Arkansas Children:
Lacking Preventive Health Care

Arkansas Advocates for Children and Families

March 2011

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EXECUTIVE SUMMARY

Children covered by Medicaid in Arkansas are not receiving the level of preventive care they need to diagnose potential health problems. The Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program is a Medicaid requirement that ensures low-income children covered by Medicaid receive comprehensive preventive care. This helps identify and treat physical or mental health problems that could interfere with their growth or development. The federal Department of Health and Human Services has set a target of 80 percent for the number of Medicaid-enrolled children who should receive EPSDT screenings and services in any given year.[1] While screening rates have increased in the past five years, Arkansas is far from reaching that goal.

Just 38 percent of eligible children received their needed check-ups in 2008.

Arkansas can take the following steps to improve access to preventive care for children and meet federal requirements.

- Encourage the use of electronic medical records (EMR)/ Health Information technology (HIT) systems that track EPSDT services.
- Increase EPSDT screening reimbursement for providers, including additional incentives to improve the quality of specific components, such as developmental screenings.

- Provide incentives, combined with ongoing education, for health care providers to improve the quantity and quality of screenings.
- Use the state's new school wellness centers as models for better access to services.
- Require children entering preschool or state-subsidized child care programs to undergo full EPSDT screenings or comprehensive well-child screenings.

INTRODUCTION

The Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program is a federal Medicaid requirement that ensures low-income children receive comprehensive preventive care. It is designed to identify and treat physical or mental health problems that could interfere with child growth or development. The Centers for Medicare and Medicaid Services (CMS) set 80 percent as the target for the percentage of Medicaid-enrolled children who should receive EPSDT screenings and services in any given year.[2] Arkansas is far from reaching that goal.

EPSDT rules requires that children on Medicaid (which includes ARKids First A in Arkansas) receive all the screenings — and most treatments—deemed necessary by their doctor or primary care provider. Although diagnosis and treatment are critical components of ensuring healthy children, this brief examines only the EPSDT screening rates. Low screening rates, however, do raise questions about whether children are getting the treatment they need.

WHY USE THE EARLY PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) PROGRAM?

The EPSDT program was enacted in 1967 as an amendment to Title XIX (Medicaid) to provide preventive care to children.[3] Regular check-ups, also referred to as well-child visits, are used by physicians to identify and treat physical and mental health problems in children. Ideally this is done before health problems interfere with a child's growth and development and turn into complex and costly health issues.[4] A study of Medicaid-enrolled children in three states found that when children see their regular doctor as recommended, it reduces the number of avoidable hospitalizations.[5] This finding holds true across geographic and ethnic groups, regardless of the level of poverty in the family, level of local resources, or the presence of chronic illness.[6]

Children enrolled in Medicaid are more likely than other children to be in poor health and have complex medical

WHAT HAPPENS DURING AN EPSDT SCREENING?

Federal law requires that the EPSDT screening include a comprehensive physical and mental health assessment, an unclothed physical exam, immunizations, and health education. It also must have laboratory tests including an assessment of lead in the blood for younger children, as well as vision, dental, and hearing services.[9] These medical, vision, hearing, and dental screenings must be conducted according to an established schedule, but the federal EPSDT guidelines leave it to the states to determine their own schedules for health screenings.[10] States may not provide fewer services than required under federal law, but may go beyond the federal requirement. Arkansas adds a nutritional assessment that includes offering information on the Body Mass Index (BMI). The state also requires that the BMI be calculated annually after age 2.[11]

For the most part (exceptions noted below), Arkansas Medicaid uses the American Academy of Pediatrics (AAP) guidelines on what services are conducted during an EPSDT screening and how frequently they are performed.[12] Arkansas requires check-ups at the following ages:

- In the first year: Newborn, one month, two months, four months, six months, and nine months.
- In the toddler years: 12 months, 15 months, 18 months, and 24 months.
- In the preschool years: annually, at ages 3, 4, and 5.
- In the elementary years: at ages 6 and 8.
- Starting at age 10, annual screenings.

In addition to these, the American Academy of Pediatrics also recommends a visit at three to five days after birth (primarily to check feeding and jaundice), at 30 months, at 7 years, and at 9 years.[13]

problems.[7] An examination of National Health and Nutrition Examination Survey data found that in children on Medicaid, 18 percent between the ages of 2 and 20 were obese, 10 percent had high cholesterol, and 4 percent had high blood pressure.[8] EPSDT targets early health risks like lead poisoning, obesity, dental issues, iron deficiency, vision impairment, and hearing problems. Largely because of EPSDT, children enrolled in Medicaid are as likely as privately insured children to have well-child visits, and they are more likely than uninsured children to have such visits.

