

**AN OVERVIEW
OF THE
ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES**



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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)**.
- Arkansas Medicaid is detailed in the **Arkansas Medicaid State Plan** and through **Provider Manuals**.
- The **Health Care Financing Administration (HCFA)** administers the Medicaid Program for the federal government. HCFA authorizes funding levels and approves each state's State Plan, ensuring compliance with federal regulations.

Eligibility

Individuals are certified as eligible for Medicaid Services by **DHS Field Staff** located in **County Offices** or by **District Social Security Offices**.

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; some specialized enhancements are funded 90% by the federal government.

Services

Services may be rendered by both **private and public providers**.

Mandatory Services are required by the federal government.

Optional Services are those 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. Optional services are approved in advance by HCFA and are funded at the same level as mandatory services.

ARKANSAS MEDICAID

Program Costs

SFY	Total (in mill)	Unduplicated Recipients	Average Cost
1994	\$1,095	342,264	\$3,199
1995	\$1,205	349,072	\$3,452
1996	\$1,284	365,650	\$3,512
1997	\$1,347	363,881	\$3,702
1998	\$1,458	415,605	\$3,508
1999 (Proj)	\$1,426	434,827	\$3,279

Average Cost per prescription in SFY98 was \$35.41



Arkansas Economics (SFY98)

		Medicaid Represents
Arkansas Medical Economy	\$ 7.76 billion	18.8%
State of Arkansas Budget (est)	\$ 8.08 billion	18.5%
State General Revenue Funded Budget	\$ 2.90 billion	12.1%
<i>(includes trust fund)</i>		
Arkansas Population*		% population served by Medicaid
All Ages	2,522,765	16%
Elderly	359,918	18%
Adult (20 - 64)	1,434,019	8%
Children (19 and under)	728,828	32%

*Source: Institute for Economic Advancement at UALR

76.06% of all Nursing Home residents in SFY97 were Medicaid Eligible



Provider Communications handled approximately 144,000 telephone inquiries in SFY98.

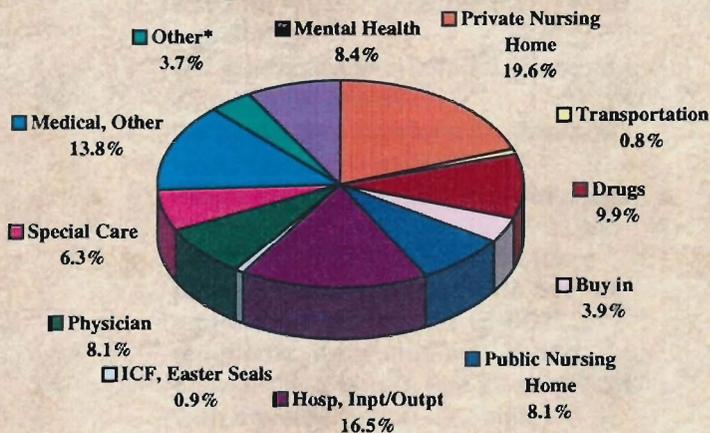
SFY99 Medicaid Operating Budget

(millions)	
General Revenue	\$300.1
Other Revenue	\$58.8
Trust Fund	\$50.3
Federal Revenue	\$1,088.0
Total Program	\$1,497.2

Medicaid Trust Fund Analysis

(millions)	
SFY99 Est. Receipts	\$40.4
SFY98 Carryover	\$9.9
Available	\$50.3
SFY99 Est. Needed	\$50.3
SFY99 Est Carryover	\$0.0

Expenditures SFY 1998



*Special Care includes Home Health, Private Duty Nursing, Personal Care and Hospice Services. Transportation includes emergency and non-emergency. Other includes vendor contracts, Medicare co-pay and deductibles, and other adjustments. Buy-in includes Medicare premiums.

Medicaid has approx. 22,000 actively ENROLLED providers
approx. 8,500 are PARTICIPATING Providers

18,217,738 claims were processed in SFY98
Average processing time was 3.3 days



The medical cost for 42% of all babies born to Arkansas residents is paid for by Medicaid

INNOVATIONS

AUTOMATED ELIGIBILITY VERIFICATION & CLAIMS SUBMISSION SYSTEM (AEVCS)

enables providers to electronically confirm each patient's eligibility & submit claims

Non-Emergency Transportation Services

regionalized dispatching and transportation services at capitated rates to reduce costs and control fraud & abuse

ConnectCare Managed Care Program

an award-winning primary care physician program that has accomplished cost containment goals while maintaining provider and recipient satisfaction

Children's Medical Services

offers case management, direct care services, and family support to children with disabilities

ARKids First

allows uninsured children of working families to access health insurance by providing primary-care coverage as in Medicaid with slightly less benefits and copayments for most services

Services Covered by Arkansas Medicaid

Services Mandated by 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
- Lab and X-ray
- Nursing Facility (for over age 21)
- Nurse Midwife
- Nurse Practitioner (family & pediatric)
- Physician
- Rural Health Clinics

Optional Services Chosen by Arkansas:

- Ambulatory Surgical Center
- Audiology (for EPSDT, under age 21)*
- Certified Registered Nurse Anesthetist
- Child Health Management Services (EPSDT, under age 21)*
- Chiropractor
- Dental (EPSDT, under age 21)*
- Developmental Day Treatment Clinic Services
- Domiciliary Care
- Durable Medical Equipment
- End Stage Renal Disease Services
- Hospice
- Hyperalimentation
- Inpatient Psychiatric (under age 21)
- Inpatient Rehabilitative Hospital
- Intermediate Care Facility for Mentally Retarded
- Medical Supplies
- Nursing Facility (under age 21)
- Occupational Therapy, Physical Therapy, Speech Pathology (EPSDT, under age 21)*
- Orthotic Appliances and Prosthetic Devices (EPSDT, under age 21)*
- Personal Care
- Podiatry
- Portable X-ray Services
- Prescription Drugs
- Private Duty Nursing (for ventilator dependent, all ages, and high technology non-ventilator dependent, under age 21)*
- Psychology Services (EPSDT, under age 21)*
- Rehabilitative Services for Persons with Mental Illness
- Rehabilitative Services for Persons with Physical Disabilities
- Respiratory Care (EPSDT, under age 21)*
- Targeted Case Management (for pregnant women, recipients age 60 and over, under age 21 EPSDT* recipients, recipients age 21 and younger and adults age 22 and older with developmental disability)
- Transportation (public, non-public, ambulance)
- Ventilator Equipment
- Vision Services

