ARKANSAS DEPARTMENT OF HUMAN SERVICES

Request for Information
Data Appendix

Behavioral Health Services, Developmental Disabilities Services and Care for the Aged, Frail and Physically Disabled

May 15, 2015

Introduction and methodological notes

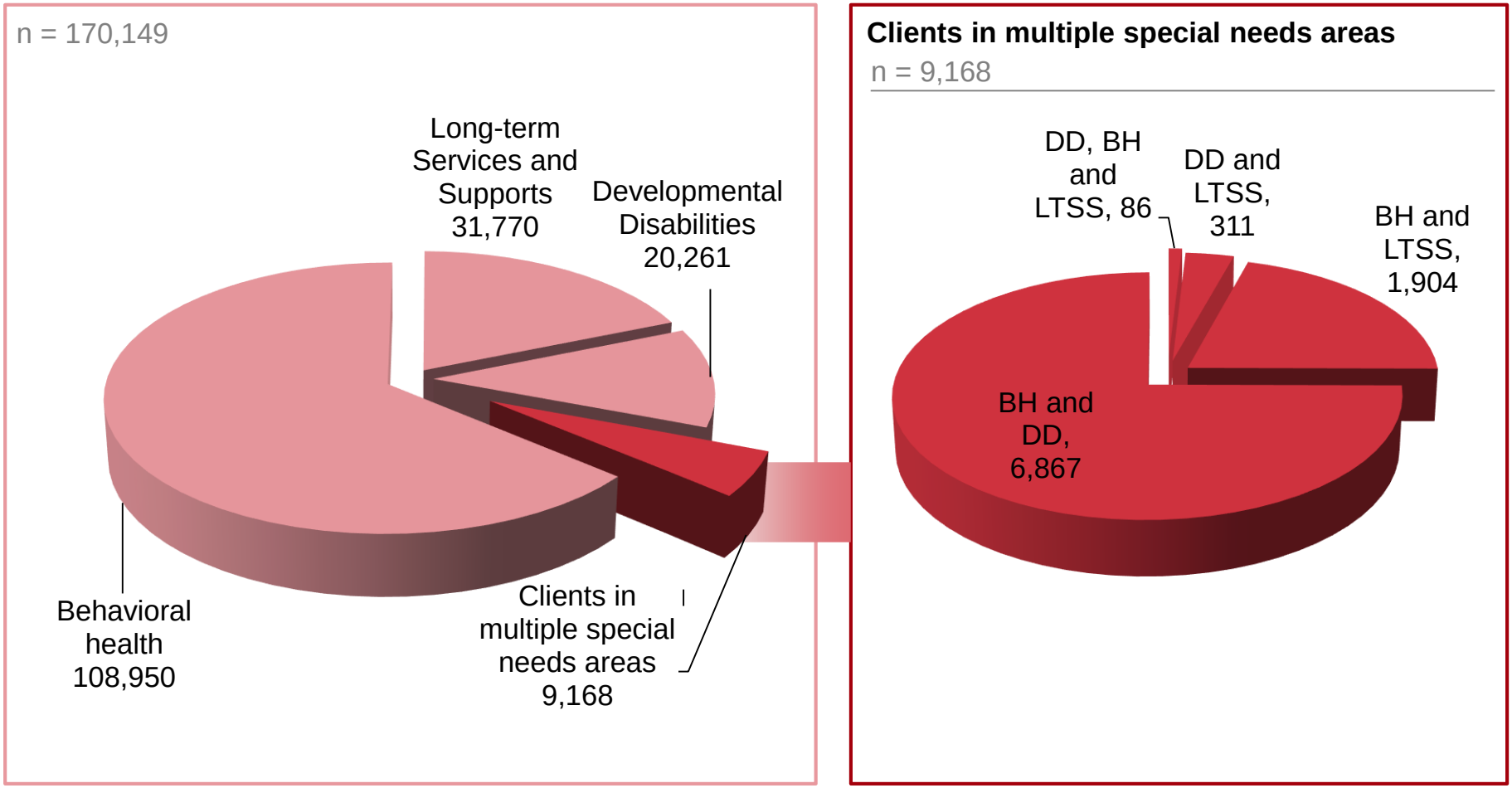
- The data contained in the following exhibits is based on an analysis of SFY2011-SFY2014 Medicaid claims data for the set of services – and recipients of those services – deemed to be included in the areas of Behavioral Health Services (BH), Developmental Disabilities Services (DD), and care for the Aged, Frail and Physically Disabled (collectively referred to as Long-Term Services and Supports, LTSS)
- The categories of service included in these analyses, in terms of spending, unique clients, associated “halo” spend (Medicaid-funded medical, inpatient, outpatient and pharmacy spend), and provider landscape, represent the full scope of this Request for Information at the present time.
- Full definitions of service categories and additional analytical and methodological notes are provided in the footnotes of each exhibit as well as in the definitions section at the end of this document.

Overview of Behavioral Health (BH), Developmental Disabilities (DD), and Long-term Supports and Services (LTSS) populations

Clients with claims in one service area
Clients with claims across multiple service areas

Exhibit 1: Arkansas Medicaid special needs clients by area, SFY2014

Number of unique clients

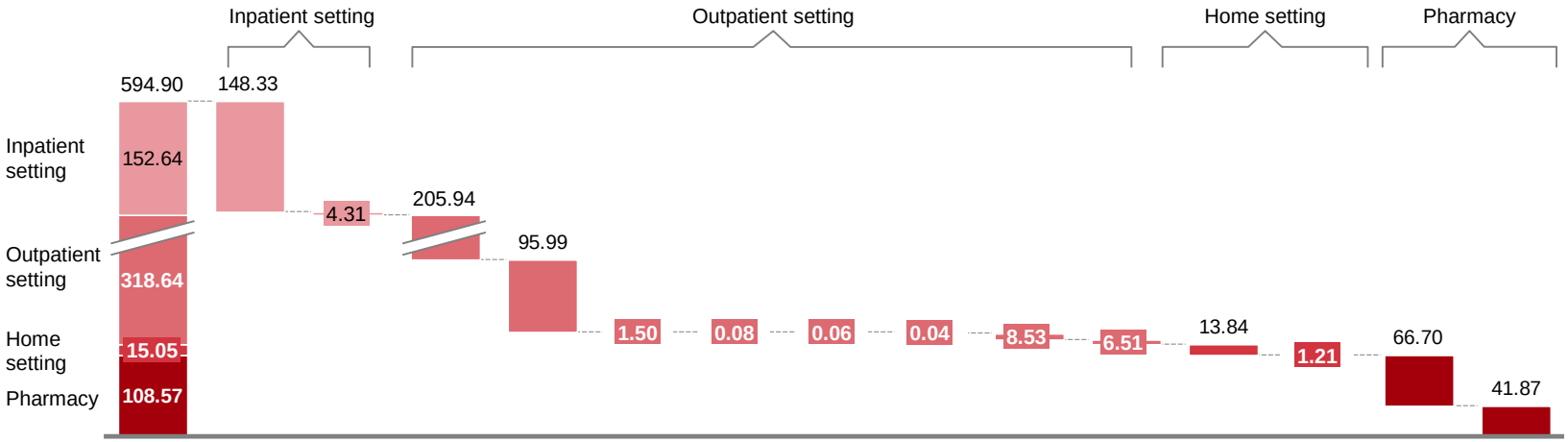


1 For inclusion in a given special needs area, a client must have at least one claim in one of the spending categories considered as part of a given special needs area as shown in Exhibits 2 (Behavioral Health), 12 (Developmental Disabilities) and 22 (Long-Term Services and Supports)

Source: SFY2014 Medicaid claims

Behavioral Health Medicaid spend overview

Exhibit 2: Behavioral Health Medicaid spend, SFY2014
$ millions



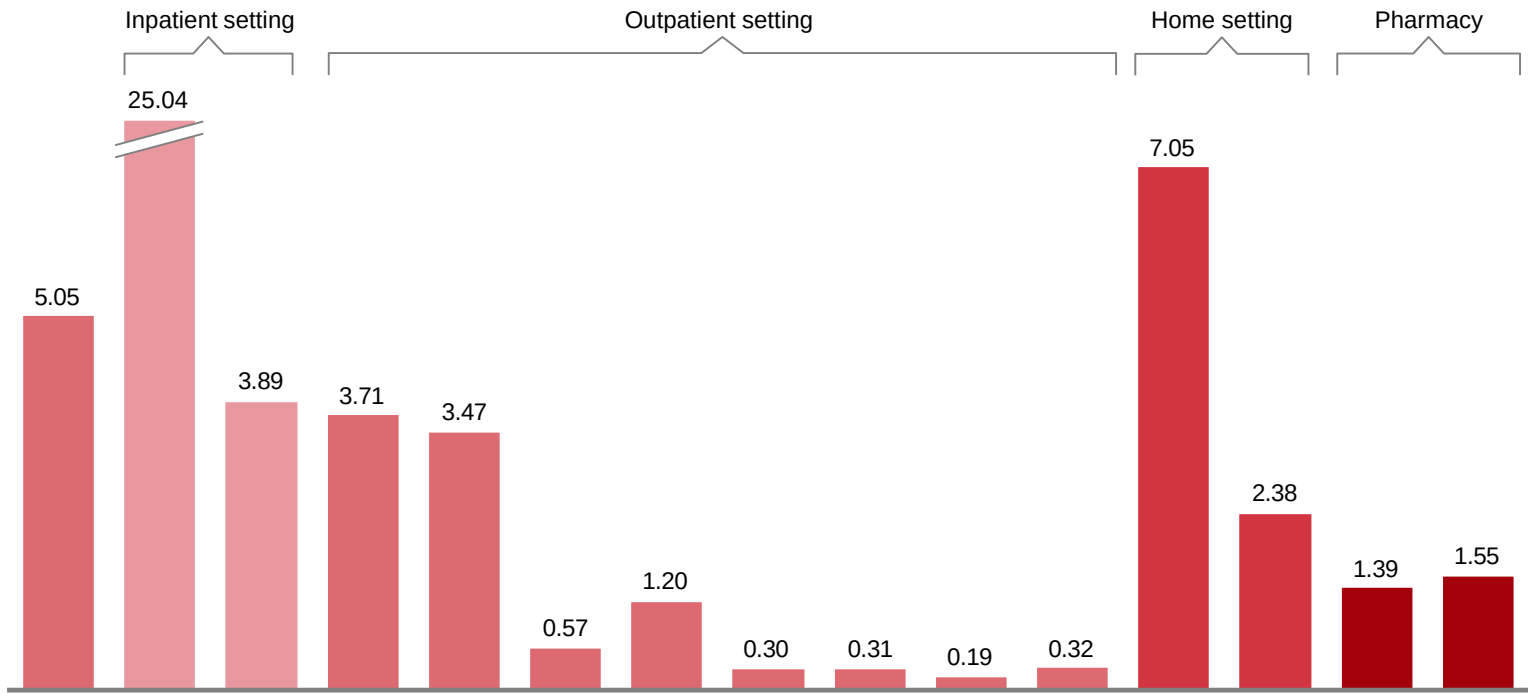
	BH Services	Children	Adults	Children	Adults	Children	Adults	Sub-stance abuse treatment services[1]	School-Based MH Services	Children	Adults	Personal care services	Home health services	Children	Adults
		Inpatient Psychiatric		Rehabilitative Ser-vices for Persons with Mental Illness		Licensed mental health professionals				Behavioral health services in other settings				Specialty pharmacy	
SFY2011-2014 Annual growth %	**1.5**	**-0.4**	**-0.4**	**3.3**	**-0.2**	**27.0**	**27.1**	**---**	**-2.1**	**4.3**	**5.4**	**10.0**	**-3.2**	**4.8**	**-4.0**
2011-2014 Annual growth per capita, %	**-0.6**	**-2.1**	**-6.5**	**2.2**	**-0.5**	**15.0**	**25.2**	**--**	**1.9**	**-1.0**	**1.3**	**3.1**	**0.1**	**1.8**	**-2.4**
Unique clients[2] SFY 2014 Number	**117,807**	**5,923**	**1,106**	**55,443**	**27,624**	**2,627**	**66**	**187**	**133**	**43,680**	**19,870**	**1,963**	**510**	**47,821**	**27,047**
Individual claims SFY 2014 Number	**5,500,872**	**120,827**	**2,162**	**2,601,924**	**1,469,707**	**15,191**	**212**	**1,093**	**1,415**	**160,428**	**125,967**	**70,132**	**3,239**	**543,929**	**384,646**

1 Growth rates not listed since Substance Abuse Treatment Services Program was launched during SFY2012
2 Unique clients may be duplicated across categories since individuals may receive services in multiple categories in a given year. The total at left represents a non-duplicated count of all individuals who received BH services.

Source: SFY2011-2014 Medicaid claims

Behavioral Health Medicaid spend overview

Exhibit 3: Behavioral Health Medicaid spend per unique client, SFY2014
$ thousands



SFY2011-2014 Annual growth %	**-0.6**	**-2.1**	**-6.5**	**2.2**	**-0.5**	**15.0**	**25.2**	**--**	**1.9**	**-1.0**	**1.3**	**3.1**	**0.1**	**1.8**	**-2.4**

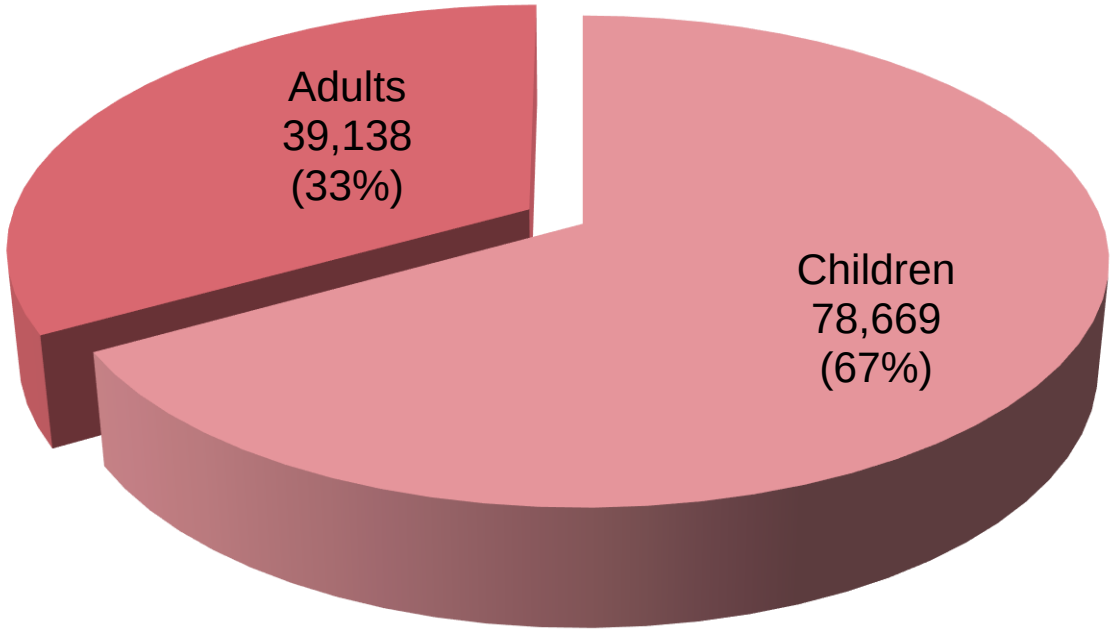
1 Growth rates not listed since Substance Abuse Treatment Services Program was launched during SFY2012

Source: SFY2011-2014 Medicaid claims

Behavioral Health Medicaid population overview

Exhibit 4: Behavioral Health clients by age, SFY2014

n = 117,807



Source: SFY2014 Medicaid claims

Behavioral Health Medicaid population overview

Exhibit 5: Behavioral Health clients by BH service area and Medicare eligibility status, SFY2014

$ millions

1 Includes all clients under the age of 65 who have not been verified as Dual-eligible in the Medicaid Management Information System
2 Includes all clients age 65 and over as well as clients who are under 65 and have been verified as Dual-eligible in the Medicaid Management Information System

