care Provider

PD/QA

Program Development and Quality Assurance

QA

Quality Assurance

QIO

Quality Improvement Organization

SFY

State Fiscal Year – July 1 to June 30

SPA

State Plan Amendment

SURS

Surveillance and Utilization Review Subsystem

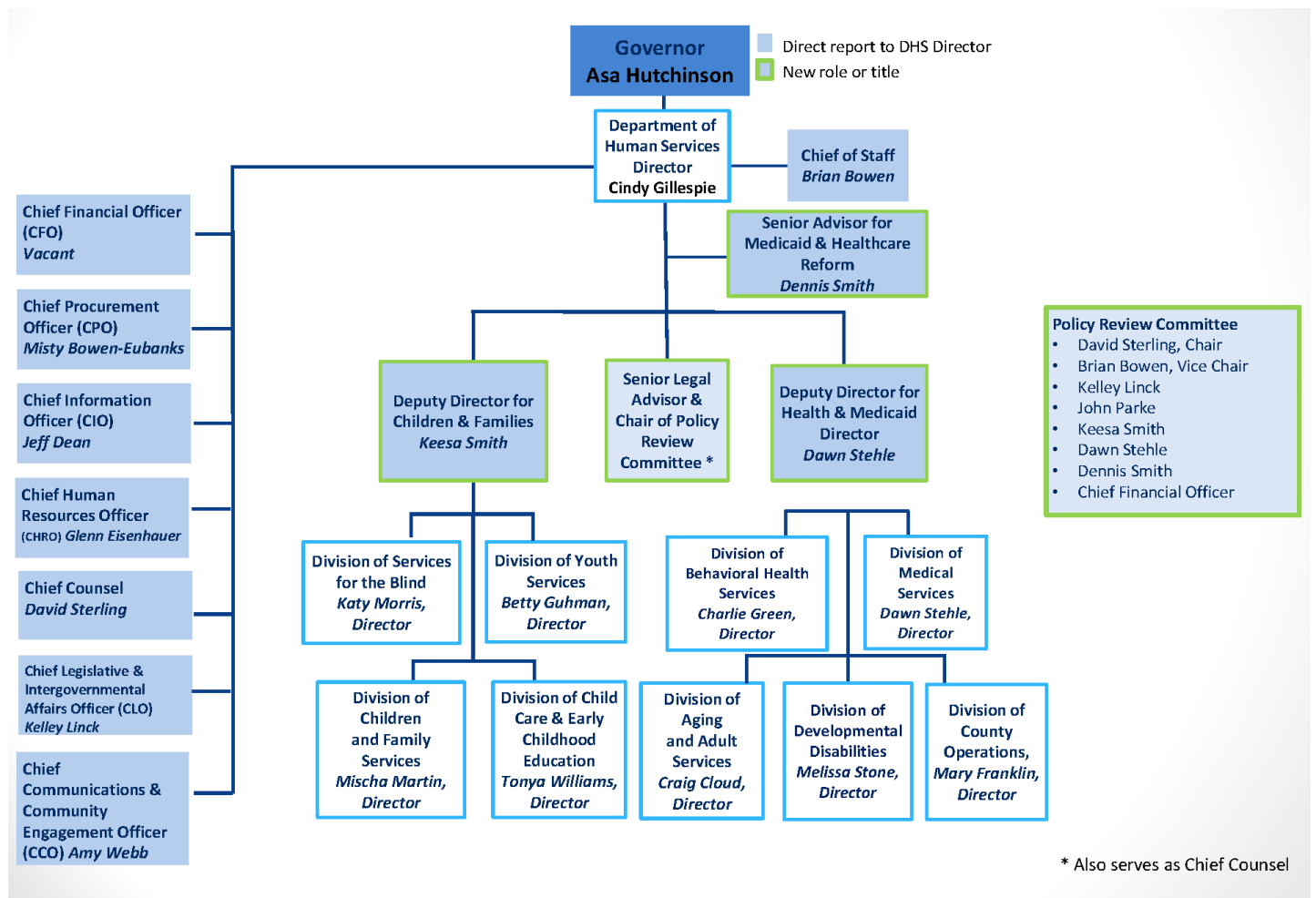
TEFRA

Tax Equity and Financial Responsibility Act

UR

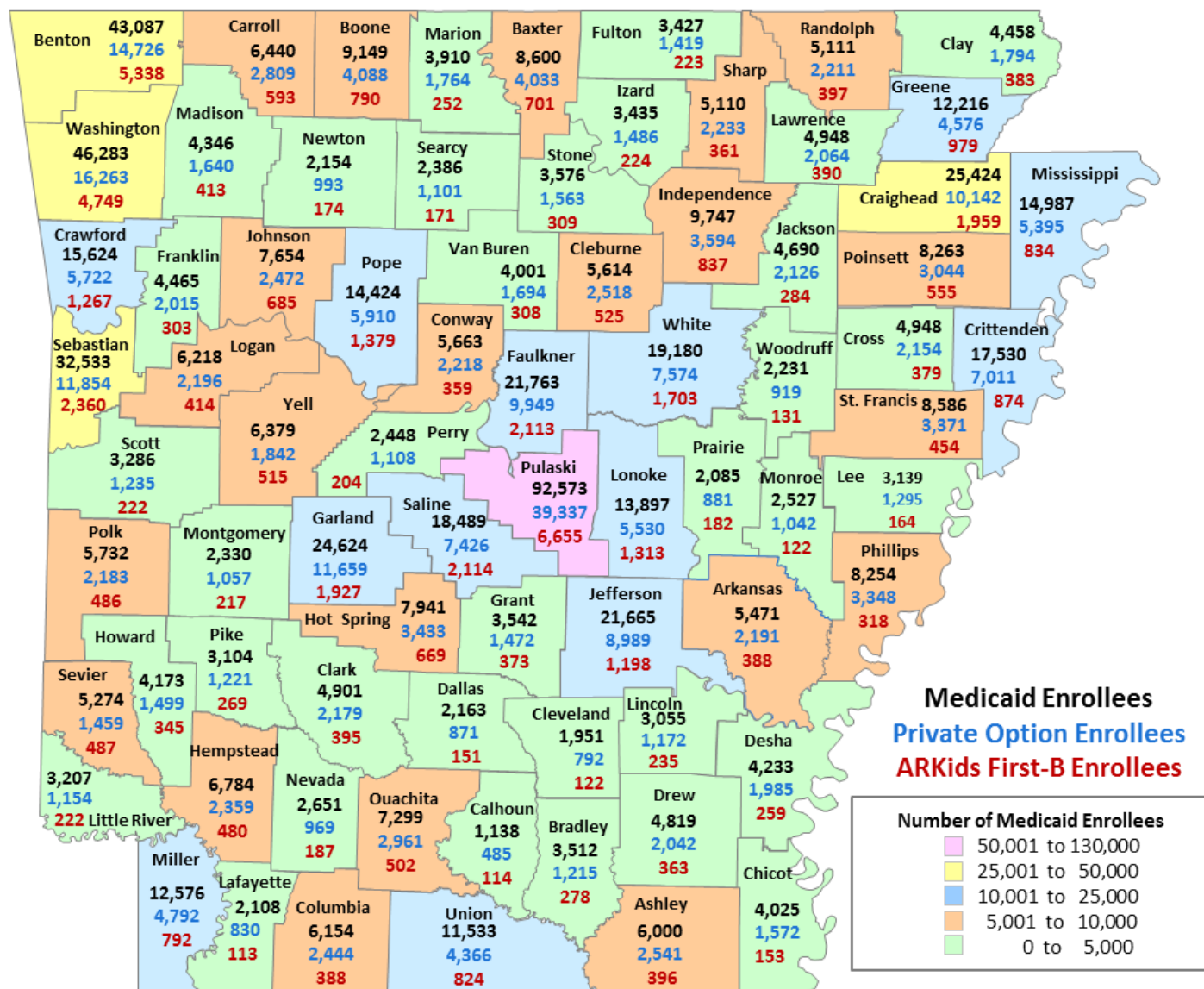
Utilization Review

Department of Human Services (DHS) Executive Staff Organizational Chart