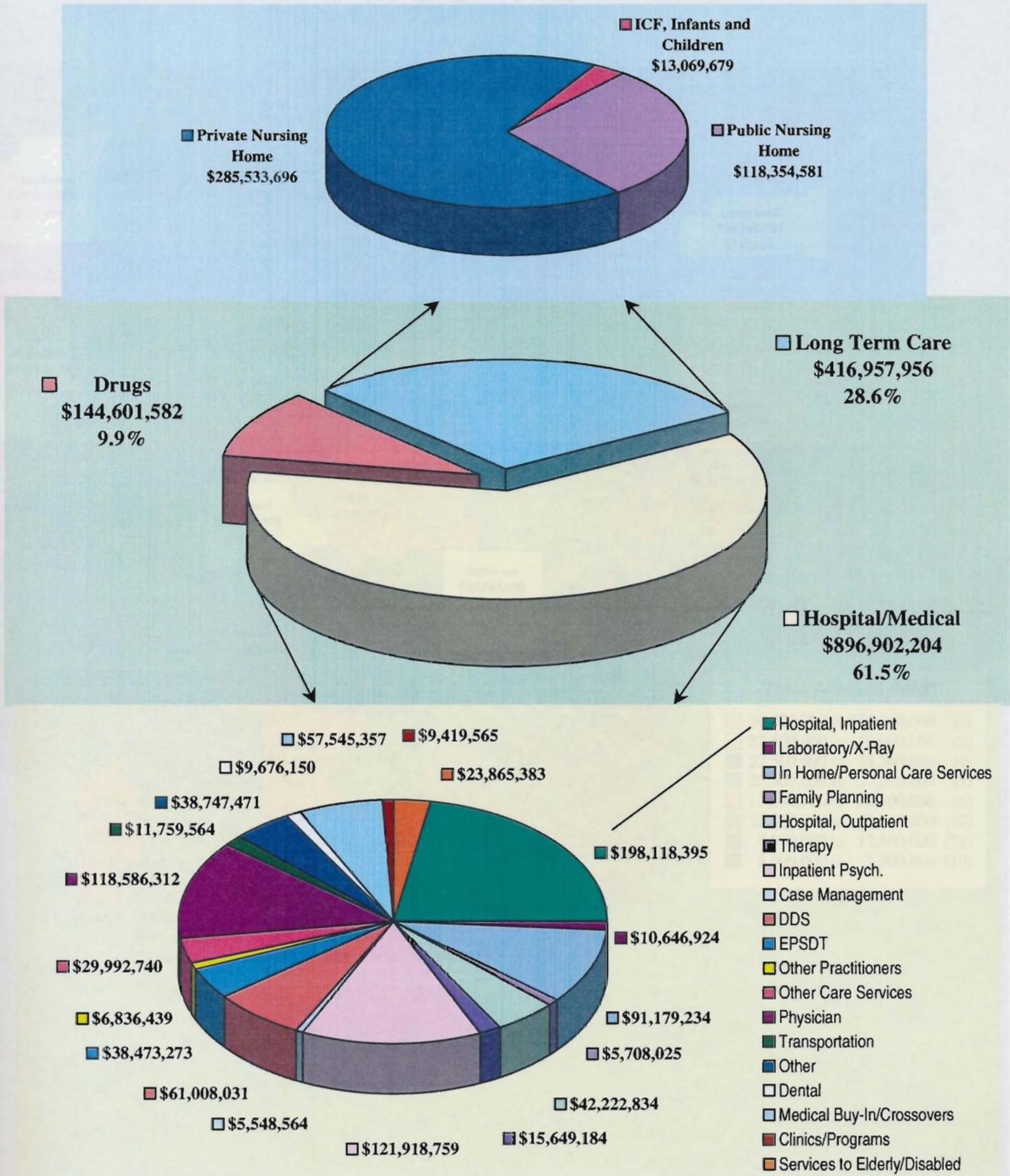
**Note: These services are limited to individuals under 21, in the EPSDT program.*

Major Benefit Limitations on Services:

- Twelve visits to physicians, clinics and/or hospital outpatient departments per state fiscal year
- Lab and X-ray services limited to total benefit payment of \$500 per state fiscal year. Exceptions for EPSDT recipients
- Three pharmaceutical prescriptions, including refills, per month (family planning prescriptions not counted against benefit limit; unlimited prescriptions for nursing facility recipients and EPSDT recipients under age 21); extensions will be considered up to a maximum of six prescriptions per month for recipients at risk of institutionalization.
- Inpatient hospital days limited to 20 per state fiscal year. Exceptions for EPSDT recipients and organ transplant patients
- Co-Pay: Recipients must pay 41% of first day of hospital stay, \$1 - \$3 of every prescription

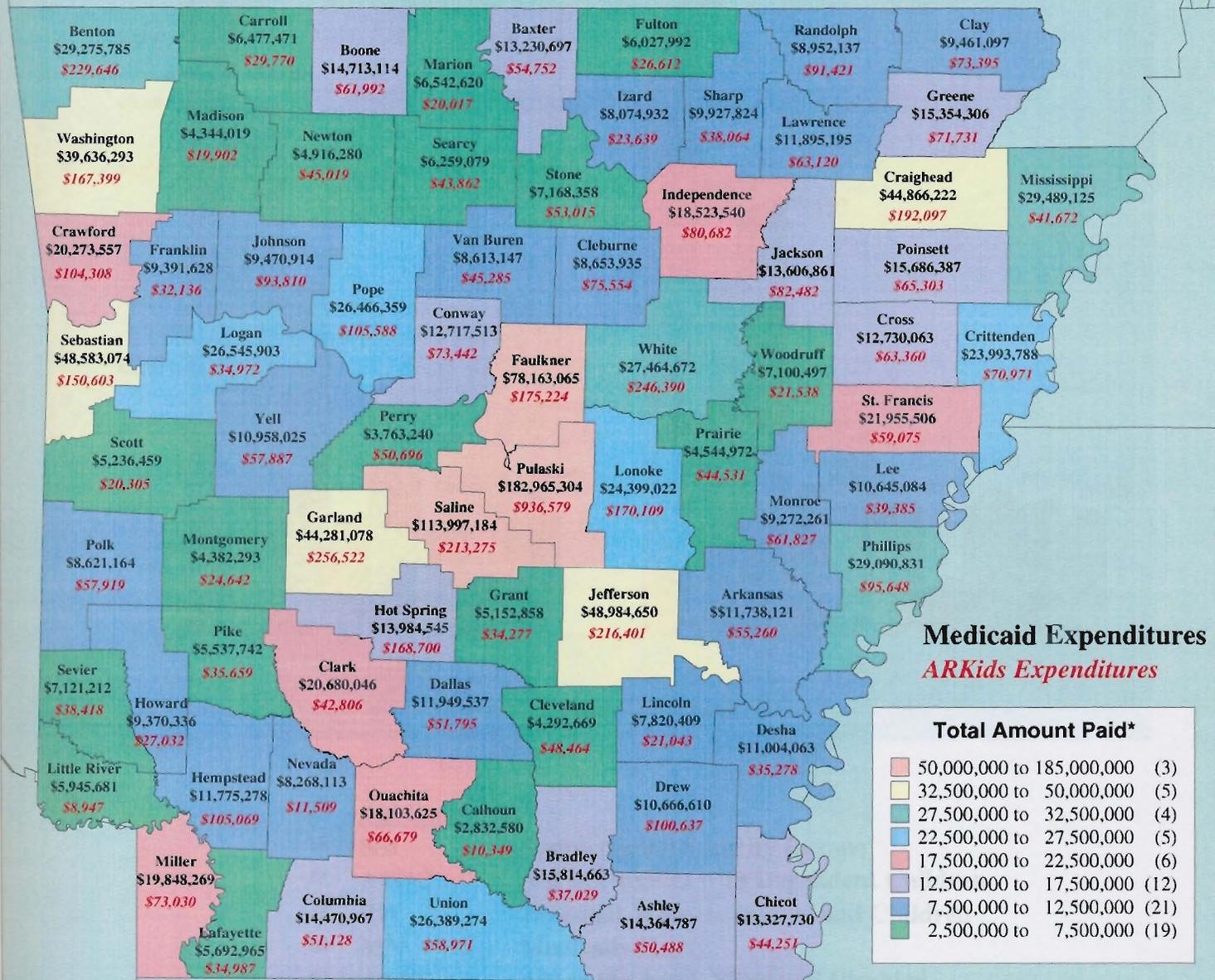
Any and all exceptions to benefit limits are based on medical necessity.