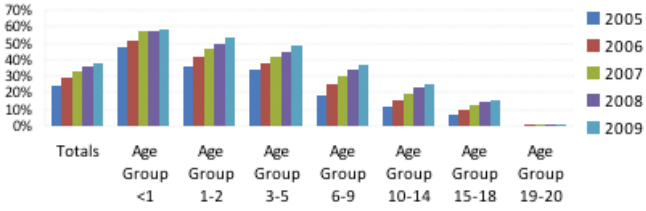
WHO RECEIVES EPSDT SCREENINGS AND SERVICES?[14]

There are 696,192 children under the age of 18 in Arkansas, according to the U.S. Census 2006-2008 American Community Survey.[15] Fifty-four percent of those (376,526) qualified for EPSDT services at some point during the 2009 federal fiscal year. An additional 35,569 young adults between the ages of 18 and 20 also qualified for services. Of the children eligible for EPSDT screenings, the percentage receiving at least one screening has improved from 24 percent in the 2005 federal fiscal year to 38 percent in the 2009 federal fiscal year (figure 1).[16]

Figure 1: Children receiving at least one screen

Source: Arkansas reports to federal Center for Medicare and Medicaid Services, as cited in several reports.(2004 data is not available.)[18]

Figure 2: Children Receiving at Least One Screen, by Age



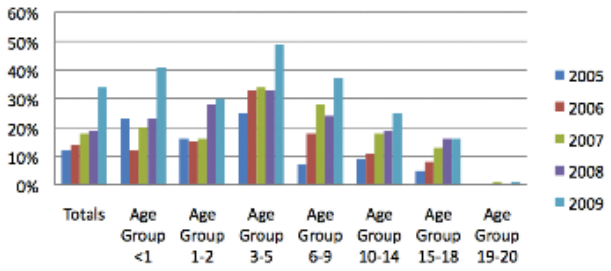
Source: Arkansas Department of Human Services

MORE CHILDREN ARE RECEIVING AT LEAST ONE REQUIRED SCREENING. The percentage of eligible children receiving at least one of the required screenings has improved from 24 percent in 2005 to 38 percent in 2009 (figure 1).[17] While the increase is encouraging, only receiving one of several required screenings in one calendar year is troubling, especially for very young children who require more check-ups to ensure their development is on track (see box on Page 2).

The rates have improved in all age groups except the oldest (19-20 year olds). The screening rates are highest in the youngest children (figure 2). However, it's important to remember that more frequent and multiple screenings are critical for children under the age of 2. Despite higher screening rates, the youngest children are still not getting the services they need.

Figure 3: Screening Ratio by Age Group 2005 - 2009

Children receive fewer than 50 percent of required screens but the ratio is increasing

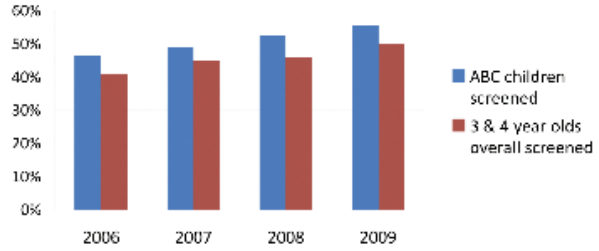


Most children still do not receive all required screenings, but the percentage is improving. Even when screenings are conducted, all the pieces required for a full EPSDT check-up are often not included.

The screening ratio is the percentage of scheduled screenings that children received according to the recommended schedule. In 2009, children received 34 percent of the screenings they should have received. While we're still under 50 percent, this is up from 19 percent in 2008 (figure 3).

Young children are more likely to receive some but not all required screenings; early childhood providers play a critical role in improving that. Children between the ages of 3 and 5 are the most likely to have scheduled EPSDT visits. Children of this age are required to have vaccinations before enrolling in elementary school and this provides an opportunity for an EPSDT visit. Early childhood programs offer a great opportunity to connect children to health services. Children enrolled in the state-funded Arkansas Better Chance (ABC) preschool program and the federally funded Head Start preschool program are required to have a health screening

Figure 4: Screening rates of children in Arkansas Better Chance (ABC) programs

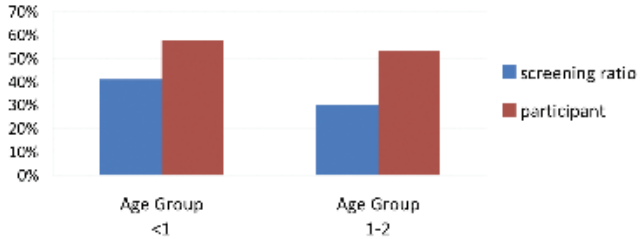


Source: Arkansas Department of Human Services

within 45 days of enrollment.[19] Both are open to low-income children, most of whom are 3 and 4 years old.[20]