Source: SFY2014 Medicaid claims

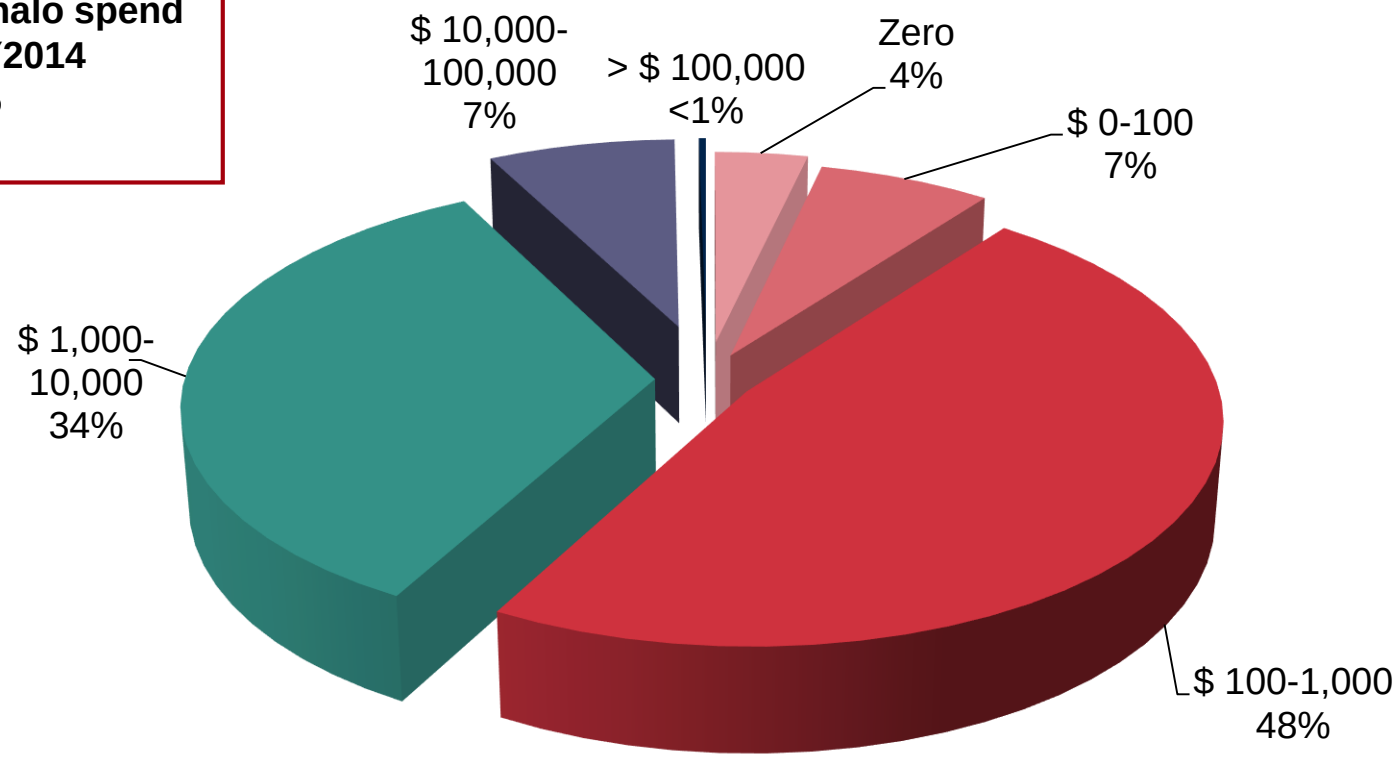
Behavioral Health Medicaid halo spend overview

Exhibit 6: Percentage of distinct Behavioral Health clients by amount of Medicaid-funded halo[1] spend, SFY2014

n = 84,959

Medicaid-funded halo spend of BH clients, SFY2014

- Mean: $3,687.15
- Median: $740.16



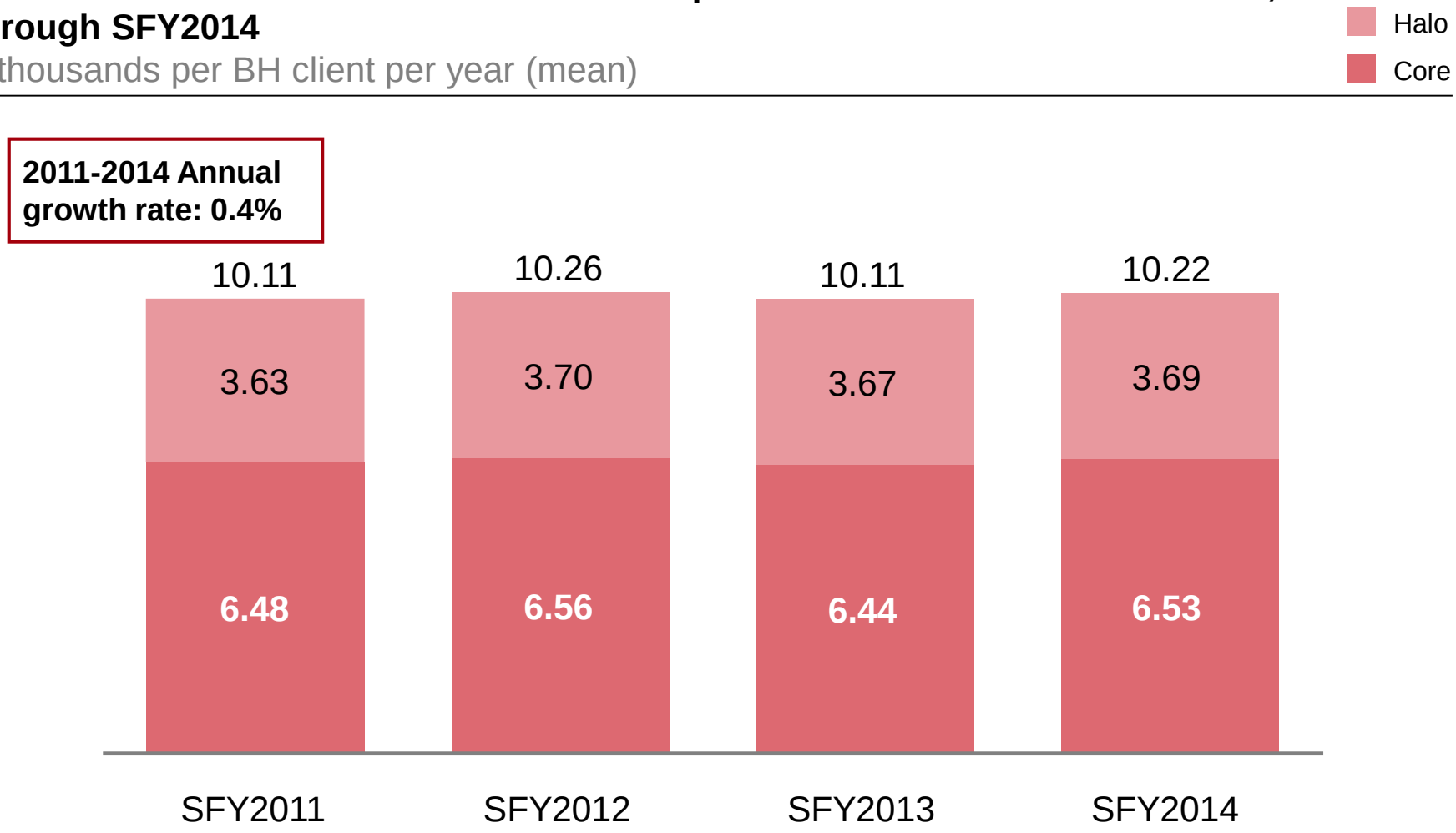
1 Halo spend includes Medicaid-only Inpatient, Outpatient, Pharmacy and Professional Claims outside of the areas defined as "core" on the preceding pages.

Source: SFY2014 Medicaid claims

Behavioral Health Medicaid core and halo spend

Exhibit 7: Medicaid-funded core and halo spend[1] of Behavioral Health clients, SFY2011 through SFY2014

$ thousands per BH client per year (mean)



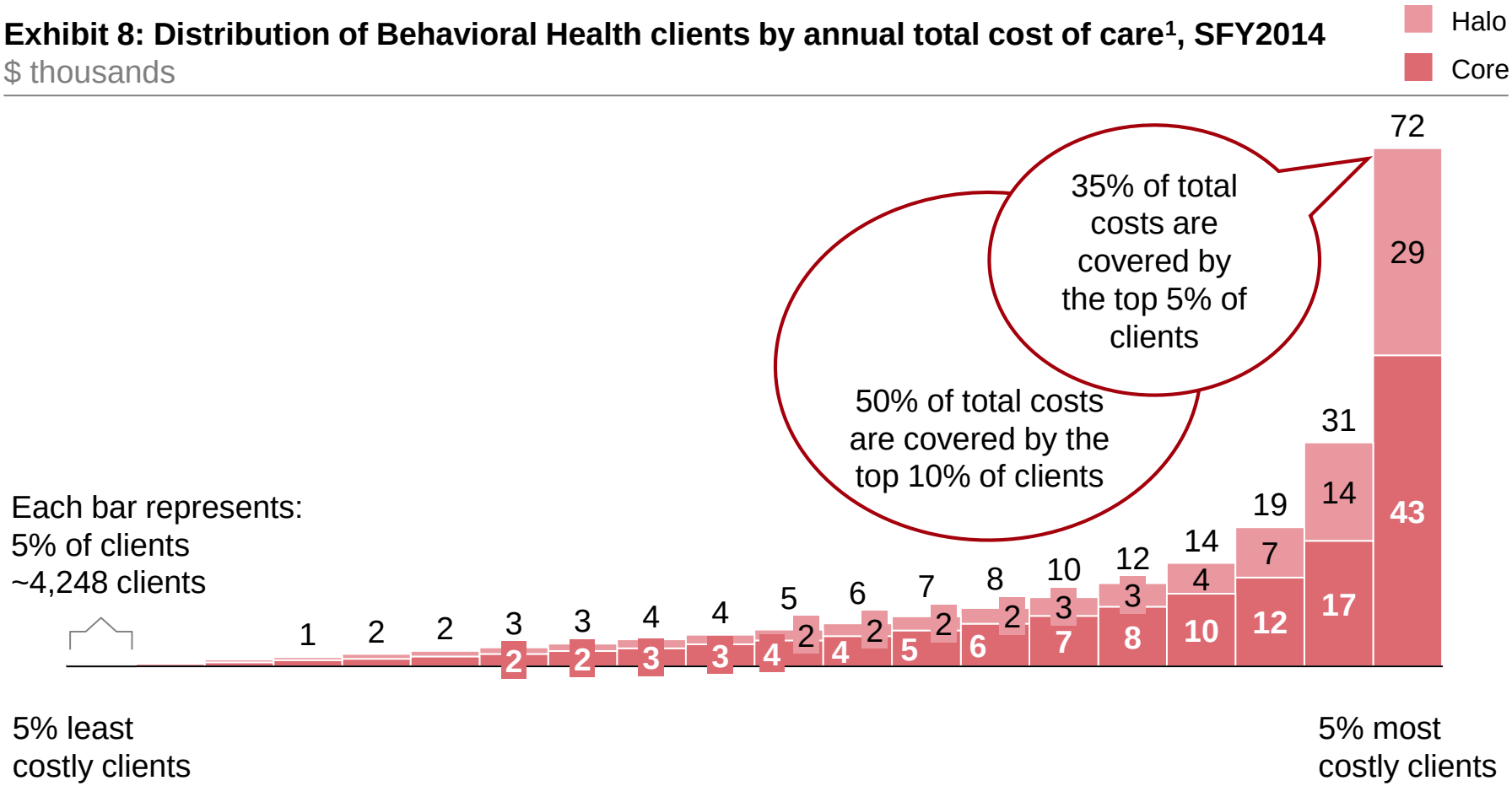
1 For this analysis, the included population consists of clients who received specialty behavioral health services only, including Inpatient Psychiatric, RSPMI, LMHP, School-based MH Services or Substance Abuse Treatment Services (approximately 85,000 individuals in SFY2014). Medicaid clients who received care for behavioral health diagnoses in other settings only (e.g., primary care) are excluded from this analysis. For the included population, core spend includes all services listed above as well as Personal Care Services, Home Health Services and specialty (psychotropic) pharmaceuticals. All other pharmacy spend for these clients, as well as all other inpatient, outpatient and professional claims (even if for a behavioral health diagnosis code), are included as "halo" spend.

Source: SFY2011-2014 Medicaid claims

Behavioral Health core and halo spend

Exhibit 8: Distribution of Behavioral Health clients by annual total cost of care[1], SFY2014

$ thousands



1 For this analysis, the included population consists of clients who received specialty behavioral health services only, including Inpatient Psychiatric, RSPMI, LMHP, School-based MH Services or Substance Abuse Treatment Services (approximately 85,000 individuals in SFY2014). Medicaid clients who received care for behavioral health diagnoses in other settings only (e.g., primary care) are excluded from this analysis. For the included population, core spend includes all services listed above as well as Personal Care Services, Home Health Services and specialty (psychotropic) pharmaceuticals. All other pharmacy spend for these clients, as well as all other inpatient, outpatient and professional claims (even if for a behavioral health diagnosis code), are included as "halo" spend.

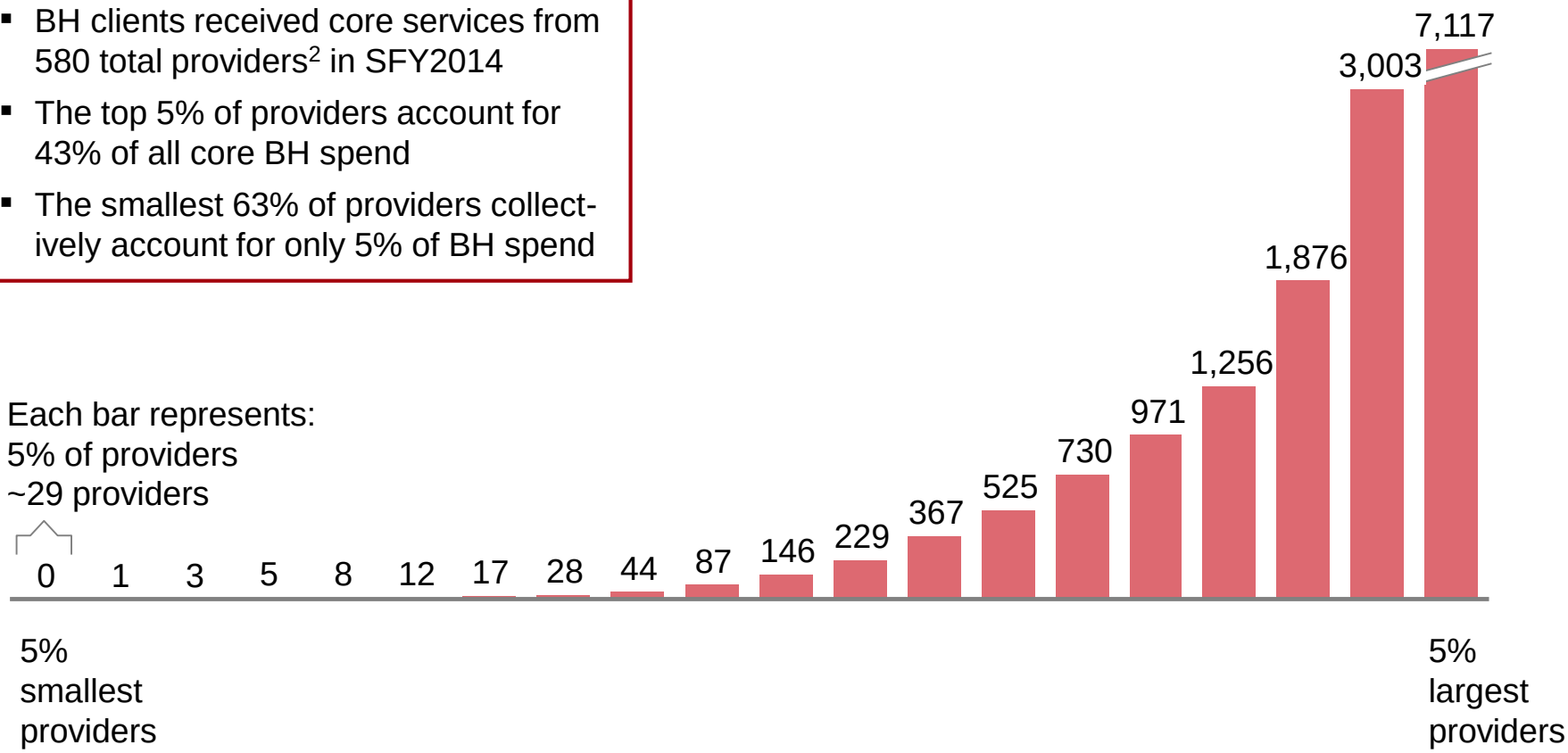
Source: SFY2014 Medicaid claims

Behavioral Health provider landscape

Exhibit 9: Distribution of Behavioral Health providers by average annual claims, SFY2014[1]

Paid claims, $ thousands

- BH clients received core services from 580 total providers[2] in SFY2014
- The top 5% of providers account for 43% of all core BH spend
- The smallest 63% of providers collectively account for only 5% of BH spend



1 Includes specialty behavioral health providers only, including Inpatient Psychiatric, RSPMI, LMHP, School-based MH Services, Substance Abuse Treatment Services, and Personal Care and Home Health providers who delivered services to behavioral health clients. Excludes pharmacy providers and providers in other settings (e.g., primary care) who provided services for behavioral health diagnoses.