Arkansas Medicaid Program Benefit Expenditures SFY98



Paid Claims By County

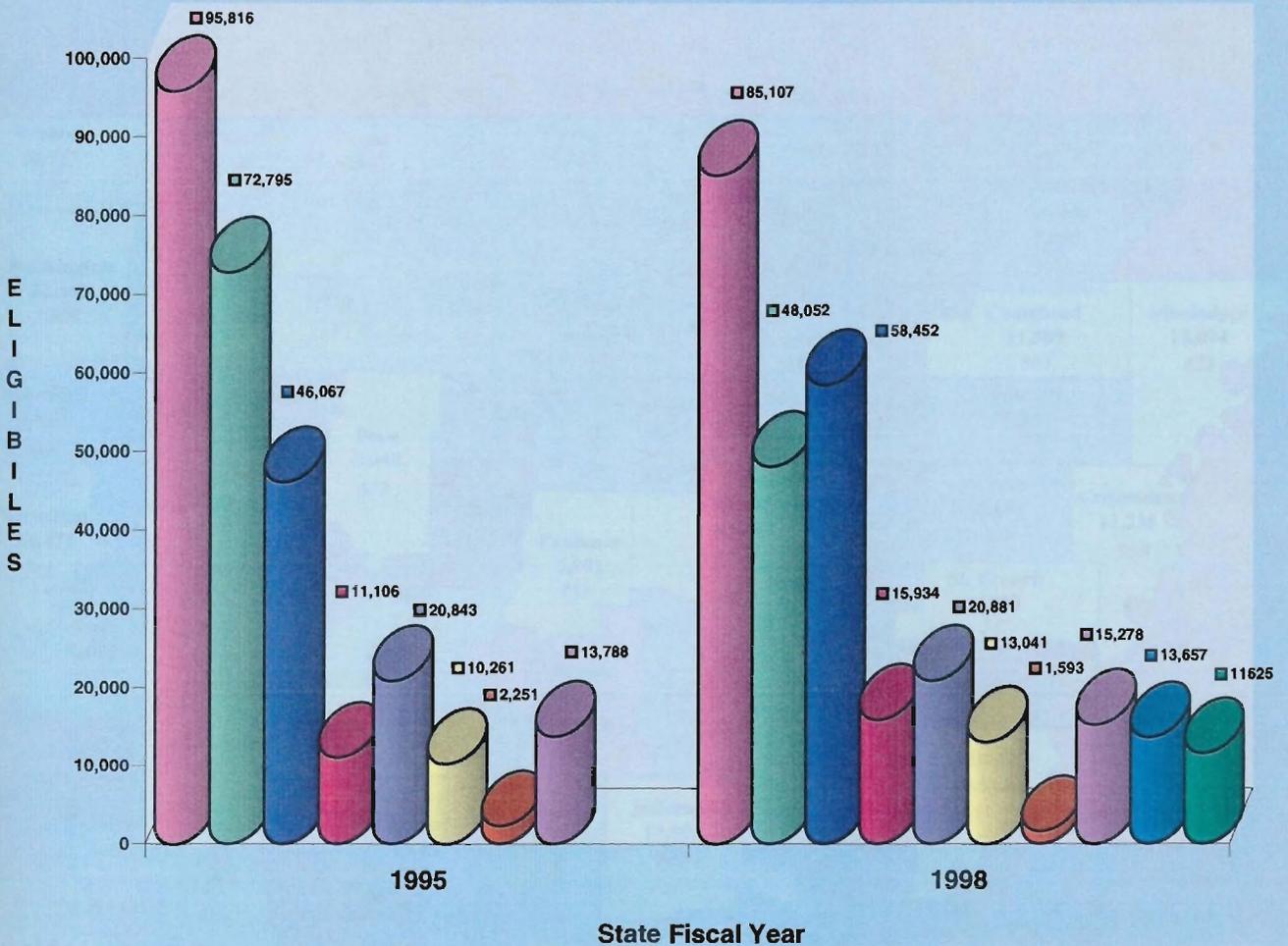
SFY 1998



Source: DHS; Division of Medical Services
 Medicaid Decision Support System
 *Does not include \$6,846,773 attributed to unspecified counties