As shown in figure 4, children in ABC programs are more likely to have received a health screening than other 3- and 4-year-old children overall (56 percent of ABC children versus 50 percent of all 3- and 4-year-old children). Children enrolled in the Head Start program are even more likely to receive all required EPSDT screenings. This is likely due to the stronger requirement that children receive all EPSDT-required screenings and follow-up services, including dental care.[21] In 2008-2009, 88 percent of all Arkansas Head Start enrollees received all required medical screenings; the percentage increased to 94 percent when children who were enrolled in Head Start for fewer than 45 days were excluded.[22]

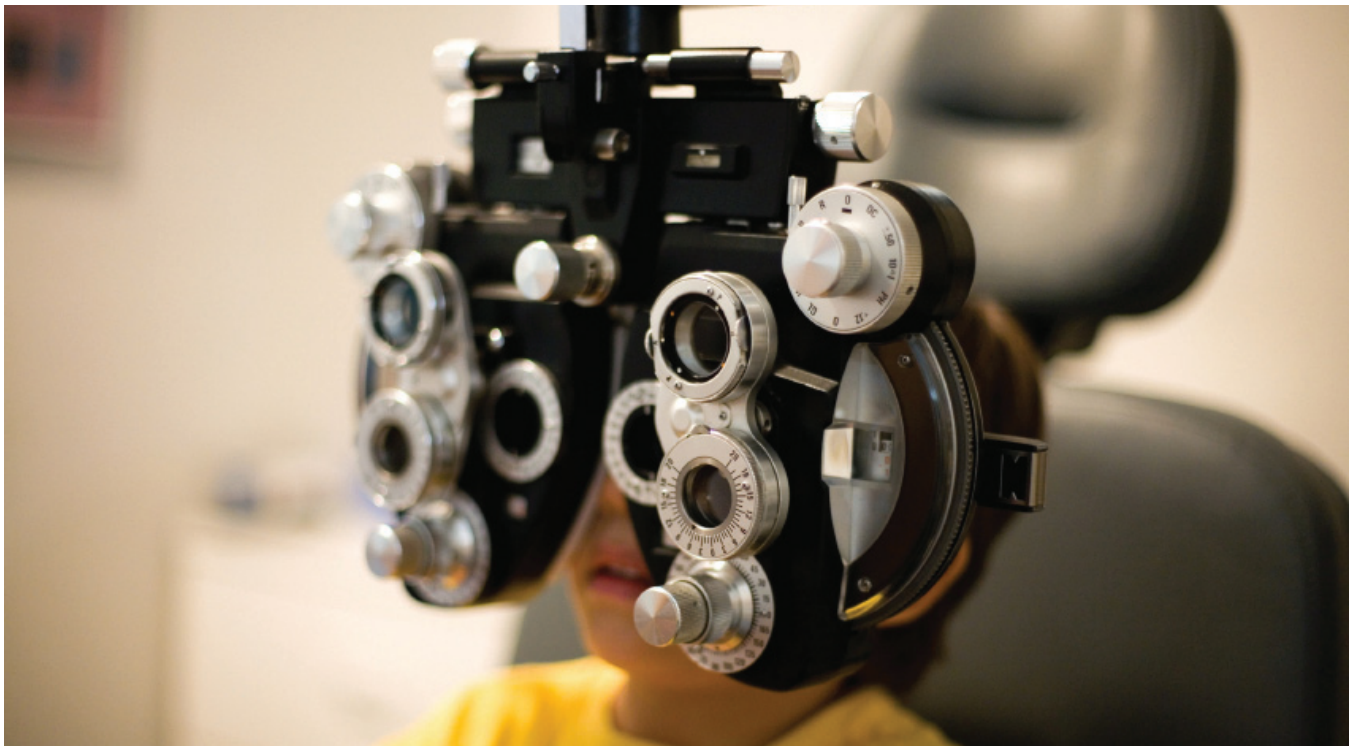
Figure 5: 2009 Screening & Participant Ratios for Children Under 2 Years of Age

