

**Arkansas Department of Human Services  
Division of Medical Services  
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Revised 12/18/95



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Thanks to the employees of the DMS Financial Activities and Systems & Support Sections for their contributions in completing this report. Special thanks to Myra Spring.



## ARKANSAS MEDICAID

12-18-95

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### Medicaid Overview

#### I. INTRODUCTION

Health care both in Arkansas and in the nation, perhaps the dominant public policy issue of the 1990's, has changed enormously in this century in virtually all aspects -- the diseases, the treatments, and, of course, the payment vehicles. Consider the following health care notes taken from postcards mailed in Arkansas during the early years of the century:

From the Clay county town of Rector in 1911, "The smallpox are all over town and we are afraid we will get them."

A Van Buren woman wrote in 1913, "I am just able to sit up and have been sick in bed five weeks with typhoid fever -- all but three have it."

A 1910 visitor to Little Rock penned, "The climate in Arkansas is very bad. There are many little puddles of stagnant water with malaria all over them. There's more chills, fever and malaria than I ever heard of before."

Writing from El Dorado in 1911 a Union county woman said, "Now you wonder why you don't hear from me but child my hands are too full to write. Amos had a spell of tonsillitis; Elizabeth has the measles and Henry has been in bed for a week with neuralgia. Please write and tell me all the news and especially about the infantile paralysis."

Arkansans of these earlier generations were plagued by diseases mostly long since eradicated by modern medicine -- health care that can do wonders. We are now confronted with the charge of developing ways to make the best use of limited funds in order to maximize the benefit of public health programs like Medicaid. It seems apparent that there will be no National Health Care Plan in the foreseeable future. It will likely be the state's charge to lead the way in improving the existing system.

Many of the states moving forward with health reform are using their Medicaid programs as the core of what will likely be limited reform plans. As we contemplate the best way to proceed with any Arkansas reform plan, I believe it would be helpful to display the history of our Medicaid program and to show who uses the services, what is covered, at what cost, and what goes into the administration of the program that commands a major segment of the state's budget.

#### History & Background

Medicaid actually has its roots in the 1930's when concern for the poor and aged spawned the Social Security Act of 1935. The elderly got some financial protection, and the poor began to receive some type of "welfare" assistance, especially families with dependent children.

By 1965, there was increasing public concern about rising health care costs resulting in congressional action in the creation of Title XVIII [Medicare] and Title XIX [Medicaid]. There are, of course, major differences in the programs. While Medicare is uniform across the nation, Medicaid is actually 54 different programs administered by the states and territories. While administered within federal guidelines, the services offered, the eligibility rules, and payment mechanisms differ between the states.



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Initially Arkansas made limited use of the new program for nursing home care. By 1970, Arkansas was ready to launch a broader Medicaid program. As will be evidenced by the contents of the report, the program has greatly expanded over the past 24 years in response to many congressional mandates and state initiatives to provide better health care to more Arkansans.

Often thought of as simply a giant welfare program, the Arkansas Medicaid program in actuality functions as the insurance program that served 367,000 of our citizens last year, and not just the very poor. The impact of the one billion dollars paid out by the program is enormous and perhaps too little understood. Consider the following facts:

1. More than 60% of the patient days at Arkansas Children's Hospital -- the nation's sixth largest pediatric facility -- were Medicaid covered.
2. Valued community programs serving young people such as Centers for Youth and Families and Youth Home in Little Rock, and the Ozark Guidance Center of Springdale -- all are majority Medicaid funded.
3. In excess of 40% of the babies born in Arkansas last year were covered by Medicaid as we funded an outreach campaign on radio, TV, and in print to increase both awareness and access to prenatal care.

Rural hospitals have been major beneficiaries of Medicaid. Public schools have also been brought into our provider network to enable funding of school based services such as health screening, and provision of therapy services required by handicapped students. The state's system of mental health care is another example. Without Medicaid funding, the network of community mental health centers and psychiatric hospitals likely would not be viable. It is Medicaid funding that makes programs possible for our developmentally handicapped citizens such as the Human Development Centers, the Pathfinders programs, and the United Cerebral Palsy Center .

If low income elderly Arkansans had to depend solely on Medicare for their health care needs, the scope of coverage would be sadly lacking. The facts are that Medicaid will spend in excess of \$150 million -- not counting nursing home care -- to supplement shortcomings of the Medicare service package. Medicaid will pay the Medicare premiums for some 75,000 low income Medicare recipients this year, along with their deductibles and co-payments. Prescription drugs and eyeglass services are not covered by Medicare, but -- because of Medicaid -- these vital needs are supplied to thousands of elderly Arkansans. In the nursing home area, the Medicaid program covers approximately 85% of the services provided in Arkansas.

While providing the multitude of services reflected in this report, we at DHS have striven for innovation and efficiency. Examples would include our 3.6% administrative overhead, the nation's most advanced point-of-sale, electronic eligibility, claims processing system (which Blue Cross has joined), and our managed care system (under which each Medicaid recipient is being linked to a primary care physician). The latter, our state's first entry into Medicaid managed care, is a success with almost 1,300 primary care physicians signed up, an ample number to serve the improved continuity of care needs we are seeking for the Medicaid patients. In the future, we must weigh the potential benefits of other forms of managed care.