MEDICAID ELIGIBLES

FAMILY CASELOAD BY AID TYPE COMPARISON



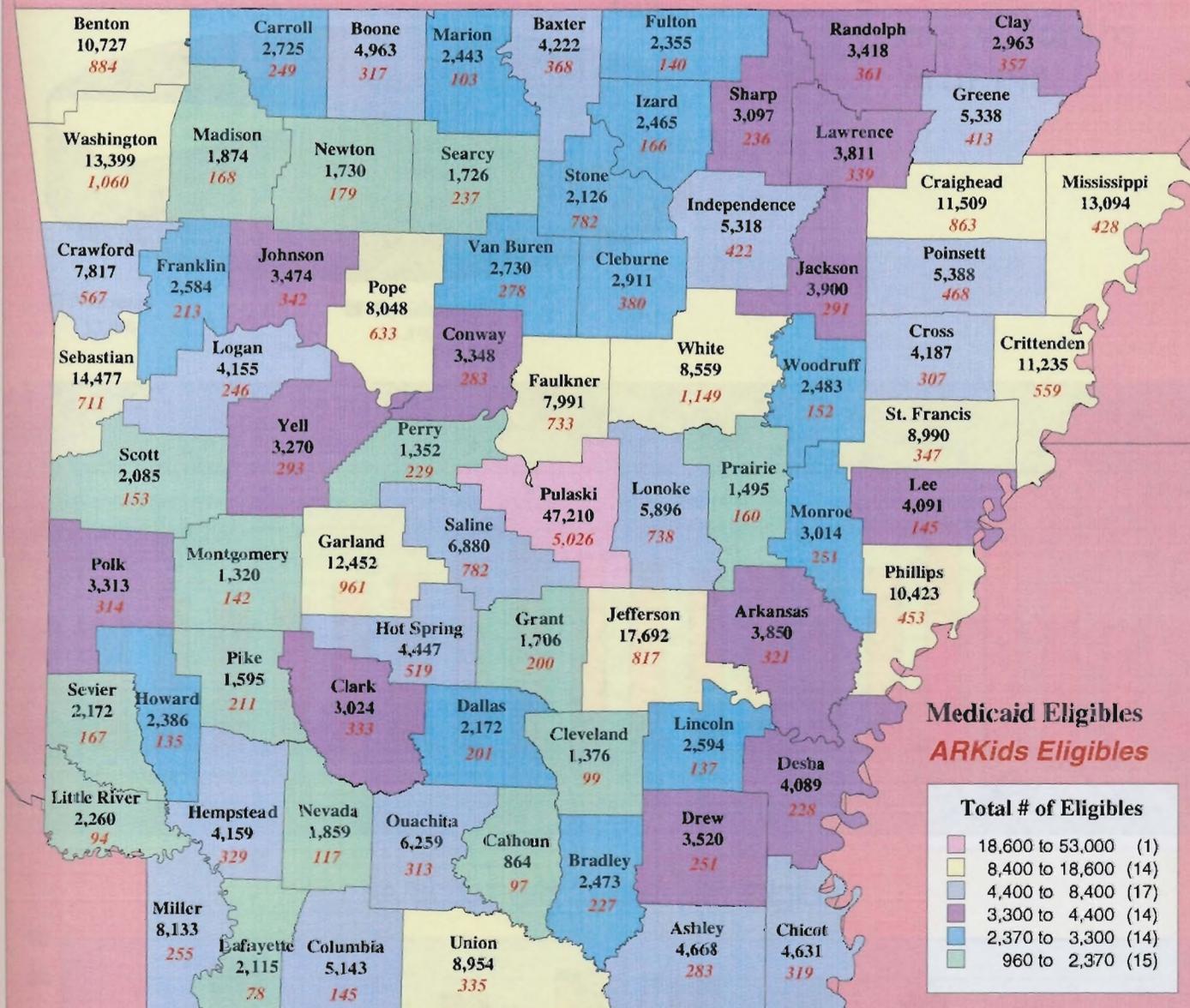
Aid Categories

- SSI Supplemental Security Income
- AFDC Aid to Families with Dependent Children
- PW Pregnant Women, Infants and Children
- MN Medically Needy
- AABD Aid to the Aged, Blind and Disabled
- U-18 Under Age 18
- FC Foster Care
- QMB Qualified Medicare Beneficiary
- FP Family Planning
- ARKids ARKids Group

*Refugees is another aid category; however, the numbers are too low to appear in the graph.
There was an average of two (2) per month in SFY 98.*

Eligibles by County

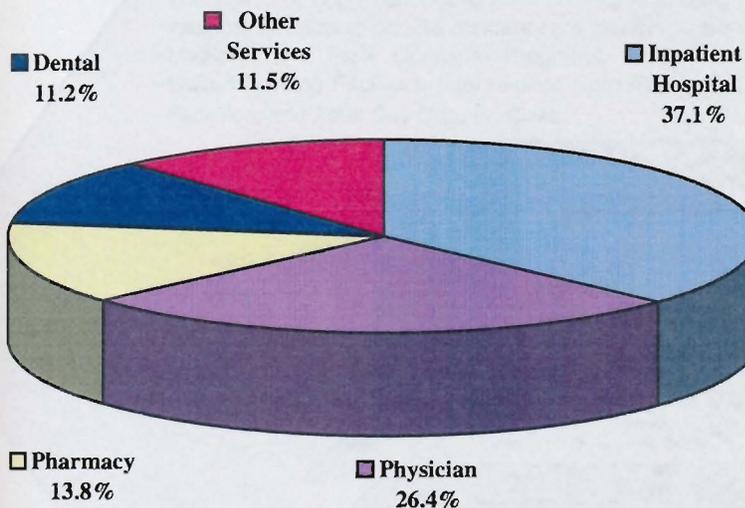
SFY 1998



Source: DHS; Division of Medical Services
Medicaid Decision Support System

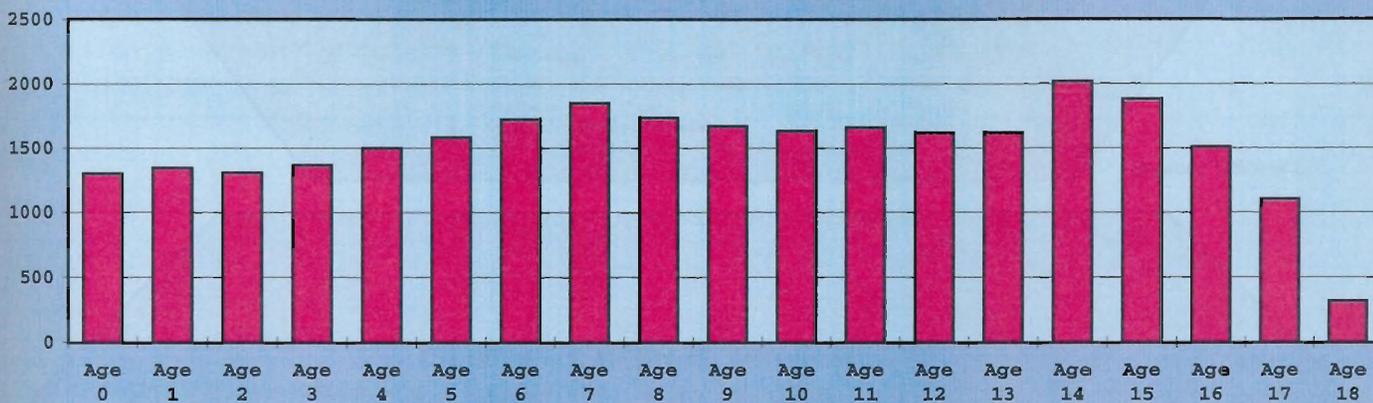
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Expenditures by Provider Type

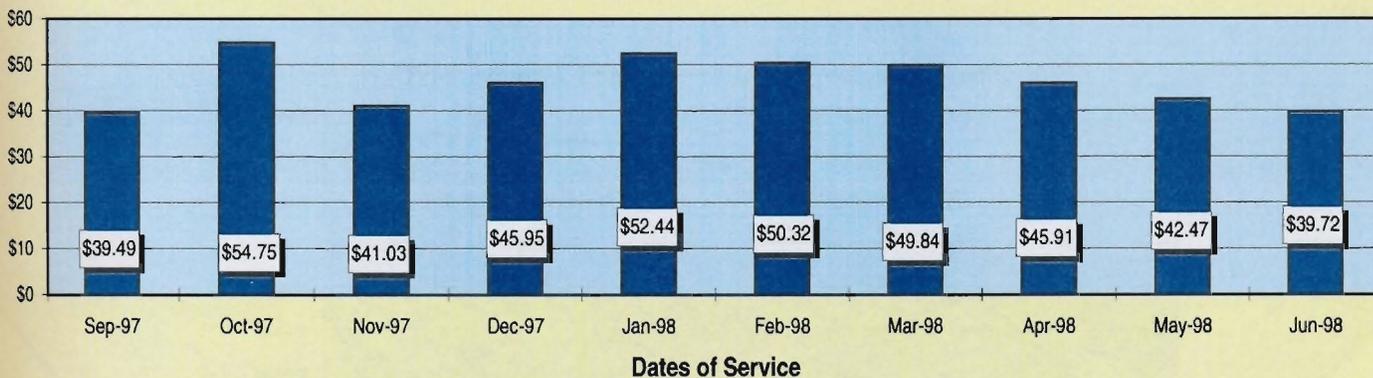


Median Age For ARKids Enrollees Was 8 years, 4 Months in SFY98.