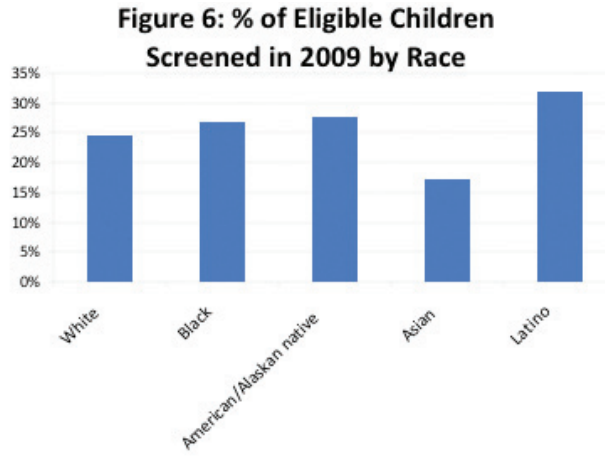


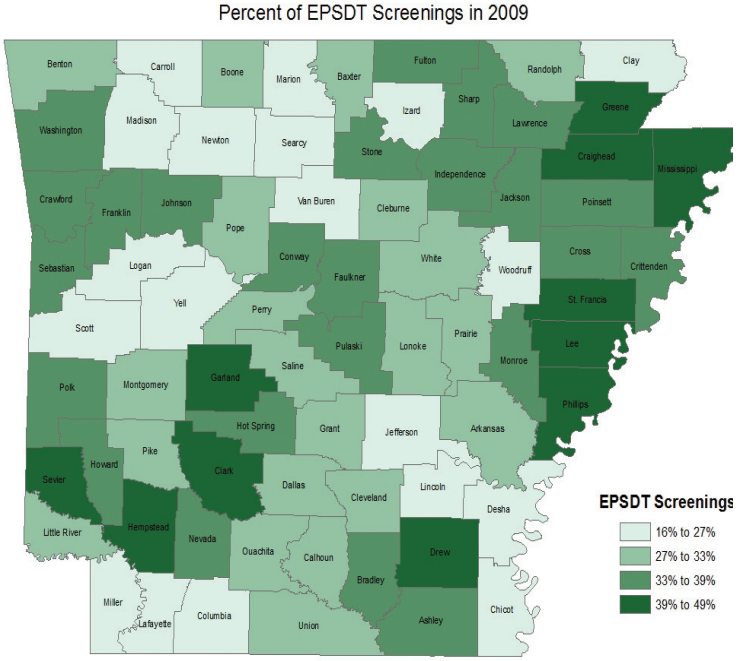
Source: Arkansas Department of Human Services

Although the youngest children are most likely to receive at least one screening, most children are not receiving all the EPSDT screenings they need. A majority of children between the ages of 1 and 2 receive at least one EPSDT screening (53 percent), but only 30 percent of scheduled screenings are actually given (figure 5).

SCREENINGS BY RACE AND GENDER. Analyzing EPSDT screening rates by race is challenging, as different categories are used to count those eligible and those who receive services. Moreover, race and ethnicity questions are







Source: Arkansas Department of Human Services

not required by the federal government to be reported, so they are often not included. Figure 6 provides the best information available on screenings by race. Of the children eligible for EPSDT screenings in the 2009 federal fiscal year, nearly 31 percent were classified as unknown. In categories where it was possible to match the race of those eligible and those receiving services, Asian children were less likely to be screened than children in other ethnic groups.[23]

Gender differences are slight, though boys consistently receive screenings at slightly higher rates than girls (about 2 percentage points higher).

Geographic differences are significant. In Drew County, 49.1 percent of eligible children had at least one screening. In Scott County, only 15.9 percent of eligible children had at least one screening. The median was 33 percent. That means half the counties screened more than 33 percent of children and half screened fewer. See the map on the previous page and Appendix A for a table of county-by-county percentages.

Fourteen counties improved screening rates by more than 10 percentage points in the past four years. The number of children receiving at least one EPSDT screening increased in most counties, reflecting an overall increase of 6.2 percentage points statewide. The following counties increased rates more than 10 percentage points:

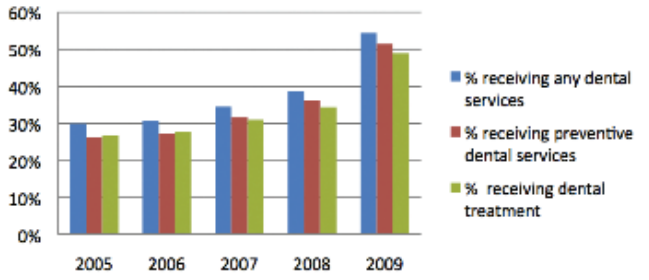
COUNTY	FFY06 PERCENT SCREENED*	FFY09 PERCENT SCREENED*	PERCENTAGE POINT INCREASE BETWEEN '06 AND '09
CLARK	30.9%	41.4%	10.5
CRAIGHEAD	30.4%	42.4%	12.0
DREW	27.0%	49.1%	22.1
FRANKLIN	20.5%	34.7%	14.2
FULTON	22.6%	34.9%	12.3
HEMPSTEAD	25.7%	40.9%	15.2
HOWARD	20.2%	33.6%	13.5
JACKSON	23.5%	38.1%	14.5
LEE	33.0%	44.2%	11.2
MISSISSIPPI	27.6%	43.1%	15.5
PHILLIPS	35.6%	45.7%	10.0
PRAIRIE	20.1%	30.5%	10.4
SEVIER	34.4%	45.9%	11.5
SHARP	24.0%	35.4%	11.4

Source: Arkansas Department of Human Services

MORE YOUNG CHILDREN ARE RECEIVING RECOMMENDED DENTAL SCREENINGS AND SERVICES.