People often remark about the "Medicaid cost explosion" and certainly with an expected expenditure of \$1.3 billion this year -- 74% federal; 26% state -- our budget has grown significantly over the last few years. It is important to note, however, the factors that drove these costs such as the many



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federal mandates, the state decision to expand prenatal care, and to provide optional services. Along with medical inflation, the technological miracles of medicine are something Medicaid helped fund. It is also noteworthy that unlike virtually all private insurance companies Medicaid has no preexisting condition clauses. The AIDS patient, the person in need of a \$200,000 organ transplant, or the child born with multiple handicapping conditions that may require a lifetime of high cost health care -- many people turn to Medicaid for the source of their health coverage.

What does the future hold for our Medicaid program? Certainly, the Medicaid program will not be given the same level of fund increases. Hopefully, implementation of appropriate management programs will prevent the need to reduce benefits. However, if we find it necessary to implement more aggressive forms of managed care, such as use of a health maintenance organization, we will need the support of the provider and beneficiary communities to insure that services are of high quality and provide needed access so that Medicaid dollars are still available for all. As we respond to funding changes, it is my hope that this report will give the reader the best possible understanding of the scope and benefits of this huge, complex program as it is currently delivered.

Ray Hanley  
Director  
Division of Medical Services  
Arkansas Department of Human Services



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## Medicaid Overview

## II. UTILIZATION OF SERVICES

### MEDICAID ELIGIBLES

**How do they become Eligible?**

**Who are they?**

**How have their numbers increased?**

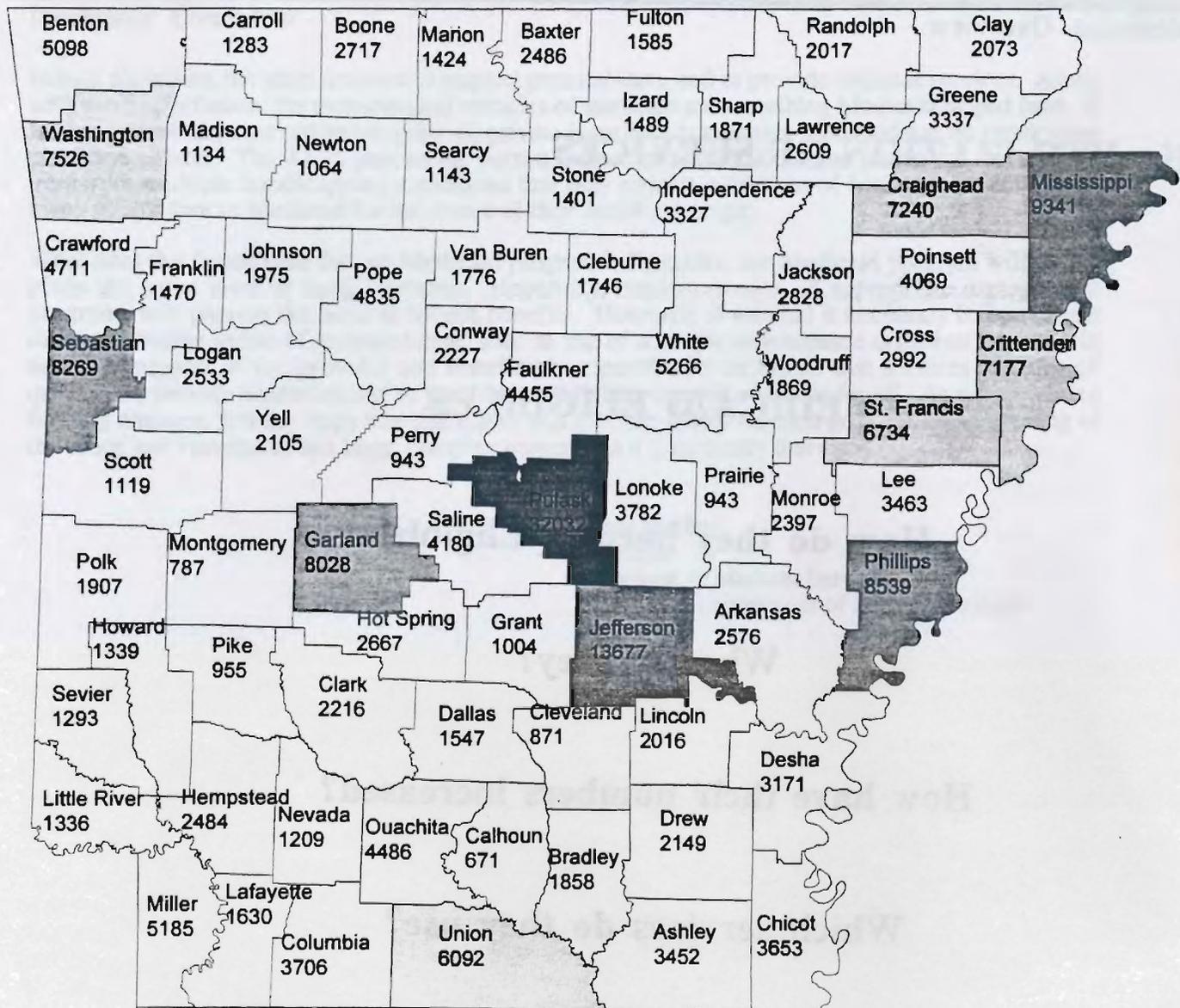
**Which services do they use?**

Number of Eligibles

Based on Medicaid Report HMG8701

(1)	1400 to 32100	<input checked="" type="checkbox"/>
(2)	1000 to 10000	<input checked="" type="checkbox"/>
(4)	800 to 10000	<input checked="" type="checkbox"/>
(5)	800 to 8000	<input type="checkbox"/>
(9)	400 to 6000	<input type="checkbox"/>
(25)	200 to 4000	<input type="checkbox"/>
(30)	800 to 2000	<input type="checkbox"/>

