DHS - MEDICAL SERVICES

Enabling Laws

Act 1236 of 2007
Act 1284 of 2007
A.C.A. §25-10-102
A.C.A. §20-77-All subsections

History and Organization

MEDICAID PROGRAM OVERVIEW
Medicaid is a joint federal-state program of medical assistance for eligible individuals based on financial need and/or health status.

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

Section 7 of Arkansas Act 280 (1939) and Act 416 (1977) authorized the State of Arkansas to establish and maintain a medical care program for the indigent and vested responsibility for regulating and administering the program in the Department of Human Services (DHS).

ADMINISTRATION
Arkansas Medicaid was implemented on January 1, 1970.

- DHS administers the Medicaid Program through the Division of Medical Services (DMS).
- The Arkansas Medicaid program is detailed in the Arkansas Medicaid State Plan and through Provider Manuals.
- The Centers for Medicare and Medicaid Services (CMS) administers the Medicaid Program for the U.S. Department of Health and Human Services. CMS authorizes federal funding levels and approves each state's State Plan, ensuring compliance with human services federal regulations.

ELIGIBILITY
SSI individuals are deemed Medicaid eligible by District Social Security Offices. Non-SSI individuals are certified as eligible for Medicaid Services by DHS field staff located in county offices throughout the state.

FUNDING
Funding is shared between the federal government and the states, with the federal government matching the state share at an authorized rate between 50 and 90 percent, depending on the program.

The federal participation rate is adjusted each year to compensate for changes in the per capita income of each state relative to the nation as a whole.

- Arkansas funds approximately 27% of Arkansas Medicaid Program-related Costs; the federal

government funds approximately 73%. State funds are drawn from directly appropriated state general revenues, license fees, drug rebates, recoveries and the Medicaid Trust Fund.
- Administrative Costs for Arkansas Medicaid are generally funded 50% by Arkansas and 50% by the federal government, although some specialized costs are funded 75% or 90% by the federal government.

SERVICES
Medicaid covered services may be rendered by both private and public providers.

- Mandatory Services are specific services required by the federal government. They include such things as child health services, family planning, home health, in-patient and out-patient hospital services, physician services, and others.
- Optional Services are services beyond the mandatory services which the state has elected to provide. Many of these optional services enable recipients to receive care in less costly home or community based settings. The Arkansas Medicaid program includes over 45 optional services which are approved in advance by CMS. Optional services are federally funded at the same level as mandatory services.
- Waiver and Demonstration Services are CMS approved services that, by design, waive one or more of the basic tenets of the federal Medicaid program, such as the requirement that benefits must be uniform throughout all geographic areas of the state or must be comparable in amount, duration, and scope for all population groups. Waiver and demonstration services allow states to provide services in different or more creative ways. Arkansas has approximately ten active waiver or demonstration programs including such programs as ARKids First, ARHealthNetworks, IndependentChoices, and Women's Health.

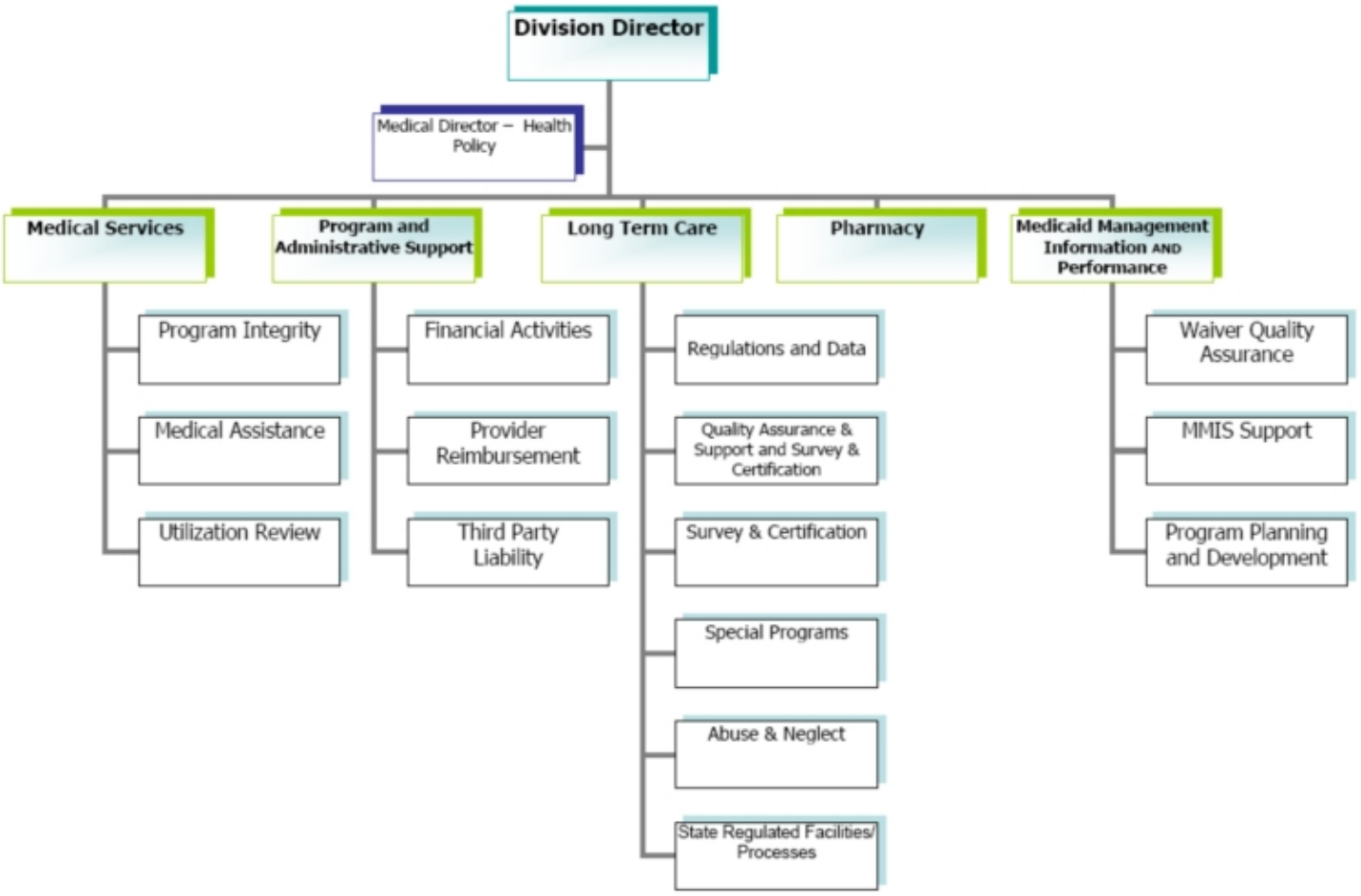
ORGANIZATION
The Division of Medical Services consists of five (5) administrative and program areas :

- Medical Services
- Prescription Drugs
- Office of Long Term Care
- Medicaid Management Information and Performance
- Program and Administrative Support

DMS operations are administered by approximately 270 employees--145 long-term care employees and 125 employees in the remaining four areas. Each of the five program areas provides a variety of informational resources concerning the delivery of program services, and monitors program performance to ensure that resources are utilized in the most cost effective and efficient manner.

PROGRAM ACHIEVEMENTS
- Automated Eligibility Verification & Claims Submission Systems (AEVCS) - Enables providers to electronically confirm each patient's eligibility and submit claims
- Assisted Living - This waiver offers certain individuals an alternative to remaining in their private dwelling or going to a nursing home
- TEFRA Waiver - Parents above a certain income level pay a premium for the Medicaid services for their child(ren)
- Non-Emergency Transportation Services - Regionalized transportation services at capitated rates to reduce costs and control fraud and abuse

- Independent Choices - Demonstration program that allows recipients to make decisions regarding their personal care by offering a cash allowance and counseling service
- ConnectCare Primary Care Case Management Program - An award-winning primary care physician program that has accomplished cost containment goals while maintaining provider and recipient satisfaction
- ARKids First B - Allows uninsured children of working families to access health insurance by providing primary-care coverage in Medicaid with slightly fewer benefits and cost-sharing for most services
- Medicaid Infrastructure Grant (MIG) - In SFY 2005, the CMS awarded Arkansas a MIG with which the state will work to expand and improve the Medicaid Buy-In Program known as Working Disabled. CMS has renewed this grant each year.



Agency Commentary

The Division of Medical Services (DMS) of the Department of Human Services (DHS) provides financial assistance for necessary medical services to families and individuals whose incomes and/or resources are insufficient to meet the costs of those services or who otherwise meet Arkansas Medicaid eligibility requirements. The Division of Medical Services administers the Arkansas Medicaid Program including the State Child Health Insurance Program (SCHIP), and the Office of Long Term Care.

The Division of Medical Services is financed by a mixture of funding sources, including: State General Revenues, prescription drug rebates, Tobacco Settlement Funds, Tobacco Tax Revenues, Quality Assurance Fees, Arkansas Soft Drink Tax Revenues, transfers from other State Agencies for services to specific Medicaid eligibility population groups, and Federal Medicaid funds (Social Security Title XIX) and SCHIP funds (Social Security title XXI).

Medicaid

Medicaid services are organized in four general program areas:

1. Prescription Drugs
2. Long Term Care
3. Hospital and Medical Services
4. Tobacco Settlement Medicaid Expansion

These four general program areas encompass 67 different programs and services offered through the Medicaid Program. The relative distribution of Medicaid funds to the four general areas are depicted in the chart at the end of the Commentary (see chart Medicaid Expenditures SFY 08).

The Medicaid Program was implemented in Arkansas on January 1, 1970. Individuals are certified as eligible for Medicaid Services by DHS Field Staff located in County Offices or by District Social Security Offices.

Growth in the Medicaid Program is influenced by a number of factors that extend beyond normal inflation. The increases in the Medicaid eligibility population as well as the number and types of services utilized by the population influences the rise in expenditures. Growth in the Hospital Medical Program expenditures is due in part to an increase in eligibles, medical inflation, and increased utilization in specific areas, i.e. Mental Health services, therapy services, and the various waiver programs.

The Division of Medical Services is on the cutting edge of discovering efficiencies to improve access to programs while containing program costs. Faced with the challenge of promoting the efficiency of the Medicaid Program, Arkansas Medicaid has improved the access of Medicaid recipients to mainstream private-sector medical care by combining state of the art technology with a self-administered managed-care program that provides health care innovations to citizens of Arkansas.

Current Innovations:

Inpatient Quality Incentive (IQI) program was implemented in SFY 2007 awarding about $4.8 million in incentive payment to 29 qualifying hospitals and July 2008, Medicaid awarded $4.9 million in incentive payments to 34 qualifying hospitals and another $900,000 is expected to be paid out to these same 34 qualifying hospitals during the remainder of SFY 2009. IQI payments are available to in-state and border city acute care hospitals that are subject to the $850 per diem cost limit. To qualify for the 2008 incentive payments, a hospital had to comply with at least one of two separate performance thresholds. New for 2008 is a special recognition available for hospitals such as Critical Access Hospitals and others

which are not eligible for the IQI payment due to a different inpatient reimbursement methodology.

Early Periodic Screening Diagnosis and Treatment (EPSDT) Quality Incentive payments are planned to be implemented in SFY 2009. These incentive payments will be a two tiered bonus system as recommended by the Arkansas Medical Society. Tier 1 payment will be based on the number of medical screens provided to beneficiaries by any qualifying EPSDT/Medical provider. Tier 2 payment will be payable to qualifying PCPs only and will be based on the ratio of actual medical screens performed compared to expected medical screens given the number of beneficiaries and the length of enrollment.

Also planned for SFY09 is a Pay-For-Performance program for speech, occupational, and physical therapist involving an online course and exam to promote better understanding of and compliance with the Medicaid program and related procedures.

The ARHealthNetworks waiver program provides a "safety net" benefits package for working uninsured Arkansans age 19 through 64 with family income at or below 200% of the Federal Poverty Level.

The Evidence Based Prescription Drug Program is a program utilized by the Division of Medical Services Pharmacy unit providing the best selection of prescription drugs in a given class, based on efficacy and cost minimization to the state.

Another innovation utilized by the pharmacy unit is the Smart PA. This program verifies prior authorization (PA) eligibility by reading a recipient's Medicaid profile, including medications, procedures, and diagnosis, at the Point of Sale (POS). If criteria are met a PA is setup automatically.

In State Fiscal Year 2007 and 2008, Centers for Medicare and Medicaid Services awarded a Medicaid Transformation Grant to develop and implement an electronic verification of proof of citizenship.

Long Term Care

The Office of Long Term Care (OLTC) is the unit of state government responsible for the regulation of long term care facilities in Arkansas. These facilities include Nursing Homes, Intermediate Care Facilities for the Mentally Retarded (ICF/MR), Residential Care Facilities (RCF), Adult Day Care, Adult Day Health Care, Post-Acute Head Injury Facilities, Assisted Living Facilities (ALF) and Psychiatric Residential Treatment Facilities (PRTF). In total, OLTC is responsible for regulating approximately 450 facilities, serving in excess of 22,000 disabled Arkansans daily. This regulation of facilities includes conducting on-site inspections of facilities (which frequently occurs multiple times in a year), investigations of complaints against facilities, medical need determinations for placement into facilities, and licensure of facilities and facility administrators. For the calendar year 2007, the Office of Long Term Care performed approximately 1,000 state and federal surveys and complaint investigations of long term care facilities.

The Office of Long Term Care also performs criminal record background checks on the employees and applicants of facilities the Office regulates, and the Office is responsible for the administration of the training and certification of Certified Nursing Assistance (CNAs), who are long term care facility caregivers that are employed in long term care facilities and hospital-based facilities.

Current Innovation: The Arkansas Innovative Performance Program for Nursing Homes offers extensive quality improvement assistance to Arkansas' Medicaid certified nursing homes through on-site facility consultation and training.

PROGRAM REQUESTS

While understanding there is a limited amount of State dollars available for additional funding levels, the following requests are required to maintain critical programs and provide for the inescapable increases and federal mandates of the Medicaid Program:

Request #1 - Growth: The growth in the Medicaid Program is influenced by a number of factors that extend beyond normal inflation and which are generally unaffected by DMS policy decisions. For example, if the Medicaid eligible population increases as a result of a declining economy, the number of individuals accessing services will increase--without any changes in Medicaid policy. Likewise, because Medicaid is an entitlement program, if (for whatever reason) the number and/or types of services utilized by the eligible population changes, the cost to the Arkansas Medicaid program could increase accordingly. Finally, there are a significant number of facilities that receive reimbursement for services to Medicaid recipients using a cost-based methodology. For these facilities (UAMS, ACH, nursing homes, the State Hospital, etc.), as medical costs continue to climb, so to do DMS expenditures.

DMS change level requests, which are based on historical cost trends and anticipated socioeconomic conditions, provide for modest growth rates in all program categories. Growth rates anticipated and requested are stable or below the 2008/2009 biennial budget requests for this type of growth factor in all categories.

Request #2 - FMAP Rate Change: This request results from a recent change in the Federal Medical Assistance Percentage of .01% for SFY 2010 and .07% for SFY 2011. This decrease in federal matching affects almost all Medicaid programs.

Request #3 - Unfunded Appropriation: Arkansas' Medicaid program often undergoes changes that require additional appropriation to be able to respond to federal and state mandates to the extent funds are available. This request is for appropriation only.

Request #4 - Prescription Drugs (Medication Therapy Management): Medication Therapy Management (MTM) is a comprehensive patient centered service that focuses on the patient's total drug therapy needs. The intention of MTM is to optimize the patient's drug regimen to best achieve appropriate therapeutic goals for the patient in the specific subset identified, to improve that patient's health outcome, and to reduce the risks of adverse events. While there is a small funding request to initiate and operate this program, it is anticipated that, in the long run, MTM may decrease Medicaid medical expenses such as ER visits, hospitalization, physician visits, etc.

Request #5 - Hospital/Medical (Replace Trust Fund): The Medicaid Trust Fund had accumulated a balance which was used in place of additional general revenue in funding the SFY 2008 and SFY 2009 budgets. Because the Medicaid Trust Fund balance will be depleted during SFY10, the Trust Fund will not be available as a funding source to the extent that it was in the base year (SFY 2009). Therefore, this request is to replace the Trust Fund balance with State General Revenue.

Request #6 - Hospital/Medical (Various Rate Changes): This request relates to presently contemplated rate increases for such things as physician rates, the establishment of a ventilator unit at the state nursing facility, as well as various court-mandated increases. The request also provides for rate increases that are not specifically known or approved at this time, but that based on previous years operations, DMS management knows will be necessary. DMS must have some budget flexibility to address increases in reimbursement rates to ensure that Medicaid recipients have appropriate access to medical services. In addition, it may be necessary to add services and/or increase rates for certain

services to support the development and operation of a statewide trauma system.

Request #7 - Hospital/Medical (Optometric Rate Change): This request is for increases in the reimbursement rates for eye exams, spectacle prescription services, and contact lens exams to bring the rates to or near the current Medicare reimbursement rates. This request also supports an increase in the contact lens material reimbursement rate for Keratoconic lenses, adds a code for an external photo of the eye necessary for diagnosis of specific ocular problems, and expands sensorimotor testing to include adults, as medically necessary.

Request #8 - Hospital/Medical (ACS Waivers): This request pertains to the three line items titled ACS Waivers - COLA, Transportation, and Expansion and will provide for increases due to the cost of living, gasoline and other transportation costs, and the number of waiver slots filled. The request is for appropriation only. The funding is being requested by the DHS Division of Developmental Disability Services.

Request #9 - Hospital/Medical Expansion (ARHealthNetworks): The increase in the requested appropriation and non SGR funding for Medicaid Expansion programs is primarily attributable to the planned growth in the ARHealthNetworks program. This program has had several changes related to eligibility and program cost that will likely cause the program to grow in the future. In addition, the upcoming Health Risk Assessment and Feasibility Study will provide management with information to further grow the program. The aggressive growth planned for ARHealthNetworks in both the Hospital/Medical and Prescription Drug categories, drives this biennial budget request.

Request #10 - Medicaid Expansion (Breast & Cervical Cancer): This request will reclassify the Breast and Cervical Cancer program administered by the Arkansas Department of Health from "regular" Medicaid to Medicaid Expansion. DMS management believes that this program is an extension of services to the 19-64 year old population and, therefore, is more appropriately classified as an Expansion program.

Request #11 - Hospital/Medical (Substance Abuse): DMS, in conjunction with the DHS Division of Behavioral Health Services, continues to develop a program to address substance abuse by Medicaid recipients. It is anticipated that the plan development will be complete during SFY09 and the program could become operational during SFY09 or SFY10, assuming a funding source is identified. This request is for appropriation only.