Enrollment by Age

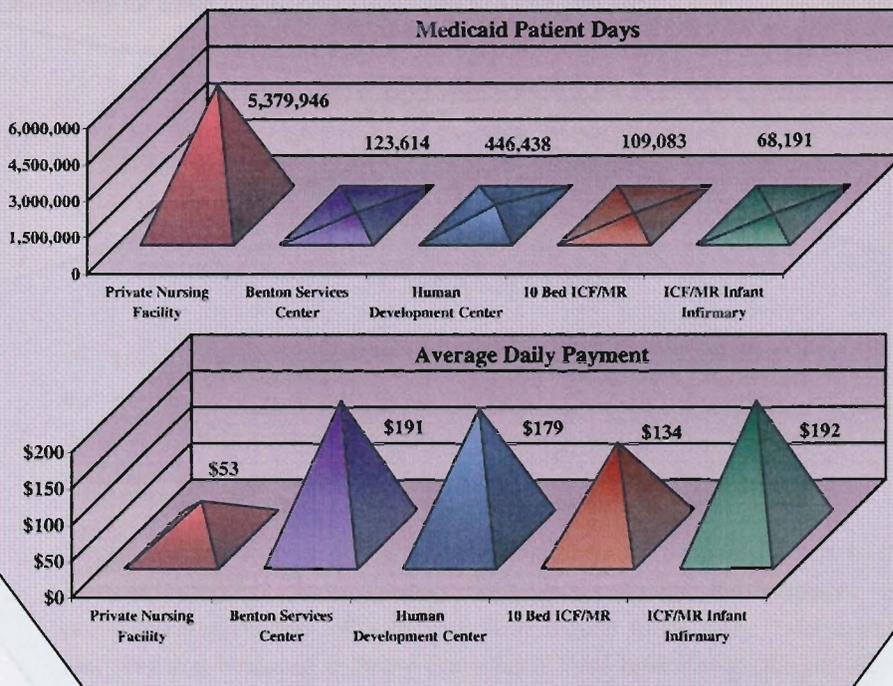


ARKids Paid Claims per Eligible



OFFICE OF LONG TERM CARE

The Office of Long Term Care prior authorizes nursing facility services, reimburses providers, and inspects facilities to ensure resident care standards are met as required by Federal Medicare, State Medicaid, and State Licensure Programs. Long Term Care facilities include Nursing Facilities, Skilled Nursing Facilities, Intermediate Care Facilities for the Mentally Retarded, Residential Care Facilities, and Adult Day Care Facilities.

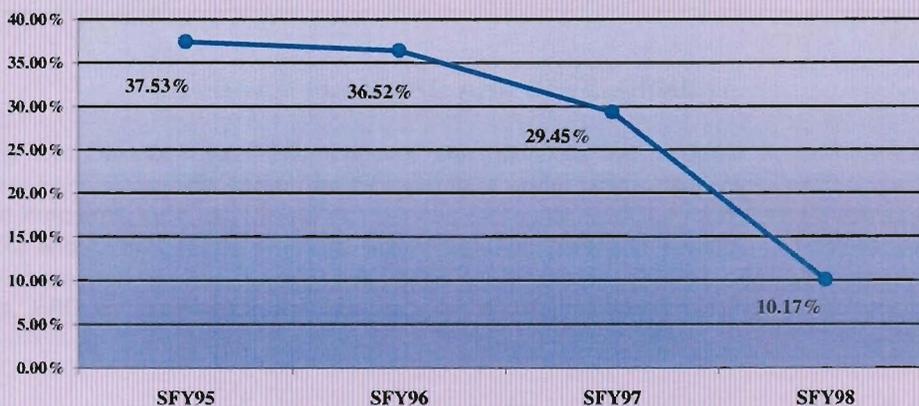


Source: Office of LTC

CHILDREN'S MEDICAL SERVICES

Children's Medical Services ensures that Arkansas' children with disabilities such as spina bifida and cerebral palsy, and chronic illnesses such as cystic fibrosis reach their greatest potential through direct care services, case management, and family support. A community-based staff develops a community-based system of services for the comprehensive needs of these families with a primary goal to keep family units intact. In an effort to control costs, a Medicaid Prior Approval Process for therapies, medical equipment, and in-home care administered by Children's Medical Services was implemented in the fall of 1997.

Prior Approval Impact Percentage Growth in Expenditures



THIRD PARTY LIABILITY

Third Party Liability identifies Medicaid recipients who have other medical insurance or payment sources that must pay first. These sources include health and liability insurance, court settlements, and absent parents. Federal and State statutes require Medicaid agencies to pursue Third Party Liability to reduce Medical Assistance payments.

Collections for State Fiscal Year 1998 were **\$13,646,005.40**.

FIELD AUDIT UNIT

The Medicaid *Field Audit Unit* of the Division of Medical Services is responsible for performing on-site/in-house audits of Medicaid providers to insure compliance with federal and state regulations and policy. Staff of the Field Audit Unit also monitor and conduct surveys of Transportation Brokers.

The goal of the Unit is to verify the nature and extent of services paid for by the Medicaid program, while insuring quality medical care for recipients and protecting the integrity of both state and federal funds. The total amount identified in overpayments for the State Fiscal Year 1998 was \$2,131,927.68

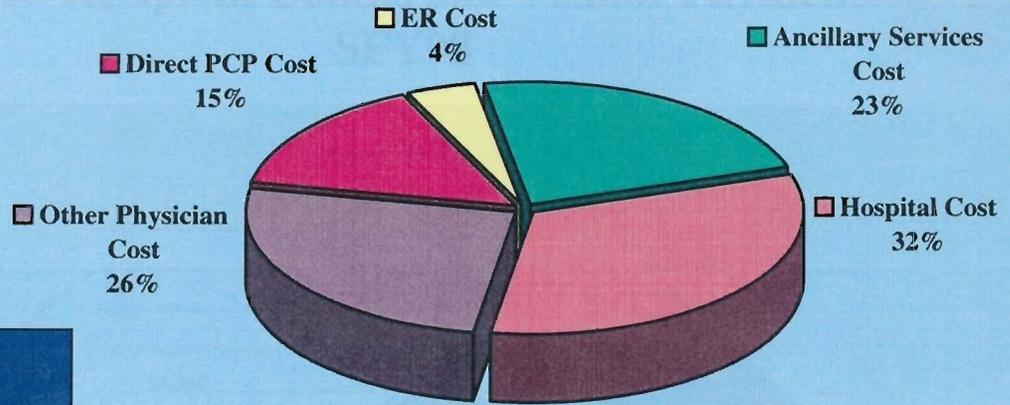
UTILIZATION REVIEW

Utilization Review identifies possible fraud and abuse, monitors the quality of services delivered, and authorizes necessary medical services. This section assures both quality and efficiency in Medicaid care through competent providers. Utilization review is constantly trying new methods to eliminate waste and unnecessary services from the Medicaid Program while assuring that the quality of care is equal to that of privately insured Arkansans. In SFY98, \$2.8 Million was identified and \$2.7 Million was recouped.

PROGRAM PLANNING AND DEVELOPMENT

Program Planning and Development (PPD) develops and maintains the Medicaid State Plan and Child Health Insurance Program State Plan. This section writes separate provider policy manuals for each of the thirty eight (38) different Medicaid Programs, such as: Physician, Pharmacy, Hospital, Dental, Prosthetics, Podiatrist, Hearing, Visual Care, Chiropractic, and EPSDT (Early, Periodic, Screening, Diagnosis, and Treatment). Provider manuals contain such information as covered services, benefit limits, benefit extension procedures, prior approval requirements, and billing procedures. PPD also develops new waiver programs and the resulting provider manuals for initiatives such as ARKids First.

PRIMARY CARE PHYSICIAN (PCP) PROGRAM EXPENDITURES SFY98
PCP PROGRAM ENTITLED *ConnectCare*



Total Cost \$184,901,206
Cost Per Enrollee \$101*

Arkansas Medicaid's *ConnectCare* program enables every eligible recipient to have his or her own primary care physician. The primary care physician is an advocate for the patient, coordinating care, making referrals when necessary, and minimizing the need to go to a hospital emergency department for treatment. Added benefits of *ConnectCare* are consolidation of medical records, wellness education and 24 hour access to care.