# Arkansas Medicaid Eligibles Concentration by County



## Number of Eligibles

Based on Medicaid Report HMGR970J, 6/95

■	14000 to 32100	(1)
■	10000 to 14000	(1)
■	8000 to 10000	(4)
□	6000 to 8000	(5)
□	4000 to 6000	(9)
□	2000 to 4000	(25)
□	600 to 2000	(30)



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### Arkansas Medicaid Eligibles in Ascending Order by County

County	Eligibles	County	Eligibles
Calhoun	671	Hempstead	2,484
Montgomery	787	Baxter	2,486
Cleveland	871	Logan	2,533
Perry	943	Arkansas	2,576
Prairie	943	Lawrence	2,609
Pike	955	Hot Springs	2,667
Grant	1,004	Boone	2,717
Newton	1,064	Jackson	2,828
Scott	1,119	Cross	2,992
Madison	1,134	Desha	3,171
Searcy	1,143	Independence	3,327
Nevada	1,209	Greene	3,337
Carroll	1,283	Ashley	3,452
Sevier	1,293	Lee	3,463
Little River	1,336	Chicot	3,653
Howard	1,339	Columbia	3,706
Stone	1,401	Lonoke	3,782
Marion	1,424	Poinsett	4,069
Franklin	1,470	Saline	4,180
Izard	1,489	Faulkner	4,455
Dallas	1,547	Ouachita	4,486
Fulton	1,585	Crawford	4,711
Lafayette	1,630	Pope	4,835
Cleburne	1,746	Benton	5,098
Van Buren	1,776	Miller	5,185
Bradley	1,858	White	5,266
Woodruff	1,869	Union	6,092
Sharp	1,871	St. Francis	6,734
Polk	1,907	Crittenden	7,177
Johnson	1,975	Craighead	7,240
Lincoln	2,016	Washington	7,526
Randolph	2,017	Garland	8,028
Clay	2,073	Sebastian	8,269
Yell	2,105	Phillips	8,539
Drew	2,149	Mississippi	9,341
Clark	2,216	Jefferson	13,677
Conway	2,227	Pulaski	32,032
Monroe	2,397		

Source: HMGR 970J, June, 1995

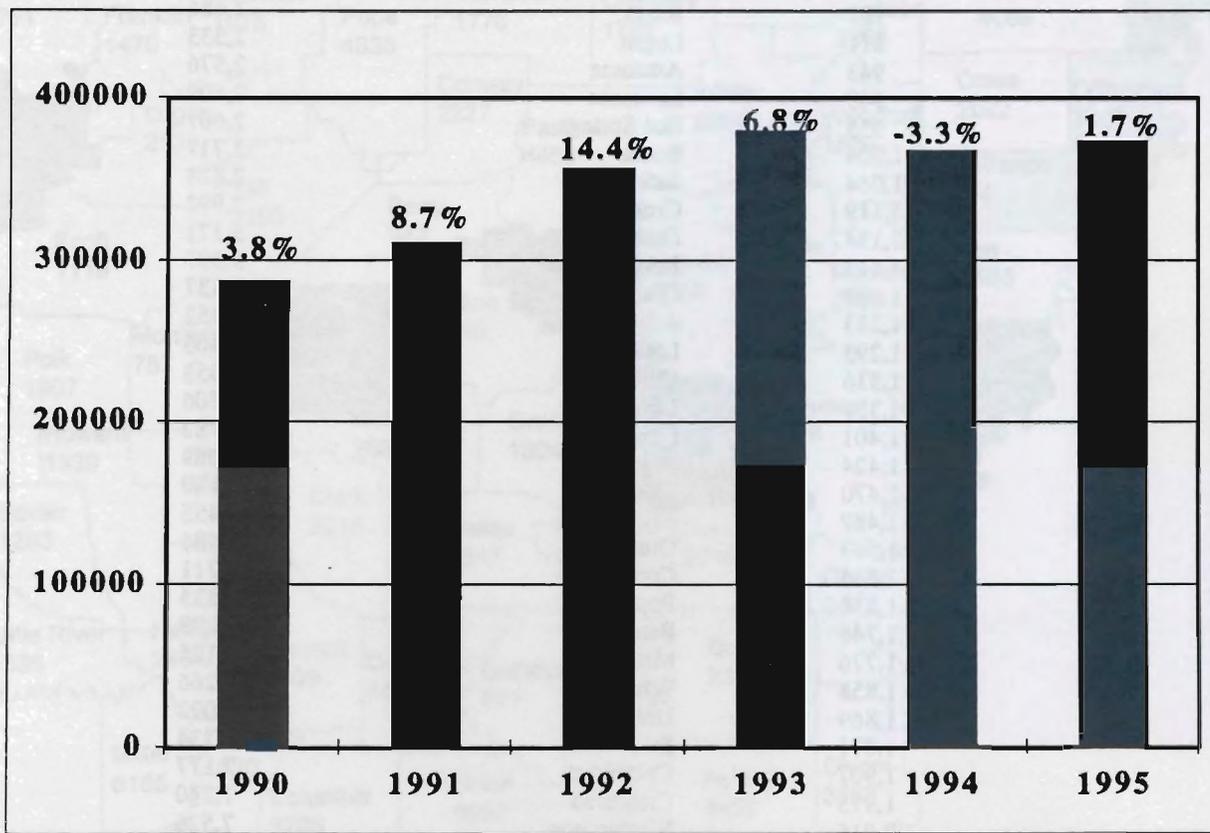


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### Arkansas Medicaid Eligible Annual Growth-- SFY 90 Thru SFY 95