Request #12 - Hospital/Medical PEER (MITA): DMS requires additional SGR to match federal funds in order to take advantage of enhanced funding opportunities from CMS. With access to enhanced federal funding, DMS will develop Medicaid Information Technology Architecture (MITA) projects and lead collaborative efforts with key stakeholders to develop and implement several major health information technology (HIT) projects including health information exchange, electronic health records, etc. DMS anticipates 75% and 90% federal funding for most of the costs, and the requested SGR will provide matching funds to access the federal funds. In addition, in the near future, unless specified MITA work is completed, CMS will cease all funding for MMIS enhancements.

Request #13 - Hospital/Medical Contract (Policy Manual Review): DMS will outsource the technical writing of all Medicaid provider manuals and automate the process as much as possible for policy review, approval, cross-referencing to rules and regulations, and retaining history of policy changes. DMS currently has 57 provider manuals. DMS will require an initial review and reconciliation of existing policies, so the first year will be more costly than subsequent years.

ADMINISTRATIVE REQUESTS

The Division of Medical Services' (DMS) primary responsibility is the management of the Arkansas Medicaid Program. DMS consists of five organizational units: (1) Medical Services (2) Pharmacy (3) Office of Long-Term Care (4) Medicaid Management Information and Performance (5) Program and Administrative Support. These units set policy and manage funding for the delivery of health services to Medicaid recipients. In addition, the Office of Long Term Care sets policy and monitors the delivery of services in private nursing homes. Collectively, the units of DMS provide program information and monitor program performance to ensure that resources are utilized in the most cost effective and efficient manner.

Request #1 -Position Restorations: The Division of Medical Services requests the restoration of two (2) unbudgeted positions. This will allow DMS the flexibility to fill these positions if the funds become available during the biennium.

Request #2 - New Positions: The Division of Medical Services requests appropriation only for 28 new positions. All 28 positions will be funded by a mixture of Third Party Liability collections and federal funds. No state funds are requested for these positions.

The two (2) Health Research Analyst positions are designated for performing research and analysis activities to support the DMS Medical Director for Policy, specifically, and Medicaid policy making generally. These positions will project spending trends, identify met and unmet program needs, conduct and/or evaluate impact studies for various program and policies, perform data mining activities in MMIS, data warehouse, and other data resources, prepare statistical analysis and produce written reports of findings.

Five (5) positions are requested to form a Behavior Health Unit within DMS. This unit will be responsible for recommending policies and procedures relative to behavioral health services under the Arkansas Medicaid State Plan as well as monitoring and managing those services to ensure the most efficient and effective use of Medicaid funds. This unit will perform such duties as researching current behavioral heath care issues and programming, developing and coordinating contract activities, addressing provider and beneficiary issues and appeals, maintaining relevant parts of policy manuals while ensuring compliance with state and federal regulations, and representing DMS in various departmental and public venues. The positions consist of one Medical Assistance Manager, one Nursing Services Unit Manager, two Program Administrators, and one Program Manager.

Two (2) positions are related to a new Contract Oversight Unit that is being established within DMS. In SFY08, the Division of Medical Services entered into contracts with a dollar value of $84,121,482, exclusive of the EDS contract. This Unit will be responsible for DMS contract performance monitoring and evaluation as well as determining and implementing corrective action, if appropriate. These two positions which consist of an Assistant Director and a licensed Mental Health Practitioner, will supplement existing positions within the unit.

One position requested is for a Chief Program Administrator to oversee the Medicaid Dental and Visual programs and consultant contracts with EDS, Connect Care, Arkansas Healthcare Access and the Optometric and Arkansas State Dental Associations. This position will also oversee the Medicaid Managed Care Services contract which includes ambulance and nonemergency transportation, primary physicians and early periodic screening diagnosis and treatment (EPSDT).

One position requested is for a Systems/Data Analyst II. The Program Integrity (PI) unit of DMS recently began the Medi/Medi project which takes Medicaid data and compares it to Medicare data to identify outliers in provider billings. This project will require someone to extract and coordinate data with CMS contractors. Under the DRA, CMS has also created MIG (Medicaid Integrity Group) and 1Stop which also requires data sharing and coordination. In addition, this position will gather and research data for the PERM project. This position would also extract and analyze data for PI reviews as well as analyze data for Pharmacy reviews, which appears to be a growing trend in provider fraud and abuse.

The Information Systems Coordinator position is requested to take advantage of opportunities offered by MITA (Medicaid Information Technology Architecture) for Division and Department IT initiatives and needs. This requires a high level staff dedicated primarily to researching, designing, and developing MITA initiatives as well as writing APDs, RFPs, and contracts related to MITA. This position would also assist with other APDs, RFPs, and contracts for MMIS enhancements and changes.

The Waiver Quality Assurance position is currently part of a grant within the Division of Aging and Adult Services. This request would make the grant position, which expires September 30, 2009, permanent. This position assists with Quality Management tasks including the creation and distribution of Quality Management reports and monitoring of Quality Management strategies for each Home and Community Based Services Waiver.

The Assistant Chief Program Administrator for Long Term Care Programs is a position that will be part of the Provider Reimbursement unit of DMS. This position will assist the Program Administrator by assessing current reimbursement methodologies used in reimbursing Long Term Care providers to ensure that the mission and goals of DMS are met. This position will be responsible for establishing rates in accordance with applicable state and federal laws and rules, supervising desk reviews and on-site audit functions, and resolving reimbursement issues that arise with Long Term Care providers. This additional position will ensure continued timely and accurate rate setting and financial oversight of this very important Medicaid program.

The Pharmacy Program Analyst position will assist in the development of cost containment strategies such as establishing generic upper limits, assisting in data research for the PDL, assisting providers with product availability, and working closely with state agencies and associations in setting acceptable pricing strategies. The position will also be responsible for reporting the effect of cost containment strategies on expenditures and assisting with inquiries from outside agencies and public officials. Other responsibilities include researching and analyzing errors or inconsistencies within a data base and determining appropriate corrective action, discussing problems and solutions with database users, generating and review of system reports, maintaining the documentation on system files and reports, recommending data base improvements and coordination of system modifications with the appropriate personnel.

The Nursing Services Unit Manager position for the Office of Long Term Care (OLTC) will provide oversight of the Assisted Living and Residential Care Unit and be responsible for the licensure and inspection of 175 facilities that house the aged and disabled. The position will supervise sixteen (16) positions, including the nurses and life safety code surveyors who perform the inspections. The position is responsible for ensuring that facilities are licensed appropriately, that staff is trained and that staff performs inspections in accordance with applicable state laws and regulations. With Assisted Living in its relative infancy, it is expected that the number of such facilities will increase by approximately 95% over the next few years. This is based on the number of Assisted Living Permits of Approval sought through, or approved by, the Health Services Permit Agency. With this growth rate, the complexity of managing the Assisted Living licensing will magnify and require adequate managers. This management position

requires that the incumbent be familiar with regulations applicable to both facility types, survey protocol, and state law governing the program, and the ability to supervise to ensure that the unit's functions are carried out in mandated timeframes and in the mandated processes. Given the scope of duties as well as the dramatic increase in the numbers of facilities, the Office of Long Care requires an additional position at a Nursing Services Unit Manager level to ensure that the required functions can be performed in a timely and professional manner.

The OLTC Engineer Supervisor position will assure that long term care facilities are inspected for compliance with life safety code standards. Prior to a long term care facility receiving a license, the facility must be constructed in strict adherence to the applicable building codes. Under federal requirement, once a facility is licensed it must undergo periodic review of the facility's adherence to those codes. As has been demonstrated by the news reports of resident deaths in long term care facilities due to fires resulting from the lack of adherence to those standards, the Office of Long Term Care must ensure that the individuals who perform the inspections are properly trained and certified and perform their functions timely and correctly. In addition, the failure to perform these federally mandated functions could result in penalties being assessed the State of Arkansas, including fines that would come from General Revenue. The dramatic increase in the number of new Assisted Living Facilities, coupled with the condition of older facilities, necessitates that this position be in place to provide for appropriate supervision and training of Life Safety.

One of the requested positions is for a Special Projects Manager (DHS Program Administrator) within the Program and Administrative Support Section of DMS. DMS operates in a dynamic environment with strong interrelationships with other divisions within DHS and other state agencies. DMS officials are also often involved in work groups involving a variety of constituents. Examples of this include the System of Care, Long-Term Care Planning Commission, etc. This position would serve to support the Division's role in these groups by providing financial and other analysis on an as-needed basis. This position would also serve as a liaison to other divisions within DHS and provide analysis and support to a variety of ad hoc projects that are an inherent part of operating in the dynamic world of health policy.

DMS requests a Senior Auditor position to support the Provider Reimbursement unit. This position performs desk reviews of annual and semi-annual cost reports submitted by 225 nursing facilities, 35 ICF's/MR, and 6 Human Development Centers, who receive reimbursement through the Division of Medical Services. Federal law requires that the Medicaid agency provide for periodic audits of Medicaid providers. In addition to the desk reviews mentioned above, onsite reviews of 10 to 15 percent of the nursing facility cost reports are completed each year. It is the auditor's responsibility to ensure that the cost report desk and onsite reviews are completed accurately and in compliance with all State and Federal regulations and requirements. Currently the Provider Reimbursement audit unit which has five Junior Auditor positions only has one Senior Auditor position.

A DMS Business Operations Manager position is requested for the Third Party Liability unit of DMS. This unit is currently staffed by 10-12 employees and generated (health & casualty insurance collections) or saved (cost avoidance) the Medicaid program approximately $42,000,000.00 in SFY08. The activities of the unit are very complicated, often involving complex legal issues and requiring frequent interaction with providers, contractors, and a variety of lawyers and other court officials. This position is requested to provide leadership to this unit and oversee its operations and staff. The goal is to provide leadership that will take the unit to the next level of performance and increase revenue to the division. The objective of this position is to attract someone with a legal and managerial background. Currently, the highest grade working in the unit is a 23.

DMS is requesting two Research Project Analyst positions for its Program Integrity (PI) unit. PI is implementing a new enrollment disclosure process as required by 42CFR Section 455.104-106. This will require PI to research information on disclosure forms which have negative feedback from preliminary research by our contractor. We are also required under the False Claims Act to monitor the compliance of the Act for providers receiving funding of $5 million or greater. These positions will perform these functions and will also cross train with the Data Analyst II and assist in the coordination and reporting of data.

The Utilization Review unit of DMS requests two Nursing Services Unit Manager positions to be responsible for planning, coordination, scheduling and directing utilization management activities. Also, these positions will be responsible for formulating and recommending Medicaid policy changes as a result of identified issues. In the last two years, the job duties of these positions have significantly increased in scope, responsibility, and number. Job duties have increased due to additional educational activities for physicians and providers, brought on by increased demand from these entities as well as increased supervision resulting from additional staff to handle the increased duties and workload As demonstrated, the duties and responsibilities for this position - and the increase in the scope of the units' work and personnel - clearly warrant these additional positions. The additional positions would be able to supervise the performance of each aspect of the unit without being burdened by direct program requirements that are handled by the Registered Nurse Supervisors. Further, the increase in duties assigned to the unit and the additional supervisory duties and requirements would make it difficult, if not impossible, to fill the current positions should they be vacated. The additional positions would alleviate that problem by providing positions that are commensurate with the duties and scope of work.

One of the positions requested is a Computer Support Specialist to fill the role of a Desktop PC Technician. The typical tech to PC ratio is 1:100. DMS has approximately 250 staff members, but has only one PC technician. One extra tech would provide quicker response times and would provide backup coverage when the other technician is away from the office or otherwise engaged. This position is also identified as being the one to facilitate the planned e-Doc work involving the scanning of paper files and creation of retrievable electronic files for DMS, thus freeing up storage/office space and better complying with security rules.

The Medicaid Management Information and Performance section of DMS requests a DHS Program Administrator to assist with program development and oversight responsibilities. As DMS outsources policy clean up, development, and maintenance, it retains the need for contractor oversight as well as program development responsibilities. This position will work closely with DMS and other Department or Division staff to develop new Medicaid programs or enhance, expand, or alter existing programs. The position would also oversee policy development and approval, including APD and legislative processes and have responsibility for maintaining and updating the Medicaid State Plan, required by CMS for federal funding.

The Office of Long Term Care requests a DHS Program Manager position to function as an Abuse/Neglect Unit Manager. Pursuant to federal requirements, states must have a means of making "findings" or administrative determinations as to whether Certified Nurse Aides (CNAs) have committed abuse or neglect of long term care residents, or have misappropriated the property of long term care residents. Under state requirements, these findings are extended to all employees of long term care facilities. Once a determination is made that results in a finding of abuse, neglect or misappropriation, the affected long term care employee is entitled to a hearing on the merits. These functions require the person in the OLTC Abuse/Neglect Unit making the determinations to have an in-depth knowledge and understanding of federal and state laws and regulations concerning abuse, neglect and misappropriation to be able to

understand, evaluate and accord the appropriate weight to give the evidence to make a determination; and to be able to present the case to a hearing officer when the case is appealed. This position receives approximately three thousand (3,000) reports per year that must be evaluated. In 1999, the position handled seventy-four appeals, but has increased to as many as one hundred forty appeals. The number of reports that must be evaluated to determine whether a long term care facility employee committed abuse, neglect or misappropriation, coupled with the increase in appeals demonstrates that an additional, higher graded position is required to fully create and staff an abuse/neglect unit. At present, the current Grade 20, Program Coordinator is perilously close to not being able to conduct all hearings that are being requested. The DHS Program Manager position is necessary to assure that appeals are handled timely and professionally.

The Office of Long Term Care requests a DHS Program Administrator in the Survey and Certification unit. The Office of Long Term Care must assure that all long term care facility surveyors are trained appropriately according to federal Centers for Medicare and Medicaid Services requirements and that surveyors successfully pass the federal certification examination within six to twelve months of employment. Additionally, CMS requires continuous training regarding federal survey standards to all nursing facility and ICF/MR certified surveyors. This position is requested to accomplish this training and to organize a training academy for surveyors. Failure to obtain and maintain an educator possessing federal surveyor trainer qualifications will jeopardize Arkansas' long term care certification.

Request #3 - Transfer of Positions: The Division requests the transfer of one unneeded Document Examiner II position to OCC which has a need for the position. This transfer request is for both appropriation and funds. In addition, the Division requests the transfer of five positions to DMS as follows: Two positions to the newly created Contract Oversight Unit responsible for contract performance monitoring and evaluation of approximately $84 million in contracts, exclusive of the EDS contract (appropriation only). One position to act as a liaison to the DHS Office of Finance and Administration to ensure accurate and timely federal reporting and also to prepare and analyze data for internal reporting of financial data (restoration of appropriation). Two positions to be utilized in the DMS Third Party Liability unit to ensure third parties are identified, medical histories are reviewed, and appropriate parties are notified that monies are due (restoration of appropriation/one position was unbudgeted).

Request #4 - Equipment & Vehicles: DMS requests appropriation only to purchase ten (10) new vehicles each year of the biennium. About half of these vehicles will be replacement vehicles and half would be additional. DMS currently has thirteen vehicles that meet the criteria for replacement, but have not been replaced through the DFA MMV Fund. DMS has concern about the safety of staff in these vehicles and the increased liability to the state. This request also includes monies for the purchase of equipment to implement a document imaging system and fund other equipment needs of the division.

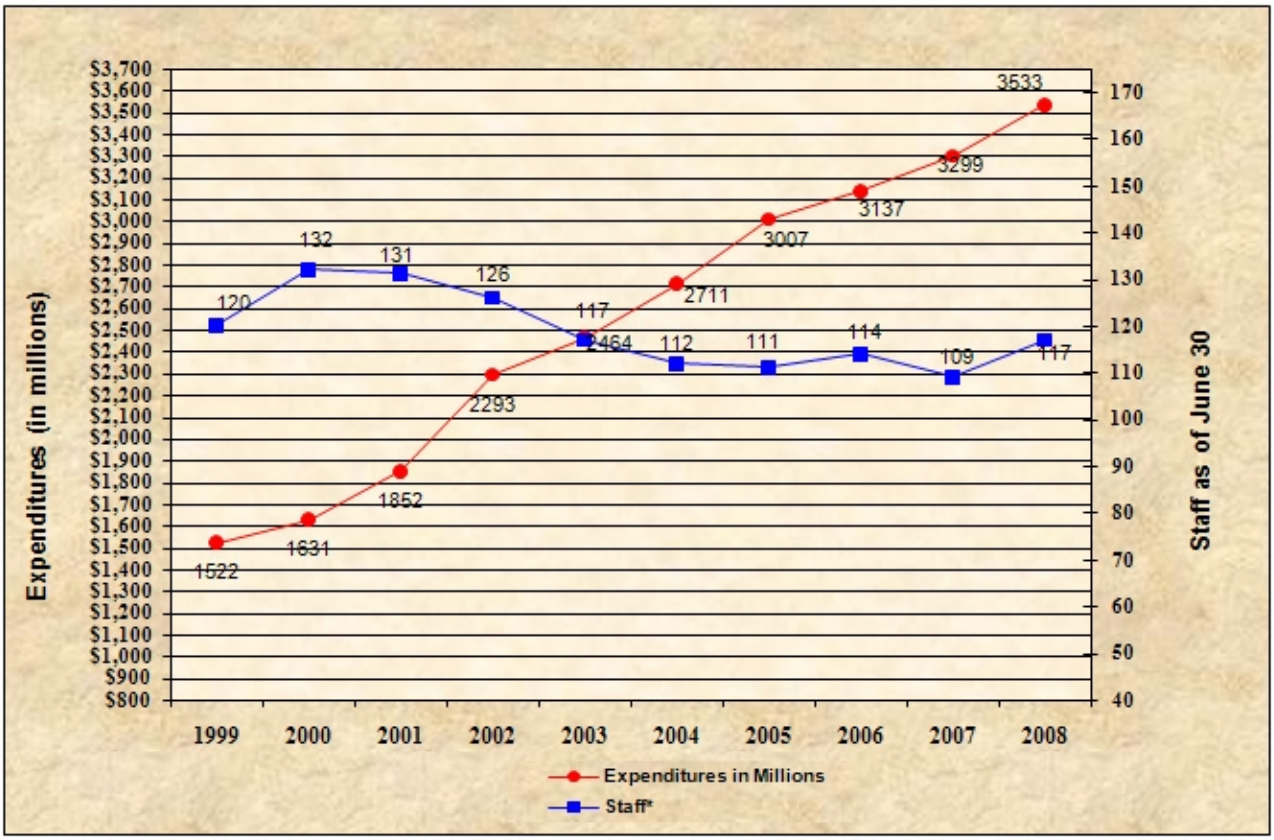
Request #5 - Data Processing: This request is made to ensure funding for anticipated additional costs of data processing services billed through the Department of Information Services. This request is included in the Information Technology Plan for the division. This request is for appropriation only.