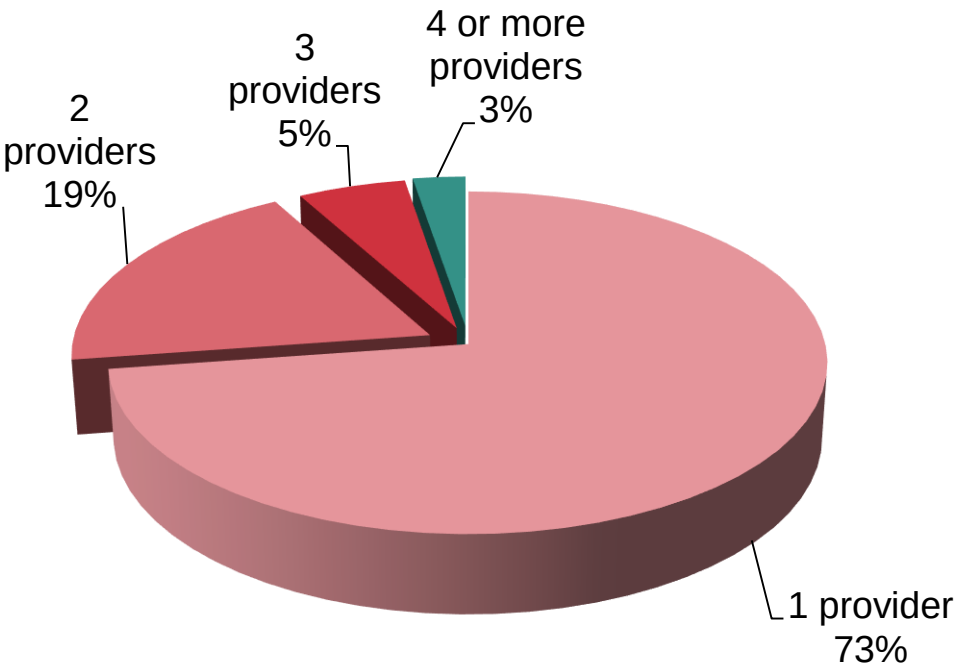
2 Based on unique Provider IDs, where an individual provider organization may have multiple provider IDs due to multiple distinct sites or billing entities

Source: SFY2014 Medicaid claims

Behavioral Health provider landscape

Exhibit 10: Number of distinct Behavioral Health clients by number of Medicaid providers seen[1], SFY2014

n = 84,959



Number of providers seen[2]	% of clients	Average total BH spend per client $ thousands
1	73	3.1
2	19	8.7
3	5	16.5
4 or more	3	30.1

1 Includes specialty behavioral health providers only, including Inpatient Psychiatric, RSPMI, LMHP, School-based MH Services, Substance Abuse Treatment Services, and Personal Care and Home Health providers who delivered services to behavioral health clients. Excludes pharmacy providers and providers in other settings (e.g., primary care) who provided services for behavioral health diagnoses.

2 Based on unique Provider IDs, where an individual provider organization may have multiple provider IDs due to multiple distinct sites or billing entities

Source: SFY2014 Medicaid claims

State Medicaid benchmark data for Behavioral Health

This page is intended to provide a set of benchmarked indicators sourced from publicly available research and reports. Data pertaining to Arkansas on this page may not match that provided on the preceding charts due to differing time periods and methodologies. Methodological details for these indicators are provided in their original sources. Their inclusion on this page is not meant as an endorsement of the indicator or source, nor as an affirmation of the results for the state of Arkansas.

Exhibit 11: State Medicaid Benchmark data for Behavioral Health

Description	Calculation	United States	Arkansas
1. Total medication use for people with a mental disorder	▪ Mean expenses per person with care for a mental disorder for prescribed medicines (2012)	▪ $850 per person	▪ $1,269 per person
2. Residential psychiatric program utilization	▪ Inpatient psychiatric admissions per 100,000 Medicaid eligible adults and children ▪ Median length of stay in inpatient psychiatric facilities	▪ Children – Admissions: 2.0 – Length of stay: 83 days ▪ Adults – Admissions: 17.4 – Length of stay: 58	▪ Children – Admissions: 4.6 – Length of stay: 83 days ▪ Adults – Admissions: 8.3 – Length of stay: 34
3. Children taking medication for a behavioral disorder	▪ Prevalence data of all children receiving ADHD Medication Treatment, aged 4-17 (2011-12)	▪ 6.1%	▪ 9.9%
4. Mental health admissions	▪ Total number of discharges for CSS principle diagnosis, *All Mental Health Diagnoses*, categories 650-663, 670 (2012)	▪ 5.7% of total discharges	▪ 4.9% of total discharges
5. Suicide rate	▪ Suicide Rate per 100,000 people (2013)	▪ 12.6 people	▪ 17.3 people

Sources:

1 MEPS (U.S.), SFY2012 Arkansas Medicaid Claims data (Arkansas) http://meps.ahrq.gov/mepsweb/data_stats/tables_compendia_hh_interactive.jsp?_SERVICE=MEPSSocket0&_PROGRAM=MEPSPGM.TC.SAS&File=HCFY2012&Table=HCFY2012_CNDXP_CA&_Debug=

2 Substance Abuse and Mental Health Services Administration (SAMHSA). (2013).Table 62. http://media.samhsa.gov/data/2012BehavioralHealthUS/2012-BHUS.pdf

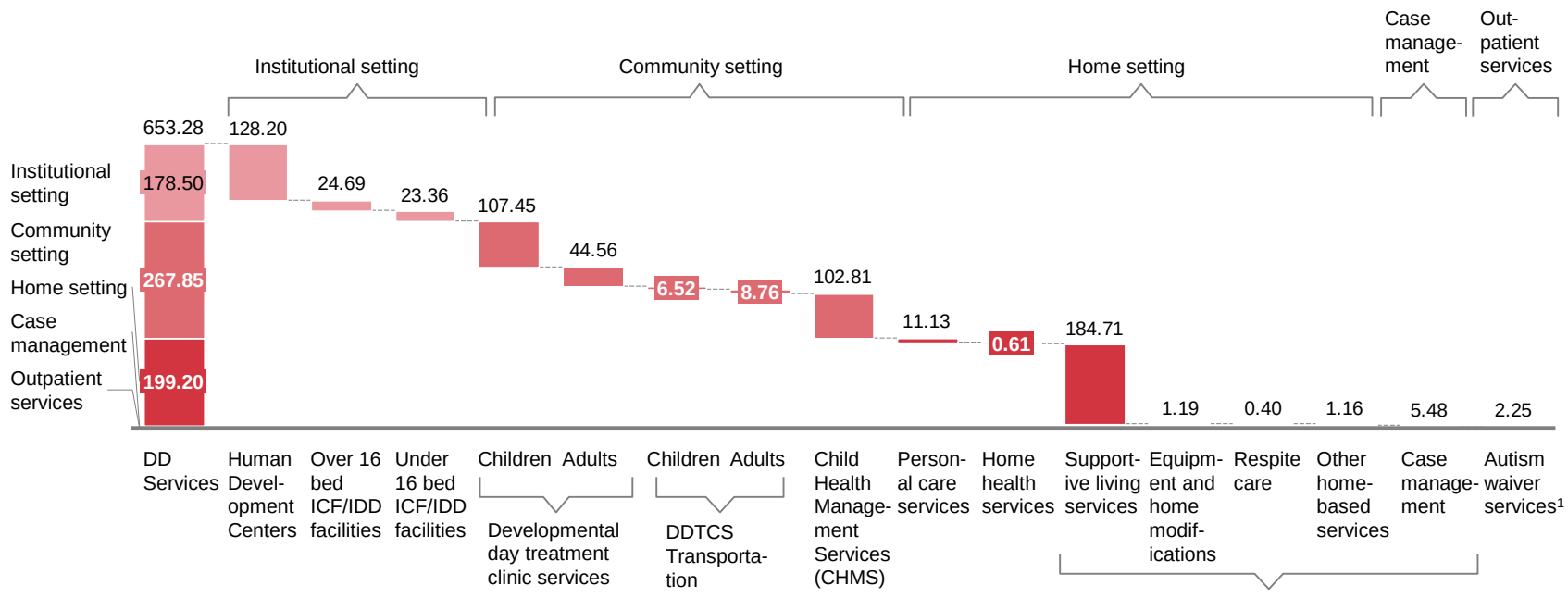
3 CDC http://www.cdc.gov/ncbddd/adhd/medicated.html

4 HCUPnet http://hcupnet.ahrq.gov/HCUPnet.jsp

5 AFSP https://www.afsp.org/understanding-suicide/facts-and-figures

Developmental Disabilities Medicaid spend overview

Exhibit 12: Developmental Disabilities Medicaid spend, SFY2014
$ millions



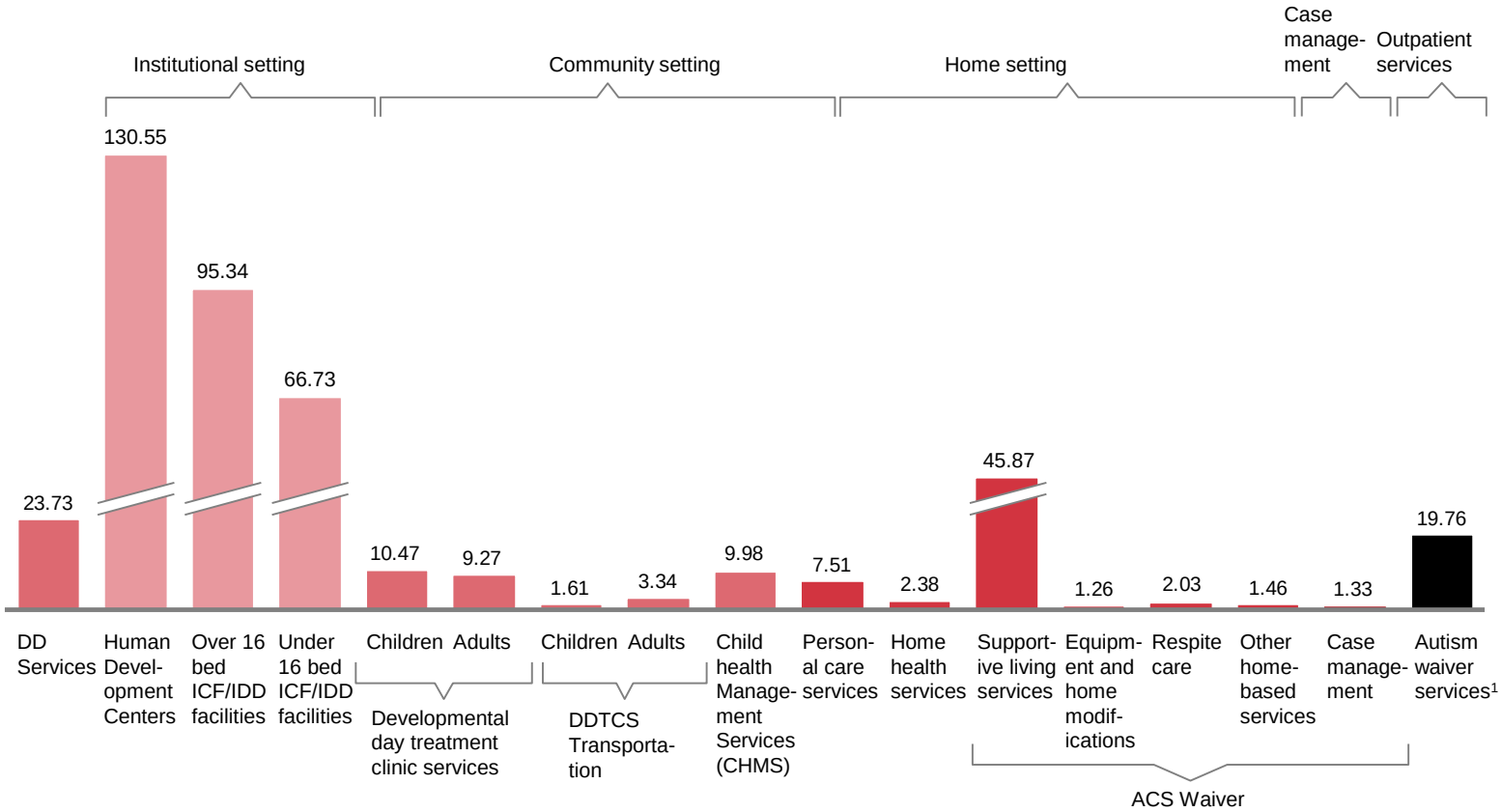
2011-2014 Annual growth, %	**5.3**	**5.3**	**3.2**	**1.6**	**1.0**	**3.0**	**3.2**	**2.7**	**9.8**	**7.7**	**-8.9**	**7.0**	**-0.1**	**-5.4**	**13.2**	**0.7**	**--**
2011-2014 Annual growth per capita, %	**2.2**	**6.7**	**1.3**	**1.3**	**0.4**	**1.0**	**5.1**	**1.1**	**2.8**	**1.3**	**4.5**	**6.8**	**-7.6**	**3.4**	**-0.8**	**0.3**	**--**
Unique clients[2] SFY 2014, Number	**27,525**	**982**	**259**	**350**	**10,265**	**4,808**	**4,040**	**2,619**	**10,304**	**1,483**	**258**	**4,027**	**951**	**196**	**793**	**4,110**	**114**
Individual claims SFY 2014, Number	**2,138,374**	**56,542**	**14,219**	**13,906**	**476,280**	**211,231**	**40,474**	**43,068**	**947,972**	**66,167**	**2,455**	**190,767**	**7,138**	**1,782**	**7,701**	**46,152**	**12,520**

1 Growth rates not listed since Autism Intensive Intervention Provider Waiver was launched during SFY2013
2 Unique clients may be duplicated across categories since individuals may receive services in multiple categories in a given year. The total at left represents a non-duplicated count of all individuals who received DD services.