Source: HCFA 2082; % Increase from prior year is displayed



Medicaid Overview

**Arkansas Medicaid Eligibles By Age**

	<u>1990</u>	<u>1991</u>	<u>1992</u>	<u>1993</u>	<u>1994</u>	<u>1995</u>
<b>Under 1</b>	16,852	20,699	21,427	19,925	16,613	16,590
<b>1 - 5</b>	49,236	59,552	68,563	76,648	72,989	73,480
<b>6 - 14</b>	48,106	53,344	62,129	68,091	69,464	73,033
<b>15 - 20</b>	27,588	29,516	33,546	34,844	33,872	34,482
<b>21 - 44</b>	58,195	62,129	74,251	80,121	76,060	75,822
<b>45 - 64</b>	23,551	23,621	28,101	31,679	30,957	32,161
<b>65 - 74</b>	21,910	21,793	24,068	24,459	24,349	24,558
<b>75 - 84</b>	25,042	24,404	25,811	26,023	25,329	25,316
<b>85 &amp; Over</b>	5,844	4,760	17,751	18,068	17,942	18,253
<b>Unknown Age</b>	9,609	11,111	0	0	0	0
<b>TOTAL</b>	285,933	310,929	355,647	379,858	367,575	373,695

Source: HCFA 2082 Report



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Arkansas Medicaid Vendor Payments By Age  
(in millions)

	<u>1990</u>	<u>1991</u>	<u>1992</u>	<u>1993</u>	<u>1994</u>	<u>1995</u>
<b>Under 1</b>	\$36.0	\$47.7	\$52.0	\$53.0	\$52.4	\$54.1
<b>1 - 5</b>	35.5	44.8	72.5	87.3	96.2	108.1
<b>6 - 14</b>	38.8	46.6	63.0	93.8	92.8	107.3
<b>15 - 20</b>	46.0	52.2	65.2	91.3	90.6	93.6
<b>21 - 44</b>	116.0	135.6	187.0	267.2	227.2	230.0
<b>45 - 64</b>	70.6	78.8	107.6	136.5	136.5	144.5
<b>65 - 74</b>	49.9	56.5	69.1	81.0	80.2	85.1
<b>75 - 84</b>	88.7	95.0	112.5	134.0	134.3	142.2
<b>85 &amp; Over</b>	39.1	33.7	112.2	147.3	152.6	162.7
<b>Unknown Age</b>	48.7	61.3	0	0	0	0
<b>TOTAL</b>	\$569.3	\$652.0	\$851.1	\$1,091.4	\$1,057.8	\$1,127.5

Source: HCFA 2082 Report



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**Arkansas Medicaid Recipients By Type of Service**

	<u>1990</u>	<u>1991</u>	<u>1992</u>	<u>1993</u>	<u>1994</u>	<u>1995</u>
<b>Inpatient Hospital</b>	58,058	71,536	78,583	78,711	76,604	73,744
<b>Mental Hospital</b>	0	19	45	17	6	3
<b>Aged</b>						
<b>Inpatient Psyc U21</b>	750	986	1,359	1,951	2,224	2,669
<b>ICF/MR</b>	1,674	1,809	1,863	1,868	1,873	1,866
<b>ICF</b>	19,957	0	0	0	0	0
<b>SNF</b>	1,830	20,851	21,071	21,309	21,648	21,642
<b>Physician Services</b>	205,592	223,481	245,164	270,622	265,551	258,449
<b>Dental Services</b>	38,170	31,832	42,427	42,507	45,638	47,241
<b>Other Practitioner</b>	42,095	43,538	58,664	66,046	66,247	66,729
<b>Outpatient Hospital</b>	106,738	124,250	139,607	155,009	157,170	157,781
<b>Clinic Services</b>	21,328	28,663	35,537	45,164	44,977	48,075
<b>Home Health (includes Personal Care)</b>	16,016	14,066	15,524	17,685	19,376	20,413
<b>Family Planning</b>	17,210	16,268	17,432	20,488	18,823	18,302
<b>Lab &amp; X-Ray</b>	79,400	86,248	104,883	116,669	117,080	119,260
<b>Prescription Drugs</b>	199,043	213,780	239,723	255,555	256,355	251,811
<b>EPSDT</b>	47,002	56,892	74,824	79,749	81,377	81,424
<b>Rural Health Clinic</b>	0	6	1,766	5,536	12,095	18,872
<b>Other Care</b>	50,751	58,739	78,526	84,766	141,984	250,903
<b>TOTAL</b>	905,614	992,964	1,156,999	1,263,652	1,329,028	1,439,184
<b>Unduplicated Recipients</b>	257,420	279,057	311,015	341,786	342,250	349,072

Source: HMGR 580 Report

(Total line is duplicated figure. Recipients can be in several categories)



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III. COVERED MEDICAID SERVICES

MEDICAID BENEFIT SERVICES DEFINED

The following pages are taken from the handbook supplied to Medicaid recipients. They describe what is covered, for whom, and gives a layman's explanation of the services.