Request #6 - Maintenance and Operations: DMS requests appropriation and funds for Maintenance and Operating costs to support staff. These requests include the following:
3% increase in rent of office space for the Donaghey Plaza anticipated for the biennial period. This request will be 50% general revenue and 50% federal funds.
$50,000 for office restructuring to increase usage of existing space. This request will be 50% general revenue and 50% federal funds.

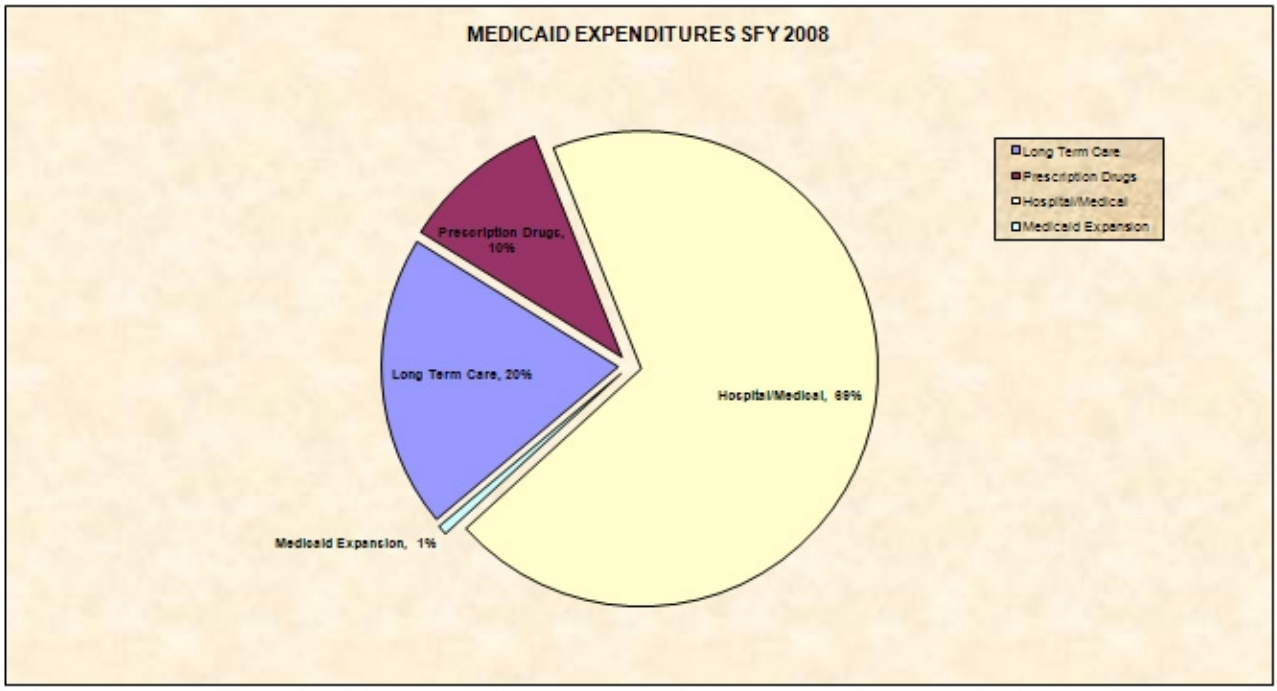
The remaining requests are travel-related and primarily result from required statewide travel to perform such functions as surveying nursing homes for compliance with state and federal guidelines for Medicaid and Medicare certification, performing on-site financial reviews of cost reports for nursing homes, and performing Program Integrity reviews. These costs are anticipated to increase due to the cost of gasoline and other travel-related cost increases:
25% increase in fuel purchases for state vehicles for each year of the biennium
20% increase in mileage reimbursement for each year of the biennium
15% increase in meals and lodging reimbursement for each year of the biennium

These travel expenses are requested to be funded at 25% general revenue and 75% federal funds.

MEDICAID STAFFING COMPARED TO EXPENDITURES



Staff above reflect DMS filled positions excluding OLTC staff.



Audit Findings

DIVISION OF LEGISLATIVE AUDIT
AUDIT OF :
DEPARTMENT OF HEALTH AND HUMAN SERVICES

FOR THE YEAR ENDED JUNE 30, 2006

Findings	Recommendations
Audit findings are reported under the DHS-Director's Office/Office of Chief Counsel.	.

Employment Summary

	Male	Female	Total	%
White Employees	35	157	192	72 %
Black Employees	6	65	71	27 %
Other Racial Minorities	2	0	2	1 %
Total Minorities			73	28 %
Total Employees			265	100 %

Publications

A.C.A. 25-1-204

Name	Statutory Authorization	Required for		# of Copies	Reason(s) for Continued Publication and Distribution
		Governor	General Assembly		
None	N/A	N	N	0	N/A

Department Appropriation Summary

		Historical Data						Agency Request and Executive Recommendation											
		2007-2008		2008-2009		2008-2009		2009-2010						2010-2011					
Appropriation		Actual	Pos	Budget	Pos	Authorized	Pos	Base Level	Pos	Agency	Pos	Executive	Pos	Base Level	Pos	Agency	Pos	Executive	Pos
36E	DMS-Alcohol Drug Prevention Waiver	0	0	0	0	1,250,000	0	0	0	20,000,000	0	0	0	0	0	30,000,000	0	0	0
4KS	Nursing Home Quality	289,491	0	1,500,000	0	1,500,000	0	1,500,000	0	1,500,000	0	1,500,000	0	1,500,000	0	1,500,000	0	1,500,000	0
642	DHS Medicaid Expansion Program	103,955	2	117,264	2	103,342	2	122,793	2	122,793	2	122,793	2	125,069	2	125,069	2	125,069	2
648	Medicaid Exp-Prescription Drugs	2,725,825	0	2,845,491	0	6,080,000	0	2,845,491	0	6,541,937	0	6,541,937	0	2,845,491	0	27,471,014	0	12,845,491	0
648	Medicaid Exp-Hospital & Medical Services	20,686,379	0	31,164,332	0	60,556,174	0	31,164,332	0	74,479,346	0	74,479,346	0	31,164,332	0	211,238,137	0	131,164,332	0
876	Nursing Home Closure Costs	0	0	50,000	0	50,000	0	50,000	0	50,000	0	50,000	0	50,000	0	50,000	0	50,000	0
878	Long Term Care Facility Receivership	0	0	100,000	0	100,000	0	100,000	0	100,000	0	100,000	0	100,000	0	100,000	0	100,000	0
896	Division of Medical Services	19,678,852	284	21,821,300	300	21,576,581	302	22,653,854	300	25,298,205	334	24,169,088	320	22,985,808	300	25,979,826	334	24,521,810	320
897	ARKIDS B Program	95,236,267	0	111,561,360	0	116,703,139	0	111,561,360	0	137,495,216	0	137,495,216	0	111,561,360	0	157,738,482	0	157,738,482	0
897	Hospital & Medical Services	2,408,153,725	0	2,634,264,168	0	2,897,206,587	0	2,634,264,168	0	2,999,642,523	0	2,999,642,523	0	2,634,264,168	0	3,224,177,831	0	3,224,177,831	0
897	Prescription Drugs	340,641,183	0	385,263,250	0	440,746,167	0	385,263,250	0	439,819,588	0	439,819,588	0	385,263,250	0	475,423,172	0	475,423,172	0
897	Private Nursing Home Care	534,359,123	0	548,872,748	0	627,094,449	0	548,872,748	0	592,888,856	0	592,888,856	0	548,872,748	0	618,038,129	0	618,038,129	0
898	Child & Family Life Inst	0	0	2,100,000	0	2,100,000	0	2,100,000	0	2,100,000	0	2,100,000	0	2,100,000	0	2,100,000	0	2,100,000	0
898	Infant Infirmary	19,544,582	0	19,971,685	0	21,338,175	0	19,971,685	0	22,130,751	0	22,130,751	0	19,971,685	0	22,931,565	0	22,931,565	0
898	Public Nursing Home Care	162,058,661	0	166,564,251	0	170,497,211	0	166,564,251	0	184,273,474	0	184,273,474	0	166,564,251	0	193,145,084	0	193,145,084	0
Total		3,603,478,043	286	3,926,195,849	302	4,366,901,825	304	3,927,033,932	302	4,506,442,689	336	4,485,313,572	322	3,927,368,162	302	4,990,018,309	336	4,863,860,965	322
Funding Sources			%		%				%		%		%		%		%		%
General Revenue	4000010	675,208,553	18.7	714,396,942	18.2			714,581,739	18.2	807,796,426	18.9	773,091,475	18.6	714,655,422	18.2	919,195,601	20.0	885,845,545	20.0
Federal Revenue	4000020	2,596,894,010	72.1	2,817,473,636	71.8			2,817,993,423	71.8	3,063,657,595	71.8	2,962,680,511	71.4	2,818,200,706	71.8	3,299,942,549	71.9	3,157,814,084	71.4
Trust Fund	4000050	69,504,661	1.9	157,368,800	4.0			157,368,800	4.0	111,777,789	2.6	129,639,582	3.1	157,368,800	4.0	50,250,000	1.1	50,250,000	1.1
Drug Rebates	4000200	29,765,477	0.8	27,160,000	0.7			27,160,000	0.7	27,160,000	0.6	29,512,056	0.7	27,160,000	0.7	27,160,000	0.6	31,937,947	0.7
Insurance Premium Tax	4000298	6,923,958	0.2	0	0.0			0	0.0	5,124,419	0.1	5,124,419	0.1	0	0.0	0	0.0	0	0.0
Miscellaneous Transfers	4000355	115,000	0.0	115,000	0.0			115,000	0.0	115,000	0.0	115,000	0.0	115,000	0.0	115,000	0.0	115,000	0.0
Quality Assurance Fee	4000395	64,756,303	1.8	56,544,651	1.4			56,544,651	1.4	60,589,214	1.4	60,589,214	1.5	56,544,651	1.4	62,947,653	1.4	62,947,653	1.4
Reimbursement	4000425	0	0.0	100,000	0.0			100,000	0.0	100,000	0.0	100,000	0.0	100,000	0.0	100,000	0.0	100,000	0.0
Tobacco Settlement	4000495	8,025,170	0.2	10,491,607	0.3			10,494,371	0.3	19,216,727	0.5	19,216,727	0.5	10,495,509	0.3	60,927,976	1.3	60,926,977	1.4
Various Program Support	4000730	152,284,911	4.2	142,545,213	3.6			142,675,948	3.6	169,109,506	4.0	168,940,372	4.1	142,728,074	3.6	170,966,937	3.7	170,793,250	3.9
Total Funds		3,603,478,043	100.0	3,926,195,849	100.0			3,927,033,932	100.0	4,264,646,676	100.0	4,149,009,356	100.0	3,927,368,162	100.0	4,591,605,716	100.0	4,420,730,456	100.0
Excess Appropriation/(Funding)		0		0				0		241,796,013		336,304,216		0		398,412,593		443,130,509	
Grand Total		3,603,478,043		3,926,195,849				3,927,033,932		4,506,442,689		4,485,313,572		3,927,368,162		4,990,018,309		4,863,860,965	

Agency Position Usage Report

FY2006 - 2007						FY2007 - 2008						FY2008 - 2009					
Authorized in Act	Budgeted			Unbudgeted	% of Authorized Unused	Authorized in Act	Budgeted			Unbudgeted	% of Authorized Unused	Authorized in Act	Budgeted			Unbudgeted	% of Authorized Unused
	Filled	Unfilled	Total	Total			Filled	Unfilled	Total	Total			Filled	Unfilled	Total	Total	
292	257	37	294	-2	11.99 %	305	257	43	300	5	15.74 %	305	265	37	302	3	13.11 %

Authorized in Act may differ from Authorized reflected on the Appropriation Summary due to Reallocation of Resources (Act 1279 of 2007 section 18(d)), Miscellaneous Federal Grant (A.C.A. 19-7 -501 et seq.) and POOL positions (A.C.A. 21-5-214(5)(A)).

Analysis of Budget Request

Appropriation: 36E - DMS-Alcohol Drug Prevention Waiver

Funding Sources: PWF - Grants Paying

The Alcohol and Drug Abuse Prevention appropriation was created by Act 1236 of 2007 section 8 to allow for future Medicaid waivers for substance abuse services. The goal was to utilize the appropriation in support of an affordable substance abuse benefit package for both adult and adolescent services. However, this appropriation was not funded in the current 2007-2009 biennium.

The Agency Change Level request for this appropriation is $20,000,000 in FY2010 and $30,000,000 in FY2011 in unfunded appropriation.

The Executive Recommendation does not provide for continuing this appropriation into the 2009-2011 biennium.

Appropriation Summary

Appropriation: 36E - DMS-Alcohol Drug Prevention Waiver
Funding Sources: PWF - Grants Paying

	Historical Data			Agency Request and Executive Recommendation					
	2007-2008	2008-2009	2008-2009	2009-2010			2010-2011		
Commitment Item	Actual	Budget	Authorized	Base Level	Agency	Executive	Base Level	Agency	Executive
Grants and Aid 5100004	0	0	1,250,000	0	20,000,000	0	0	30,000,000	0
Total	0	0	1,250,000	0	20,000,000	0	0	30,000,000	0

The Executive Recommendation does not provide for continuing this appropriation into the 2009-2011 biennium.

Change Level by Appropriation

Appropriation: 36E - DMS-Alcohol Drug Prevention Waiver
Funding Sources: PWF - Grants Paying

Agency Request

Change Level		2009-2010	Pos	Cumulative	% of BL	2010-2011	Pos	Cumulative	% of BL
C05	Unfunded Appropriation	20,000,000	0	20,000,000	100.0	30,000,000	0	30,000,000	100.0

Executive Recommendation

Change Level		2009-2010	Pos	Cumulative	% of BL	2010-2011	Pos	Cumulative	% of BL
C05	Unfunded Appropriation	0	0	0	0.0	0	0	0	0.0

Justification	
C05	DMS, in conjunction with the DHS Division of Behavioral Health Services, continues to develop a program to address substance abuse by Medicaid recipients. It is anticipated that the plan development will be complete during SFY09 and the program could become operational during SFY09 or SFY10, assuming a funding source identified. This request is for appropriation only.

Analysis of Budget Request

Appropriation: 4KS - Nursing Home Quality

Funding Sources: TLT - Long Term Care Trust Fund

The Nursing Home Quality of Life appropriation provides for two (2) new approaches to nursing home care. These approaches are as follows:

- Eden Alternative approach
- Greenhouse Project approach

Both the Eden Alternative and the Greenhouse Project are attempts to create a new model for long term care facilities that emphasizes a more home-like environment over traditional institutional settings. Evidence indicates that residents of facilities operated under either approach perform significantly better than residents of traditional long term care facilities.

The Eden Alternative approach allows residents choices in their everyday living that are traditionally dictated to the resident by the facility. These choices include, among others, the choice of meals (what is served and when) and the care routine. It also utilizes permanent assignments of caregivers to create familiarity and trust.

The Greenhouse Project approach utilizes Eden Alternative principals, but with a strikingly different physical plant. Greenhouse Project facilities are constructed on the premise that the elders will thrive in a nursing home if it's built to resemble living in one's own house. This means that facilities are built in small, separate units with each unit housing its own kitchen and laundry, and with no more than ten (10) beds - all of which are private rooms. This gives residents more privacy and more control over their lives. Additionally, Greenhouse Project facilities stress resident participation. This is performed in a number of ways. For example:

1. Residents are encouraged to participate in meal planning and preparation. The facility is constructed so that residents can both gather around the kitchen and observe or participate in meal preparation. This gives them meaningful experiences and allows a time for interaction between the elders and the staff.

2. Residents are encouraged to use their skills and interests for the benefit of other residents. An emphasis is placed on what residents can do rather than just their physical ailments and disabilities.

3. The use of "universal" workers. Under this concept, each unit or house is staffed by the same CNAs and nurses who not only perform traditional care, but also perform laundry and meal preparation. This aids in worker retention by varying the duties of the workers. It also allows the workers to better learn the desires and abilities of residents, and to encourage their participation in various aspects of their own care, as if they were home. The staffs are assigned only to one particular unit or house allowing the elders to become better acquainted with their caregivers.

Facilities that adopt the Eden Alternative/Greenhouse Project model are operated at the same cost as traditional facilities. Once a facility has adopted the model, there is no additional cost, making the on-going project cost-neutral. The cost of building a facility to meet Greenhouse Project requirements are approximately the same as for a traditional facility.

There are, however, one-time or initial startup costs for training and physical plant changes for existing facilities. In order to encourage the adoption of the Eden Alternative/Greenhouse Project model, the U. S. Department of Health and Human Services' proposed that the Arkansas Department of Human Services utilize some of the funding collected that is associated with the imposition of civil penalties levied on long-term care facilities in the Long-Term Care Trust Fund.

As the licensing and regulatory agency, the Office of Long Term Care believes that encouraging the adoption of these models benefits the State of Arkansas in a number of ways. First, the models provide a higher level of care for residents, at little or no cost to the State. Second, the adoption of these models results in an inarguable increase in the quality of life for residents. Third, adoption of this proposal places Arkansas in a leadership role in remaking the long-term care model, and demonstrates the State's commitment to seeking improvement in long-term care.

Funding for this program is derived from other revenues which are indicated as the Long-Term Care Trust Fund. This fund consist of all moneys and interest received from the imposition of civil penalties levied by the state on long-term care facilities found to be out of compliance with the requirements of federal or state law or regulations. Under this appropriation, funds are targeted for Eden Alternative/Greenhouse Project related grants to facilities. The funding would be provided by grants for:

- Eden Alternative Associate Training to providers; and
- Greenhouse Project development for new construction of facilities.

The Agency Base Level and total request for this appropriation is $1,500,000 each year of the biennium.

The Executive Recommendation provides for the Agency Request.