Source: SFY2011-2014 Medicaid claims

Developmental Disabilities Medicaid spend overview

Exhibit 13: Developmental Disabilities Medicaid spend per unique client, SFY2014
$ thousands



2011-2014 Annual growth %	**2.2**	**6.7**	**1.3**	**1.3**	**0.4**	**1.0**	**5.1**	**1.1**	**2.8**	**1.3**	**4.5**	**6.8**	**-7.6**	**3.4**	**-0.8**	**0.3**	**--**

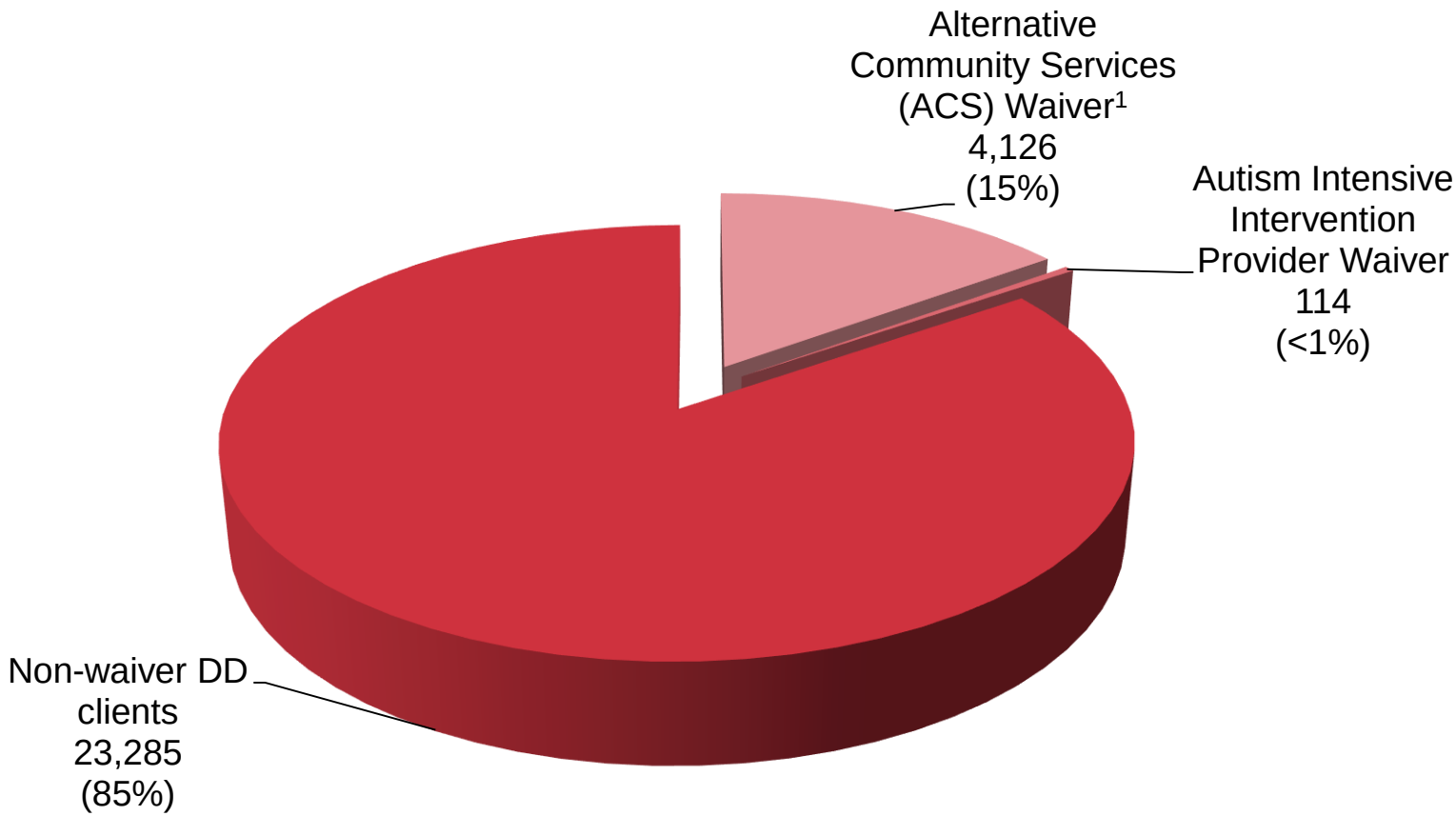
1 Autism intensive intervention provider waiver was launched during SFY2013

Source: SFY2011-2014 Medicaid claims

Developmental Disabilities Medicaid population overview

Exhibit 14: Developmental Disabilities clients by waiver/program, SFY2014

n = 27,525



1 Approximately 3,000 individuals have applied for, but are not currently receiving, waiver services through the Alternative Community Services (ACS) Waiver

Source: SFY2011-2014 Medicaid claims

Developmental Disabilities Medicaid population overview

Exhibit 15: Developmental Disabilities clients by DD service area and Medicare eligibility status, SFY2014

$ millions

1 Includes all clients under the age of 65 who have not been verified as Dual-eligible in the Medicaid Management Information System
2 Includes all clients age 65 and over as well as clients who are under 65 and have been verified as dual-eligible in the Medicaid Management Information System

Source: SFY2014 Medicaid claims

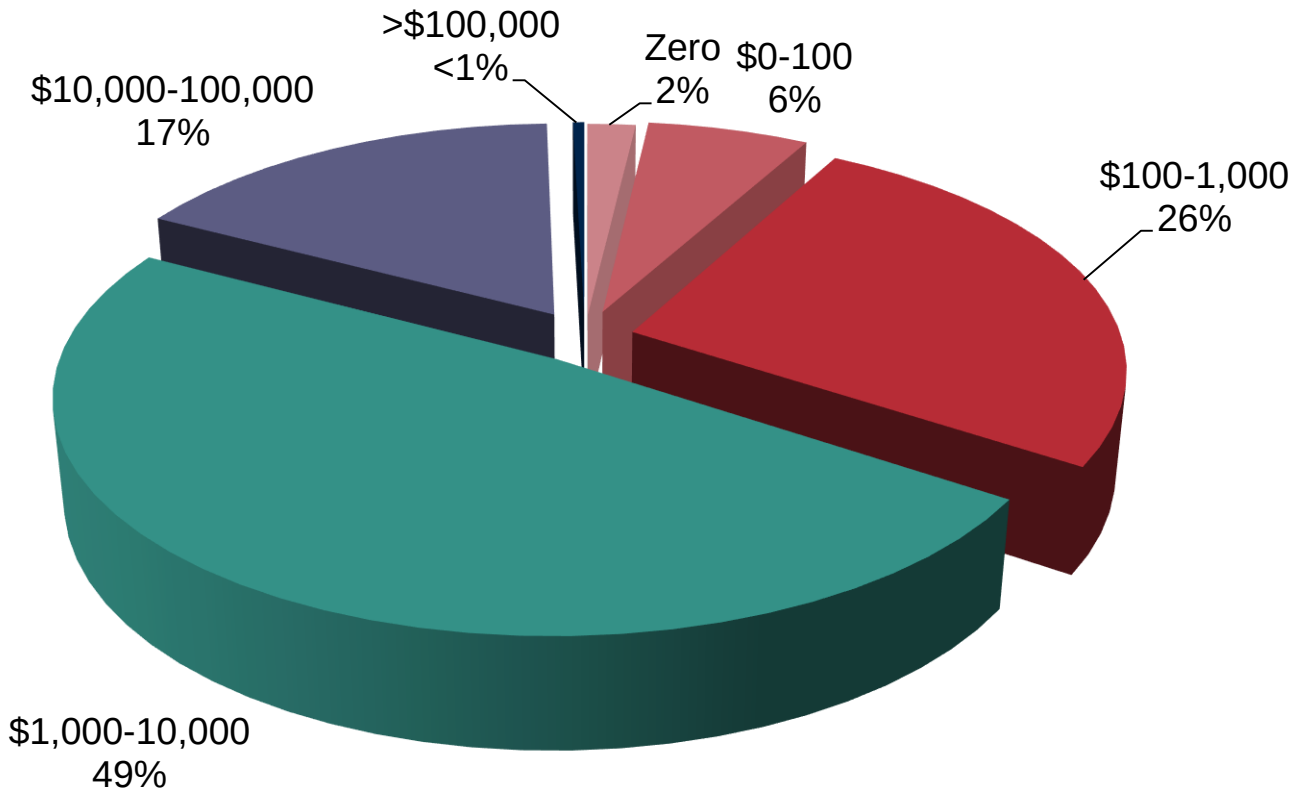
Developmental Disabilities Medicaid halo spend overview

Exhibit 16: Percentage of distinct Developmental Disabilities clients by amount of Medicaid-funded halo[1] spend, SFY2014

n = 27,525

Medicaid-funded halo spend of DD clients, SFY2014

- Mean: $6,379.48
- Median: $2,151.88



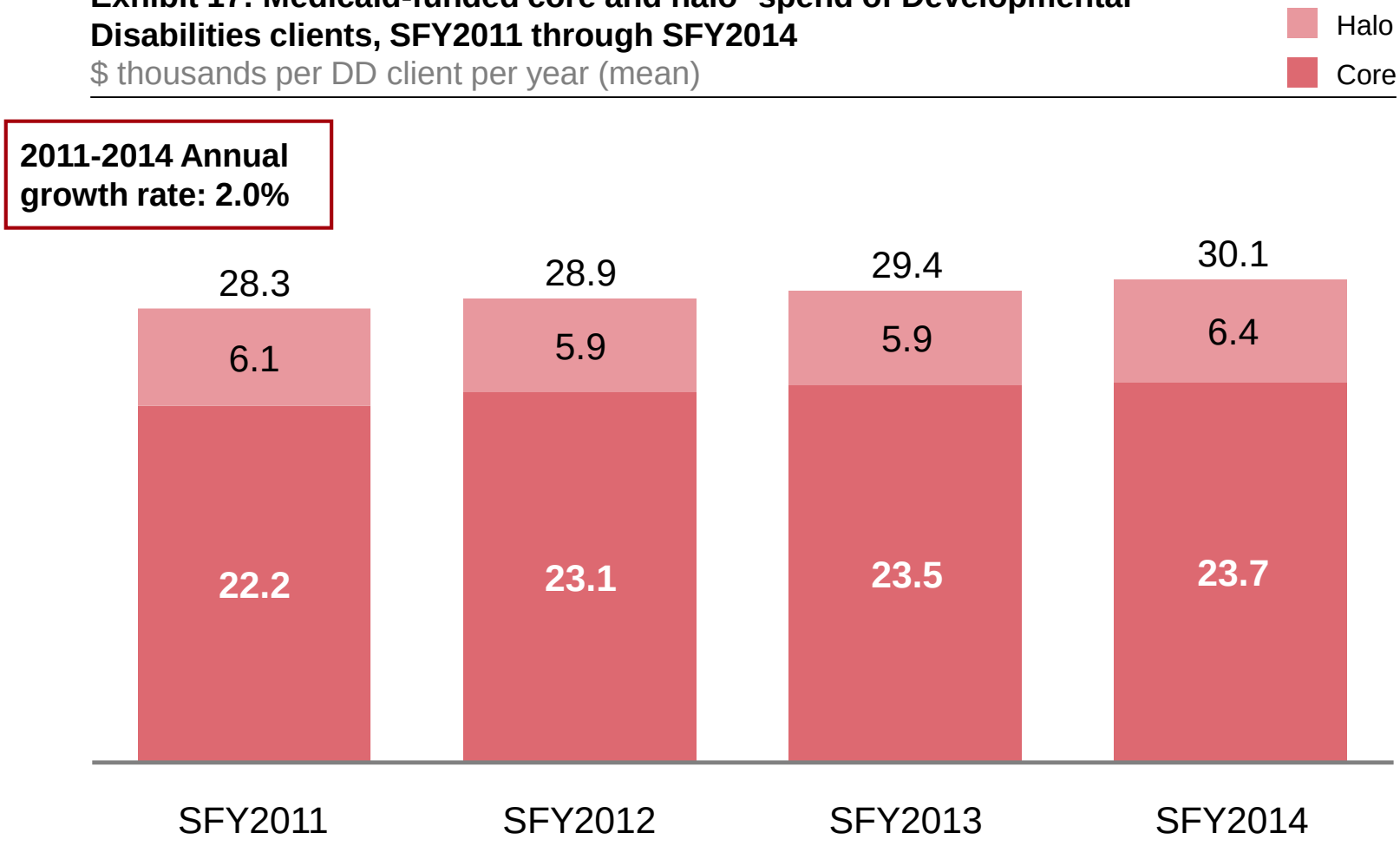
1 Halo spend includes Medicaid-only Inpatient, Outpatient, Pharmacy and Professional Claims outside of the areas defined as "core" on the preceding pages.

Source: SFY2014 Medicaid claims

Developmental Disabilities Medicaid core and halo spend

Exhibit 17: Medicaid-funded core and halo[1] spend of Developmental Disabilities clients, SFY2011 through SFY2014

$ thousands per DD client per year (mean)



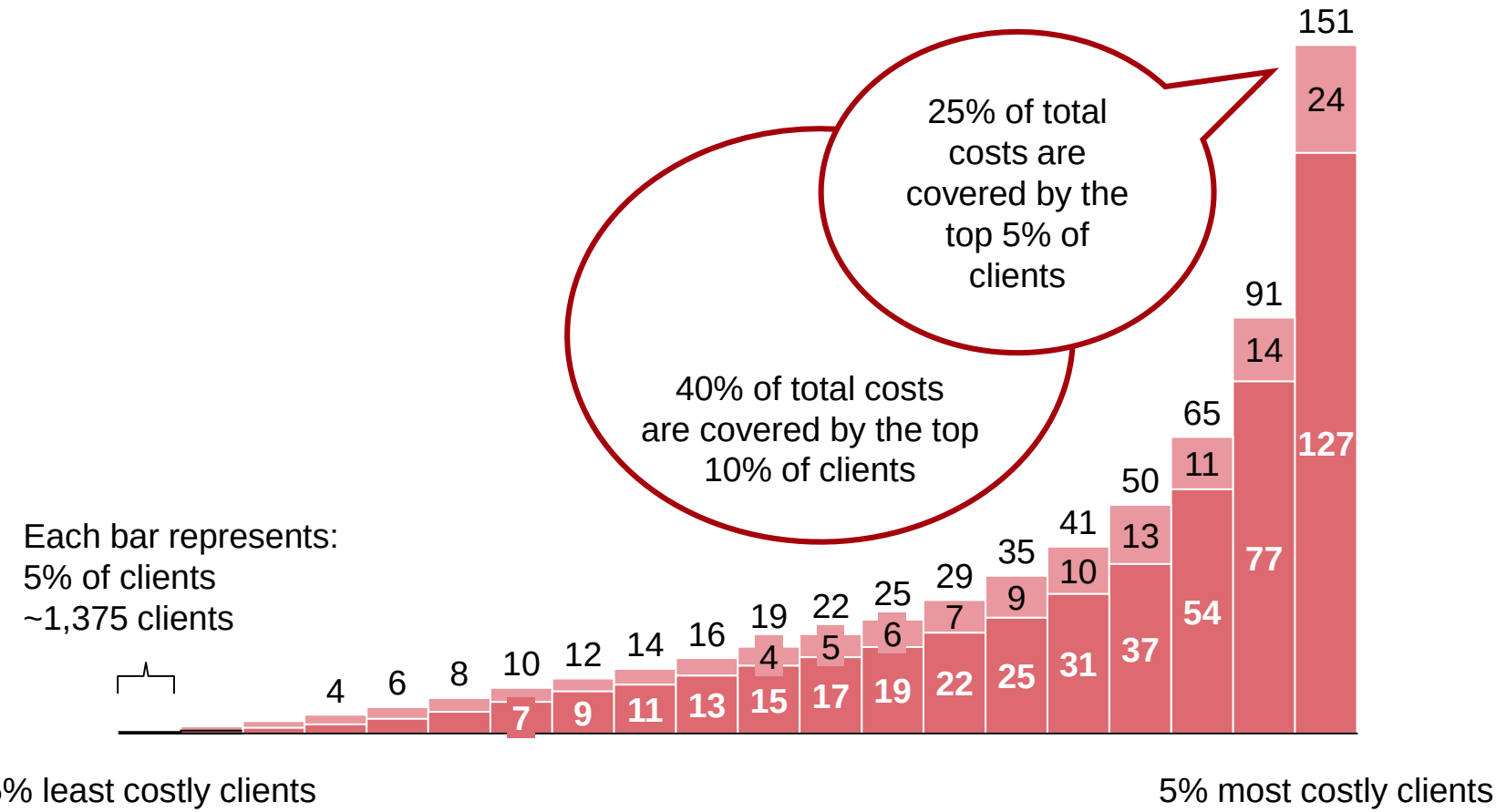
1 Halo spend includes Medicaid-only Inpatient, Outpatient, Pharmacy and Professional Claims outside of the areas defined as "core" on the preceding pages

Source: SFY2011-2014 Medicaid claims

Developmental Disabilities Medicaid core and halo spend

Exhibit 18: Distribution of Developmental Disabilities clients by average annual total cost of care, SFY2014