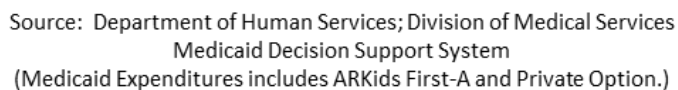
December 5, 2016

Map - Enrollees by County



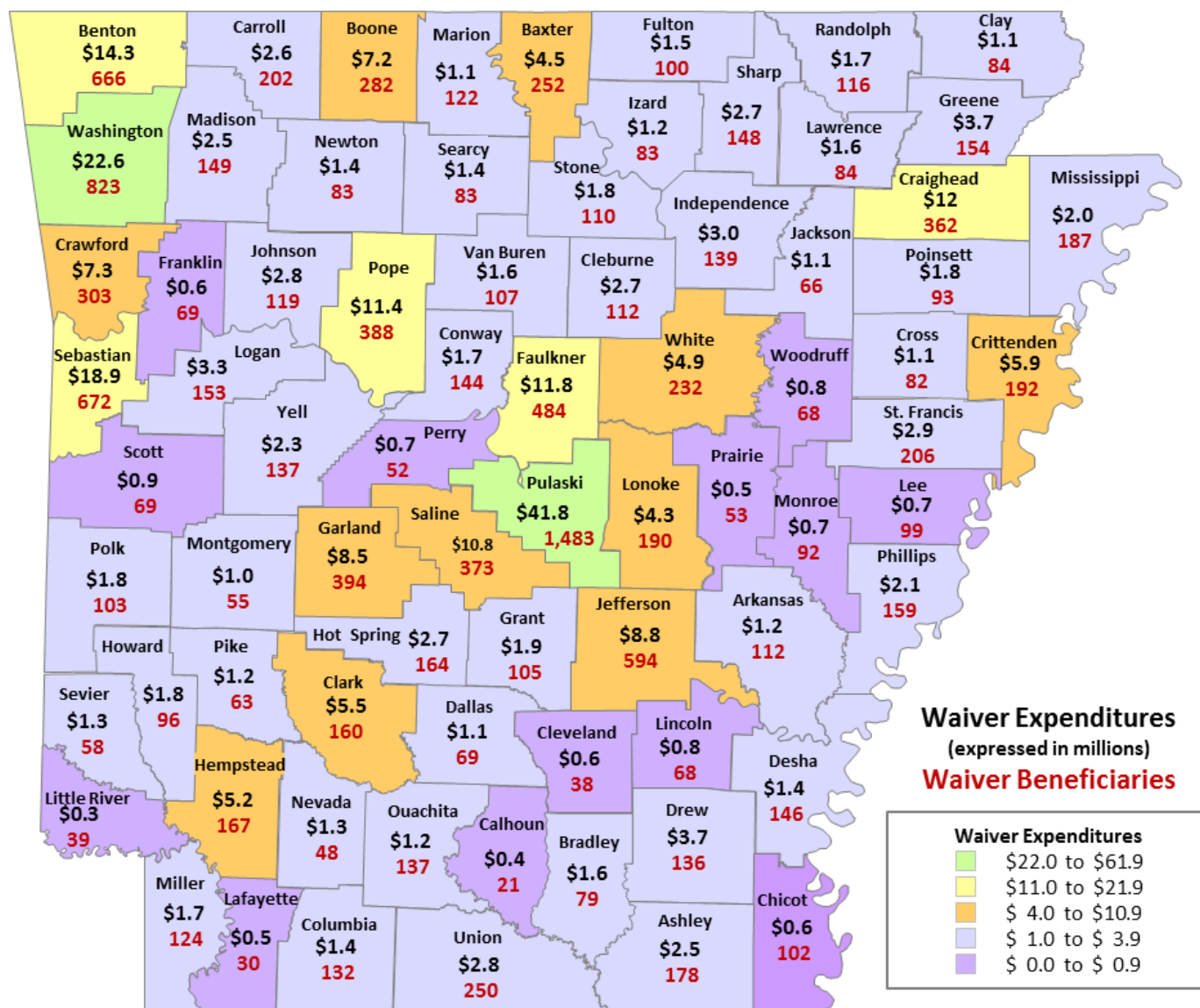
Source: Department of Human Services, Division of Medical Services
 Medicaid Decision Support System