Appropriation Summary

Appropriation: 4KS - Nursing Home Quality
Funding Sources: TLT - Long Term Care Trust Fund

	Historical Data			Agency Request and Executive Recommendation					
	2007-2008	2008-2009	2008-2009	2009-2010			2010-2011		
Commitment Item	**Actual**	**Budget**	**Authorized**	**Base Level**	**Agency**	**Executive**	**Base Level**	**Agency**	**Executive**
Grants and Aid 5100004	289,491	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000
Total	289,491	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000
Funding Sources									
Trust Fund 4000050	289,491	1,500,000		1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000
Total Funding	289,491	1,500,000		1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000
Excess Appropriation/(Funding)	0	0		0	0	0	0	0	0
Grand Total	289,491	1,500,000		1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000

Analysis of Budget Request

Appropriation: 642 - DHS Medicaid Expansion Program

Funding Sources: PTA - Medicaid Expansion Program Account

The Medicaid Expansion Program provides appropriation for the administration component of the Medicaid Expansion Program established by Initiated Act 1 of 2000 for the Division of Medical Services. The expanded Medicaid programs are as follows:

1. Expansion of Medicaid coverage and benefits to pregnant women with incomes up to 200 percent of the Federal Poverty Level (approved for implementation November 1, 2001);

2. Expansion of inpatient and outpatient hospital reimbursements and benefits to adults age 19 to 64 to reduce coinsurance payment from 22 percent to 10 percent of the cost of the first Medicaid covered day of each admission and cover additional medically necessary days in the hospital from 20 days up to 24 allowed days per State Fiscal Year (approved for implementation November 1, 2001);

3. Expansion of non-institutional coverage and benefits to adults aged 65 and over. Referred to as ARSeniors, this program extends full Medicaid benefits to adults age 65 and over who have been identified as Qualified Medicare Beneficiaries (QMB) and meet specific income limits (approved for implementation October 1, 2002); and

4. Creation of a limited benefit package to assist adults age 19 to 64 who are uninsured low-wage employees of small Arkansas businesses. This program, ARHealthNetworks, was approved by the Centers for Medicare and Medicaid Services (CMS) as a Section 1115 demonstration waiver though the Health Insurance Flexibility and Accountability (HIFA) office of the Secretary of the federal Department of Health and Human Services. Enrollment in the program began December 20, 2006 with coverage effective January 2007.

Funding for this appropriation is derived from tobacco settlement funds and federal revenue provided through the U. S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.

Base Level salaries for classified positions reflect the recommendations of the Pay Plan Study. A 2.3% Cost of Living Allowance is reflected in the second year of the biennium. The Base Level request for Regular Salaries may include board member Stipend payments and Career Service payments for eligible employees. Personal Services Matching includes a $75 increase in the monthly contribution for State employee's health insurance for a total State match per budgeted employee of $425.

The Agency Base Level request for this appropriation is $122,793 in FY2010 and $125,069 in FY2011 with 2 budgeted Base Level positions. There is no Change Level request.

The Executive Recommendation provides for the Agency Request.

Appropriation Summary

Appropriation: 642 - DHS Medicaid Expansion Program
Funding Sources: PTA - Medicaid Expansion Program Account

		Historical Data			Agency Request and Executive Recommendation					
		2007-2008	2008-2009	2008-2009	2009-2010			2010-2011		
Commitment Item		**Actual**	**Budget**	**Authorized**	**Base Level**	**Agency**	**Executive**	**Base Level**	**Agency**	**Executive**
Regular Salaries	5010000	74,025	76,167	63,896	79,293	79,293	79,293	81,200	81,200	81,200
#Positions		**2**	**2**	**2**	**2**	**2**	**2**	**2**	**2**	**2**
Personal Services Matching	5010003	24,067	23,124	21,473	25,527	25,527	25,527	25,896	25,896	25,896
Operating Expenses	5020002	5,863	15,973	15,973	15,973	15,973	15,973	15,973	15,973	15,973
Conference & Travel Expenses	5050009	0	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000
Professional Fees	5060010	0	0	0	0	0	0	0	0	0
Data Processing	5090012	0	0	0	0	0	0	0	0	0
Capital Outlay	5120011	0	0	0	0	0	0	0	0	0
Total		103,955	117,264	103,342	122,793	122,793	122,793	125,069	125,069	125,069
Funding Sources										
Federal Revenue	4000020	51,978	58,632		61,397	61,397	61,397	62,535	62,535	62,535
Tobacco Settlement	4000495	51,977	58,632		61,396	61,396	61,396	62,534	62,534	62,534
Total Funding		103,955	117,264		122,793	122,793	122,793	125,069	125,069	125,069
Excess Appropriation/(Funding)		0	0		0	0	0	0	0	0
Grand Total		103,955	117,264		122,793	122,793	122,793	125,069	125,069	125,069

Tobacco Settlement Funds do not carry forward into the new biennium unless criteria is met as prescribed in Initiated Act 1 of 2000.
FY2009 Appropriation Carry Forward Amount is $12,110.26.

CARRY FORWARD OF ANY UNEXPENDED BALANCE OF APPROPRIATION AND/OR FUNDING FROM FISCAL YEAR 2008 TO FISCAL YEAR 2009

Agency: Human Services Department-MEDICAL SERVICES

Program: DHS Medicaid Expansion Program

Act #: 1284 of 2007 Section(s) #: 4 & 6

Estimated Carry Forward Amount $ 11,600.00 Appropriation [X] Funds [ ]

Funding Source: Tobacco Settlement

Accounting Information:

Business Area: 0710 Funds Center: 642 Fund: PTA Functional Area: HHS

Line Item	Commitment Item	Estimated Carry Forward Amount	Actual Carry Forward Amount
Operating Expenses	5020002	9,600.00	10,110.26
Conference & Travel Expenses	5050009	2,000.00	2,000.00
Total		$ 11,600.00	$ 12,110.26

Current law requires a written statement be submitted to the DFA Office of Budget stating the reason(s) to carry forward appropriation and/or funding for a program or a specific line item within a program from the first fiscal year of the biennium to the second fiscal year of the biennium.

Justification for carry forward of unexpended balance of appropriation and/or funding:

To ensure the agency has adequate appropriation available to meet any changes to the Medicaid Expansion Program.

Actual Funding Carry Forward Amount $ 0.00

Current status of carry forward appropriation/funding:

Currently, Carry Forward appropriation is blocked. However, the appropriation is available if Medical Expansion Program changes require additional appropriation.

John Selig
Director

08-08-2008
Date

Analysis of Budget Request

Appropriation: 648 - Tobacco-Delay Draw-Paying

Funding Sources: PTD - Medicaid Expansion Program Account

Medicaid Expansion Program - Prescription Drugs referenced on page 263

The Medicaid Expansion Program - Prescription Drugs provides appropriation for the prescription drugs component of the Medicaid Expansion Program established by Initiated Act 1 of 2000. This appropriation is funded through tobacco settlement funds and federal revenue provided through the U. S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.

The Agency Base Level request for this appropriation is $2,845,491 each year of the biennium.

The Agency Change Level request for this appropriation is $3,696,446 in FY2010 and $24,625,523 in FY2011 which includes adjustments for the FMAP reduction. The following delineates the agency request:

- $246,420 in FY2010 and $500,575 in FY2011 for growth.
- $1,502,261 in FY2010 and $1,756,594 in FY2011 to reclassify the Breast and Cervical Cancer program to the Medicaid Expansion program.
- $947,765 in FY2010 and $2,288,354 in FY2011 for program expansion.
- $1,000,000 in FY2010 and $20,080,000 in FY2011 in unfunded appropriation to allow the Division the capability to respond to federal and/or state mandates.

The Executive Recommendation provides for Base Level. Additionally, $3,696,446 in FY2010 and $10,000,000 in FY2011 in additional appropriation is provided for to allow for growth and unfunded appropriation which allows the Division the capability to respond to federal and/or state mandates.

Medicaid Expansion Program - Hospital and Medical Services referenced on page 264

The Medicaid Expansion Program - Hospital and Medical Services provides appropriation for the Hospital/Medical component of the Medicaid Expansion Program established by Initiated Act 1 of 2000. This appropriation is funded through tobacco settlement funds and federal revenue provided through the U. S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.

The Agency Base Level request for this appropriation is $31,164,332 each year of the biennium.

The Agency Change Level request for this appropriation is $43,315,014 in FY2010 and $180,073,805 in FY2011 which includes adjustments for the FMAP reduction. The following delineates the agency request:

- $2,273,484 in FY2010 and $4,843,778 in FY2011 for growth.
- $10,970,807 in FY2010 and $11,738,763 in FY2011 to reclassify the Breast and Cervical Cancer program to the Medicaid Expansion program.

- $18,070,723 in FY2010 and $42,991,264 in FY2011 for program expansion.
- $12,000,000 in FY2010 and $120,500,000 in FY2011 in unfunded appropriation to allow the Division the capability to respond to federal and/or state mandates.

The Executive Recommendation provides for Base Level. Additionally, $43,315,014 in FY2010 and $100,000,000 in FY2011 in additional appropriation is provided for to allow for growth and unfunded appropriation which allows the Division the capability to respond to federal and/or state mandates.

Appropriation Summary

Appropriation: 648 - Tobacco-Delay Draw-Paying / Medicaid Expansion Program - Prescription Drugs
Funding Sources: PTD - Medicaid Expansion Program Account

		Historical Data			Agency Request and Executive Recommendation					
		2007-2008	2008-2009	2008-2009	2009-2010			2010-2011		
Commitment Item		Actual	Budget	Authorized	Base Level	Agency	Executive	Base Level	Agency	Executive
Medicaid Exp-Prescrip Drugs	5100004	2,725,825	2,845,491	6,080,000	2,845,491	6,541,937	6,541,937	2,845,491	27,471,014	12,845,491
Total		2,725,825	2,845,491	6,080,000	2,845,491	6,541,937	6,541,937	2,845,491	27,471,014	12,845,491
Funding Sources										
Federal Revenue	4000020	319,276	375,408		375,408	2,155,450	407,862	375,408	3,295,028	441,025
Tobacco Settlement	4000495	2,406,549	2,470,083		2,470,083	3,386,487	2,684,049	2,470,083	4,095,986	2,905,041
Total Funding		2,725,825	2,845,491		2,845,491	5,541,937	3,091,911	2,845,491	7,391,014	3,346,066
Excess Appropriation/(Funding)		0	0		0	1,000,000	3,450,026	0	20,080,000	9,499,425
Grand Total		2,725,825	2,845,491		2,845,491	6,541,937	6,541,937	2,845,491	27,471,014	12,845,491

Tobacco Settlement Funds do not carry forward into the new biennium unless criteria is met as prescribed in Initiated Act 1 of 2000.

FY2009 Appropriation Carry Forward Amount is $3,274,175.41.

Appropriation Summary

Appropriation: 648 - Tobacco-Delay Draw-Paying / Medicaid Expansion Program - Hospital and Medical Services

Funding Sources: PTD - Medicaid Expansion Program Account

		Historical Data			Agency Request and Executive Recommendation					
		2007-2008	2008-2009	2008-2009	2009-2010			2010-2011		
Commitment Item		Actual	Budget	Authorized	Base Level	Agency	Executive	Base Level	Agency	Executive
Medicaid Exp-Hosp/Med Srvs	5100004	20,686,379	31,164,332	60,556,174	31,164,332	74,479,346	74,479,346	31,164,332	211,238,137	131,164,332
Total		20,686,379	31,164,332	60,556,174	31,164,332	74,479,346	74,479,346	31,164,332	211,238,137	131,164,332
Funding Sources										
Federal Revenue	4000020	15,119,735	23,201,440		23,201,440	46,710,502	24,889,990	23,201,440	68,188,182	26,789,459
Tobacco Settlement	4000495	5,566,644	7,962,892		7,962,892	15,768,844	8,547,826	7,962,892	22,549,955	9,218,651
Total Funding		20,686,379	31,164,332		31,164,332	62,479,346	33,437,816	31,164,332	90,738,137	36,008,110
Excess Appropriation/(Funding)		0	0		0	12,000,000	41,041,530	0	120,500,000	95,156,222
Grand Total		20,686,379	31,164,332		31,164,332	74,479,346	74,479,346	31,164,332	211,238,137	131,164,332

Tobacco Settlement Funds do not carry forward into the new biennium unless criteria is met as prescribed in Initiated Act 1 of 2000.

FY2009 Appropriation Carry Forward Amount is $27,604,955.59

Change Level by Appropriation

Appropriation: 648 - Tobacco-Delay Draw-Paying / Medicaid Expansion Program - Prescription Drugs

Funding Sources: PTD - Medicaid Expansion Program Account

Agency Request

Change Level		2009-2010	Pos	Cumulative	% of BL	2010-2011	Pos	Cumulative	% of BL
BL	**Base Level**	**2,845,491**	**0**	**2,845,491**	**100.0**	**2,845,491**	**0**	**2,845,491**	**100.0**
C01	Existing Program	1,194,185	0	4,039,676	142.0	2,788,929	0	5,634,420	198.0
C05	Unfunded Appropriation	1,000,000	0	5,039,676	177.1	20,080,000	0	25,714,420	903.7
C07	Agency Transfer	1,502,261	0	6,541,937	229.9	1,756,594	0	27,471,014	965.4

Executive Recommendation

Change Level		2009-2010	Pos	Cumulative	% of BL	2010-2011	Pos	Cumulative	% of BL
BL	**Base Level**	**2,845,491**	**0**	**2,845,491**	**100.0**	**2,845,491**	**0**	**2,845,491**	**100.0**
C01	Existing Program	1,194,185	0	4,039,676	142.0	2,788,929	0	5,634,420	198.0
C05	Unfunded Appropriation	2,502,261	0	6,541,937	229.9	7,211,071	0	12,845,491	451.4
C07	Agency Transfer	0	0	6,541,937	229.9	0	0	12,845,491	451.4

Justification	
C01	Growth - The growth in the Medicaid Program is influenced by a number of factors that extend beyond normal inflation and which are generally unaffected by DMS policy decisions. Examples are, Medicaid eligible population increases as a result of a declining economy, the number of eligibles accessing services increases, the number and type of services utilized changes, reimbursement for services that use a cost based methodology increase. FMAP Rate Adjustment – This request results from a recent change in the Federal Medical Assistance Percentage of 0.01% for SFY 2010 and 0.07% for SFY 2011. This decrease in federal matching affects all Medicaid programs. Program Expansion - The increase in the requested growth rates for Medicaid Expansion programs is primarily attributable to the planned growth in the ARHealthNetworks program. This program has had several changes related to eligibility and program cost that will likely cause the program to grow in the future. In addition, the upcoming Health Risk Assessment and Feasibility Study will provide management with information to further grow the program. The aggressive growth planned for ARHealthNetworks in both the Hospital/Medical and Prescription Drug categories, drives this biennial budget request.
C05	Arkansas' Medicaid program often undergoes changes that require additional appropriation to be able to respond to federal and state mandates to the extent funds are available. This request is for appropriation only.
C07	This request is to reclassify the Breast and Cervical Cancer program administered by the Arkansas Department of Health from 'regular' Medicaid to Medicaid Expansion. DMS management believes that this program is an extension of services to the 19-64 year old population and therefore, is more appropriately classified as an Expansion program.

Change Level by Appropriation

Appropriation: 648 - Tobacco-Delay Draw-Paying / Medicaid Expansion Program - Hospital and Medical Services

Funding Sources: PTD - Medicaid Expansion Program Account

Agency Request

Change Level		2009-2010	Pos	Cumulative	% of BL	2010-2011	Pos	Cumulative	% of BL
BL	**Base Level**	**31,164,332**	**0**	**31,164,332**	**100.0**	**31,164,332**	**0**	**31,164,332**	**100.0**
C01	Existing Program	20,344,207	0	51,508,539	165.3	47,835,042	0	78,999,374	253.5
C05	Unfunded Appropriation	12,000,000	0	63,508,539	203.8	120,500,000	0	199,499,374	640.2
C07	Agency Transfer	10,970,807	0	74,479,346	239.0	11,738,763	0	211,238,137	677.8

Executive Recommendation

Change Level		2009-2010	Pos	Cumulative	% of BL	2010-2011	Pos	Cumulative	% of BL
BL	**Base Level**	**31,164,332**	**0**	**31,164,332**	**100.0**	**31,164,332**	**0**	**31,164,332**	**100.0**
C01	Existing Program	20,344,207	0	51,508,539	165.3	47,835,042	0	78,999,374	253.5
C05	Unfunded Appropriation	22,970,807	0	74,479,346	239.0	52,164,958	0	131,164,332	420.9
C07	Agency Transfer	0	0	74,479,346	239.0	0	0	131,164,332	420.9

Justification	
C01	The growth in the Medicaid Program is influenced by a number of factors that extend beyond normal inflation and which are generally unaffected by DMS policy decisions. Examples are, Medicaid eligible population increases as a result of a declining economy, the number of eligibles accessing services increases, the number and type of services utilized changes, reimbursement for services that use a cost based methodology increase. FMAP Rate Adjustment - This request results from a recent change in the Federal Medical Assistance Percentage of 0.01% for SFY 2010 and 0.07% for SFY 2011. This decrease in federal matching affects all Medicaid programs. Program Expansion - The increase in the requested growth rates for Medicaid Expansion programs is primarily attributable to the planned growth in the ARHealthNetworks program. This program has had several changes related to eligibility and program cost that will likely cause the program to grow in the future. In addition, the upcoming Health Risk Assessment and Feasibility Study will provide management with information to further grow the program. The aggressive growth planned for ARHealthNetworks in both the Hospital/Medical and Prescription Drug categories, drives this biennial budget request.
C05	Arkansas' Medicaid program often undergoes changes that require additional appropriation to be able to respond to federal and state mandates to the extent funds are available. This request is for appropriation only.
C07	This request is to reclassify the Breast and Cervical Cancer program administered by the Arkansas Department of Health from 'regular' Medicaid to Medicaid Expansion. DMS management believes that this program is an extension of services to the 19-64 year old population and therefore, is more appropriately classified as an Expansion program.

CARRY FORWARD OF ANY UNEXPENDED BALANCE OF APPROPRIATION AND/OR FUNDING FROM FISCAL YEAR 2008 TO FISCAL YEAR 2009

Agency: Human Services Department-MEDICAL SERVICES

Program: Tobacco-Delay Draw-Paying

Act #: 1284 of 2007 Section(s) #: 5 & 6

Estimated Carry Forward Amount $ 31,182,907.00 Appropriation [X] Funds [ ]

Funding Source: Tobacco Settlement

Accounting Information:

Business Area: 0710 Funds Center: 648 Fund: PTD Functional Area: HHS

Line Item	Commitment Item	Estimated Carry Forward Amount	Actual Carry Forward Amount
Grants and Aid	5100004	31,182,907.00	30,879,131.00
Total		$ 31,182,907.00	$ 30,879,131.00

Current law requires a written statement be submitted to the DFA Office of Budget stating the reason(s) to carry forward appropriation and/or funding for a program or a specific line item within a program from the first fiscal year of the biennium to the second fiscal year of the biennium.