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**Medicaid Overview****ARKANSAS MEDICAID COVERED SERVICES**

**AMBULATORY SURGICAL CENTER SERVICES** - Medicaid will pay for services furnished in an ambulatory surgical center if the surgical procedure is covered by the Medicaid Program.

**CHILD HEALTH MANAGEMENT SERVICES (CHMS)** -- Medicaid will pay for medical, multi-discipline diagnosis and evaluation for early intervention and prevention for recipients under age 21 in the Child Health Services (EPSDT) Program. Services include medical, psychological, speech and language pathology, occupational therapy and physical therapy, behavioral and audiology.

**CHILD HEALTH SERVICES - EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT)** -- The Child Health Services (EPSDT) Program is a free preventive health care service for everyone who is under the age of 21 (even mothers and fathers who are under 21) and are recipients of Medicaid. If the recipient accepts Child Health Services (EPSDT), the worker in the county office will show the recipient a list of participating providers in the area, and the recipient may select a provider of their choice. Transportation, counseling, helps with scheduling appointments and referral services are also provided. After an examination, a doctor or nurse will talk to the recipient about any problems found. If a recipient is interested in receiving Child Health Services (EPSDT) for any member of their family or want more information, they may contact the local county office.

**CHIROPRACTIC SERVICES** - Recipients age 21 and older are not eligible to receive chiropractic services. Visits, for recipients under age 21 in the Child Health Services (EPSDT) Program, are unlimited. Benefits are limited to manipulation of the spine to correct a dislocation that can be verified by X-ray. The chiropractor is required to have the X-rays, but Medicaid does not pay for them.

**DENTAL SERVICES** - Recipients age 21 and older are not eligible to receive dental services, except for certain medical and/or surgical procedures performed by a dentist. Most dental services, for recipients under age 21 in the Child Health Services (EPSDT) Program, are covered under Medicaid. Lengthy or complicated dental procedures must be approved by Medicaid before they are done. These procedures must be supported by X-ray and the dentist's plan of treatment. Medical services provided by a dentist are benefit limited per year (July 1 through June 30). Surgical procedures provided by a dentist are not benefit limited. This benefit limit does not apply to recipients under age 21 in the Child Health Services (EPSDT) Program.

**DEVELOPMENTAL DAY TREATMENT CLINIC SERVICES (DDTCS)** -- Medicaid will pay for developmental day treatment clinic services. Persons eligible for DDTCS must be developmentally disabled and must be pre-school age or age 18 or above. These services must be prescribed by a physician and provided according to a written plan of care.

**DDS HOME AND COMMUNITY BASED ALTERNATIVE COMMUNITY SERVICES** - Medicaid offers certain "home and community-based services" as an alternative to institutionalization. These services are available for a limited number of eligible individuals with a developmental disability who would otherwise require an ICF-MR (Intermediate Care Facility - Mentally Retarded) level of care. The "home and community-based services" available through the waiver program include the following services:

- Case Management
- Respite Care
- In-home Services (personal care, homemaker services, residential habilitation)
- Day Habilitation Services
- Consultation Services



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- Alternative Living Services (supportive living, specialized family care for children)
- Non-medical Transportation
- Physical Adaptations/Adaptive Aids

**DOMICILIARY CARE** - Medicaid will pay for domiciliary care, which is room and board for patients who have to be away from home while they are receiving daily active medical treatment. These benefits are unlimited for patients who are receiving daily treatments and who live too far from the provider to travel back and forth every day. Transportation will be authorized by the county office if needed. Transportation between the domiciliary provider and the treatment facility will be furnished by the domiciliary provider.

**DURABLE MEDICAL EQUIPMENT (DME)** -- Recipients, under age 21 in the Child Health Services (EPSDT) Program, are eligible for durable medical equipment, if the equipment is medically necessary and prescribed by a physician. Recipients age 21 and older are eligible for a restricted list of durable medical equipment. Some equipment must be approved ahead of time by the Medicaid office in Little Rock.

**ELDER CHOICES SERVICES** - Medicaid offers a home and community-based waiver program for recipients age 65 and older who require an intermediate level of care in a nursing facility. The following services are designed to maintain the recipient in their own home rather than going to a nursing home:

- Adult Foster Care
- Home Delivered Meals
- Adult Day Health Care
- Respite Care
- Homemaker Services
- Chore Services
- Adult Day Care
- Personal Emergency Response System

**EMERGENCY SERVICES** - In order for services to be considered emergency services, the services must meet the Medicaid emergency criteria. A recipient should not seek treatment in a hospital emergency room unless it is an emergency, and the services cannot be obtained from their physician. The recipient could be financially responsible for these services.

**FAMILY PLANNING SERVICES** - Medicaid pays for these services for persons who are of childbearing age. These benefits are available for services provided through the local county health department offices or in a physician's office. These visits do not count against the physician visit limit each year, if the physician notes that the services are family planning services when he/she bills Medicaid. The services are limited to basic family planning examinations and follow-up family planning visits each year (July 1 through June 30). Services for recipients under age 21 in the Child Health Services (EPSDT) Program are unlimited.