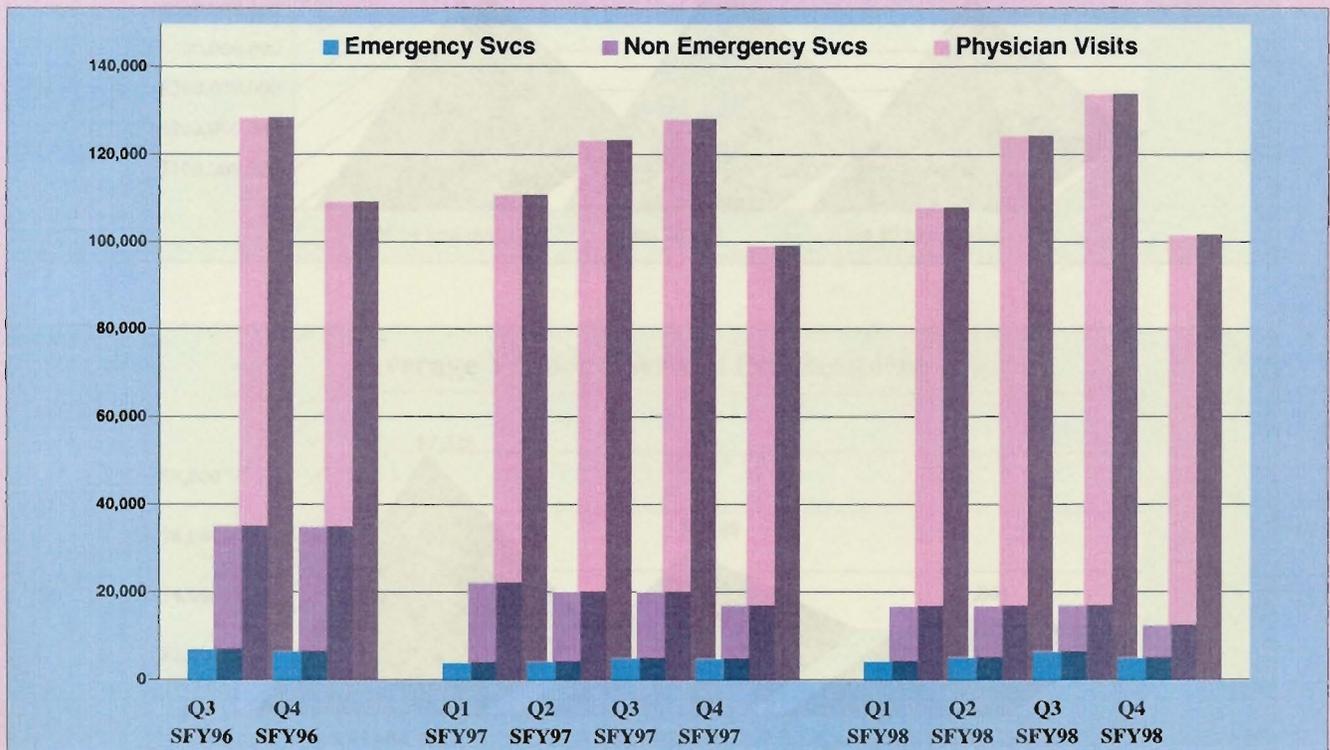
*Source: AFMC

1997 Ford Foundation
Award Recipients



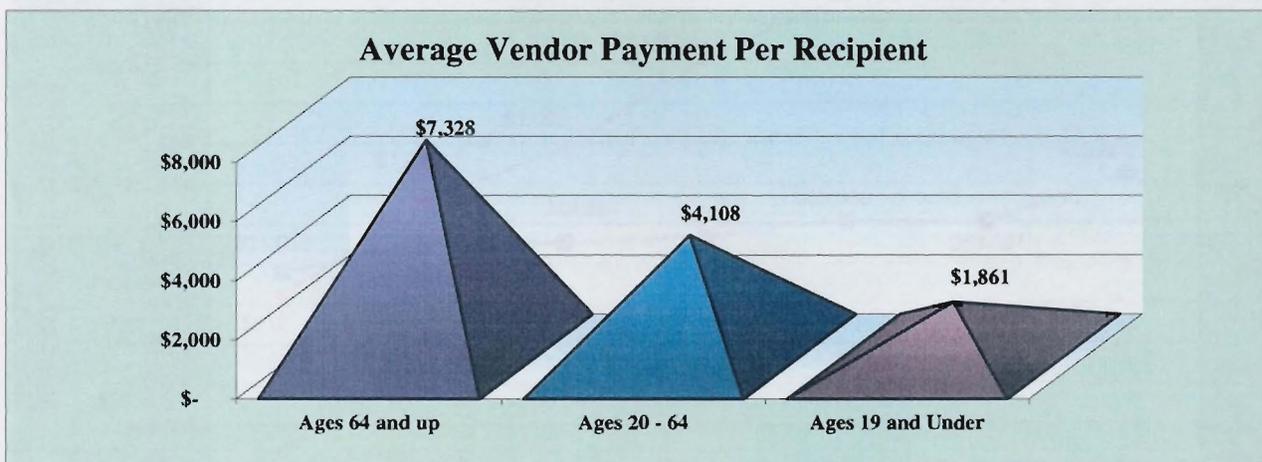
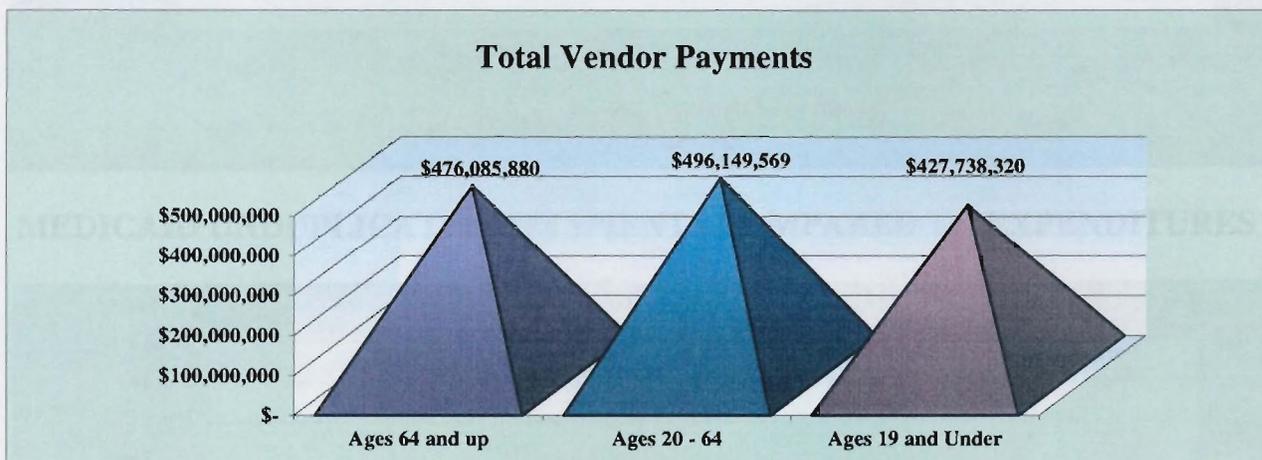
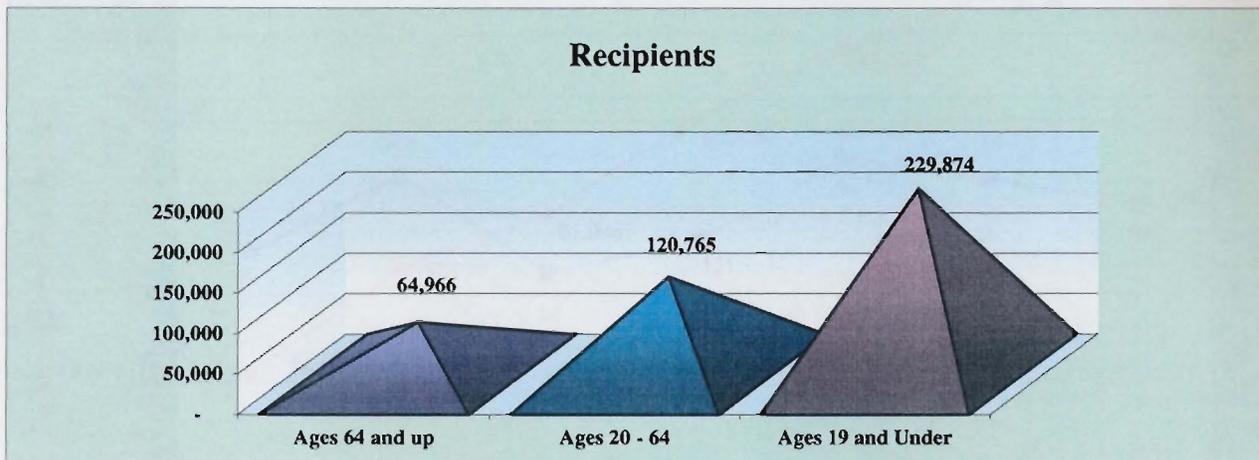
Innovations in American
Government
State of Arkansas
Department of Human
Services
ConnectCare