Justification for carry forward of unexpended balance of appropriation and/or funding:

To ensure the agency has adequate appropriation available to meet any changes to the Medicaid Expansion Program.

Actual Funding Carry Forward Amount $ 0.00

Current status of carry forward appropriation/funding:

Currently, Carry Forward appropriation is blocked. However, the appropriation is available if Medical Expansion Program changes require additional appropriation.

John Selig
Director

08-08-2008
Date

Analysis of Budget Request

Appropriation: 876 - Nursing Home Closure Costs

Funding Sources: TLT - Long Term Care Trust Fund

Nursing Home Closure Costs appropriation is available in the event the Division of Medical Services finds it necessary to take over the operation of a nursing home in an emergency situation. The purpose of any take-over would be for the protection of the health or property of residents of long-term care facilities, including, but not limited to, the payment for the costs of relocation of residents to other facilities, maintenance and operation of a facility pending correction of deficiencies or closure, and reimbursement of residents for personal funds lost.

Funding for this appropriation is derived from other revenues which are indicated as the Long-Term Care Trust Fund. This fund consist of all moneys and interest received from the imposition of civil penalties levied by the state on long-term care facilities found to be out of compliance with the requirements of federal or state law or regulations.

The Agency Base Level and total request for this appropriation is $50,000 each year of the biennium.

The Executive Recommendation provides for the Agency Request.

Appropriation Summary

Appropriation: 876 - Nursing Home Closure Costs
Funding Sources: TLT - Long Term Care Trust Fund

	Historical Data			Agency Request and Executive Recommendation					
	2007-2008	2008-2009	2008-2009	2009-2010			2010-2011		
Commitment Item	**Actual**	**Budget**	**Authorized**	**Base Level**	**Agency**	**Executive**	**Base Level**	**Agency**	**Executive**
Expenses 5900046	0	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000
Total	0	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000
Funding Sources									
Trust Fund 4000050	0	50,000		50,000	50,000	50,000	50,000	50,000	50,000
Total Funding	0	50,000		50,000	50,000	50,000	50,000	50,000	50,000
Excess Appropriation/(Funding)	0	0		0	0	0	0	0	0
Grand Total	0	50,000		50,000	50,000	50,000	50,000	50,000	50,000

Analysis of Budget Request

Appropriation: 878 - Long Term Care Facility Receivership

Funding Sources: DLT - Long Term Care Facility Receivership Fund

As authorized by Arkansas Code Annotated §20-10-901 et seq., the Long Term Care Facility Receivership appropriation is used to pay the expenses of receivers appointed, if a nursing home is placed in receivership. Payment may not be made from this account until a court of law has found that a nursing home has insufficient funds to pay a receiver after all other operating expenses of the facility have been paid. The funding for this appropriation is from reimbursement for services provided by the agency.

The Agency Base Level and total request for this appropriation is $100,000 each year of the biennium.

The Executive Recommendation provides for the Agency Request.

Appropriation Summary

Appropriation: 878 - Long Term Care Facility Receivership
Funding Sources: DLT - Long Term Care Facility Receivership Fund

	Historical Data			Agency Request and Executive Recommendation					
	2007-2008	2008-2009	2008-2009	2009-2010			2010-2011		
Commitment Item	Actual	Budget	Authorized	Base Level	Agency	Executive	Base Level	Agency	Executive
Expenses 5900046	0	100,000	100,000	100,000	100,000	100,000	100,000	100,000	100,000
Total	0	100,000	100,000	100,000	100,000	100,000	100,000	100,000	100,000
Funding Sources									
Reimbursement 4000425	0	100,000		100,000	100,000	100,000	100,000	100,000	100,000
Total Funding	0	100,000		100,000	100,000	100,000	100,000	100,000	100,000
Excess Appropriation/(Funding)	0	0		0	0	0	0	0	0
Grand Total	0	100,000		100,000	100,000	100,000	100,000	100,000	100,000

Analysis of Budget Request

Appropriation: 896 - DHS–Admin Paying Account

Funding Sources: PWP - Administration Paying

Act 348 of 1985 authorized the reorganization of the Department of Human Services. As part of this reorganization, the Division of Social Services became the Division of Economic and Medical Services. Act 164 of 1995 eliminated the Division of Economic and Medical Services, creating the Division of Medical Services, while functions at the county level were assigned to the Division of County Operations (formerly the Division of Program Operations). The Division of Medical Services' primary responsibility is management of the Arkansas Medicaid program, which was created by the passage of Title XIX of the Social Security Act of 1965, with Arkansas implementing the program on January 1, 1970.

Medicaid enables states to furnish:

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

Each state has some sort of Medicaid program to meet the federal mandates and requirements as laid out in Title XIX. Arkansas, however, established a medical care program 26 years before passage of the federal laws requiring health care for the needy: Section 7 of Act 280 of 1939 and Act 416 of 1977 authorized the State of Arkansas to establish and maintain a medical care program for the indigent and vested responsibility for regulating and administering the program in the Arkansas Department of Human Services. This program receives federal grants under Title XIX. Thus Arkansas Medicaid is a joint federal and state program that provides necessary medical services to eligible persons who are not able to pay for such services. Individuals are certified as eligible for Medicaid services through the state's county Human Services Offices or District Social Security Offices. The Social Security Administration automatically sends SSI recipient information to DHS.

The Arkansas Medicaid Program is divided into three (3) forms of services:

1. Services Mandated by the Federal Government
2. Optional Services Chosen by Arkansas
3. Waivers Approved by the Centers for Medicare and Medicaid Services (CMS)

These services are as follows:

Services Mandated by the Federal Government:

- Child Health Services (EPSDT - Early and Periodic Screening, Diagnosis and Treatment)
- Family Planning
- Federally Qualified Health Centers (FQHC)
- Home Health
- Hospital, Inpatient and Outpatient
- Laboratory and X-Ray
- Medical and Surgical Services of a Dentist
- Nurse Midwife

- Nurse Practitioner (Family and Pediatric)
- Nursing Facility Services (Age 21 or Older)
- Physician
- Rural Health Clinics

Optional Services Chosen by Arkansas:

- ✓ Ambulatory Surgical Center Services
- ✓ Audiological Services (Under Age 21)
- ✓ Certified Registered Nurse Anesthetist (CRNA)
- ✓ Child Health Management Services (CHMS) (Under Age 21)
- ✓ Chiropractic Services
- ✓ Dental Services (Under Age 21)
- ✓ Developmental Day Treatment Clinic Services (DDTCS) (Preschool and Age 18 or Older)
- ✓ Developmental Rehabilitation Services (Under Age 3)
- ✓ Domiciliary Care Services
- ✓ Durable Medical Equipment
- ✓ End-Stage Renal Disease (ESRD) Facility Services
- ✓ Hearing Aid Services (Under Age 21)
- ✓ Hospice Services
- ✓ Hyperalimentation Services
- ✓ Inpatient Psychiatric Services Under Age 21
- ✓ Intermediate Care Facility Services for Mentally Retarded
- ✓ Licensed Mental Health Practitioner Services (Under Age 21)
- ✓ Medical Supplies
- ✓ Nursing Facility Services (Under Age 21)
- ✓ Occupational, Physical, Speech Therapy Services (Under Age 21)
- ✓ Orthotic Appliances
- ✓ Personal Care Services
- ✓ Podiatrist Services
- ✓ Portable X-Ray Services
- ✓ Prescription Drugs
- ✓ Private Duty Nursing Services (for Ventilator-Dependent All Ages and High-Tech Non-Ventilator Dependent Persons (Under 21)
- ✓ Prosthetic Devices
- ✓ Radiation Therapy Center
- ✓ Rehabilitative Hospital Services
- ✓ Rehabilitative Services for Persons with Mental Illness (RSPMI)
- ✓ Rehabilitative Services for Persons with Physical Disabilities (RSPD) (Under Age 21)
- ✓ Rehabilitative Services for Youth and Children (RSYC) (Under Age 21)
- ✓ Respiratory Care Services (Under Age 21)
- ✓ School-Based Mental Health Services (Under Age 21)
- ✓ Targeted Case Management for Pregnant Women
- ✓ Targeted Case Management Beneficiaries Age 60 and Older
- ✓ Targeted Case Management for Beneficiaries of Children's Services (Under 21)
- ✓ Targeted Case Management for Beneficiaries of Children's Services who are SSI Beneficiaries or TEFRA Waiver Beneficiaries (Under Age 16)
- ✓ Targeted Case Management for Beneficiaries in the Division of Children and Family Services (Under Age 21)
- ✓ Targeted Case Management for Beneficiaries in the Division of Youth Services (Under Age 21)

- ✓ Targeted Case Management for Beneficiaries Age 21 and under with a Developmental Disability
- ✓ Targeted Case Management for Beneficiaries Age 22 and over with a Developmental Disability
- ✓ Targeted Case Management Services for other Beneficiaries Under Age 21
- ✓ Transportation Services (Ambulance, Non-Emergency)
- ✓ Ventilator Equipment
- ✓ Visual Services

Waivers Approved by the Centers for Medicare and Medicaid Services (CMS):

- ❖ Alternatives for Adults with Physical Disabilities Waiver
- ❖ AR HealthNet
- ❖ ArKids B Waiver
- ❖ DDS Alternative Community Services Waiver
- ❖ ElderChoices Waiver
- ❖ Living Choices (Assisted Living)
- ❖ Non-Emergency Transportation
- ❖ Tax Equity Fiscal Responsibility Act of 1982 (TEFRA)
- ❖ Women's Health (Family Planning)

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:

- Twelve visits to hospital outpatient departments allowed per state fiscal year.
- A total of twelve office visits allowed per state fiscal year for any combination of the following: certified nurse midwife, physician, medical services provided by a dentist, medical services furnished by an optometrist, and Rural Health Clinics.
- One basic family planning visit and three (3) periodic family planning visits per state fiscal year. Family planning visits are not counted toward other service limitations.
- Lab and x-ray services limited to total benefit payment of $500 per state fiscal year, except for EPSDT beneficiaries.
- Three pharmaceutical prescriptions are allowed per month (family planning and smoking cessation prescriptions are not counted against benefit limit; unlimited prescriptions for nursing facility beneficiaries and EPSDT beneficiaries under age 21). Extensions will be considered up to a maximum of six (6) prescriptions per month for beneficiaries at risk of institutionalization. Beneficiaries receiving services through the Independent Choices waiver may receive up to nine (9) medically necessary prescriptions per month. Medicare-Medicaid beneficiaries (duel eligibles) are no longer eligible for Medicaid prescription drug benefits after January 1, 2006.
- Inpatient hospital days limited to 24 per state fiscal year, except for EPSDT beneficiaries and certain organ transplant patients.
- Co-insurance: Some beneficiaries must pay 10% of first Medicaid covered day of hospital stay.
- Beneficiaries in the Working Disabled aid category must pay 25% of the charges for the first Medicaid covered day of inpatient hospital services and must also pay co-insurance for some additional services.
- Some beneficiaries must pay $.50 - $3 of every prescription, and $2 on the dispensing fee for prescription services for eyeglasses. Beneficiaries in the Working Disabled aid category must pay a higher co-payment for these services and also must pay co-payments for some additional services.

Additional information for limitations relating to children:

- The families of some children are responsible for coinsurance, co-payments, or premiums.
- Co-insurance: Arkids B beneficiaries must pay 20% of the charges for the first Medicaid covered

day of inpatient hospital services and must also pay co-insurance for some outpatient services.

- Co-Pay: Arkids B beneficiaries must pay a higher co-payment for these services and also must pay co-payments for some outpatient services.
- Premiums: Based on family income certain TEFRA beneficiaries must pay a premium.

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

The Division consists of the Director's Office and five (5) distinct organizational units:

Medical Services: The Office of Medical Services includes the following operations: Program Integrity, Medical Assistance and Utilization Review. The Program Integrity section is federally mandated to comply with federal regulations outlined in 42 CFR Part 455 and 456. The goal of the Program Integrity section is to ensure payments are consistent with the quality of care being provided, verify that medical services are medically necessary and rendered as billed, payments for services are correct and funds identified for collection are pursued. Program Integrity performs on site reviews to ensure providers are in compliance with Medicaid policy. The Medical Assistance section administers the Dental, Visual and Child Health Services (EPSDT) Medicaid programs and oversees the non-emergency transportation program, Medicaid Managed Care Systems and ConnectCare programs. This section also assists providers and beneficiaries in resolving matters related to billing and coverage. The Utilization Review section develops healthcare polices based on recognized standards of care, current healthcare initiatives and participation from community stakeholders to ensure adequate coverage benefits for Medicaid beneficiaries. Utilization review monitors the quality and medical necessity of services delivered by Medicaid health care providers. In addition this section is responsible for the prior authorization of medically necessary services such as transplants, extension of benefits, prosthetics, hearing aids, hyperalimentation services and out of state transportation.

Medicaid Management, Information, and Performance (MMIP): The Office of Medicaid Management, Information, and Performance is responsible for developing and maintaining the Medicaid State Plan and provider policy, administering the Medicaid Management Information System (MMIS) which processes all Medicaid claims, and assuring quality in the Medicaid waivers approved by CMS. The MMIP Section consists of three Units. The Program Planning and Development (PPD) Unit develops and maintains the Medicaid State Plan and the State's Child Health Insurance Program Plan, both required by CMS. This Unit develops and maintains 57 different Medicaid provider policy manuals, which include information on covered services, benefit limits, prior approvals, and billing procedures. The MMIS Systems and Support Unit procures and administers the contracted fiscal agent that operates the MMIS. This Unit also monitors the fiscal agent's contract compliance, performs quality assurance reviews on how the MMIS operates, manages requests for modifications to the MMIS, develops enhancements to the MMIS, and develops and produces reports from the Medicaid data warehouse. The Waiver Quality Assurance Unit is responsible for monitoring operation of the Medicaid waiver programs. The Waiver QA Unit assures compliance with CMS requirements for operating the waivers through case reviews, data analysis, technical assistance to operating agencies, communication and coordination with CMS, developing new waivers and amendments to existing waivers, and developing QA strategies and interagency agreements for the waivers.

Long Term Care: The Office of Long Term Care (OLTC) is the unit of state government responsible for the regulation of long term care facilities in Arkansas. These facilities include Nursing Homes, Intermediate Care Facilities for the Mentally Retarded (ICF/MR), Residential Care Facilities (RCF), Adult Day Care, Adult Day Health Care, Post-Acute Head Injury Facilities, Assisted Living Facilities (ALF) and Psychiatric Residential Treatment Facilities (PRTF). This regulation of facilities includes conducting on-site

inspections of facilities, investigations of complaints against facilities, medical need determinations for placement into facilities, and licensure of facilities and facility administrators. In addition, the Office of Long Term Care administers a criminal record background check on the employees and applicants and of facilities the Office regulates, and the Office is responsible for the administration of the training and certification of Certified Nursing Assistance (CNAs), who are long term care facility caregivers that are employed in long term care facilities and hospital-based facilities. The Office of Long Term Care includes the following operations: Quality Assurance & Support, Survey & Certification, Special Programs, Abuse & Neglect, and State Regulated Facilities.

Program and Administrative Support: The Office of Program and Administrative Support includes the following operations: Financial Activities, Provider Reimbursement and Third Party Liability. The Financial Activities unit performs such functions as program and operational budgeting, expenditure monitoring and evaluation, federal and state reporting, and administrative support such as personnel management, contract issuance and management, requests for proposals, and the preparation of interagency agreements. The Provider Reimbursement unit is responsible for maintaining rate files, establishing and administering methodologies for provider reimbursements, including cost reports and cost settlements, and financial aspects of the Office of Long-Term Care such as budgeting, reimbursement, and audits of provider cost reports. The Third Party Liability area is responsible for implementing cost-avoidance procedures to prevent the payment of Medicaid money when other (third) parties such as private insurance companies should pay the claim. In addition, in those instances where cost-avoidance is not successful, the Third Party Liability unit is responsible for pursuing recoupment of Medicaid monies.

Pharmacy: The Pharmacy Office is responsible for assuring that medically necessary pharmaceutical therapy is provided to Arkansas Medicaid recipients. It seeks to deliver these services cost effectively while complying with all state and federal requirements. The OBRA 90 statute requires states to cover all outpatient drugs by a manufacturer who signs a rebate agreement with the Centers for Medicare / Medicaid (CMS) as well as to establish a Drug Utilization Review (DUR) Board which is under the direction of the Pharmacy Office. The Office researches clinical data, develops the clinical criteria and edits for various drugs and drug classes, then works directly with the states fiscal agent to apply the criteria and edits within the software, is the project manager for the stated Evidenced-based prescription drug program, researches and reviews claims information to assist providers, beneficiaries and interested parties and researches exception criteria to assist physicians.

The Agency is funded through general revenue (DEM - Medical Services Fund Account), federal and other revenues. Federal revenue is provided through the U. S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. Other revenues which are indicated as various program support are derived from Third Party Liability Recovery, Nurse Aide Training and Long Term Care Licensure Fees.

Base level positions were changed from unclassified to Professional and Executive Pay Plan to reflect the recommendations of the Pay Plan Study and salaries were adjusted accordingly. Base Level salaries for classified positions reflect the recommendations of the Pay Plan Study. A 2.3% Cost of Living Allowance is reflected in the second year of the biennium. The Base Level request for Regular Salaries may include board member Stipend payments and Career Service payments for eligible employees. Personal Services Matching includes a $75 increase in the monthly contribution for State employee's health insurance for a total State match per budgeted employee of $425.

The Agency Base Level request for this appropriation is $22,653,854 in FY2010 and $22,985,808 in FY2011 with 300 budgeted base level positions.

The Agency Change Level request for this appropriation is $2,644,351 in FY2010 and $2,994,018 in FY2011 with a general revenue request of $144,980 in FY2010 and $222,949 in FY2011. The general revenue request consists of the following components:

- $158,781 in FY2010 and $237,007 in FY2011 in new general revenue for the state match on the operating expenses line item; and
- ($13,801) in FY2010 and ($14,058) requested to be transferred to the DHS Administration Fund Account which is associated with a request to transfer one (1) position to the Office of Chief Counsel.