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



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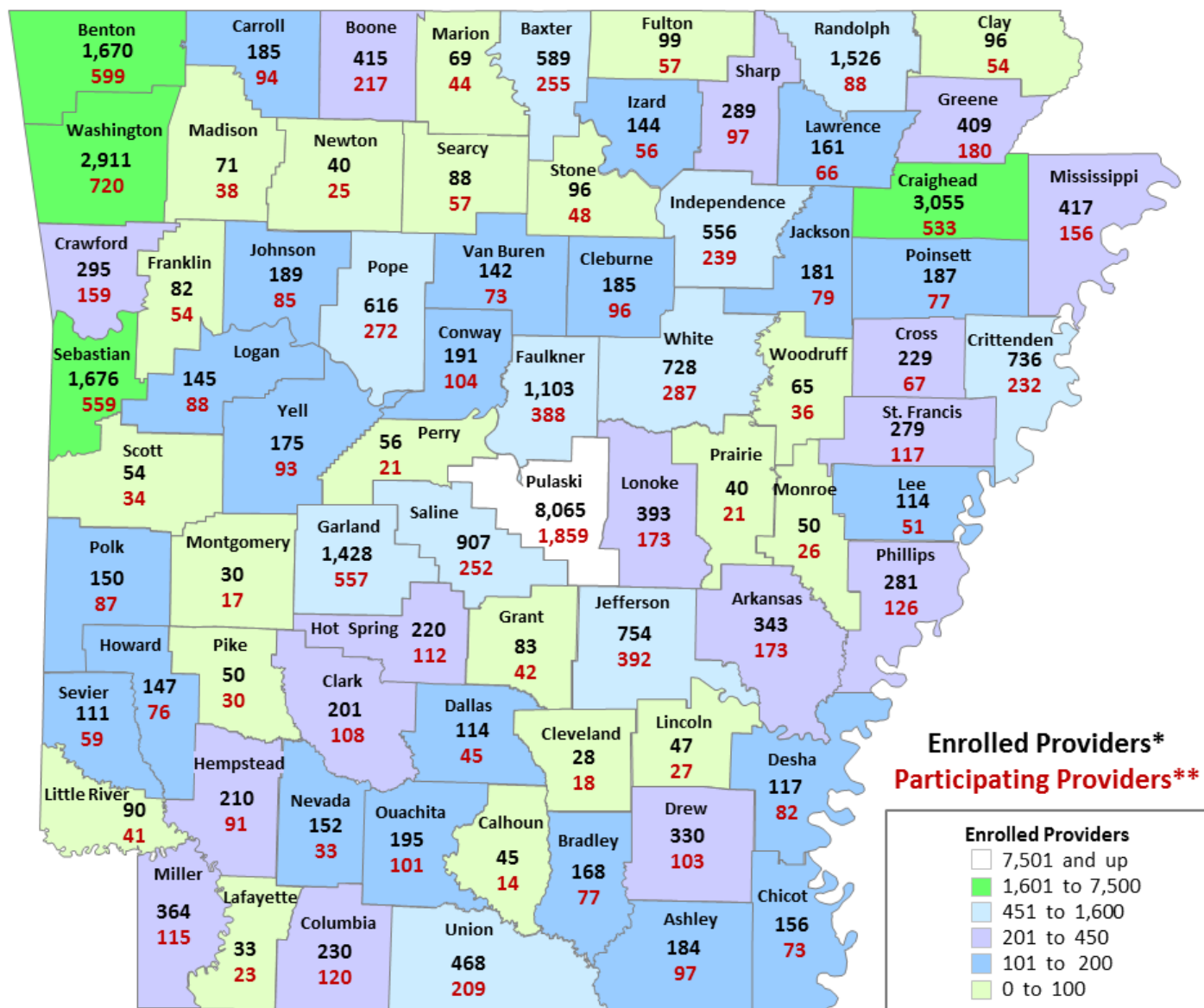
Map - Waiver Expenditures and Waiver Beneficiaries by County



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



*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 2015

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Phone Numbers and Internet Resources

Quick Reference Guide

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

Hotlines

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

Internet Resources

Access Arkansas	https://access.arkansas.gov
Arkansas Foundation for Medical Care	http://www.afmc.org
Arkansas Medicaid.....	https://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