$ thousands

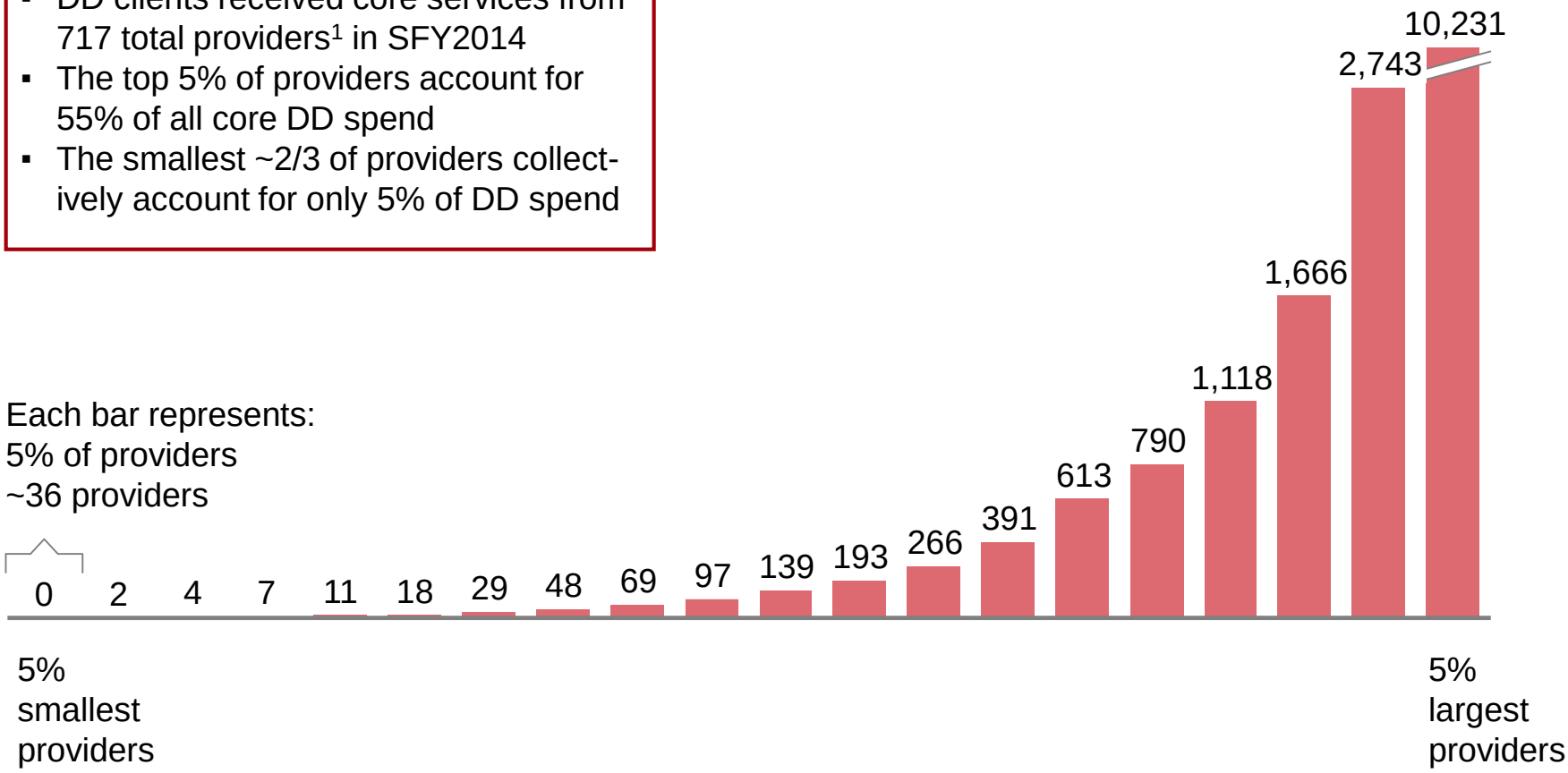


Source: SFY2011-2014 Medicaid claims

Developmental Disabilities Medicaid provider landscape

Exhibit 19: Distribution of Developmental Disabilities providers by average annual claims, SFY2014
Paid claims, $ thousands

- DD clients received core services from 717 total providers[1] in SFY2014
- The top 5% of providers account for 55% of all core DD spend
- The smallest ~2/3 of providers collectively account for only 5% of DD spend



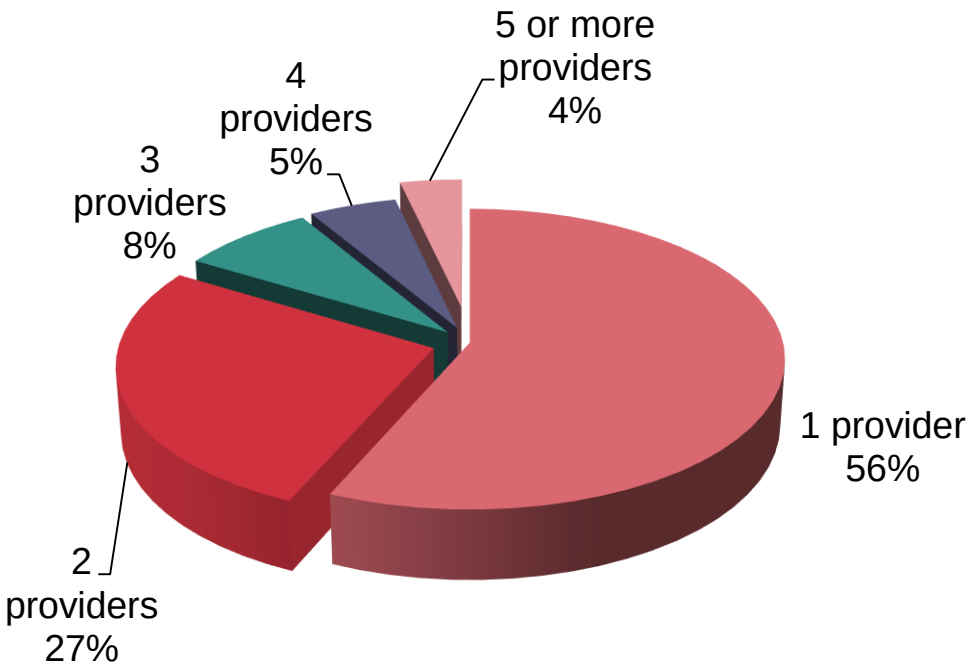
1 Based on unique Provider IDs, where an individual provider organization may have multiple provider IDs due to multiple distinct sites or billing entities

Source: SFY2014 Medicaid claims

Developmental Disabilities Medicaid provider landscape

Exhibit 20: Number of distinct Developmental Disabilities clients by number of Medicaid providers seen, SFY2014

n = 27,525



Number of providers seen[1]	% of clients	Average total DD spend per client $ thousands
1	56	19.1
2	27	18.1
3	8	37.1
4	5	54.9
5 or more	4	67.5

1 Based on unique Provider IDs, where an individual provider organization may have multiple provider IDs due to multiple distinct sites or billing entities

Source: SFY2014 Medicaid claims

State Medicaid benchmark data for Developmental Disabilities

This page is intended to provide a set of benchmarked indicators sourced from publicly available research and reports. Data pertaining to Arkansas on this page may not match that provided on the preceding charts due to differing time periods and methodologies. Methodological details for these indicators are provided in their original sources. Their inclusion on this page is not meant as an endorsement of the indicator or source, nor as an affirmation of the results for the state of Arkansas.

Exhibit 21: State Medicaid Benchmark data for Developmental Disabilities

Description	Calculation	United States	Arkansas
1. HCBS absolute numbers – DD	▪ Utilization of HCBS waivers per 100,000 of the U.S. or AR general population, 2012	▪ 156 per 100,000 for people birth-21 ▪ 181 per 100,000 for people 22+	▪ 123 per 100,000 for people birth-21 ▪ 143 per 100,000 for people 22+
2. ICF/IDD absolute numbers – DD	▪ Number of enrollees using ICF/IDD per 100,000 of the U.S. or AR general population, 2012	▪ 6 per 100,000 people birth to 21 ▪ 35 per 100,000 for people 22+	▪ 31 per 100,000 for people birth-21 ▪ 58 per 100,000 for people 22+
3. Number of people living in large state facilities– DD	▪ Count of clients living in a state facility categorized as large, 16+ beds, as a percent of all ICF/IDD and IDD Waiver clients, 2012	▪ 26,503 people (3.1%)	▪ 951 people (15.0%)
4. Persons waiting for residential services	▪ Persons with IDD on a waiting list for, but not receiving, residential services, per 100,000 of the Medicaid population, 2013	▪ 558 per 100,000 for U.S. Medicaid population	▪ 506 per 100,000 for AR Medicaid population
5. Persons living with family or in own home setting	▪ Percentage of IDD living in their own home or a family home, 2012	▪ 64%	▪ 41%

Sources:

1 “In-home and residential long-term supports and services for persons with Intellectual or Developmental Disabilities: Status and Trends Through 2014.” University of Minnesota. https://risp.umn.edu/RISP_FINAL_2012.pdf

2 See #1 and Kaiser Family Foundation, http://kff.org/health-reform/state-indicator/waiting-lists-for-hcbs-waivers/

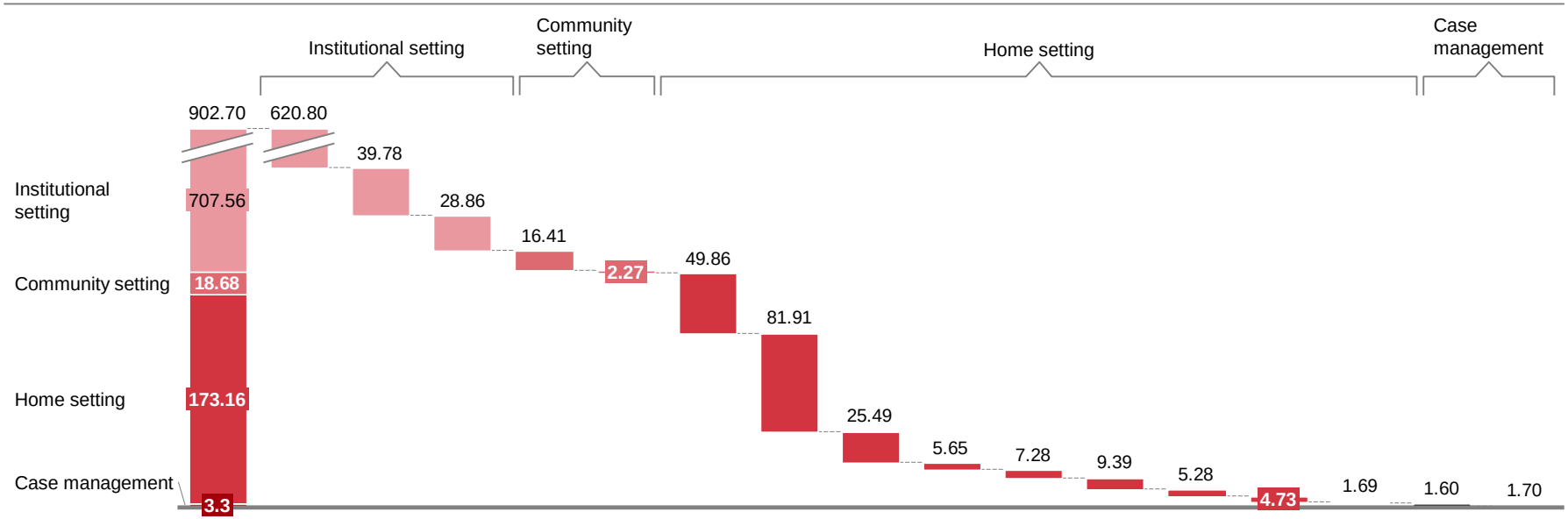
3 “The Case for Inclusion, 2014.” United Cerebral Palsy. http://cfi2014.ucp.org/data/

4 Kaiser Family Foundation, http://kff.org/health-reform/state-indicator/waiting-lists-for-hcbs-waivers/

5 See #1

Long-Term Services and Supports Medicaid spend overview

Exhibit 22: Long-Term Services and Supports Medicaid spend, SFY2014
$ millions



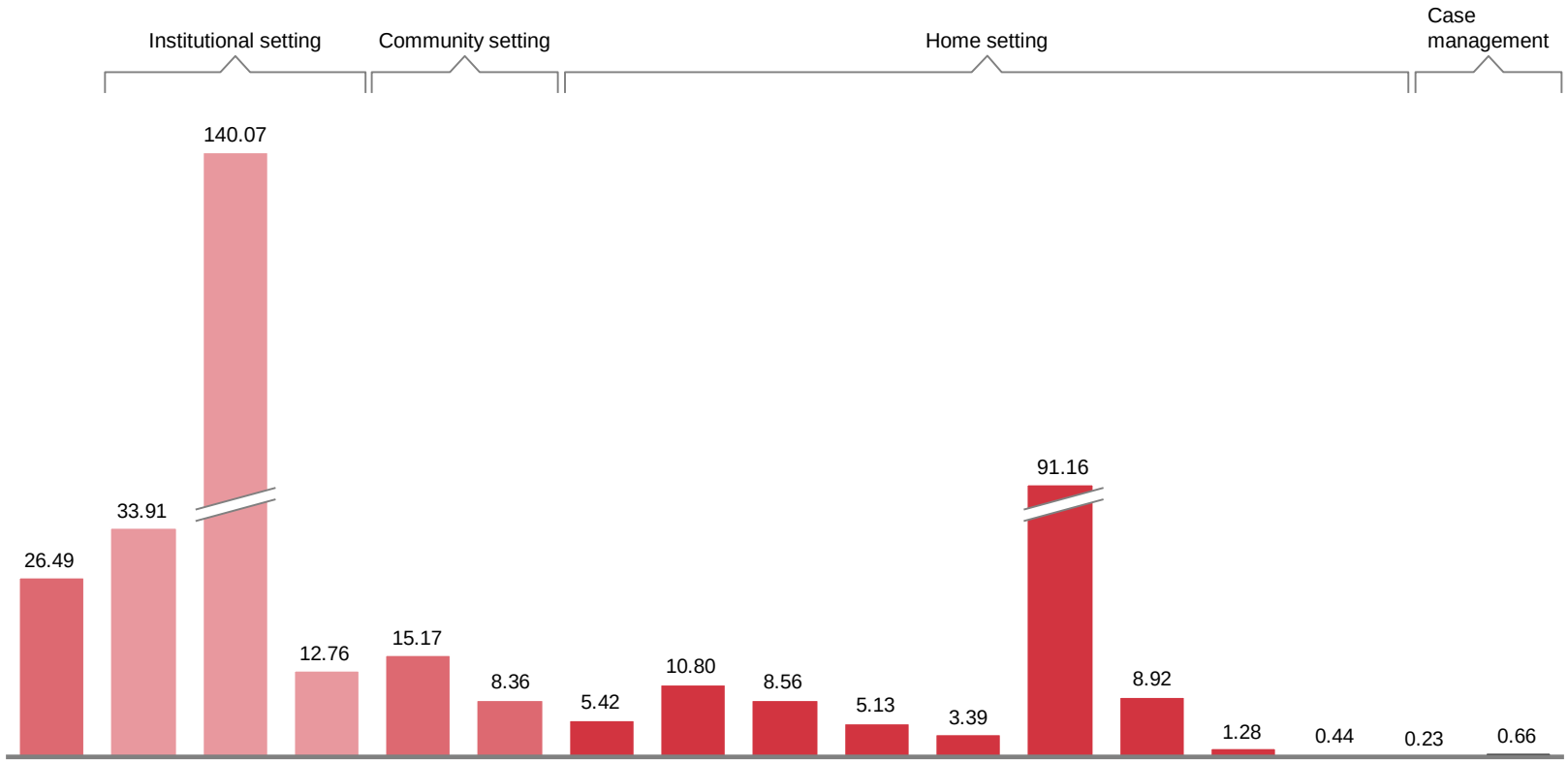
	LTSS Services	Private Nursing Facilities	Public Nursing Facilities	Nursing Home Hospice	Assisted Living	Adult day care	Person-al care services	Person-al care services (waiver)	Self-directed care	Respite care	Home health services	Private Duty Nursing	Hospice	Home delivered meals	Equipm-ent and environ-mental adapt-ations	Case manage-ment	Case manage-ment (waiver)
SFY2011-2014 Annual growth %	**1.5**	**2.0**	**-2.8**	**8.0**	**16.4**	**-8.9**	**2.5**	**4.8**	**0.5**	**-36.7**	**-2.9**	**-0.6**	**2.2**	**-9.0**	**1.0**	**14.6**	**1.6**
Unique clients[1] SFY 2014 Number	**34,071**	**18,310**	**284**	**2,261**	**1,082**	**272**	**9,198**	**7,585**	**2,976**	**1,102**	**2,148**	**103**	**592**	**3,700**	**3,857**	**6,893**	**2,597**
Individual claims SFY 2014 Number	**2,034,610**	**926,768**	**13,941**	**21,505**	**30,834**	**9,465**	**320,994**	**402,322**	**63,962**	**27,418**	**30,747**	**1,132**	**3,526**	**51,608**	**43,151**	**63,183**	**24,054**

1 Unique clients may be duplicated across categories since individuals may receive services in multiple categories a given year. The total at left represents a non-duplicated count of all individuals who received LTSS services.