While it is difficult to track every service used under EPSDT, it is possible to look in more detail at children who receive dental screenings and services as a separate category. The American Dental Association (ADA) recommends a dental visit when a child's first tooth emerges but no later than the child's first birthday. [24]

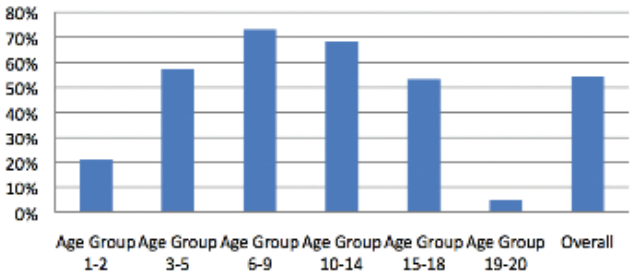
Figure 7: Children over the age of one receiving dental services



Source: Arkansas Department of Human Services

Overall, 54 percent of Arkansas children over the age of 1 who were enrolled in Medicaid received some form of dental services in 2009 (figure 7). This is up from 39 percent in 2008 and 30 percent in 2005. In fact, Arkansas is above the national average for preventive dental services (50.6 percent among children on Medicaid versus 43.5 percent, nationally.) and also boasts a large increase over a short period of time.[25] Children between the ages of 6 and 9 are most likely to receive dental services, while children under the age of 2 and over the age of 18 are least likely (figure 8).

Figure 8: Children receiving any dental services in 2009



Source: Arkansas Department of Human Services

The Head Start program has helped children access preventive care. In 2008-2009, 66 percent of children in Head Start received dental preventive care, and 81 percent of Head Start children who needed dental treatment received it.[26]

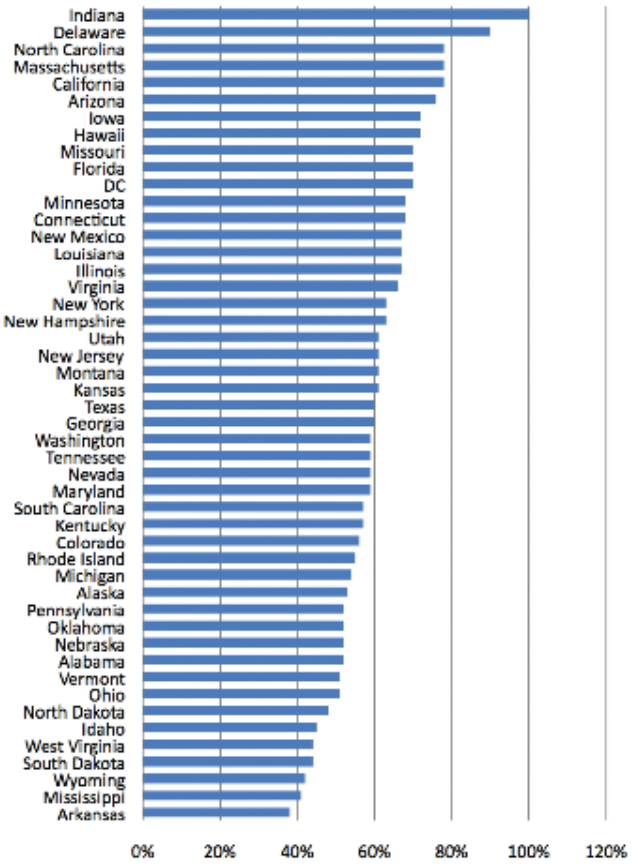
Also, while the number of dentists in the state hasn't changed much in recent years, the ratio accepting Medicaid has. In 2005, 39.6 percent of 1,158 dentists accepted Medicaid. By 2009, that had increased to 58.2 percent of 1,178 dentists.

ARKANSAS AND OTHER STATES: COMPARING APPLES AND ORANGES

Although states have been required to submit annual EPSDT reports to the Centers for Medicare and Medicaid Services since 1990, the quality of the reports has been uneven and the accuracy of the data provided is inconsistent.[27] For example, it is not clear whether undocumented screenings are due to screenings not being performed, or because of inaccurate coding. States have historically had difficulty collecting the information, since Medicaid providers may not consistently report well-child visits, immunizations, and other components of EPSDT.[28] For this reason, many states complain

Figure 9: 2008 EPSDT Screens by State

Note: every state measures completed screens differently



Source: 2008 all state report. Baltimore, MD: Centers for Medicare and Medicaid Services; 2009.