The following delineates the agency request:

- 28 new positions with salary and matching appropriation to allow the Division to design programs, perform analysis and research to keep up with the ever changing public health care issues.
- Transfer 2 positions from the Office of Chief Counsel with salary and matching appropriation only to assist with contract oversight.
- Transfer 1 position from the Division of Behavioral Health Services with salary and matching appropriation only to perform research and analysis of innovations.
- Transfer 2 positions from the Division of Children and Family Services with salary and matching appropriation only to assist the Third Party Liability unit to ensure third parties are identified.
- Transfer 1 position with salary and matching appropriation and general revenue (noted above) to the Office of Chief Counsel to perform receptionist duties for the appeals and hearings section.
- Restoration of 2 positions that are authorized but not budgeted with salary and matching appropriation only to assist in meeting established staffing patterns.
- $561,753 in FY2010 and $874,661 in FY2011 for the Operating Expenses line item for building and grounds maintenance, rent of facilities, mileage, meal and lodging, and fuel purchases.
- $195,000 each year of the biennium for the Capital Outlay line item to allow for the purchase of 10 vehicles each year. 5 vehicles would be replacements and 5 would be additional vehicles each year.
- $30,000 each year of the biennium for the Data Processing Services line item to allow for increased costs of data processing services from the Department of Information Services.

The Executive Recommendation provides for Base Level. Additionally, 14 new positions with salary and matching appropriation have been provided for, of which, 5 of these new positions will create the new behavior health unit within DMS. The transfer of positions, as well as, the restoration of positions has been provided for with salary and matching appropriation. The transfer of general revenue (noted above) to the Office of Chief Counsel associated with the request to transfer 1 position has been recommended. $200,000 each year of the biennium in additional appropriation for the Operating Expenses line item, as well as, $100,000 in new general revenue each year of the biennium has been recommended. Finally, the $195,000 each year of the biennium for the Capital Outlay line item and the $30,000 each year of the biennium for the Data Processing Services line item is recommended.

In summary, the Executive Recommendation for new general revenue above the Base Level is:

- $100,000 each year of the biennium associated with the request for additional Operating Expenses appropriation; and
- ($13,801) in FY2010 and ($14,058) in FY2011 requested to be transferred to the DHS Administration Fund Account which is associated with a request to transfer one (1) position to the Office of Chief Counsel.

The above General Revenue transfer that the Executive Recommendation has provided for is from existing allocation of General Revenue from the Division of Medical Services to the Director Office's/Office of Chief Counsel.

Appropriation Summary

Appropriation: 896 - DHS–Admin Paying Account
Funding Sources: PWP - Administration Paying

		Historical Data			Agency Request and Executive Recommendation					
		2007-2008	2008-2009	2008-2009	2009-2010			2010-2011		
Commitment Item		**Actual**	**Budget**	**Authorized**	**Base Level**	**Agency**	**Executive**	**Base Level**	**Agency**	**Executive**
Regular Salaries	5010000	12,194,659	13,849,258	13,341,592	14,345,945	15,757,318	15,174,095	14,623,050	16,065,227	15,468,601
#Positions		**284**	**300**	**302**	**300**	**334**	**320**	**300**	**334**	**320**
Extra Help	5010001	88,697	126,892	126,892	126,892	126,892	126,892	126,892	126,892	126,892
#Extra Help		**7**	**7**	**7**	**7**	**7**	**7**	**7**	**7**	**7**
Personal Services Matching	5010003	3,640,440	3,781,515	4,044,462	4,312,382	4,758,607	4,574,466	4,367,231	4,819,411	4,632,682
Overtime	5010006	0	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000
Operating Expenses	5020002	3,022,160	3,152,863	3,152,863	3,152,863	3,714,616	3,352,863	3,152,863	4,027,524	3,352,863
Conference & Travel Expenses	5050009	156,932	235,840	235,840	235,840	235,840	235,840	235,840	235,840	235,840
Professional Fees	5060010	269,608	355,132	355,132	355,132	355,132	355,132	355,132	355,132	355,132
Data Processing	5090012	0	0	0	0	0	0	0	0	0
Capital Outlay	5120011	198,035	195,000	195,000	0	195,000	195,000	0	195,000	195,000
Data Processing Services	5900044	108,321	119,800	119,800	119,800	149,800	149,800	119,800	149,800	149,800
Total		19,678,852	21,821,300	21,576,581	22,653,854	25,298,205	24,169,088	22,985,808	25,979,826	24,521,810
Funding Sources										
General Revenue	4000010	4,621,975	4,843,573		5,028,370	5,173,350	5,114,569	5,102,053	5,325,002	5,187,995
Federal Revenue	4000020	8,117,737	13,551,183		14,068,205	15,321,457	14,727,123	14,274,350	15,780,082	14,943,909
Various Program Support	4000730	6,939,140	3,426,544		3,557,279	4,271,530	4,102,396	3,609,405	4,338,593	4,164,906
Total Funding		19,678,852	21,821,300		22,653,854	24,766,337	23,944,088	22,985,808	25,443,677	24,296,810
Excess Appropriation/(Funding)		0	0		0	531,868	225,000	0	536,149	225,000
Grand Total		19,678,852	21,821,300		22,653,854	25,298,205	24,169,088	22,985,808	25,979,826	24,521,810

The FY2009 Budgeted amount in Regular Salaries exceeds the authorized amount due to salary adjustments during the 2007-2009 biennium.

Change Level by Appropriation

Appropriation: 896 - DHS–Admin Paying Account
Funding Sources: PWP - Administration Paying

Agency Request

Change Level		2009-2010	Pos	Cumulative	% of BL	2010-2011	Pos	Cumulative	% of BL
BL	**Base Level**	**22,653,854**	**300**	**22,653,854**	**100.0**	**22,985,808**	**300**	**22,985,808**	**100.0**
C01	Existing Program	1,865,500	23	24,519,354	108.2	2,205,677	23	25,191,485	109.6
C02	New Program	274,584	5	24,793,938	109.4	280,309	5	25,471,794	110.8
C05	Unfunded Appropriation	253,746	2	25,047,684	110.6	254,862	2	25,726,656	111.9
C07	Agency Transfer	220,521	4	25,268,205	111.5	223,170	4	25,949,826	112.9
C08	Technology	30,000	0	25,298,205	111.7	30,000	0	25,979,826	113.0

Executive Recommendation

Change Level		2009-2010	Pos	Cumulative	% of BL	2010-2011	Pos	Cumulative	% of BL
BL	**Base Level**	**22,653,854**	**300**	**22,653,854**	**100.0**	**22,985,808**	**300**	**22,985,808**	**100.0**
C01	Existing Program	736,383	9	23,390,237	103.3	747,661	9	23,733,469	103.3
C02	New Program	274,584	5	23,664,821	104.5	280,309	5	24,013,778	104.5
C05	Unfunded Appropriation	253,746	2	23,918,567	105.6	254,862	2	24,268,640	105.6
C07	Agency Transfer	220,521	4	24,139,088	106.6	223,170	4	24,491,810	106.6
C08	Technology	30,000	0	24,169,088	106.7	30,000	0	24,521,810	106.7

Justification	
C01	The Division of Medical Services requests appropriation only for 23 new positions to be funded by a mixture of Third Party Liability collections and federal funds with no state funds required. An Assistant Director Medical Services - Grade N906 to directly supervise the new Contract Oversight Unit. Licensed Certified Social Worker C121 to perform as a Licensed Mental Health Practitioner to monitor quality assurance, prior authorization and retrospective review contracts. Three DHS DMS Business Operations Manager C127. One to direct the Medicaid Dental and Visual program. One for the pharmacy program to identify and implement cost containment strategies. One to provide leadership to the Third Party Liability Unit to take the unit to the next level. Two DHS DMS Medical Assistance Manager C125 positions. One for MITA Planning and Implementation to take advantage of the opportunities offered by MITA for Division and Department IT. One for directing the financial and rate setting activities for Long Term Care Programs. One Engineer, PE C124 for the Office of Long Term Care to adequately assure that facilities are inspected for compliance with life safety code standards. Three Nursing Services Unit Manager C123. Two for Utilization Review to plan, coordinate, schedule and direct utilization management activities. One for the Office of Long Term Care to provide oversight of the Assisted Living and Residential Care Unit and licensure and inspection of 175 facilities. Five DHS Program Administrator C122. One for the Office of Long Term Care to accomplish required training and to organize a training academy for surveyors. Two to act as Health Research Analysts. One for Policy Planning & Development to work with others to develop new Medicaid programs or enhance existing programs. One position for Financial Activities to serve as a liaison to other divisions and provide analysis and support to a variety of ad hoc projects. One Computer Support Specialist C119 to provide quicker response times, backup coverage, assist with e-Doc to scan paper files and complying with security rules. One Information Systems Coordination Specialist C119 for Program Integrity to begin Medi/Medi project which bumps Medicaid data up to Medicare data to look at outliers. Two DHS Program Manager C119. One to lead the OLTC Abuse/Neglect Unit to handle appeals in accordance with state and federal requirements. One for Waiver Quality Assurance to assist with the creation and distribution of Quality Management reports and monitoring of Quality Management strategies for each Home and Community Based Waiver. One Senior Auditor for Provider Reimbursement to perform desk reviews of annual and semi-annual cost reports. Two Research Project Analyst, C117 for Program Integrity to implement a new enrollment disclosure process as required by federal regulations. Maintenance and operations is requested to restructure space, increase for rent and travel expenses.
C02	Five (5) positions for a new Behavioral Health Unit within DMS. Behavioral Health is a growing concern and issue facing health care today. This unit will be established to research, develop and manage program issues, policy development, coordinate activities, respond to provider/beneficiary issues, appeals, participate in expansion of services such as substance abuse. The unit will have involvement with CMS both regional and central offices, Governor's office, legislative entities, and DHS staff. The new positions requested for this unit are as follows: one (1) DHS DMS Medical Assistance Manager - C125; one (1) Nursing Services Unit Manager - C123; two (2) DHS Program Administrator - C122; one (1) DHS Program Manager - C119. These positions will be funded by a mixture of Third Party Liability collections and federal funds. No State funds are requested to support these positions.
C05	This is to request restoration of two (2) positions which will allow positions to be filled as necessary to meet the demands of the Division. This request is appropriation only.This request is to purchase ten (10) new vehicles each year of the biennium, half would be replacement vehicles and half would be additional vehicles. DMS currently has thirteen vehicles that meet the criteria for replacement but have not been replaced through DFA MMV Fund. DMS has concern about the safety of staff in these vehicles and the increased liability for the state. This request also includes $45,000 for the purchase of equipment that may be necessary for the implementation of an image document system or other equipment needs for the Division. Request is for appropriation only.

Change Level by Appropriation

	Justification
C07	The Division requests the transfer of one unneeded Document Examiner II position to the Office of Chief Counsel which has a need for the position. This transfer request is both appropriation and funds. In addition, the Division requests the transfer of five positions to DMS as follows: two positions to the newly created Contract Oversight Unit responsible for contract performance monitoring and evaluation; one position to act as a liaison to the DHS Office of Finance and Administration to ensure accurate and timely federal reporting and also to prepare and analyze data for internal reporting; two positions to be utilized in the DMS Third Party Liability unit to ensure third parties are identified, medical histories are reviewed, and appropriate parties are notified that monies are due. These five positions are transfer of appropriation only.
C08	The Division of Medical Services is requesting additional purchase of Data Processing to cover anticipated increased costs of monthly billings from the Dept. of Information Services(DIS). This request is included in the Information Technology Plan (ITP) for theDivision on page 7, section Major Application Information Medicaid MMIS- IT Services-DIS. This request is appropriation only.

Analysis of Budget Request

Appropriation: 897 - DHS-Grants Paying Account

Funding Sources: PWD - Grants Paying

Private Nursing Home Care Appropriation referenced on page 286

The Private Nursing Home Care appropriation pays expenses for individuals who reside in nursing homes and are eligible to receive Medicaid Benefits. The residents in nursing home facilities have chronic, medical needs. The referring physician must certify medical need with documented evidence of why services are needed in order for a person to be to admitted and remain in a nursing home. Each Medicaid certified nursing facility evaluates each nursing home applicant's need for nursing home services. A thorough and complete evaluation must be conducted to ensure that individuals who do not require nursing home services are not admitted to nursing facilities. For Medicaid eligible recipients, the Office of Long Term Care cannot guarantee Medicaid reimbursement for any applicant admitted prior to approval by the Office of Long Term Care Medical Needs Determination section. No applicant with diagnoses or other indicators of mental illness, mental retardation, or developmental disabilities may be admitted to nursing home care prior to evaluation and approval by the Office of Long Term Care.

In general, nursing homes provide total care for their residents--meeting needs from social to dietary to medical. They are staffed by licensed nurses and certified nursing assistants. Nursing homes accept a variety of payment methods, such as private pay (which includes insurance), Medicaid, and Medicare. No age requirement applies to nursing home placements.

In addition to the provider payments noted above, Act 689 of 1987 created the Long Term Care Aide Training program. Under this Act, the Office of Long Term Care was required to establish a training program to be completed by all aides in long term care facilities who provide personal care to residents. This program consists of 75 hours of training and is payable from the Private Nursing Home Care appropriation.

Funding for this program is derived from general revenues (DGF - DHS Grants Fund Account), federal and other revenues. Federal revenue derived from Title XIX - Medicaid, U. S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. Other revenues which are indicated as quality assurance fee per Act 635 of 2001, various program support which can include nursing home administration fees and Medicaid match, and miscellaneous transfers derived from Act 1217 of 2007 section 7.

The Agency Base Level request for this appropriation is $548,872,748 each year of the biennium with general revenue of $93,680,072.

The Agency Change Level request for this appropriation is $44,016,108 in FY2010 and $69,165,381 in FY2011 with general revenue request of $3,893,602 in FY2010 and $8,400,884 in FY2011 which includes adjustments for the FMAP reduction. The following delineates the agency request:

- $29,016,108 in FY2010 and $52,965,381 in FY2011 for growth.
- $15,000,000 in FY2010 and $16,200,000 in FY2011 in unfunded appropriation to allow the Division

the capability to respond to federal and/or state mandates.

The Executive Recommendation provides for the Agency Request.

In summary, the Executive Recommendation for new general revenue above the Base Level is:

- $3,839,114 in FY2010 and $8,019,471 in FY2011 for growth; and
- $54,488 in FY2010 and $381,413 in FY2011 for the FMAP change.

Prescription Drugs Appropriation referenced on page 287

The Prescription Drugs appropriation is an optional Medicaid service chosen by Arkansas. The program allows eligible recipients to obtain prescription medication through participating pharmacies in Arkansas. Reimbursement for the program is based on the drug cost and the fee for dispensing pharmaceuticals. The Omnibus Budget Reconciliation Act of 1990 authorized rebates from pharmaceutical manufacturers. The federal share is returned and the amount retained by the state is calculated based upon the state matching rate for Medicaid.

Funding for this program is derived from general revenues (DGF - DHS Grants Fund Account), federal and other revenues. Federal revenue derived from Title XIX - Medicaid, U. S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. Other revenues which are indicated as drug rebates, and various program support which can include Medicaid match.

The Agency Base Level request for this appropriation is $385,263,250 each year of the biennium with general revenue of $101,909,220.

The Agency Change Level request for this appropriation is $54,556,338 in FY2010 and $90,159,922 in FY2011 with general revenue request of $9,793,027 in FY2010 and $19,300,423 in FY2011 which includes adjustments for the FMAP reduction. The following delineates the agency request:

- $34,458,599 in FY2010 and $68,716,516 in FY2011 for growth.
- ($1,502,261) in FY2010 and ($1,756,594) in FY2011 to reclassify the Breast and Cervical Cancer program to the Medicaid Expansion program.
- $1,600,000 each year of the biennium for a medication therapy management program.
- $20,000,000 in FY2010 and $21,600,000 in FY2011 in unfunded appropriation to allow the Division the capability to respond to federal and/or state mandates.

The Executive Recommendation provides for the Agency Request for appropriation. Additionally, general revenue has been provided for in the amount of $7,048,398 in FY2010 and $14,199,931 in FY2011.

In summary, the Executive Recommendation for new general revenue above the Base Level is:

- $7,010,345 in FY2010 and $13,933,560 in FY2011 for growth; and
- $38,053 in FY2010 and $266,371 in FY2011 for the FMAP change.

Hospital and Medical Services Appropriation referenced on page 288

The Hospital and Medical Services appropriation is one of several federally supported and state administered assistance programs within the Medicaid program and consists of many services including inpatient and outpatient hospital, community mental health centers, community health centers, rural health clinics, home health, private duty nursing, personal care, hospice, practitioners such as physicians, dentists, audiologist, psychologist, speech, occupational and physical therapists, maternity clinics, family planning, laboratory and x-ray services, case management , transportation and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for children under 21 years of age which is the Child Health Services Program. Waiver services are also included in this appropriation. Waiver services are those that the Centers for Medicare and Medicaid Services have waived traditional provisions of the Medicaid regulations and allow deviations in how and where the services are provided and include programs such as Elderchoices, DDS-Non-institutional Waiver and Adults with Physical Disabilities. Payments are made directly to providers for services for individuals who are eligible for Medicaid services. The State establishes reimbursement rates and the methodology for rate setting. However, the Centers for Medicare and Medicaid Services must approve the state's policy(ies) and regulations in order for the State to be in compliance with guidelines established in federal law.

Funding for this program is derived from general revenues (DGF - DHS Grants Fund Account), federal and other revenues. Federal revenue derived from Title XIX - Medicaid, U. S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. Other revenues which are indicated as Medicaid trust fund, insurance premium tax per Act 2222 of 2005 and as various program support which can include matching funds from UAMS (from general revenue), Department of Education (from cash funds), Arkansas Children's Hospital, DHS Divisions (from general revenue) for services such as Therapies, Transportation, Waiver services, UPL-Upper Payment Limit match, DSH-Disproportionate Share Hospital payments, etc. Additionally, tobacco settlement funding can be utilized in this appropriation if Act 2 of the First Extraordinary Session of 2002 section 11 is invoked and approved by the Governor and the Chief Fiscal Officer of the State.

The Agency Base Level request for this appropriation is $2,634,264,168 each year of the biennium with general revenue of $469,208,860.

The Agency Change Level request for this appropriation is $365,378,355 in FY2010 and $589,913,663 in FY2011 with general revenue request of $74,672,970 in FY2010 and $166,050,057 in FY2011 which includes adjustments for the FMAP reduction. The following delineates the agency request:

- $178,111,661 in FY2010 and $368,691,140 in FY2011 for growth.
- ($10,970,807) in FY2010 and ($11,738,763) in FY2011 to reclassify the Breast and Cervical Cancer program to the Medicaid Expansion program.
- $48,237,501 in FY2010 and $70,961,286 in FY2011 for various rate changes.
- $150,000,000 in FY2010 and $162,000,000 in FY2011 in unfunded appropriation to allow the Division the capability to respond to federal and/or state mandates.