Source: SFY2011-2014 Medicaid claims

Long-Term Services and Supports Medicaid spend overview

Exhibit 23: Long-Term Services and Supports Medicaid spend per unique client, SFY2014
$ thousands



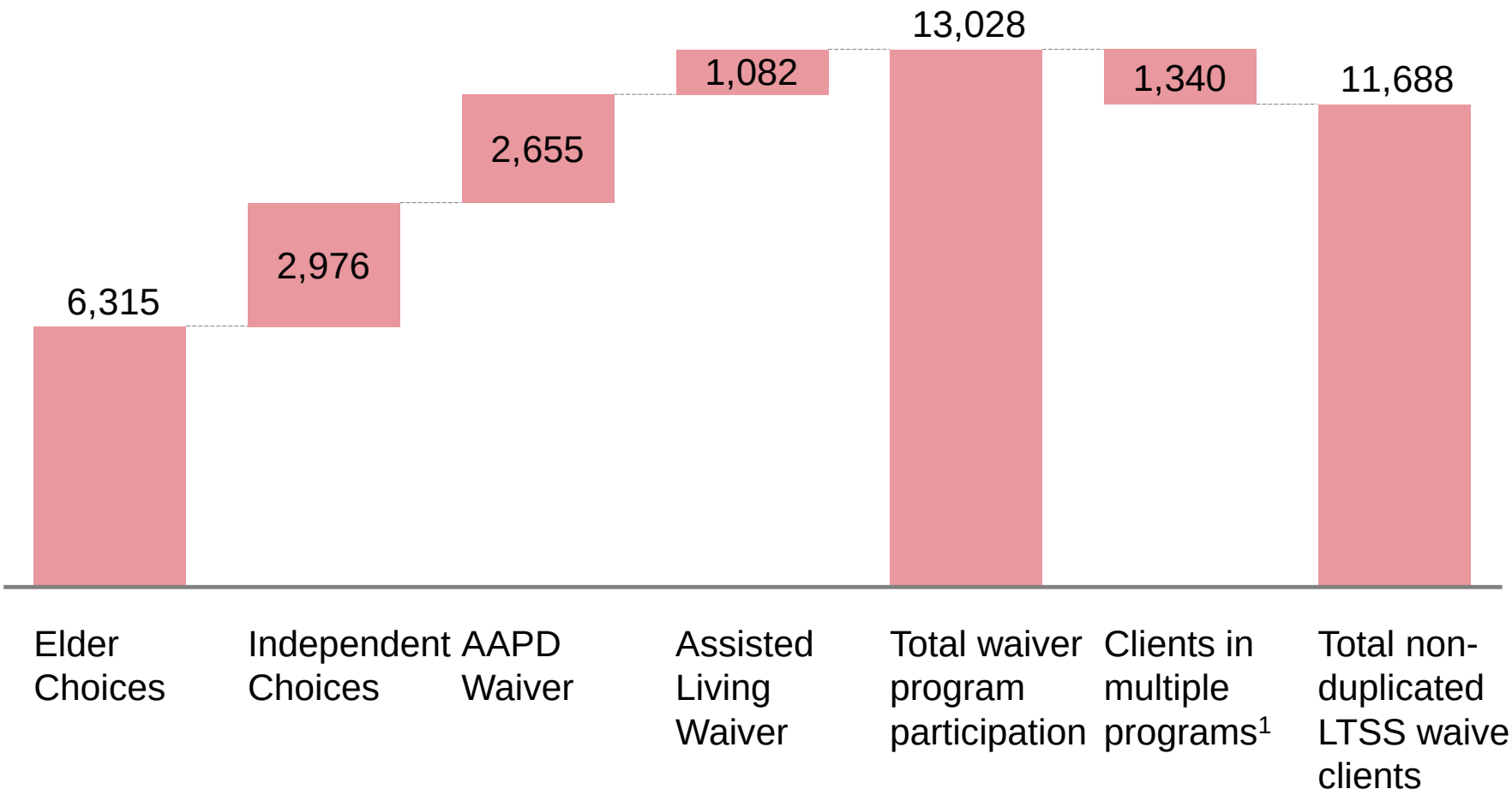
	LTSS Services	Private Nursing Facilities	Public Nursing Facilities	Nursing Home Hospice	Assisted Living	Adult day care	Personal care services (non-waiver)	Personal care services (waiver)	Self-directed care	Respite care	Home health services	Private Duty Nursing	Hospice	Home deli-vered meals	Equipm-ent and environ-mental adapt-ations	Case manage-ment	Case manage-ment (waiver)
SFY2011-2014 Annual growth %	**2.8**	**3.1**	**0.4**	**5.8**	**4.3**	**1.0**	**4.0**	**8.9**	**4.8**	**-7.1**	**-0.3**	**-2.3**	**4.4**	**-1.1**	**8.7**	**21.4**	**-0.1**

Source: SFY2011-2014 Medicaid claims

Long-Term Services and Supports Medicaid population overview

Exhibit 24: Long-Term Services and Supports waiver clients by program, SFY2014

Number of clients

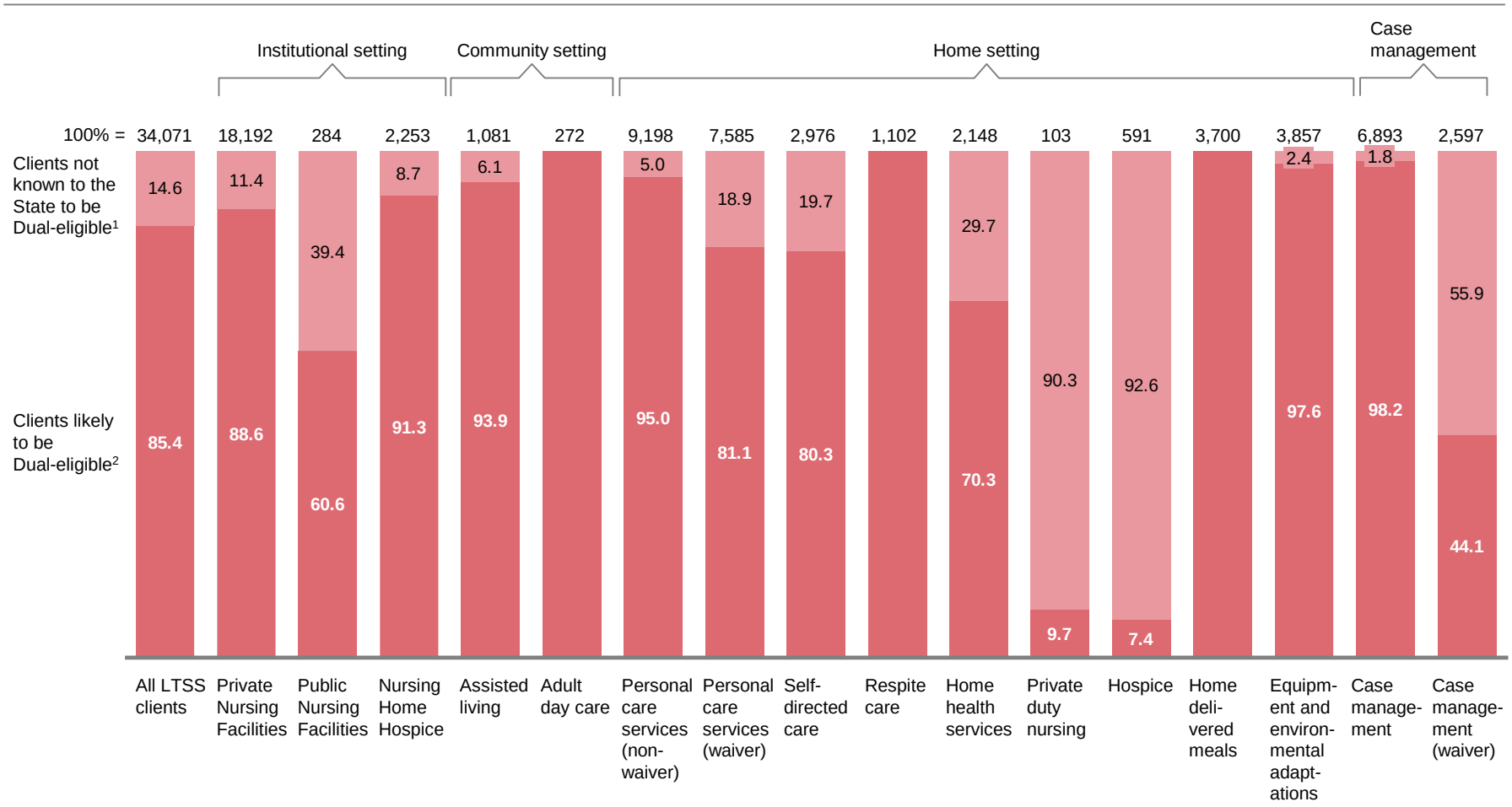


1 Includes 1,186 clients who received both ElderChoices and IndependentChoices benefits, as well as other clients who may have had claims in multiple programs throughout SFY2014

Source: SFY2014 Medicaid claims

Long-Term Services and Supports Medicaid population overview

Exhibit 25: Long-Term Services and Supports clients by LTSS service area and Medicare eligibility status, SFY2014



1 Includes all clients under the age of 65 who have not been verified as Dual-eligible in the Medicaid Management Information System
2 Includes all clients age 65 and over as well as clients who are under 65 and have been verified as dual-eligible in the Medicaid Management Information System

Source: SFY2014 Medicaid claims

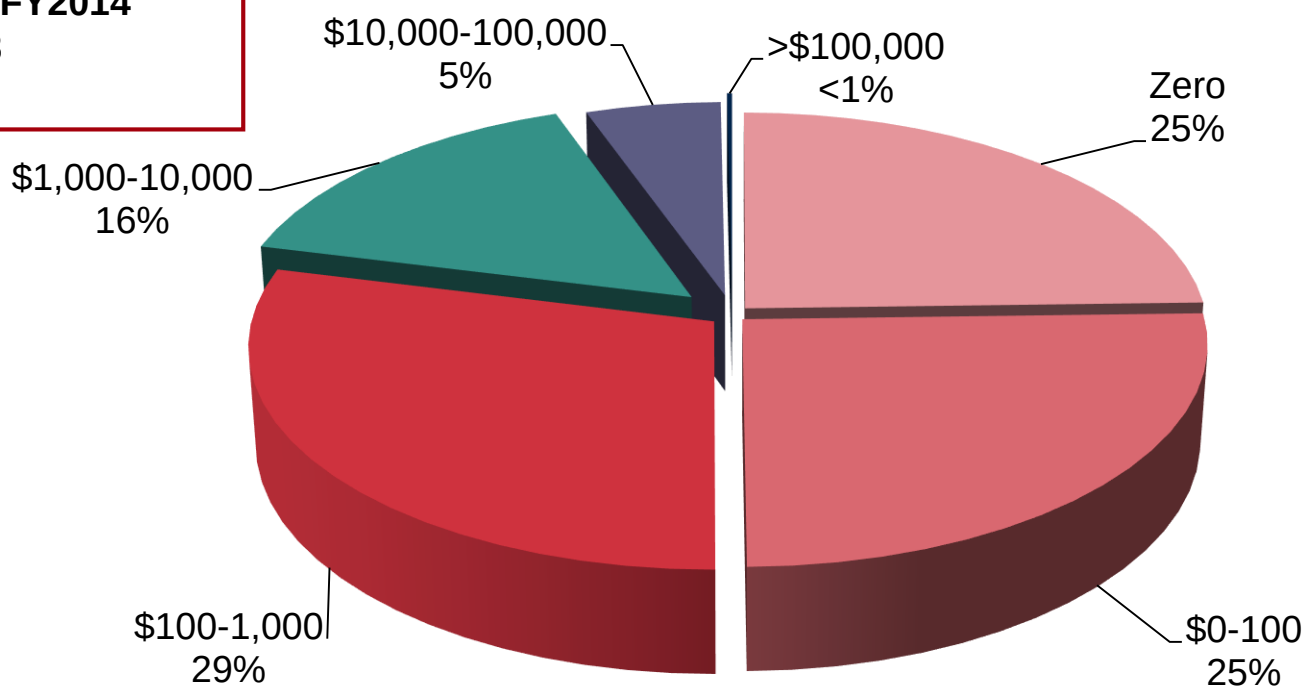
Long-Term Services and Supports Medicaid halo spend overview

Exhibit 26: Percentage of distinct Long-Term Services and Supports clients by amount of Medicaid-funded halo[1] spend, SFY2014

n = 34,071

Medicaid-funded halo Spend of LTSS Clients, SFY2014

- Mean: $2,485.88
- Median: $100.49



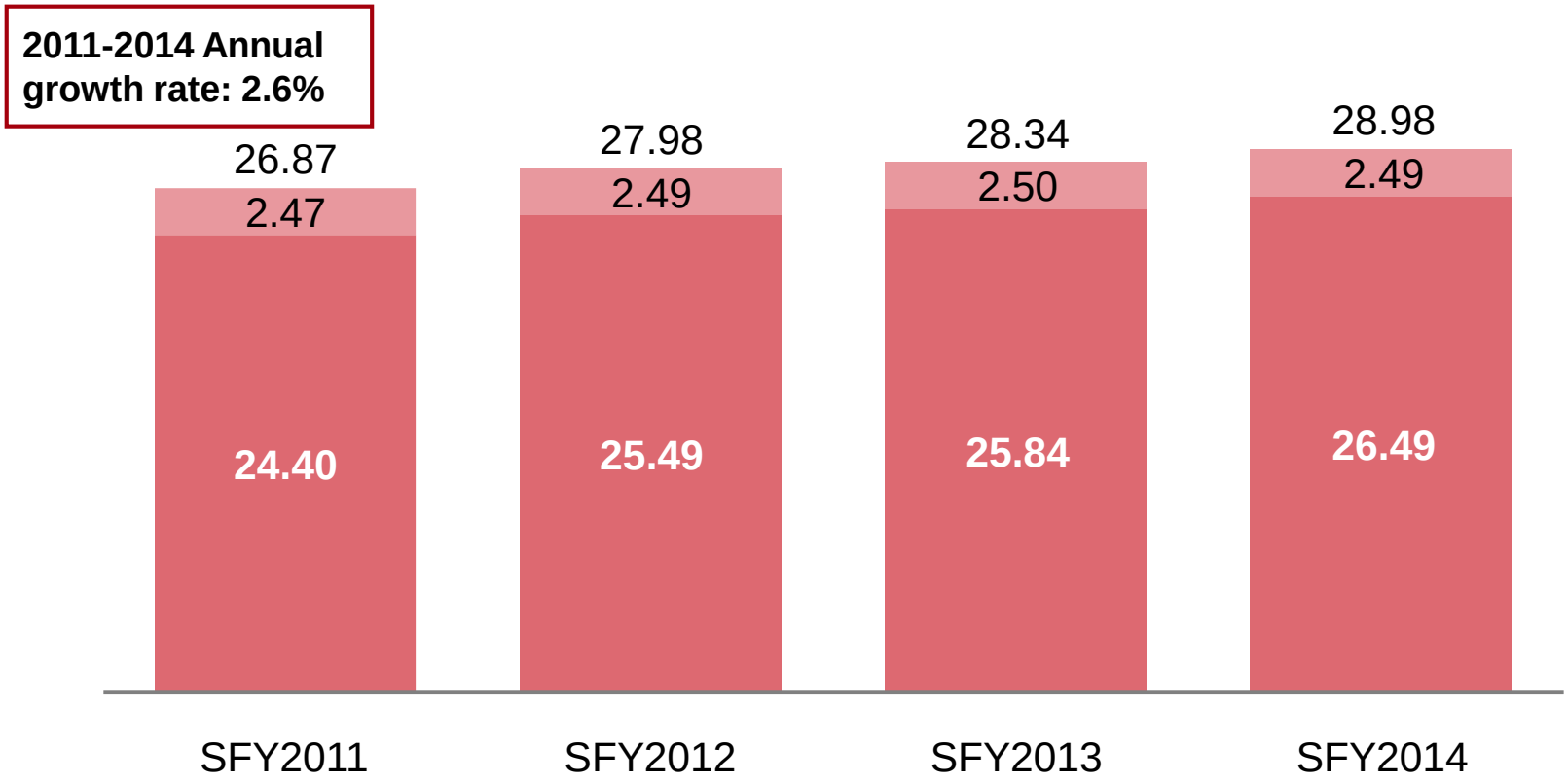
1 Halo spend includes Medicaid-only Inpatient, Outpatient, Pharmacy and Professional Claims outside of the areas defined as "core" on the preceding pages.