**FEDERALLY QUALIFIED HEALTH CENTER** - Services provided in a certified Federally Qualified Health Center are benefit limited per year (July 1 through June 30). For physician services beyond the established benefit limit, the provider must request an extension. The benefit limit does not apply to recipients under age 21 in the Child Health Services (EPSDT) Program. Services include a range of medically necessary procedures provided in a Federally Qualified Health Center.

**HEARING SERVICES** - Medicaid payment for hearing services is provided to recipients under age 21 in the Child Health Services (EPSDT) Program. These benefits must always be approved ahead of time by Medicaid. Hearing aid appliances are subject to a benefit limit.

**HOME HEALTH CARE** - Home Health services are provided for eligible persons in their homes. These services must be provided according to a plan of care prescribed by a physician and are similar to the services that patients in nursing homes receive. Home health visits by a home health nurse and/or a home health aide are limited per year (July 1 through June 30). Extensions will be considered for recipients in the Child Health Services (EPSDT) Program if medically necessary. Extensions of the benefit limit may be granted for adults (21 years of age and older) at risk of



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institutionalization (hospital, nursing home, etc.). Other home health benefits include medical supplies and physical therapy. Home health supplies are limited to a maximum reimbursement per month, per recipient. The reimbursement limit may be extended if the physician can verify medical necessity.

**HOSPICE** - Hospice services are designed to meet the needs and desires of recipients who are terminally ill, and who are not expected to live for more than six months. All efforts are directed to the enrichment of living during the final days of life and are geared to provide ongoing opportunities for the patient to be involved in life. Hospice services are available to Medicaid recipients under age 21 in the Child Health Services (EPSDT) Program.

**INPATIENT HOSPITAL SERVICES** - Medicaid pays for hospitalization when it is medically necessary. The Professional Review Organization (PRO) will determine medically necessary days prior to payment. In addition, there is an annual benefit limit for recipients age 21 and older which Medicaid will cover per year (July 1 through June 30). No extensions will be approved. The benefit limit does not apply to recipients under age 21 in the Child Health Services (EPSDT) Program. The recipient may be held financially responsible for hospital days over the allowed limit.

**OUTPATIENT HOSPITAL SERVICES** - Medicaid will pay a maximum limit on outpatient hospital visits a year (July 1 through June 30) for recipients age 21 and older. Additional services may be considered for other recipients who require treatment in order to maintain life. Outpatient services include:

- non-emergency visits to the hospital and related physician services, except for laboratory and X-ray services.
- certain therapy and treatment services received on an outpatient basis and the related physician services.

Medically necessary outpatient hospital visits are unlimited for recipients in the Child Health Services (EPSDT) Program. Take home drugs and supplies are not covered under outpatient hospital services. (See Prescription Drugs.)

Surgical procedures that are medically necessary may be done in an outpatient hospital or ambulatory surgical center. It is the responsibility of the physician to determine if the procedure can be done safely and effectively on an outpatient basis. Many surgical procedures are restricted to the outpatient setting unless approved ahead of time by the Medicaid Program for inpatient care.

**HYPERALIMENTATION SERVICES** - Medicaid covers fluids, equipment and supplies necessary for the administration of fluids in the recipient's home for parenteral and enteral nutrition therapy under the hyperalimentation program. These services may be covered only when the therapy is approved ahead of time by the Office of Medical Services and is prescribed by a physician following a period of hospitalization.

**INJECTIONS** - Medicaid will pay for allergy shots and immunizations for recipients under age 21 in the Child Health Services (EPSDT) Program, if it is medically necessary. Although some other injections are covered by Medicaid, coverage is limited for adults. All injections determined to be medically necessary are covered for recipients under age 21 in the Child Health Services (EPSDT) Program if prescribed as a result of an EPSDT (Child Health Services) screen/referral.

**INPATIENT PSYCHIATRIC PROGRAM** - Medicaid will pay for inpatient psychiatric services for persons under age 21. Psychiatric treatment must be proven medically necessary before payment will be made. Treatment for recipients under age 21 must be approved ahead of time. Lengths of stay are determined based on the medical needs of each recipient.

**LABORATORY AND X-RAY** - Medicaid payment for laboratory and X-ray services outside the hospital is limited to a maximum amount per year (July 1 through June 30) for recipients age 21 and older.



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Additional services may be granted for recipients who require supportive treatment for maintaining life, such as dialysis, radiation therapy and/or chemotherapy. The benefit limit does not apply to recipients in the Child Health Services (EPSDT) Program. Medicaid will pay for portable X-ray services at the recipient's place of residence when ordered by a physician. Portable X-ray services are included in the annual laboratory and X-ray benefit limit. Magnetic Resonance Imaging (MRI) is exempt from the annual benefit limit.

**LONG TERM CARE (NURSING HOME)** -- Reimbursement for nursing home services is provided to eligible persons who reside in Medicaid certified nursing homes. Nursing home care must be recommended by a person's physician and must be medically necessary. An application for nursing home care must be made in the County Human Services office in the county where the chosen nursing home is located.

**NURSE-MIDWIFE SERVICE** - Medicaid will pay for nurse-midwife services in an office, birthing center or clinic, recipient's home or a hospital. Services covered are prenatal care, delivery of the infant, postnatal care and newborn care.