that their official numbers are on the low side. Child advocates, on the other hand, are concerned that the numbers of visits are overstated, since a physician may report a screening even if a child did not receive all the required elements of the EPSDT screening.[29] Not meeting the requirement can have consequences: at least 28 states have been sued since 1995 by beneficiaries or by advocates for inadequate provision of EPSDT services.[30]

CMS has a goal of having at least 80 percent of Medicaid children who need a well-child visit according to the state's requirements get one.[31] Unfortunately, most states fall well short of that goal. In 2008, only two states screened at least 80 percent of Medicaid children under the EPSDT program: Indiana, which reported an implausible 100 percent, and Delaware, which reported 90 percent (see figure 1).[32] The average screening rate for states was 61 percent. Arkansas had the lowest rate of reported EPSDT screenings, at 38 percent.[33]

However, Arkansas has required more specific documentation from medical providers about the quantity and quality of EPSDT screenings. CMS has changed the report format and it is hoped that reports will be consistent and accurate across states to allow for better comparison.

WHY ARE SCREENING LEVELS SO LOW?

There are several systemic and individual causes of the low screening rates.

Lack of sufficient outreach and education. Parents of children on Medicaid are typically less aware of the importance of preventive care than are parents in the general population.[34]

Families may not fully understand why checkups are important to their child's health.[35] Also, they may not be aware of the scope of the screening and treatment services their children should receive under Medicaid.[36]

In some cases, states have been sued because of poor coordination of EPSDT programs and inadequate notification of families about the scope and availability of EPSDT services.[37] Particularly in the current economic climate, states feel the need to lower Medicaid costs even as Medicaid rolls expand because of rising unemployment. Because of this, efforts to increase EPSDT rates are likely not to be a priority.[38] Skimping on early prevention and screening is a poor long-term strategy that leads to increased medical costs.

Not enough medical providers. Other common problems are the lack of providers in general and the number of providers who don't accept Medicaid patients. In Arkansas, children in many Medicaid categories are required to have a regular source of medical care—a primary care physician. But in January 2010 more than 25,000 children enrolled in ARKids First or Medicaid (6 percent of those enrolled) did not have a primary care physician on record.[39] The lack of providers is partially a geographic issue, but the low payment rate for EPSDT services is also a problem (see below).[40] In addition, a shortage of specialty providers—such as dentists and child psychiatrists—exacerbates the problem.[41]

Many primary care doctors don't have enough time to spend with each patient. It may be difficult for them to fit in preventive screenings or to follow-up on test results.[42] When providers do give EPSDT screenings, they may not bill for the service in a way that allows for accurate counting. Complicating matters, it's difficult to see the link in the state's data systems between screenings and resulting treatment.

Low reimbursement rates for EPSDT screenings. The EPSDT reimbursement rate in Arkansas is $56.41, and is the same whether the physician provides a single element or every element of an EPSDT screening. This rate has been in place since 2004 and is low compared to other states in the region. In Louisiana, the average rate is $82.51, in Texas it is $92.63, in Oklahoma it is $88.77 and in Mississippi it is $88.10. An increase in the rate should be tied to full provision of EPSDT services.[43]

Barriers to access, such as language or transportation, are more prevalent among low-income families. Parents of children eligible for Medicaid typically have low incomes from jobs that don't provide sick pay. Missing work for a medical appointment also means missing income. These parents may not have reliable transportation or may not speak English,

making accessing care more difficult. These issues contribute to high numbers of missed appointments among Medicaid beneficiaries, making providers less willing to accept and treat Medicaid patients.[44] Finally, parents may have difficulty maintaining a regular doctor for their children, or may not see the importance of it.[45]

Many uninsured children eligible for Medicaid are not consistently enrolled, disrupting continuity of care. Annual re-enrollment requirements often push children off the rolls, making continuity of care and coherence of records difficult.

In Arkansas, almost half of the children dropped from ARKids First (20,000) each year lose coverage as a result of paperwork or procedural reasons, not because they became ineligible.[46]

WHAT APPROACHES HAVE OTHER STATES TAKEN?