Source: SFY2014 Medicaid claims

Long-Term Services and Supports Medicaid core and halo spend

Exhibit 27: Medicaid-funded core and halo[1] spend of Long-Term Services and Supports clients, SFY2011 through SFY2014

$ thousands per LTSS client per year (mean)



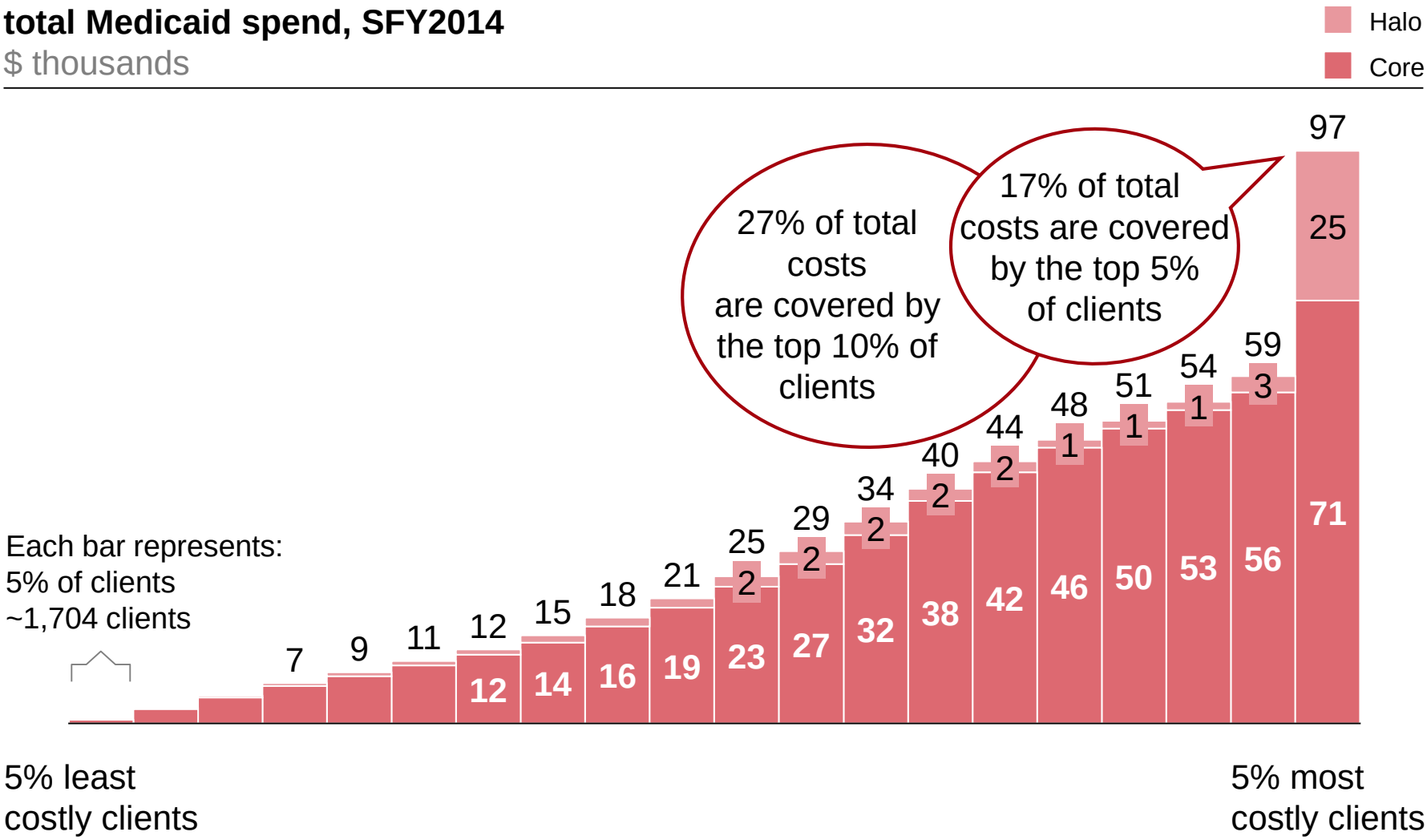
1 Halo spend includes Medicaid-only Inpatient, Outpatient, Pharmacy and Professional Claims outside of the areas defined as "core" on the preceding pages.

Source: SFY2011-2014 Medicaid claims

Long-Term Services and Supports Medicaid core and halo spend

Exhibit 28: Distribution of Long-Term Services and Supports clients by average annual total Medicaid spend, SFY2014

$ thousands



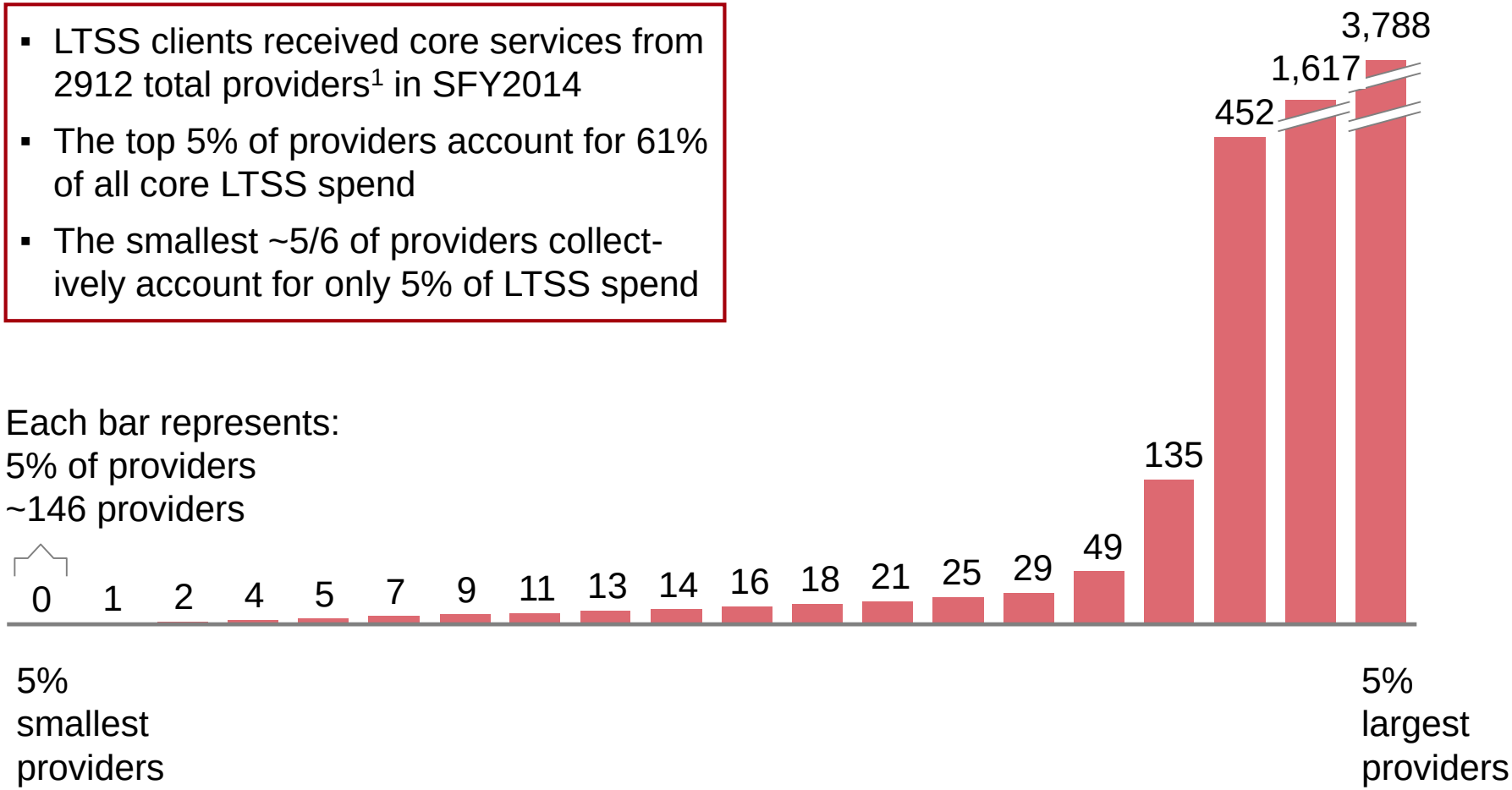
Source: SFY2014 Medicaid claims

Long-Term Services and Supports provider landscape

Exhibit 29: Distribution of Long-Term Services and Supports providers by average annual Medicaid claims, SFY2014[1]

Paid claims, $ thousands

- LTSS clients received core services from 2912 total providers[1] in SFY2014
- The top 5% of providers account for 61% of all core LTSS spend
- The smallest ~5/6 of providers collectively account for only 5% of LTSS spend



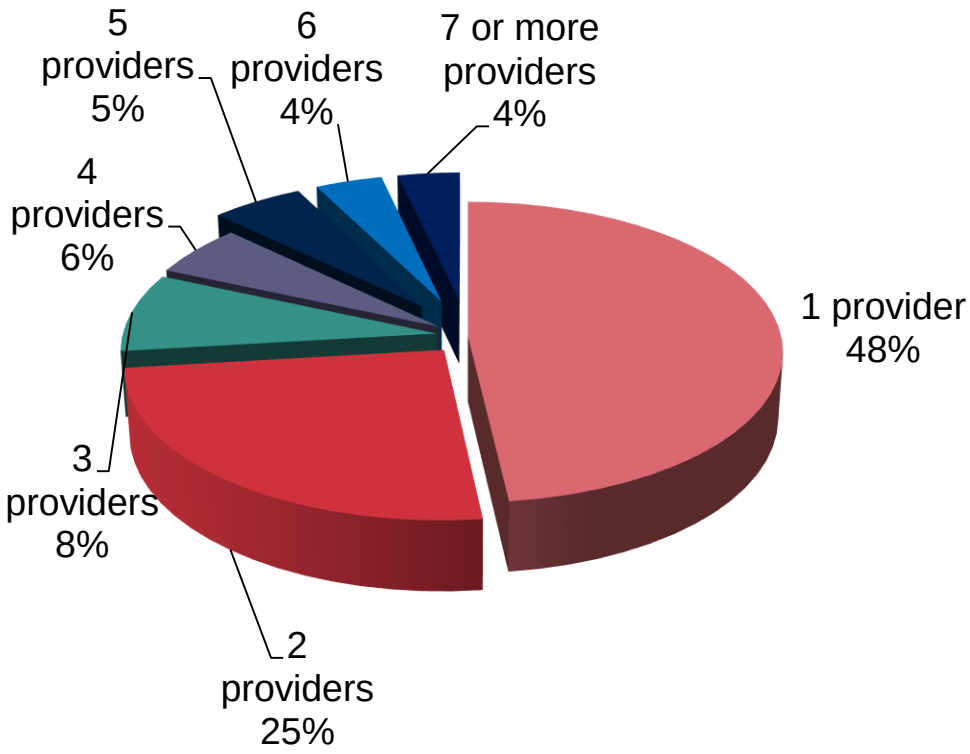
1 Based on unique Provider IDs, where an individual provider organization may have multiple provider IDs due to multiple distinct sites or billing entities

Source: SFY2014 Medicaid claims

Long-Term services and supports provider landscape

Exhibit 30: Number of distinct Long-Term Services and Supports clients by number of Medicaid providers seen, SFY2014

n = 34,071



Number of providers seen[1]	% of clients	Average total LTSS spend per client $ thousands
1	48	31.3
2	25	26.2
3	8	17.8
4	6	16.3
5	5	16.9
6	4	19.1
7 or more	4	21.8

1 Based on unique Provider IDs, where an individual provider organization may have multiple provider IDs due to multiple distinct sites or billing entities

Source: SFY2014 Medicaid claims

State Medicaid benchmark data for Long-Term Services and Supports

This page is intended to provide a set of benchmarked indicators sourced from publicly available research and reports. Data pertaining to Arkansas on this page may not match that provided on the preceding charts due to differing time periods and methodologies. Methodological details for these indicators are provided in their original sources. Their inclusion on this page is not meant as an endorsement of the indicator or source, nor as an affirmation of the results for the state of Arkansas.

Exhibit 31: State Medicaid Benchmark data for Long-Term Services and Supports

Description	Calculation	United States	Arkansas
1. HCBS share of total LTSS spend	▪ HCBS spend as percent of total LTSS spend, 2012	▪ 38.8% of Medicaid LTSS spend for Aged/Physically Disabled	▪ 31.7% of Medicaid LTSS spend for Aged/Physically Disabled
2. Nursing facility quality	▪ Percent of institutional facilities with 4+ Medicare stars ratings, 2014	▪ 44.6% of facilities as of March 2015	▪ 46.7% of facilities as of March 2015
3. Waiting list for HCBS services	▪ The number of aged and disabled individuals on the waiting list for Medicaid Section 1915 Home and Community Based Services Waivers	▪ Aged – 27,307 ▪ Aged/Disabled – 127,324	▪ No sustained waiting list
4. Home Health Patient Outcomes – Acute care	▪ Percent of patients admitted to an acute care hospital for at least 24 hours while receiving home health care, from October 2013-September 2014	▪ 25%	▪ 26%
5. Home Health Patient Outcomes – ED visit	▪ Percent of patients, receiving home health care, who needed urgent, unplanned care in the ER without being admitted as of Jan. 2015	▪ 12%	▪ 13%

Sources:

1 Medicaid.gov http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/downloads/ltss-expenditures-2012.pdf. This benchmark indicates that HCBS represents higher percentage of spend because it attributes the entire Personal Care and Home Health categories of service to the Aged and Physically disabled populations.

2 Nursing Home Compare https://data.medicare.gov/Nursing-Home-Compare/Star-Ratings/ax9d-vq6k

3 Kaiser Family Foundation http://kff.org/health-reform/state-indicator/waiting-lists-for-hcbs-waivers/

4 CMS Oasis C http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/OASIS/09aa_hhareports.html

5 CMS Home Health Care National Data https://data.medicare.gov/Home-Health-Compare/Home-Health-Care-National-Data/97z8-de96

Definitions - Behavioral Health Services (1 of 3)

Setting	Category ▪ Waiver program (If applicable)[1]	Description ▪ Analytical definition (if applicable)[2]	Recent policy changes and other notes
Inpatient Setting	Inpatient Psychiatric	A full range of short-term intensive treatment for mental health care and alcohol, tobacco and other drug prevention and treatment. Includes the Psychiatric Residential Treatment Program as well as regular acute inpatient stays at psychiatric facilities. ▪ Services are split by client age at the date of service – Children (age 0-17) – Adults (age >18)	A number of children who had previously been eligible for inpatient psychiatric services based on their status as a "family of 1" became ineligible for inpatient services on January 1, 2014.
Outpatient Setting	Rehabilitative Services for Persons with Mental Illness (RSPMI)	Services provided by DBHS-certified RSPMI providers, public or private service agencies that meets DBHS RSPMI Policy standards, offer a full array of outpatient treatment services, and are eligible to bill the Arkansas Medical Assistance Program (Medicaid) for reimbursable services. An RSPMI provider must follow an application process and become certified as an RSPMI provider by the Division of Behavioral Health Services prior to applying for Medicaid provider enrollment. ▪ Services are split by client age at the date of service – Children (age 0-17) – Adults (age >18)	A moratorium on certification of new RSPMI providers went into place in October 2008, has been renewed periodically since then and remains in effect at the pre-sent time. The Department has filed an amendment to extend the moratorium until December 31, 2015.
	Licensed mental health professionals	Services provided by DBHS-certified LMHP providers, who provide outpatient mental health services for the Arkansas Medicaid population under the age of 21, and are eligible to bill the Arkansas Medical Assistance Program (Medicaid) for reimbursable services. The applicant must apply and become certified as an LMHP provider by the Division of Behavioral Health Services prior to applying for Medicaid provider enrollment. ▪ Services are split by client age at the date of service – Children (age 0-17) – Adults (age >18)	

1 Where no specific waiver program is listed, Medicaid services for that category are part of the state plan
2 Where no specific additional definition is given, the figures provided for the category in all charts reflect all claims spend over the given period within the associated State Categories of Service (SCOS)

Source: Arkansas Department of Human Services, Arkansas Medicaid

Definitions - Behavioral Health Services (2 of 3)