**NURSE PRACTITIONER** - Visits to a nurse practitioner are limited per year (July 1 through June 30) for recipients age 21 and older. No extensions will be considered. The benefit limit does not apply to recipients under age 21 in the Child Health Services (EPSDT) Program.

**ORGAN TRANSPLANTS** - Medicaid will pay for inpatient hospital services, physician services and follow-up care required for corneal, heart, kidney, liver, single lung, skin, pancreas/kidney and non-experimental bone marrow transplants. Single lung, skin and pancreas/kidney transplants are restricted to eligible Medicaid recipients under age 21 in the Child Health Services (EPSDT) Program. Transplant procedures must always be approved ahead of time by Medicaid.

**PERSONAL CARE SERVICES** - Medicaid will pay for personal care services in the recipient's home. Personal care services must be prescribed by a physician and provided according to a plan of care. These services include assistance with personal hygiene and grooming, preparation of meals, some household services, changing bed linens and driving the recipient to the doctor. Personal care services are limited per calendar month for recipients age 21 and older. Extensions may be approved for recipients in life threatening situations and/or at risk of institutionalization. The benefit limit does not apply to recipients under age 21 in the Child Health Services (EPSDT) Program.

**PHYSICIAN SERVICES** - Visits to the doctor's office, patient's home and nursing home are limited per year (July 1 through June 30) for recipients age 21 and older. For services beyond the established benefit limit, the physician must request an extension. The benefit limit does not apply to recipients under age 21 in the Child Health Services (EPSDT) Program. If the recipient is confined to a hospital, Medicaid will pay each doctor of a different specialty for one day of care for each inpatient hospital covered day regardless of the number of visits the doctor makes per day. Medicaid will pay for a limited number of doctor consultations a year (July 1 through June 30). Additional consultations may be granted for recipients in the Child Health Services (EPSDT) Program if medically necessary. Medicaid also covers physician services for some elective surgery if it has been approved ahead of time.

**PODIATRIST SERVICES** - Medical services provided by a podiatrist are benefit limited per year (July 1 through June 30) for recipients age 21 and older. This benefit limit does not apply to recipients under age 21 in the Child Health Services (EPSDT) Program. Surgical services provided by a podiatrist are not benefit limited. Some surgical services are restricted to the outpatient setting unless approved ahead of time by the Medicaid Program for inpatient care.

**PRESCRIPTION DRUGS** - Medicaid will pay for some medicine that the doctor prescribes for the recipient. Some medicines will require approval ahead of time before the pharmacist can fill the prescription. Prescription drug benefits are limited each month for recipients age 21 and older. Extensions will be considered for recipients at risk of



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## Medicaid Overview

institutionalization. The benefit limit does not apply to recipients under age 21 in the Child Health Services (EPSDT) Program. Family planning prescriptions, like birth control pills, will not count against the monthly limit. Medicaid recipients residing in a nursing home may receive unlimited prescription drug benefits for prescription drugs covered by Medicaid. Medicaid mandates the use of generic drugs in most instances. Instead of filling the prescription with a brand or trade name product, the pharmacist must use an equivalent generic drug, if one is available. The Medicaid prescription drug program requires that the pharmacist fill each prescription from a list of drugs that Medicaid will cover. This does not prevent the recipient from purchasing the brand or trade name product, but Medicaid will only pay for the equivalent generic drug. If a physician prescribes a brand name drug that is covered under Medicaid and writes "This brand medically necessary" on the prescription, the recipient may receive the brand name drug. If the recipient receives more than the allowed number of prescriptions a month, Medicaid should be billed for the most expensive. Each prescription may be filled for a maximum of one month's supply.

**PRIVATE DUTY NURSING SERVICES** - Medicaid will pay for private duty nursing services and supplies for patients who are ventilator dependent if medically necessary and prescribed by a physician. Medicaid will also pay for private duty nursing services for non-ventilator patients with certain medical conditions for eligible recipients under age 21 in the Child Health Services (EPSDT) Program. These services are covered in the patient's home but not in a nursing home or hospital. Private duty nursing services must be approved ahead of time by Medicaid. Private duty nursing supplies are limited per month, per recipient. The reimbursement limit may be extended if the physician can verify medical necessity.

**PROSTHETICS** - A range of prosthetic services are available to Medicaid recipients based on the age of the recipient. Most prosthetic services are available to recipients under age 21 in the Child Health Services (EPSDT) Program. Services include, but are not limited to, prosthetic devices, orthotic appliances, diapers, underpads, nutritional formulae, specialized wheelchairs, apnea monitors and medical supplies. Some prosthetic services require approval ahead of time from the Medicaid Program.

**PSYCHOLOGY SERVICES** - Medicaid will pay for a broad range of individual and group outpatient psychology services for recipients under age 21 in the Child Health Services (EPSDT) Program if provided by a licensed psychologist and prescribed by a physician. Recipients age 21 and older are not eligible to receive services through the Psychology Program.

**REHABILITATIVE HOSPITAL SERVICES** - For recipients age 21 and older, inpatient rehabilitative hospital services are included in the annual inpatient hospital benefit limit beginning July 1 through June 30. No extensions will be approved. The benefit limit does not apply to recipients under age 21 in the Child Health Services (EPSDT) Program.

**REHABILITATIVE SERVICES FOR PERSONS WITH MENTAL ILLNESS** - Medicaid will pay for a range of rehabilitative mental health services offered by community mental health centers when provided to eligible Medicaid recipients regardless of age.