There have been a number of studies on improving the widespread problem of low EPSDT screening rates. The federal General Accountability Office (GAO) examined five states that improved EPSDT screening rates. It noted three efforts: improving data, better ensuring that managed care plans deliver services, and improving outreach to parents and patients.[47]

Incentives to providers. The American Academy of Pediatrics recommends making EPSDT benefits clear in brochures for parents, in state plans, and in contracts for managed care. States must be sure that parents know about the services and how to access them. Wisconsin penalizes health plans that do not achieve an 80 percent screening rate—a strong economic incentive to ensure that the health screenings are completed.[48]

The State of Oklahoma gives a bonus to providers who reach 60 percent of eligible children with EPSDT screenings.[49]

Incentives are only possible with good data. Primary care providers could be given incentives for using electronic health records so they can link data from various sources, including the offices of primary care providers, local health departments, and school-based clinics. That in turn would help with verifying data and the public release of the number of children receiving services, as is done in New York.[50]

Increased reimbursement rates. When the State of Florida more than doubled the fee paid to physicians (from $30 to $64.82), the screening rates also doubled, from 32 percent to 64 percent.[51]

Expanding locations where screenings may be provided. At least two states that increased EPSDT rates required managed care plans to contract with local health departments to provide some services. Another approach is the use of school-based health centers. A study of children in schools with a school-based health center found a positive effect on health, particularly in the area of psycho-social health. The strongest

effects were found in children without health insurance and in those with lower income levels, which is the population eligible for Medicaid.[52]

New provider models to improve efficiency and access. There are a number of ways to make EPSDT visits more efficient for providers without disrupting acute care services.[53] If capable, the patient or parent could complete a developmental questionnaire while waiting for a doctor, with a nurse conducting at least a portion of the initial interview.[54]

A nurse could provide most required EPSDT screening services—with the exception of the unclothed physical exam—using a nursing protocol developed by the U.S. Preventive Services Task Force.[55] Having a particular staff person with the interest, training, and time to provide the services and to ensure that they are reported and billed consistently could help to institutionalize EPSDT within pediatric practices.[56]

Better outreach to children and families about check-ups. A trial that included post card reminders, telephone calls to parents, and home visits if appointments were missed found that children had a shorter time to the fifth well-child visit, had fewer days of being under-immunized (nearly three months less per child) and more children (65 percent) had at least five well-child visits by the age of 15 months.[57] The cost of the program was $349.50 per child, although a third of the cost was a one-time expense for a technology system that generated reminder letters and call lists.[58]

ARKANSAS EFFORTS TO IMPROVE THE QUALITY AND ACCESS TO SCREENINGS

Arkansas has taken steps to improve the quantity and quality of screening rates, laying a foundation for future work. These steps are possible because of strong partnerships between Arkansas Medicaid, the Arkansas Department of Human Services Division of Child Care and Early Childhood Education (which oversees the state's child care and preschool programs), and the Arkansas Foundation for Medical Care (which provides training and resources for Medicaid providers).

In 2006, Arkansas received support through the Assuring Better Child Development (ABCD) project[59] to promote standardized developmental screening tools in physicians' offices across the state. Two doctors' offices tried using a new tool, the Ages and Stages Questionnaire (ASQ) to detect developmental delays or problems as early as possible. Their success in using the evidence-based tool prompted Medicaid and the Arkansas Foundation for Medical Care to promote the use of evidence-based tools for medical providers. This project gave Arkansas national recognition through a new grant designed to help ensure services are available and coordinated when developmental challenges are detected. Called AR LINKS (Linkages Improve Networks and Knowledge of Services), the new project seeks to improve connections between medical professionals, child care programs, and other service providers in select communities to connect children to the services they need. Five communities will participate as pilot sites for the project: Benton, Clinton, El Dorado, Forrest City, and Jonesboro. AR LINKS will result in the development of a statewide strategy to improve service provider links and care coordination for young children, particularly those with or at risk of developmental delay.

In 2006, the Arkansas Foundation for Medical Care worked with health care providers to identify best practices that can improve EPSDT rates. Nine pilot clinics tested new education tools, strategies and approaches, adapted to their particular geographic location. The compiled results help AFMC's work with clinics across the state.[60] Tools and resources can be accessed at http://afmc.org/EPSDT

In 2007, Arkansas provided one-time bonus payments to physicians who improved screening rates. While many physicians received bonuses, target thresholds were not set high enough to motivate providers to increase rates enough to make a significant difference. Direct technical assistance to ensure providers correctly documented and completed all necessary screenings appeared to do a better job of increasing rates.

RECOMMENDATIONS

Arkansas's EPSDT compliance rate is one of the country's worst in the nation. This shortchanges children living in poverty, impeding their long-term growth and potential to contribute fully to the state in the future. Arkansas can take the following steps to build up from promising efforts already underway to improve access to preventive care for children and meet federal requirements:

1. **Encourage the use of electronic medical records (EMR) and health information technology (HIT)** systems that track provision and referral for EPSDT services. Some possible ways to use EMRs and the HIT system that would improve rates and also provide better data on what screenings and services children receive include:

- Find ways to link treatment with a corresponding screening and diagnosis. In many cases, treatment provided under Medicaid is not linked back to an EPSDT screening. Better data systems and EMRs could ensure treatment is better connected to a child's original EPSDT screening.
- DHS should identify critical data points essential for tracking EPSDT services through its Medicaid data system. Based on the American Academy of Pediatrics' Bright Futures[61] guidelines, it is known as the "gold standard" for pediatric care.
- Robust HIT and EMR systems generate reminder letters and text messages to parents when screenings and/or immunizations are due for their children.
- Physicians should receive a higher reimbursement if they use a HIT system capable of accurately tracking EPSDT services and generating reminders to parents.