Setting	Category ▪ Waiver program (If applicable)[1]	Description ▪ Analytical definition (if applicable)[2]	Recent policy changes and other notes
Outpatient Setting (contd.)	Substance abuse treatment services	A range of substance abuse treatment services (SATS) provided by a duly certified SATS provider to Medicaid-eligible beneficiaries with a substance abuse diagnosis, as described in the American Psychiatric Association Diagnostic and Statistical Manual	
	School-based MH services	A range of mental health diagnostic, therapeutic, rehabilitative or palliative services provided to Medicaid-eligible recipients under age twenty-one (21) suffering from psychiatric conditions as described in the American Psychiatric Association Diagnostic and Statistical Manual	
	Behavioral health services in other settings	All Medicaid-funded services for behavioral health conditions provided outside of "core" behavioral health provider settings (ie., outside of any of the preceding core behavioral health categories) ▪ Includes all medical, outpatient or inpatient claims with a behavioral health primary or admission diagnosis code (ICD-9 codes 291-314 excluding 299 (autism) and 294 (dementia)) for services provided outside of "core" behavioral health provider settings described above ▪ Services are split by client age at the date of service – Children (age 0-17) – Adults (age >18)	
Home Setting	Personal care services	Services based on the assessed physical dependency need for "hands-on" services with the following activities of daily living (ADL): eating, bathing, dressing, personal hygiene, toileting and ambulating. ▪ Includes all non-waiver Personal Care services (procedure codes T1019 and T1020) for clients who are also receiving "core" behavioral health services (all preceding inpatient and outpatient services except for "behavioral health services in other settings")	

1 Where no specific waiver program is listed, Medicaid services for that category are part of the state plan
2 Where no specific additional definition is given, the figures provided for the category in all charts reflect all claims spend over the given period within the associated State Categories of Service (SCOS)

Source: Arkansas Department of Human Services, Arkansas Medicaid

Definitions - Behavioral Health Services (3 of 3)

Setting	Category ▪ Waiver program (If applicable)[1]	Description ▪ Analytical definition (if applicable)[2]	Recent policy changes and other notes
Home Setting (contd.)	Home health services	Medical and nursing needs that can be met with part-time or intermittent care furnished by the home health agency in the patient's place of residence ▪ Includes all non-waiver Home Health services for clients who are also receiving "core" behavioral health services (all preceding inpatient and outpatient services except for "behavioral health services in other settings")	
Pharmacy	Specialty Pharmacy	Includes all Medicaid-funded psychotropic drug spend for Medicaid clients who received services in any of the preceding inpatient or outpatient categories, including behavioral health services in other settings ▪ Claims are split by client age at the date of service – Children (age 0-17) – Adults (age >18)	

1 Where no specific waiver program is listed, Medicaid services for that category are part of the state plan
2 Where no specific additional definition is given, the figures provided for the category in all charts reflect all claims spend over the given period within the associated State Categories of Service (SCOS)

Source: Arkansas Department of Human Services, Arkansas Medicaid

Definitions - Developmental Disabilities Services (1 of 4)

Setting	Category ▪ Waiver program (If applicable)[1]	Description ▪ Analytical definition (if applicable)[2]	Recent policy changes and other notes
Institutional Setting	Human Development Centers	Human Development Centers are state-operated intermediate care facilities for individuals with intellectual/developmental disabilities (ICF/IDD) that provides residential care and active treatment services to eligible developmentally disabled individuals who require an institutional level of care.	
	Over 16 bed ICF/IDD facilities	Non-state-operated intermediate Care Facilities for the Mentally Retarded (ICFs/MR) or Intermediate Care Facility for Persons with Intellectual or Developmental Disabilities (ICF/IDD) specialize in providing services to developmentally disabled individuals. They are health facilities or a distinct part of a hospital or Skilled Nursing Facility staffed, organized, operated, and maintained to provide 24-hour long term inpatient care and other restorative services under nursing supervision. ▪ Arkansas Medicaid contracts with a small number of large (>16 bed) private ICF/IDD facilities which specialize in pediatric care.	
	Under 16 bed ICF/IDD facilities	Service definition same as above. ▪ Arkansas Medicaid contracts with a larger number of small (<16 bed) private ICF/IDD facilities which primarily care for adult IDD clients who require an institutional level of care.	

1 Where no specific waiver program is listed, Medicaid services for that category are part of the state plan
2 Where no specific additional definition is given, the figures provided for the category in all charts reflect all claims spend over the given period within the associated State Categories of Service (SCOS)

Source: Arkansas Department of Human Services, Arkansas Medicaid

Definitions - Developmental Disabilities Services (2 of 4)

Setting	Category ▪ Waiver program (If applicable)[1]	Description ▪ Analytical definition (if applicable)[2]	Recent policy changes and other notes
Community Setting	Developmental day treatment clinic services (DDTCS)	Provides an array of comprehensive day treatment (services) to individuals with developmental and/or intellectual disabilities in a clinic setting including core services such as diagnosis and evaluation, instruction in areas of self-help, socialization, etc. Core services are provided at three levels of care: Early Intervention Pre-School Adult Development ▪ Services are split by client age at the date of service – Children (age 0-17) – Adults (age >18)	
	DDTCS transportation	All non-emergency medical transportation to/from a DDTCS. Will be provided by the transportation broker for the region in which the beneficiary lives, with the exception of transportation to/from a DDTCS center when the transportation is provided by the center. ▪ Services are split by client age at the date of service – Children (age 0-17) – Adults (age >18)	
	Child Health Management Services (CHMS)	Facility-based day pediatric services delivered by eligible providers of the Arkansas Medicaid Program.	
Home Setting	Personal care services	Services based on the assessed physical dependency need for “hands-on” services with the following activities of daily living (ADL): eating, bathing, dressing, personal hygiene, toileting and ambulating. Includes all non-waiver Personal Care services (procedure codes T1019 and T1020) for clients who are also receiving “core” DD services (all preceding institutional and community services as well as services provided by the ACS Waiver)	

1 Where no specific waiver program is listed, Medicaid services for that category are part of the state plan
2 Where no specific additional definition is given, the figures provided for the category in all charts reflect all claims spend over the given period within the associated State Categories of Service (SCOS)

Source: Arkansas Department of Human Services, Arkansas Medicaid

Definitions - Developmental Disabilities Services (3 of 4)

Setting	Category ▪ Waiver program (If applicable)[1]	Description ▪ Analytical definition (if applicable)[2]	Recent policy changes and other notes
Home Setting (contd.)	Home health services	Medical and nursing needs that can be met with part-time or intermittent care furnished by the home health agency in the patient's place of residence ▪ Includes all non-waiver Home Health services for clients who are also receiving "core" DD services (all preceding institutional and community services as well as services provided by the ACS Waiver)	
	Supportive living services ▪ Alternative Community Services Waiver	A direct care staff person works in the individual's home and community on goals and objectives within four components: Residential Habilitation Supports, Companion and Activities Therapy, Direct Care Supervision, Non-Medical Transportation. ▪ Procedure code: H2016	
	Equipment and home modifications ▪ Alternative Community Services Waiver	Purchase, leasing and repair of adaptive, therapeutic and augmentative equipment and adaptations to the individual's place of residence (structure). ▪ Procedure codes: K0108, S5160, S5161, S5162, S5165, T2028	
	Respite care ▪ Alternative Community Services Waiver	Service provided to or for individuals who are unable to care for themself on a short-term basis. ▪ Procedure code: S5151	
	Other home-based services ▪ Alternative Community Services Waiver	Other home-based services not included in other categories. May include: companion and activities therapy, supplemental supports, consultation services, etc. ▪ Procedure codes: H2023 (Supported employment), T2020 (Community transition services), T2025 (Consultative clinical and therapeutic services)	

1 Where no specific waiver program is listed, Medicaid services for that category are part of the state plan
2 Where no specific additional definition is given, the figures provided for the category in all charts reflect all claims spend over the given period within the associated State Categories of Service (SCOS)

Source: Arkansas Department of Human Services, Arkansas Medicaid

Definitions - Developmental Disabilities Services (4 of 4)

Setting	Category ▪ Waiver program (If applicable)[1]	Description ▪ Analytical definition (if applicable)[2]	Recent policy changes and other notes
Case Management	Case management ▪ Alternative Community Services Waiver	Assistance provided to help plan for and get the services and supports needed, monitoring of all services and how they are provided, and annual reassessment of individual's level of care. ▪ Procedure code: T2022	
Outpatient Services	Autism waiver services ▪ Autism Intensive Intervention Provider Waiver	Provides one-on-one, intensive early intervention treatment for beneficiaries ages eighteen (18) months through six (6) years with a diagnosis of autism	

1 Where no specific waiver program is listed, Medicaid services for that category are part of the state plan
2 Where no specific additional definition is given, the figures provided for the category in all charts reflect all claims spend over the given period within the associated State Categories of Service (SCOS)

Source: Arkansas Department of Human Services, Arkansas Medicaid

Definitions – Long-Term Services and Supports (1 of 4)

Setting	Category ▪ Waiver program (If applicable)[1]	Description ▪ Analytical definition (if applicable)[2]	Recent policy changes and other notes
Institutional Setting	Private Nursing Facilities	Any non-DHS operated buildings, structure, agency, institution, or other place for the reception, accommodation, board, care, or treatment of two or more unrelated individuals, who, because of physical or mental infirmity are unable to sufficiently or properly care for themselves, and for which reception, accommodation, board, care, and treatment, a charge is made.	
	Public Nursing Facilities	Includes the Arkansas Health Center, formerly known as the Benton Services Center (BSC), a 310-bed psychiatric nursing home licensed by the Office of Long-Term Care as a skilled nursing facility, serves the needs of the elderly and persons with disabilities who require specialized services or programs that are not generally available through community nursing facilities.	
	Nursing Home Hospice	An autonomous, centrally administered, medically directed, coordinated program providing a continuum of home, outpatient, and home-like inpatient care for the terminally ill patient and family, employing an interdisciplinary team to assist in providing palliative and supportive care to meet the special needs arising out of the physical, emotional, spiritual, social and economic stresses which are experienced during the final stages of illness and during dying and bereavement, with such care being available 24 hours a day, 7 days a week and provided on the basis of need regardless of ability to pay	
Community Setting	Assisted Living ▪ Assisted Living Waiver	A special combination of housing, supportive services, personalized assistance and healthcare designed to respond to the individual needs of those who need help with activities of daily living)	

1 Where no specific waiver program is listed, Medicaid services for that category are part of the state plan
2 Where no specific additional definition is given, the figures provided for the category in all charts reflect all claims spend over the given period within the associated State Categories of Service (SCOS)

Source: Arkansas Department of Human Services, Arkansas Medicaid

Definitions – Long-Term Services and Supports (2 of 4)

Setting	Category ▪ Waiver program (If applicable)[1]	Description ▪ Analytical definition (if applicable)[2]	Recent policy changes and other notes
Community Setting (contd.)	Adult day care ▪ ElderChoices Waiver	Provide care and supervision to meet the needs of four or more adults who have functional impairments for periods of less than 24 hours but more than two hours per day, in a place other than the beneficiary's own homes ▪ Procedure codes: S5100, S5140	
Home Setting	▪ Personal care services (non-waiver)	Services based on the assessed physical dependency need for "hands-on" services with the following activities of daily living (ADL): eating, bathing, dressing, personal hygiene, toileting and ambulating. ▪ Includes all non-waiver Personal Care services (procedure codes T1019 and T1020) for clients who are over 65 years old and/or also receiving services through skilled nursing facilities, assisted living, or another LTSS Waiver program	
	Personal care services (waiver) ▪ ElderChoices and Alternatives for Adults with Physical Disabilities (AAPD) Waivers	Services similar to those described above, though provided to waiver-eligible clients through waiver services. ▪ ElderChoices: S5120 (Chore services), S5130 (Homemaker services), S5135 (Adult Companion Services) ▪ AAPD: S5125 (Agency Attendant Care)	
	Self-directed care ▪ Independent Choices Waiver	Participants, or their representatives if applicable, have decision-making authority over certain services and take direct responsibility to manage their services with the assistance of a system of available supports	
	Respite care ▪ ElderChoices Waiver	Service provided to or for individuals who are unable to care for themself on a short-term basis. ▪ Procedure codes: S5150, T1005	

1 Where no specific waiver program is listed, Medicaid services for that category are part of the state plan
2 Where no specific additional definition is given, the figures provided for the category in all charts reflect all claims spend over the given period within the associated State Categories of Service (SCOS)

Source: Arkansas Department of Human Services, Arkansas Medicaid

Definitions – Long-Term Services and Supports (3 of 4)

Setting	Category ▪ Waiver program (If applicable)[1]	Description ▪ Analytical definition (if applicable)[2]	Recent policy changes and other notes
Home Setting (contd.)	Home health services	Medical and nursing needs that can be met with part-time or intermittent care furnished by the home health agency in the patient's place of residence ▪ Includes all non-waiver Home Health services for clients who are over 65 years old and/or also receiving services through skilled nursing facilities, assisted living, or another LTSS Waiver program	
	Private duty nursing	Medically necessary services that are provided by a registered nurse or licensed practical nurse under the direction of the beneficiary's physician, to a beneficiary in his or her place of residence, a Division of Developmental Disabilities Services (DDS) community provider facility or a public school.	
	Hospice	Same services provided by Nursing Home Hospice, but focused on routine home care or continuous home care.	
	Home delivered meals ▪ ElderChoices Waiver	A meal provided to a qualified individual in his or her place of residence ▪ Procedure code: S5170	
	Equipment and environmental adaptations ▪ ElderChoices and Alternatives for Adults with Physical Disabilities (AAPD) Waivers	Purchase, leasing and repair of adaptive, therapeutic and augmentative equipment and adaptations to the individual's place of residence (structure). ▪ Spend category includes services provided through both waiver programs based on the following procedure codes: – ElderChoices: S5160, S5161, – AAPD: S5165	

1 Where no specific waiver program is listed, Medicaid services for that category are part of the state plan
2 Where no specific additional definition is given, the figures provided for the category in all charts reflect all claims spend over the given period within the associated State Categories of Service (SCOS)

Source: Arkansas Department of Human Services, Arkansas Medicaid

Definitions – Long-Term Services and Supports (4 of 4)

Setting	Category ▪ Waiver program (If applicable)[1]	Description ▪ Analytical definition (if applicable)[2]	Recent policy changes and other notes
Case Management	Case management	Assistance provided to help plan for and get the services and supports needed, monitoring of all services and how they are provided, and annual reassessment of individual's level of care. ▪ This spend category includes all Targeted Case Management (TCM) for ElderChoices Waiver clients	
	Case management ▪ Alternatives for Adults with Physical Disabilities (AAPD) Waiver	Services similar in nature to those described above ▪ This spend category includes all Counseling/Case Management for AAPD Waiver clients (procedure code T2022)	

1 Where no specific waiver program is listed, Medicaid services for that category are part of the state plan
2 Where no specific additional definition is given, the figures provided for the category in all charts reflect all claims spend over the given period within the associated State Categories of Service (SCOS)

Source: Arkansas Department of Human Services, Arkansas Medicaid

Definitions - Other analytical definitions

Analysis	Term	Analytical definition
Core and halo spend	▪ Core spend	▪ Core spend includes spend for all Medicaid claims that fall within one of the categories of service attributed to a certain population and defined as "core" to that population on the preceding pages. ▪ For Behavioral Health, the included population consists of clients who received specialty behavioral health services only, including Inpatient Psychiatric, RSPMI, LMHP, School-based MH Services or Substance Abuse Treatment Services (approximately 85,000 individuals in total for SFY2014). Medicaid clients who received care for behavioral health diagnoses in other settings only (e.g., primary care) are excluded from this analysis. For the included population, core spend includes all services listed above as well as Personal Care Services, Home Health Services and Psychotropic pharmaceuticals. All other pharmacy spend for these clients, as well as all other inpatient, outpatient and professional claims (even if for a behavioral health diagnosis code), are included as "halo" spend.
	▪ Halo spend	▪ Halo spend includes spend for all Medicaid inpatient, outpatient, pharmacy and professional claims for the identified population that do not fall into one of the service categories defined as "core" to that population on the preceding pages ▪ The distribution of Medicaid halo spend across clients in a given population is provided to indicate both the dispersion in the medical needs of special needs clients served by the Arkansas Medicaid program, as well as to indicate that a proportion of these clients are likely to be dual-eligible with Medicare and therefore have the majority of their medical expenses covered by Medicare rather than Medicaid.
Provider landscape	▪ Provider	▪ For the provider landscape analyses, a "provider" is defined as a distinct provider billing ID. A provider organization is likely to have several provider IDs if operating several distinct sites, and even a single provider site may have multiple provider IDs to correspond with different programs or services. For example, the RSPMI program within Behavioral Health consists of 291 provider sites but only 52 distinct provider organizations.

Source: Arkansas Department of Human Services, Arkansas Medicaid