ARKANSAS MEDICAID TREATMENT TRENDS

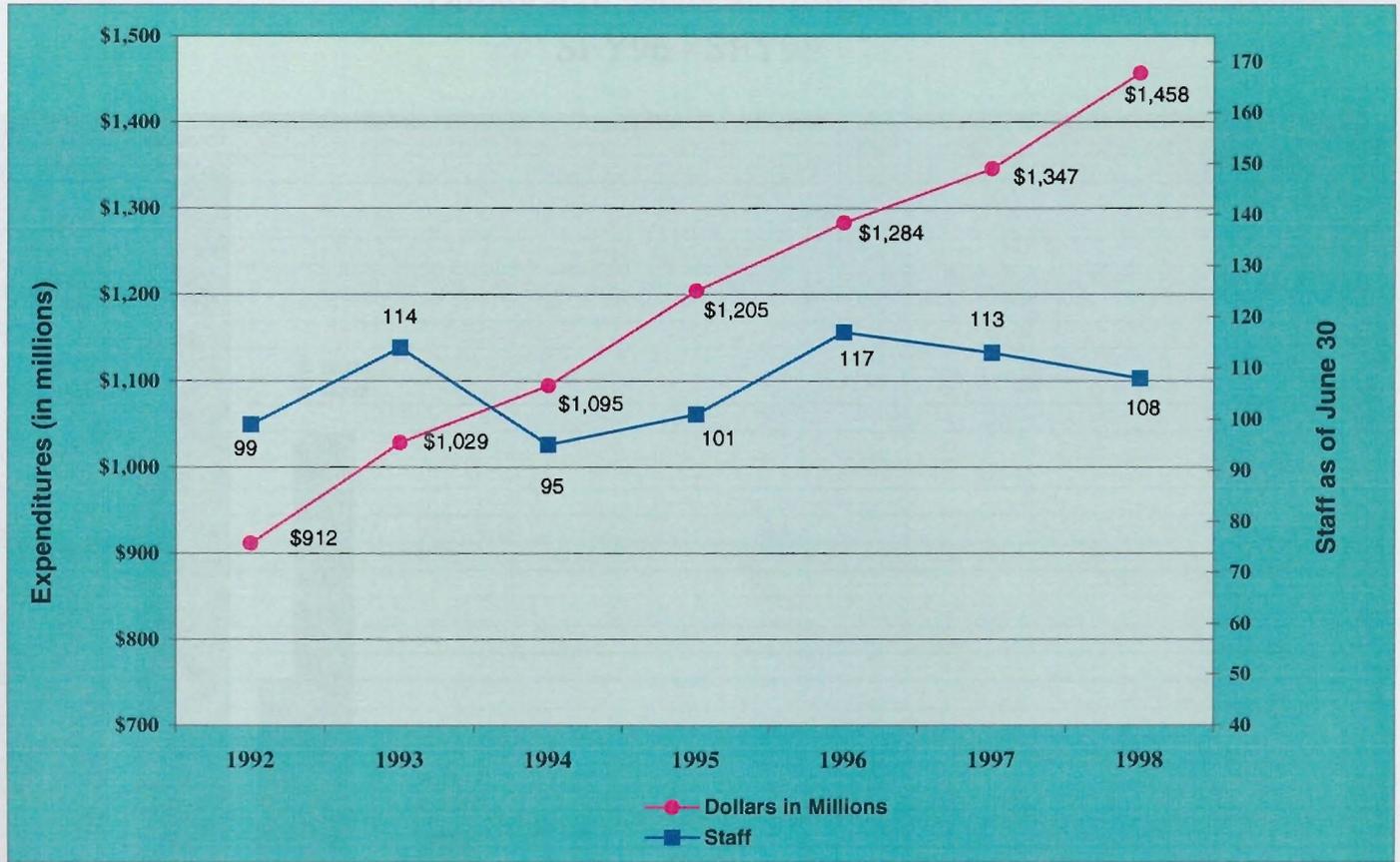


An analysis by the Arkansas Foundation for Medical Care illustrated a cost/benefit of the *ConnectCare* Program as the **nominal increase** in "less costly" physician office visits, while a **marked decrease** of approximately 60% in more expensive non-emergency visits to Hospital Emergency Rooms.