2. **Increase EPSDT screening reimbursement for providers.** The state's rate has been in place since 2004 and is low compared to other states in the region. Boosting the rate of reimbursement has improved access in other states. Tying increased reimbursement to performance—both in the number of children screened and in completeness of EPSDT screenings—could lead to higher compliance. The state could also offer bonus payments to improve the quality of specific components, such as developmental screenings.
3. **Give providers incentives and education to improve quantity and quality of screenings.** Incentives and education should build off existing DHS initiatives under the Assuring Better Child Development project. For example, incentives could encourage:

- Allowing nurses or other providers to provide most EPSDT services and screen more children.
- Use of a standardized screening tool to improve quality of screenings.
    - Improved documentation of the services.

4. **Use the state's new school wellness centers as models for better access to services, starting with well-child screenings**. In the fall of 2010, nine schools across the state[62] began the first of a five-year grant—funded by tobacco tax revenue—to create wellness centers in schools. They partner with local health providers and use qualified nurses to coordinate and help provide services. Federal Medicaid rules allow reimbursement for care in non-traditional settings, including schools.[63]

   Arkansas Medicaid policy also allows for schools to provide services, but many school officials anticipate or assume that billing will require significant paperwork. Arkansas Medicaid in the Schools (ARMITS) helps schools understand if they offer services for which they may already be able to bill.[64] State Medicaid services could also facilitate school-based health services by allowing more ease in billing and access for non-traditional environments while also linking back to a child's regular physician.

5. **Require children entering preschool or state-subsidized child care programs to have full EPSDT or comprehensive well-child screenings**. Currently, the state's Arkansas Better Chance (ABC) program requires a health screening but not all required components of a full EPSDT screening. ABC and child care centers could require a full EPSDT screening for all enrolled children.

CONCLUSION

Arkansas has made progress in improving access to preventive care for children, but we still have a long way to go. The state faces serious challenges in increasing the rates of EPSDT services, and bold action is required. California was forced by lawsuit to increase treatment capacity by finding novel ways to serve clients. Many other states, including Tennessee and Texas, have also improved EPSDT services only under court order. [65]

The federal government has set the target for EPSDT screenings and services at 80 percent of eligible children. Arkansas needs to more than double the percentage of Medicaid-enrolled children getting full EPSDT services to reach that goal. By taking the steps outlined above to improve access, Arkansas has the opportunity to improve EPSDT services without risking a costly lawsuit.

Appendix A: EPSDT Screening Rates by County

Recipient County	FFY09 Percent Screened	Recipient County	FFY09 Percent Screened
ARKANSAS	31%	LEE	44%
ASHLEY	34%	LINCOLN	20%
BAXTER	33%	LITTLE RIVER	32%
BENTON	32%	LOGAN	25%
BOONE	29%	LONOKE	30%
BRADLEY	38%	MADISON	26%
CALHOUN	29%	MARION	24%
CARROLL	27%	MILLER	27%
CHICOT	24%	MISSISSIPPI	43%
CLARK	41%	MONROE	38%
CLAY	26%	MONTGOMERY	33%
CLEBURNE	28%	NEVADA	36%
CLEVELAND	30%	NEWTON	20%
COLUMBIA	25%	OUACHITA	33%
CONWAY	34%	PERRY	30%
CRAIGHEAD	42%	PHILLIPS	46%
CRAWFORD	34%	PIKE	29%
CRITTENDEN	34%	POINSETT	39%
CROSS	36%	POLK	35%
DALLAS	28%	POPE	32%
DESHA	24%	PRAIRIE	31%
DREW	49%	PULASKI	36%
FAULKNER	34%	RANDOLPH	32%
FRANKLIN	35%	SALINE	32%
FULTON	35%	SCOTT	16%
GARLAND	41%	SEARCY	25%
GRANT	33%	SEBASTIAN	35%
GREENE	43%	SEVIER	46%
HEMPSTEAD	41%	SHARP	35%
HOT SPRING	39%	ST. FRANCIS	44%
HOWARD	34%	STONE	39%
INDEPENDENCE	36%	UNION	33%
IZARD	24%	VAN BUREN	27%
JACKSON	38%	WASHINGTON	35%
JEFFERSON	27%	WHITE	28%
JOHNSON	37%	WOODRUFF	24%
LAFAYETTE	24%	YELL	26%
LAWRENCE	37%	Total:	34%

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