The Executive Recommendation provides for the Agency Request for appropriation. Additionally, general revenue is provided for in the amount of $42,771,429 in FY2010 and $137,937,500 in FY2011. Finally, the Executive Recommendation provides for the projected excess balance of $7,923,456 in FY2010 and

$48,740,751 in FY2011 in the Medicaid Expansion Program Account be used to fund the Hospital and Medical Services appropriation in the 2009-2011 Biennium and to offset the agency general revenue request. The agency will be complying with Section 8 of Initiated Act 1 of 2000 which provides for the carry forward Tobacco Settlement Fund balance into a new biennium. The agency will invoke section 11 of Act 2 of the First Extraordinary Session of 2002 (A.C.A. §19-12-119) to maximize Tobacco Settlement Fund usage.

In summary, the Executive Recommendation for new general revenue above the Base Level is:

- $42,516,315 in FY2010 and $136,151,701 in FY2011 for growth; and
- $255,114 in FY2010 and $1,785,799 in FY2011 for the FMAP change.

ARKIDS B Program Appropriation referenced on page 289

The ArKids B program appropriation provides medical services for children who are without medical insurance coverage. Many of the parents of these children are employed but are unable to afford the necessary coverage for their children. The parents earn sufficient salaries that make them ineligible for coverage by Medicaid, thereby leaving the children without medical care.

ArKids B Program is an optional Medicaid service chosen by Arkansas and is authorized through a federal waiver to the Medicaid program that expands coverage to children in families with income at or below 200 percent of the federal poverty level. Services are available only to children through 18 years of age and are otherwise ineligible to receive Medicaid benefits. Each child must have a Primary Care Physician who will either provide the needed services or make the appropriate referral for medically necessary treatment. A patient co-payment is required per physician visit and per prescription. Effective July 1, 2006, DHS set an annual cap on cost-sharing (co-payments and coinsurance) for ARKids B families. The annual cost-sharing cap is 5% of the family's annual gross (before taxes) income.

The ArKids B Program appropriation has two (2) components and they are as follows:

- Prescription Drugs
- Hospital/Medical

Prescription Drugs component has coverage limits based on medical necessity with a $5 per prescription co-pay and the recipient must use generic and rebate manufactures.

Generally, the Hospital/Medical component benefits include such programs as inpatient hospital, physician visits, vision care (1 visit per year for routine exam and 1 pair of eyeglasses), dental services (2 visits per year for cleaning, x-rays, no orthodontia), medical supplies, home health services and emergency room services, ambulance (emergency only), ambulatory surgical center, durable medical equipment ($500 per year), family planning, FQHC, nurse midwife, outpatient mental and behavior health ($2,500 limit), podiatry, RHC and speech therapy with some form of co-pay required. Immunizations and preventative health screenings per protocols provided by the primary care physician or Division of Health require no patient co-payments.

Funding for this program is derived from general revenues (DGF - DHS Grants Fund Account), federal and other revenues. Federal revenue derived from Title XIX - Medicaid, U. S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. Other revenues, which are indicated as various

program support, can include Medicaid match.

The Agency Base Level request for this appropriation is $111,561,360 each year of the biennium with general revenue of $30,300,065.

The Agency Change Level request for this appropriation is $25,933,856 in FY2010 and $46,177,122 in FY2011 with general revenue request of $4,340,385 in FY2010 and $9,711,283 in FY2011 which includes adjustments for the FMAP reduction. The following delineates the agency request:

- $1,663,187 in FY2010 and $4,481,124 in FY2011 for growth for the prescription drugs component.
- $14,270,669 in FY2010 and $30,895,998 in FY2011 for growth for the Hospital/Medical component.
- $10,000,000 in FY2010 and $10,800,000 in FY2011 in unfunded appropriation for both the Prescription Drugs component and the Hospital/Medical component to allow the Division the capability to respond to federal and/or state mandates.

The Executive Recommendation provides for the Agency Request.

In summary, the Executive Recommendation for new general revenue above the Base Level is:

- $451,888 in FY2010 and $1,220,210 in FY2011 for growth for the Prescription Drugs component;
- $2,507 in FY2010 and $17,551 in FY2011 for the FMAP change for the Prescription Drugs component;
- $3,877,341 in FY2010 and $8,412,980 in FY2011 for growth for the Hospital/Medical component; and
- $8,649 in FY2010 and $60,542 in FY2011 for the FMAP change for the Hospital/Medical component.

Appropriation Summary

Appropriation: 897 - DHS-Grants Paying Account / Private Nursing Home Care
Funding Sources: PWD - Grants Paying

		Historical Data			Agency Request and Executive Recommendation					
		2007-2008	2008-2009	2008-2009	2009-2010			2010-2011		
Commitment Item		Actual	Budget	Authorized	Base Level	Agency	Executive	Base Level	Agency	Executive
Private Nursing Home Care	5100004	534,359,123	548,872,748	627,094,449	548,872,748	592,888,856	592,888,856	548,872,748	618,038,129	618,038,129
Total		534,359,123	548,872,748	627,094,449	548,872,748	592,888,856	592,888,856	548,872,748	618,038,129	618,038,129
Funding Sources										
General Revenue	4000010	75,001,753	93,680,072		93,680,072	97,573,674	97,573,674	93,680,072	102,080,956	102,080,956
Federal Revenue	4000020	390,004,850	399,138,008		399,138,008	420,215,951	420,215,951	399,138,008	437,299,503	437,299,503
Miscellaneous Transfers	4000355	115,000	115,000		115,000	115,000	115,000	115,000	115,000	115,000
Quality Assurance Fee	4000395	63,760,074	55,656,095		55,656,095	59,700,658	59,700,658	55,656,095	62,059,097	62,059,097
Various Program Support	4000730	5,477,446	283,573		283,573	283,573	283,573	283,573	283,573	283,573
Total Funding		534,359,123	548,872,748		548,872,748	577,888,856	577,888,856	548,872,748	601,838,129	601,838,129
Excess Appropriation/(Funding)		0	0		0	15,000,000	15,000,000	0	16,200,000	16,200,000
Grand Total		534,359,123	548,872,748		548,872,748	592,888,856	592,888,856	548,872,748	618,038,129	618,038,129

$115,000 cash funds transfer from the State Board of Collection Agencies.

Appropriation Summary

Appropriation: 897 - DHS-Grants Paying Account / Prescription Drugs
Funding Sources: PWD - Grants Paying

		Historical Data			Agency Request and Executive Recommendation					
		2007-2008	2008-2009	2008-2009	2009-2010			2010-2011		
Commitment Item		Actual	Budget	Authorized	Base Level	Agency	Executive	Base Level	Agency	Executive
Prescription Drugs	5100004	340,641,183	385,263,250	440,746,167	385,263,250	439,819,588	439,819,588	385,263,250	475,423,172	475,423,172
Total		340,641,183	385,263,250	440,746,167	385,263,250	439,819,588	439,819,588	385,263,250	475,423,172	475,423,172
Funding Sources										
General Revenue	4000010	77,297,556	101,909,220		101,909,220	111,702,247	108,957,618	101,909,220	121,209,643	116,109,151
Federal Revenue	4000020	224,917,094	256,194,030		256,194,030	280,957,341	281,252,175	256,194,030	305,453,529	305,932,668
Drug Rebates	4000200	29,765,477	27,160,000		27,160,000	27,160,000	29,512,056	27,160,000	27,160,000	31,937,947
Various Program Support	4000730	8,661,056	0		0	0	0	0	0	0
Total Funding		340,641,183	385,263,250		385,263,250	419,819,588	419,721,849	385,263,250	453,823,172	453,979,766
Excess Appropriation/(Funding)		0	0		0	20,000,000	20,097,739	0	21,600,000	21,443,406
Grand Total		340,641,183	385,263,250		385,263,250	439,819,588	439,819,588	385,263,250	475,423,172	475,423,172

Appropriation Summary

Appropriation: 897 - DHS-Grants Paying Account / Hospital and Medical Services
Funding Sources: PWD - Grants Paying

		Historical Data			Agency Request and Executive Recommendation					
		2007-2008	2008-2009	2008-2009	2009-2010			2010-2011		
Commitment Item		**Actual**	**Budget**	**Authorized**	**Base Level**	**Agency**	**Executive**	**Base Level**	**Agency**	**Executive**
Hospital and Medical Services	5100004	2,408,153,725	2,634,264,168	2,897,206,587	2,634,264,168	2,999,642,523	2,999,642,523	2,634,264,168	3,224,177,831	3,224,177,831
Total		2,408,153,725	2,634,264,168	2,897,206,587	2,634,264,168	2,999,642,523	2,999,642,523	2,634,264,168	3,224,177,831	3,224,177,831
Funding Sources										
General Revenue	4000010	482,757,122	469,208,860		469,208,860	543,881,830	511,980,289	469,208,860	635,258,917	607,146,360
Federal Revenue	4000020	1,755,964,328	1,907,820,865		1,907,820,865	2,063,431,984	1,986,322,500	1,907,820,865	2,214,735,613	2,117,216,908
Trust Fund	4000050	69,215,170	155,818,800		155,818,800	110,227,789	128,089,582	155,818,800	48,700,000	48,700,000
Insurance Premium Tax	4000298	6,923,958	0		0	5,124,419	5,124,419	0	0	0
Tobacco Settlement	4000495	0	0		0	0	7,923,456	0	34,219,501	48,740,751
Various Program Support	4000730	93,293,147	101,415,643		101,415,643	125,212,356	125,212,356	101,415,643	124,987,356	124,987,356
Total Funding		2,408,153,725	2,634,264,168		2,634,264,168	2,847,878,378	2,764,652,602	2,634,264,168	3,057,901,387	2,946,791,375
Excess Appropriation/(Funding)		0	0		0	151,764,145	234,989,921	0	166,276,444	277,386,456
Grand Total		2,408,153,725	2,634,264,168		2,634,264,168	2,999,642,523	2,999,642,523	2,634,264,168	3,224,177,831	3,224,177,831

Fund transfers from UAMS are from General Revenue.

Fund transfers from Department of Education are from Cash Funds.

Fund transfers from DHS Divisions are from General Revenue.

Appropriation Summary

Appropriation: 897 - DHS-Grants Paying Account / ARKids B Program

Funding Sources: PWD - Grants Paying

		Historical Data			Agency Request and Executive Recommendation					
		2007-2008	2008-2009	2008-2009	2009-2010			2010-2011		
Commitment Item		Actual	Budget	Authorized	Base Level	Agency	Executive	Base Level	Agency	Executive
ARKids B Program	5100004	95,236,267	111,561,360	116,703,139	111,561,360	137,495,216	137,495,216	111,561,360	157,738,482	157,738,482
Total		95,236,267	111,561,360	116,703,139	111,561,360	137,495,216	137,495,216	111,561,360	157,738,482	157,738,482
Funding Sources										
General Revenue	4000010	23,893,352	30,300,065		30,300,065	34,640,450	34,640,450	30,300,065	40,011,348	40,011,348
Federal Revenue	4000020	69,746,488	81,261,295		81,261,295	92,854,766	92,854,766	81,261,295	106,927,134	106,927,134
Various Program Support	4000730	1,596,427	0		0	0	0	0	0	0
Total Funding		95,236,267	111,561,360		111,561,360	127,495,216	127,495,216	111,561,360	146,938,482	146,938,482
Excess Appropriation/(Funding)		0	0		0	10,000,000	10,000,000	0	10,800,000	10,800,000
Grand Total		95,236,267	111,561,360		111,561,360	137,495,216	137,495,216	111,561,360	157,738,482	157,738,482

Change Level by Appropriation

Appropriation: 897 - DHS-Grants Paying Account / Private Nursing Home Care
Funding Sources: PWD - Grants Paying

Agency Request

Change Level		2009-2010	Pos	Cumulative	% of BL	2010-2011	Pos	Cumulative	% of BL
BL	**Base Level**	**548,872,748**	**0**	**548,872,748**	**100.0**	**548,872,748**	**0**	**548,872,748**	**100.0**
C01	Existing Program	29,016,108	0	577,888,856	105.3	52,965,381	0	601,838,129	109.6
C05	Unfunded Appropriation	15,000,000	0	592,888,856	108.0	16,200,000	0	618,038,129	112.6

Executive Recommendation

Change Level		2009-2010	Pos	Cumulative	% of BL	2010-2011	Pos	Cumulative	% of BL
BL	**Base Level**	**548,872,748**	**0**	**548,872,748**	**100.0**	**548,872,748**	**0**	**548,872,748**	**100.0**
C01	Existing Program	29,016,108	0	577,888,856	105.3	52,965,381	0	601,838,129	109.6
C05	Unfunded Appropriation	15,000,000	0	592,888,856	108.0	16,200,000	0	618,038,129	112.6

Justification	
C01	Growth - The growth in the Medicaid Program is influenced by a number of factors that extend beyond normal inflation and which are generally unaffected by DMS policy decisions. Examples are, Medicaid eligible population increases as a result of a declining economy, the number of eligibles accessing services increases, the number and type of services utilized changes, reimbursement for services that use a cost based methodology increase. FMAP Rate Adjustment – This request results from a recent change in the Federal Medical Assistance Percentage of 0.01% for SFY 2010 and 0.07% for SFY 2011. This decrease in federal matching affects all Medicaid programs.
C05	Arkansas' Medicaid program often undergoes changes that require additional appropriation to be able to respond to federal and state mandates to the extent funds are available. This request is for appropriation only.

Change Level by Appropriation

Appropriation: 897 - DHS-Grants Paying Account / Prescription Drugs
Funding Sources: PWD - Grants Paying

Agency Request

Change Level		2009-2010	Pos	Cumulative	% of BL	2010-2011	Pos	Cumulative	% of BL
BL	**Base Level**	**385,263,250**	**0**	**385,263,250**	**100.0**	**385,263,250**	**0**	**385,263,250**	**100.0**
C01	Existing Program	36,058,599	0	421,321,849	109.4	70,316,516	0	455,579,766	118.3
C05	Unfunded Appropriation	20,000,000	0	441,321,849	114.6	21,600,000	0	477,179,766	123.9
C07	Agency Transfer	(1,502,261)	0	439,819,588	114.2	(1,756,594)	0	475,423,172	123.4

Executive Recommendation

Change Level		2009-2010	Pos	Cumulative	% of BL	2010-2011	Pos	Cumulative	% of BL
BL	**Base Level**	**385,263,250**	**0**	**385,263,250**	**100.0**	**385,263,250**	**0**	**385,263,250**	**100.0**
C01	Existing Program	36,058,599	0	421,321,849	109.4	70,316,516	0	455,579,766	118.3
C05	Unfunded Appropriation	20,000,000	0	441,321,849	114.6	21,600,000	0	477,179,766	123.9
C07	Agency Transfer	(1,502,261)	0	439,819,588	114.2	(1,756,594)	0	475,423,172	123.4

Justification	
C01	Growth - The growth in the Medicaid Program is influenced by a number of factors that extend beyond normal inflation and which are generally unaffected by DMS policy decisions. Examples are, Medicaid eligible population increases as a result of a declining economy, the number of eligibles accessing services increases, the number and type of services utilized changes, reimbursement for services that use a cost based methodology increase. FMAP Rate Adjustment – This request results from a recent change in the Federal Medical Assistance Percentage of 0.01% for SFY 2010 and 0.07% for SFY 2011. This decrease in federal matching affects all Medicaid programs.-------Medication Therapy Management (MTM) is a comprehensive patient centered service that focuses on the patient's total drug therapy needs. The intention of MTM is to optimize the patient's drug regimen to best achieve appropriate therapeutic goals for the patient in the specific subset identified, to improve that patient's health outcome, and to reduce the risks of adverse events. Improving the long-range health outcomes by utilizing MTM for patients with chronic illnesses will improve the quality of life for that patient, decrease adverse events caused by medication over- or under- utilization, and may ultimately decrease the Medicaid medical expenses (ER visits, hospitalization, physician visits) triggered by that patient.
C05	Arkansas' Medicaid program often undergoes changes that require additional appropriation to be able to respond to federal and state mandates to the extent funds are available. This request is for appropriation only.
C07	This request is to reclassify the Breast and Cervical Cancer program administered by the Arkansas Department of Health from 'regular' Medicaid to Medicaid Expansion. DMS management believes that this program is an extension of services to the 19-64 year old population and therefore, is more appropriately classified as an Expansion program.

Change Level by Appropriation

Appropriation: 897 - DHS-Grants Paying Account / Hospital and Medical Services
Funding Sources: PWD - Grants Paying

Agency Request

Change Level		2009-2010	Pos	Cumulative	% of BL	2010-2011	Pos	Cumulative	% of BL
BL	**Base Level**	**2,634,264,168**	**0**	**2,634,264,168**	**100.0**	**2,634,264,168**	**0**	**2,634,264,168**	**100.0**
C01	Existing Program	200,585,017	0	2,834,849,185	107.6	411,375,982	0	3,045,640,150	115.6
C05	Unfunded Appropriation	151,764,145	0	2,986,613,330	113.4	166,276,444	0	3,211,916,594	121.9
C07	Agency Transfer	(10,970,807)	0	2,975,642,523	113.0	(11,738,763)	0	3,200,177,831	121.5
C08	Technology	24,000,000	0	2,999,642,523	113.9	24,000,000	0	3,224,177,831	122.4

Executive Recommendation

Change Level		2009-2010	Pos	Cumulative	% of BL	2010-2011	Pos	Cumulative	% of BL
BL	**Base Level**	**2,634,264,168**	**0**	**2,634,264,168**	**100.0**	**2,634,264,168**	**0**	**2,634,264,168**	**100.0**
C01	Existing Program	200,585,017	0	2,834,849,185	107.6	411,375,982	0	3,045,640,150	115.6
C05	Unfunded Appropriation	151,764,145	0	2,986,613,330	113.4	166,276,444	0	3,211,916,594	121.9
C07	Agency Transfer	(10,970,807)	0	2,975,642,523	113.0	(11,738,763)	0	3,200,177,831	121.5
C08	Technology	24,000,000	0	2,999,642,523	113.9	24,000,000	0	3,224,177,831	122.4

Justification	
C01	The growth in the Medicaid Program is influenced by a number of factors that extend beyond normal inflation and which are generally unaffected by DMS policy decisions. Examples are, Medicaid eligible population increases as a result of a declining economy, the number of eligibles accessing services increases, the number and type of services utilized changes, reimbursement for services that use a cost based methodology increase. FMAP Rate Adjustment - This request results from a recent change in the Federal Medical Assistance Percentage of 0.01% for SFY 2010 and 0.07% for SFY 2011. This decrease in federal matching affects all Medicaid programs. The Medicaid Trust Fund had accumulated a balance which was used in place of additional general revenue in SFY 2008 and SFY 2009, the remaining balance will be used in SFY 2010, but it will not be able to be used as a funding source to the extent that it was utilized in the base (SFY 2009) therefore will have to be replaced with State General Revenue. Various Rate Changes - This request relates to presently contemplated rate increases for such things as physician rates, the establishment of a ventilator unit at the Arkansas Health Center, as well as various court-mandated increases. The request also provides for rate increases that are not specifically known or approved at this time, but that based on previous years operations, DMS management know will be necessary. A likely example of this is rate increases that may be required for certain services in support of the developing statewide trauma system. The Arkansas Optometric Association requested rate increases for eye exams, spectacle prescription services, and contact lens exams to bring the rates to or near the current Medicare reimbursement rates. These rates have not been increased since September 2006. Also an increase for the contact lens material reimbursement rate for Keratoconic lenses, adding a code for an external photo of the eye necessary for diagnosis of specific ocular problems, and expand sensorimotor testing to include adults as medically necessary. -------DMS will outsource the technical writing of all Medicaid provider manuals and automate the process as much as possible for policy review, approval, cross-referencing to rules and regulations, and retaining history of policy changes. DMS currently has 57 provider manuals. DMS will require an initial review and reconciliation of existing policies, so the first year will be more costly than ongoing costs.
C05	This request will provide for increases due to the cost of living, increases due to the gasoline or other transportation costs for increases due additional number of waiver slots for the ACS waiver program. This request is appropriation only. The funding is being requested by the Division of Developmental Disability Services. Arkansas' Medicaid program often undergoes changes that require additional appropriation to be able to respond to federal and state mandates to the extent funds are available. This request is for appropriation only.
C07	This request is to reclassify the Breast and Cervical Cancer program administered by the Arkansas Department of Health from 'regular' Medicaid to Medicaid Expansion. DMS management believes that this program is an extension of services to the 19-64 year old population and therefore, is more appropriately classified as an Expansion program.