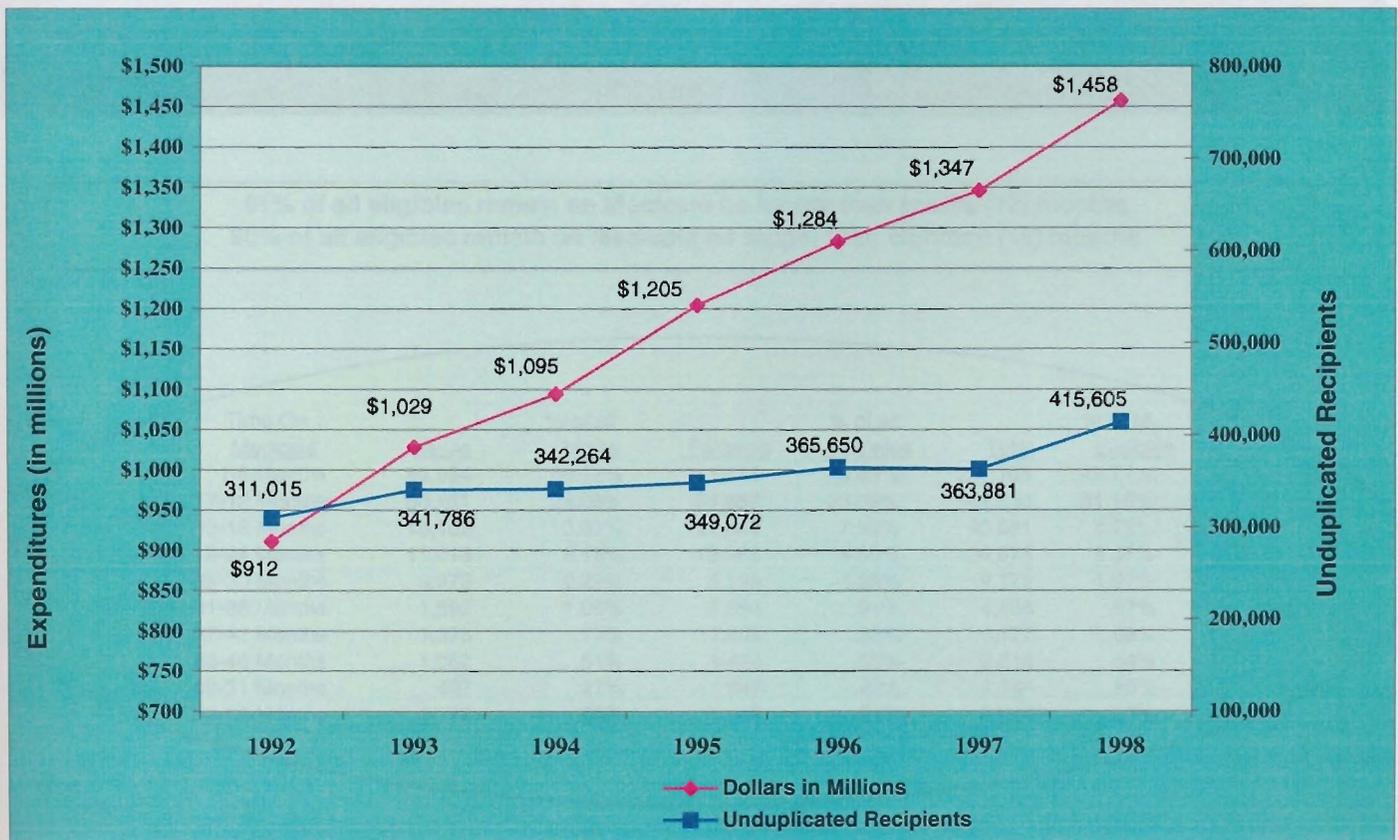
Unduplicated Recipient Counts and Vendor Payments by Age SFY98



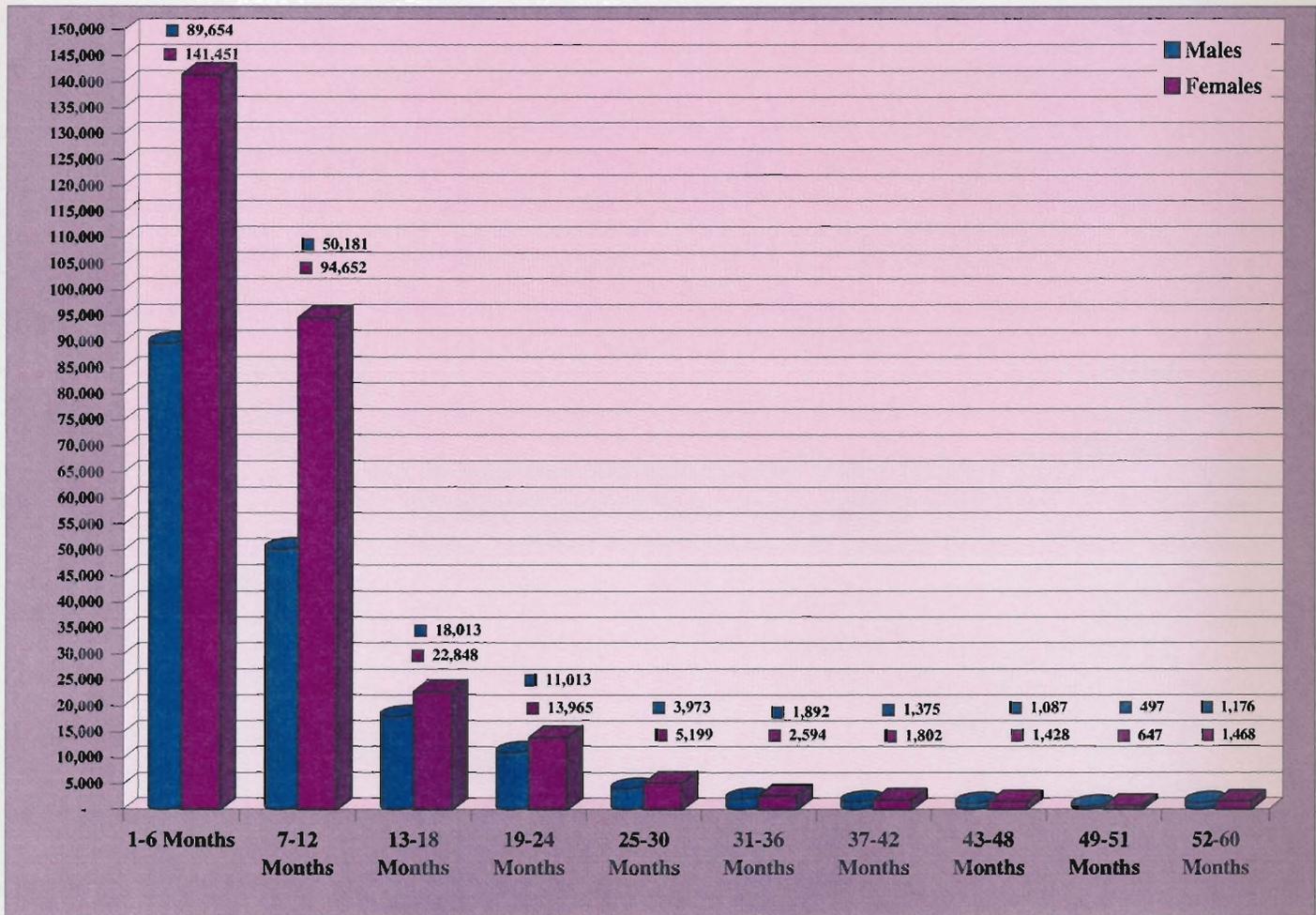
MEDICAID STAFFING COMPARED TO EXPENDITURES



MEDICAID UNDUPLICATED RECIPIENTS COMPARED TO EXPENDITURES



Duration of Medicaid Eligibility SFY96 - SFY98



81% of all eligibles remain on Medicaid no longer than twelve (12) months
90% of all eligibles remain on Medicaid no longer than eighteen (18) months

Time On Medicaid	% of all		% of all		Total	% of all Eligibles
	Males	Males	Females	Females		
1-6 Months	89,654	50.12%	141,451	49.45%	231,105	49.71%
7-12 Months	50,181	28.06%	94,652	33.09%	144,833	31.15%
13-18 Months	18,013	10.07%	22,848	7.99%	40,861	8.79%
19-24 Months	11,013	6.16%	13,965	4.88%	24,978	5.37%
25-30 Months	3,973	2.22%	5,199	1.82%	9,172	1.97%
31-36 Months	1,892	1.06%	2,594	.91%	4,486	.97%
37-42 Months	1,375	.77%	1,802	.63%	3,177	.68%
43-48 Months	1,087	.61%	1,428	.50%	2,515	.54%
49-51 Months	497	.27%	647	.22%	1,144	.25%
52-60 Months	1,176	.66%	1,468	.51%	2,644	.57%