Change Level by Appropriation

	Justification
C08	DMS requires additional State General Revenue (SGR) to match federal funds in order to take advantage of enhanced funding opportunities from CMS. With access to enhanced federal funding, DMS will develop Medicaid Information Technology Architecture (MITA) projects and lead collaborative efforts with key stakeholders to develop and implement several major Health Information Technology (HIT) projects including health information exchange, electronic health records, etc. DMS anticipates 75% and 90% federal funding for most of the costs, and the requested SGR will provide matching funds to access the federal funds. This request is in the Division IT Plan on page 17-19, section Medicaid Information Technology Architecture (MITA) Initiatives.

Change Level by Appropriation

Appropriation: 897 - DHS-Grants Paying Account / ARKids B Program
Funding Sources: PWD - Grants Paying

Agency Request

Change Level		2009-2010	Pos	Cumulative	% of BL	2010-2011	Pos	Cumulative	% of BL
BL	**Base Level**	**111,561,360**	**0**	**111,561,360**	**100.0**	**111,561,360**	**0**	**111,561,360**	**100.0**
C01	Existing Program	15,933,856	0	127,495,216	114.3	35,377,122	0	146,938,482	131.7
C05	Unfunded Appropriation	10,000,000	0	137,495,216	123.2	10,800,000	0	157,738,482	141.4

Executive Recommendation

Change Level		2009-2010	Pos	Cumulative	% of BL	2010-2011	Pos	Cumulative	% of BL
BL	**Base Level**	**111,561,360**	**0**	**111,561,360**	**100.0**	**111,561,360**	**0**	**111,561,360**	**100.0**
C01	Existing Program	15,933,856	0	127,495,216	114.3	35,377,122	0	146,938,482	131.7
C05	Unfunded Appropriation	10,000,000	0	137,495,216	123.2	10,800,000	0	157,738,482	141.4

Justification	
C01	The growth in the Medicaid Program is influenced by a number of factors that extend beyond normal inflation and which are generally unaffected by DMS policy decisions. Examples are, Medicaid eligible population increases as a result of a declining economy, the number of eligibles accessing services increases, the number and type of services utilized changes, reimbursement for services that use a cost based methodology increase. FMAP Rate Adjustment – This request results from a recent change in the Federal Medical Assistance Percentage of 0.01% for SFY 2010 and 0.07% for SFY 2011. This decrease in federal matching affects all Medicaid programs.
C05	Arkansas' Medicaid program often undergoes changes that require additional appropriation to be able to respond to federal and state mandates to the extent funds are available. This request is for appropriation only.

Analysis of Budget Request

Appropriation: 898 - DHS-Grants Paying Account

Funding Sources: PWE - Grants Paying

Child and Family Life Institute Appropriation referenced on page 298

Arkansas Code Annotated §20-78-104 authorized Arkansas Children's Hospital to provide administration for the Child Health and Family Life Institute (CHFLI). Children's Hospital and UAMS, Department of Pediatrics act in conjunction by either contract or cooperative agreement for necessary activities in the delivery of services through the CHFLI. The mission of the institute is "an initiated state effort to explore, develop, and evaluate new and better ways to address medically, socially, and economically interrelated health and developmental needs of children with special health care needs and their families. Utilizing a multidisciplinary collaboration of professionals, the Institute's priorities include wellness and prevention, screening and diagnosis, treatment and intervention, training and education, service access, public policy and advocacy, research and evaluation". Programs include such services as KIDS FIRST - a pediatric day health treatment program for preschool age children at risk for developmental delay; CO-MEND Councils of volunteer/local community activities with pooled resources to assist families; Outreach offers specialized health care at the local level for children who live in areas without specialized care available; Community Pediatrics-a support system with a pediatric team available to provide services in medically underserved areas; Children-at-Risk - diagnostic and treatment for children who have been abused and their families; Pediatric Psychology; Developmental/Physical Medicine and Rehabilitation for children with severe disabilities; and Adolescent Medicine. Children's Hospital is specifically to fund the KIDS FIRST Program as a priority when considering program funding decisions within the Institute. The Department of Pediatrics is the administrative oversight entity for cooperative agreements or contracts for the delivery of services.

Funding for this program is derived from general revenues (DGF - DHS Grants Fund Account).

The Agency Base Level and total request for this appropriation is $2,100,000 each year of the biennium.

The Executive Recommendation provides for the Agency Request.

Infant Infirmary Appropriation referenced on page 299

The Infant Infirmary Nursing Home appropriation provides for services to infants with special needs. The facilities are licensed as Private Pediatric Intermediate Care Facilities for the Mentally Retarded (ICFs/MR). Facilities receiving reimbursement through this appropriation are Arkansas Pediatric Facility, Brownwood Life Care Center, Millcreek of Arkansas and Easter Seals Children's Rehabilitation Center. These programs provide a valuable service in that many children are admitted to one of these programs when discharged from a hospital and need continuing attention and medical oversight but not on-going medical treatment.

Funding for this program is derived from general revenues (DGF - DHS Grants Fund Account), federal revenue derived from Title XIX - Medicaid, U. S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. Other revenues, which are indicated as various program support, can

include Medicaid match.

The Agency Base Level request for this appropriation is $19,971,685 each year of the biennium with general revenue of $5,424,310.

The Agency Change Level request for this appropriation is $2,159,066 in FY2010 and $2,959,880 in FY2011 with general revenue request of $181,065 in FY2010 and $378,829 in FY2011 which includes adjustments for the FMAP reduction. The following delineates the agency request:

- $659,066 in FY2010 and $1,339,880 in FY2011 for growth.
- $1,500,000 in FY2010 and $1,620,000 in FY2011 in unfunded appropriation to allow the Division the capability to respond to federal and/or state mandates.

The Executive Recommendation provides for the Agency Request.

In summary, the Executive Recommendation for new general revenue above the Base Level is:

- $179,068 in FY2010 and $364,849 in FY2011 for growth; and
- $1,997 in FY2010 and $13,980 in FY2011 for the FMAP change.

Public Nursing Home Care Appropriation referenced on page 300

The Public Nursing Home Care appropriation includes Title XIX Medicaid reimbursement for services provided in the six (6) Human Development Centers (Intermediate Care Facilities for the Mentally Retarded-ICFs/MR), the Arkansas Health Center and the thirty-one (31) 15 Bed or Less (ICFs/MR) programs across the State. Services include 24 hour a day residential, medical, psychological, education and training, life skills training and therapy services needed through staffing and case plan determination. Annual staffings are required to reassess the progress of each individual and adjustments are made in case plans when necessary to help each person attain the goals and objectives established in the case plans.

Funding for this program is derived from general revenues (DGF - DHS Grants Fund Account), federal and other revenues. Federal revenue derived from Title XIX - Medicaid, U. S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. Other revenues which are indicated as quality assurance fee per Act 635 of 2001, various program support which can include matching funds from the Human Development Centers (from general revenue), the DDS Small 10 Beds Intermediate Care Facilities for the Mentally Retarded (ICFs/MR)(from general revenue), the Arkansas Health Center (from mixed funding).

The Agency Base Level request for this appropriation is $166,564,251 each year of the biennium with general revenue of $6,930,842.

The Agency Change Level request for this appropriation is $17,709,223 in FY2010 and $26,580,833 in FY2011 with general revenue request of $188,658 in FY2010 and $475,754 in FY2011 which includes adjustments for the FMAP reduction. The following delineates the agency request:

- $7,709,223 in FY2010 and $15,780,833 in FY2011 for growth.
- $10,000,000 in FY2010 and $10,800,000 in FY2011 in unfunded appropriation to allow the Division

the capability to respond to federal and/or state mandates.

The Executive Recommendation provides for the Agency Request.

In summary, the Executive Recommendation for new general revenue above the Base Level is:

- $172,002 in FY2010 and $359,159 in FY2011 for growth; and
- $16,656 in FY2010 and $116,595 in FY2011 for the FMAP change.

Appropriation Summary

Appropriation: 898 - DHS-Grants Paying Account / Child & Family Life Institute
Funding Sources: PWE - Grants Paying

	Historical Data			Agency Request and Executive Recommendation					
	2007-2008	2008-2009	2008-2009	2009-2010			2010-2011		
Commitment Item	**Actual**	**Budget**	**Authorized**	**Base Level**	**Agency**	**Executive**	**Base Level**	**Agency**	**Executive**
Child & Family Life Inst 5100004	0	2,100,000	2,100,000	2,100,000	2,100,000	2,100,000	2,100,000	2,100,000	2,100,000
Total	0	2,100,000	2,100,000	2,100,000	2,100,000	2,100,000	2,100,000	2,100,000	2,100,000
Funding Sources									
General Revenue 4000010	0	2,100,000		2,100,000	2,100,000	2,100,000	2,100,000	2,100,000	2,100,000
Total Funding	0	2,100,000		2,100,000	2,100,000	2,100,000	2,100,000	2,100,000	2,100,000
Excess Appropriation/(Funding)	0	0		0	0	0	0	0	0
Grand Total	0	2,100,000		2,100,000	2,100,000	2,100,000	2,100,000	2,100,000	2,100,000

Appropriation Summary

Appropriation: 898 - DHS-Grants Paying Account / Infant Infirmary
Funding Sources: PWE - Grants Paying

		Historical Data			Agency Request and Executive Recommendation					
		2007-2008	2008-2009	2008-2009	2009-2010			2010-2011		
Commitment Item		Actual	Budget	Authorized	Base Level	Agency	Executive	Base Level	Agency	Executive
Infant Infirmary	5100004	19,544,582	19,971,685	21,338,175	19,971,685	22,130,751	22,130,751	19,971,685	22,931,565	22,931,565
Total		19,544,582	19,971,685	21,338,175	19,971,685	22,130,751	22,130,751	19,971,685	22,931,565	22,931,565
Funding Sources										
General Revenue	4000010	4,975,279	5,424,310		5,424,310	5,605,375	5,605,375	5,424,310	5,803,139	5,803,139
Federal Revenue	4000020	14,274,468	14,547,375		14,547,375	15,025,376	15,025,376	14,547,375	15,508,426	15,508,426
Various Program Support	4000730	294,835	0		0	0	0	0	0	0
Total Funding		19,544,582	19,971,685		19,971,685	20,630,751	20,630,751	19,971,685	21,311,565	21,311,565
Excess Appropriation/(Funding)		0	0		0	1,500,000	1,500,000	0	1,620,000	1,620,000
Grand Total		19,544,582	19,971,685		19,971,685	22,130,751	22,130,751	19,971,685	22,931,565	22,931,565

Appropriation Summary

Appropriation: 898 - DHS-Grants Paying Account / Public Nursing Home Care
Funding Sources: PWE - Grants Paying

		Historical Data			Agency Request and Executive Recommendation					
		2007-2008	2008-2009	2008-2009	2009-2010			2010-2011		
Commitment Item		Actual	Budget	Authorized	Base Level	Agency	Executive	Base Level	Agency	Executive
Public Nursing Home Care	5100004	162,058,661	166,564,251	170,497,211	166,564,251	184,273,474	184,273,474	166,564,251	193,145,084	193,145,084
Total		162,058,661	166,564,251	170,497,211	166,564,251	184,273,474	184,273,474	166,564,251	193,145,084	193,145,084
Funding Sources										
General Revenue	4000010	6,661,516	6,930,842		6,930,842	7,119,500	7,119,500	6,930,842	7,406,596	7,406,596
Federal Revenue	4000020	118,378,056	121,325,400		121,325,400	126,923,371	126,923,371	121,325,400	132,692,517	132,692,517
Quality Assurance Fee	4000395	996,229	888,556		888,556	888,556	888,556	888,556	888,556	888,556
Various Program Support	4000730	36,022,860	37,419,453		37,419,453	39,342,047	39,342,047	37,419,453	41,357,415	41,357,415
Total Funding		162,058,661	166,564,251		166,564,251	174,273,474	174,273,474	166,564,251	182,345,084	182,345,084
Excess Appropriation/(Funding)		0	0		0	10,000,000	10,000,000	0	10,800,000	10,800,000
Grand Total		162,058,661	166,564,251		166,564,251	184,273,474	184,273,474	166,564,251	193,145,084	193,145,084

Fund transfers from the Division of Developmental Disability Services are from General Revenue.

Fund transfers from the Division of Behavioral Health Services are from mixed funding sources.

Change Level by Appropriation

Appropriation: 898 - DHS-Grants Paying Account / Child & Family Life Institute
Funding Sources: PWE - Grants Paying

Agency Request

Change Level		2009-2010	Pos	Cumulative	% of BL	2010-2011	Pos	Cumulative	% of BL
BL	Base Level	2,100,000	0	2,100,000	100.0	2,100,000	0	2,100,000	100.0

Executive Recommendation

Change Level		2009-2010	Pos	Cumulative	% of BL	2010-2011	Pos	Cumulative	% of BL
BL	Base Level	2,100,000	0	2,100,000	100.0	2,100,000	0	2,100,000	100.0

Change Level by Appropriation

Appropriation: 898 - DHS-Grants Paying Account / Infant Infirmary
Funding Sources: PWE - Grants Paying

Agency Request

Change Level		2009-2010	Pos	Cumulative	% of BL	2010-2011	Pos	Cumulative	% of BL
BL	**Base Level**	**19,971,685**	**0**	**19,971,685**	**100.0**	**19,971,685**	**0**	**19,971,685**	**100.0**
C01	Existing Program	659,066	0	20,630,751	103.3	1,339,880	0	21,311,565	106.7
C05	Unfunded Appropriation	1,500,000	0	22,130,751	110.8	1,620,000	0	22,931,565	114.8

Executive Recommendation

Change Level		2009-2010	Pos	Cumulative	% of BL	2010-2011	Pos	Cumulative	% of BL
BL	**Base Level**	**19,971,685**	**0**	**19,971,685**	**100.0**	**19,971,685**	**0**	**19,971,685**	**100.0**
C01	Existing Program	659,066	0	20,630,751	103.3	1,339,880	0	21,311,565	106.7
C05	Unfunded Appropriation	1,500,000	0	22,130,751	110.8	1,620,000	0	22,931,565	114.8

Justification	
C01	Growth - The growth in the Medicaid Program is influenced by a number of factors that extend beyond normal inflation and which are generally unaffected by DMS policy decisions. Examples are, Medicaid eligible population increases as a result of a declining economy, the number of eligibles accessing services increases, the number and type of services utilized changes, reimbursement for services that use a cost based methodology increase. FMAP Rate Adjustment – This request results from a recent change in the Federal Medical Assistance Percentage of 0.01% for SFY 2010 and 0.07% for SFY 2011. This decrease in federal matching affects all Medicaid programs.
C05	Arkansas' Medicaid program often undergoes changes that require additional appropriation to be able to respond to federal and state mandates to the extent funds are available. This request is for appropriation only.

Change Level by Appropriation

Appropriation: 898 - DHS-Grants Paying Account / Public Nursing Home Care
Funding Sources: PWE - Grants Paying

Agency Request

Change Level		2009-2010	Pos	Cumulative	% of BL	2010-2011	Pos	Cumulative	% of BL
BL	**Base Level**	**166,564,251**	**0**	**166,564,251**	**100.0**	**166,564,251**	**0**	**166,564,251**	**100.0**
C01	Existing Program	7,709,223	0	174,273,474	104.6	15,780,833	0	182,345,084	109.5
C05	Unfunded Appropriation	10,000,000	0	184,273,474	110.6	10,800,000	0	193,145,084	116.0

Executive Recommendation

Change Level		2009-2010	Pos	Cumulative	% of BL	2010-2011	Pos	Cumulative	% of BL
BL	**Base Level**	**166,564,251**	**0**	**166,564,251**	**100.0**	**166,564,251**	**0**	**166,564,251**	**100.0**
C01	Existing Program	7,709,223	0	174,273,474	104.6	15,780,833	0	182,345,084	109.5
C05	Unfunded Appropriation	10,000,000	0	184,273,474	110.6	10,800,000	0	193,145,084	116.0

Justification	
C01	Growth - The growth in the Medicaid Program is influenced by a number of factors that extend beyond normal inflation and which are generally unaffected by DMS policy decisions. Examples are, Medicaid eligible population increases as a result of a declining economy, the number of eligibles accessing services increases, the number and type of services utilized changes, reimbursement for services that use a cost based methodology increase. FMAP Rate Adjustment – This request results from a recent change in the Federal Medical Assistance Percentage of 0.01% for SFY 2010 and 0.07% for SFY 2011. This decrease in federal matching affects all Medicaid programs.
C05	Arkansas' Medicaid program often undergoes changes that require additional appropriation to be able to respond to federal and state mandates to the extent funds are available. This request is for appropriation only.