**REHABILITATIVE SERVICES FOR PERSONS WITH PHYSICAL DISABILITIES**-Extended rehabilitative Services are available to eligible Medicaid recipients of all ages when medically necessary as determined by the Professional Review Organization. Services are limited to 30 days per State Fiscal Year for recipients age 21 and older. Recipients under age 21 in the Child Health Services (EPSDT) Program are not benefit limited.

**RURAL HEALTH CLINIC SERVICES** - Services provided in a Rural Health Clinic are benefit limited per year (July 1 through June 30). For physician services beyond the established benefit limit, the provider must request an extension. The benefit limit does not apply to recipients under age 21 in the Child Health Services (EPSDT) Program. Services include a range of medically necessary procedures provided in a licensed provider-based rural health clinic or a licensed independent rural health clinic.



## ARKANSAS MEDICAID

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### Medicaid Overview

**TARGETED CASE MANAGEMENT** -- Medicaid will pay for referrals for services and treatment when provided to recipients under age 21 as a result of a Child Health Services (EPSDT) screen, to recipients age 60 and older, to recipients age 21 and older with a developmental disability and to Medicaid eligible pregnant women.

**THERAPY SERVICES** - Medicaid will pay for occupational therapy, physical therapy and speech pathology services provided to recipients under age 21 in the Child Health Services (EPSDT) Program, if prescribed/referred by a physician. Recipients age 21 and older are not eligible to receive therapy services through the Therapy Program.

**TRANSPORTATION** - If a physician certifies it is medically necessary, Medicaid will pay for ambulance services in the following circumstances:

- from the place of an emergency to a hospital emergency room if the patient is admitted
- from a hospital to another hospital
- from the person's home to a hospital for admission
- from a hospital to the person's home upon discharge from inpatient services
- from a nursing home to a hospital for admission
- from the person's home to a nursing home
- from a nursing home to the person's home, and
- from one nursing home to another nursing home when the original nursing home has been decertified, and the transportation is deemed necessary.

Medicaid will not pay for the following ambulance services:

- to a hospital or other facility for outpatient care
- to or from a doctor's office or clinic

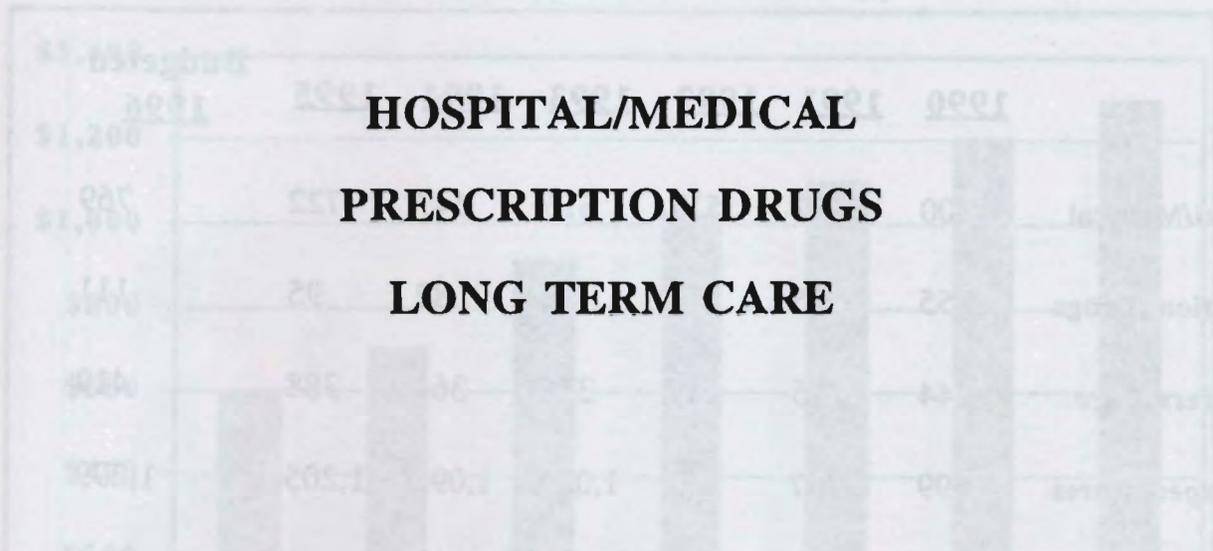
Transportation services are also available through the Private, Public and Non-Profit Transportation Programs. Medicaid may also pay for an attendant to go with the Medicaid recipient if necessary. Payment for out-of-state transportation is available for Medicaid recipients who require medical services not available in the State of Arkansas. Applications may be made at the local county office.

**VENTILATOR EQUIPMENT** - Medicaid will pay for ventilator equipment in the recipient's place of residence and certain ventilator equipment in a nursing home when determined to be medically necessary and prescribed by a physician. This equipment must be approved ahead of time by the Medicaid office in Little Rock.

**VISION CARE SERVICES** - Medicaid will pay for a limited number of vision examinations and eyeglasses each 12 months. Medicaid will pay for replacements and repair of these eyeglasses when medically necessary and when approved ahead of time by the Medicaid office. Extended visual care services are available for recipients under age 21 in the Child Health Services (EPSDT) Program.



IV. COST OF SERVICES



The Medicaid Program is divided into three separate, distinct appropriations. The Legislature, with the recommendation of the governor, votes on these three separate appropriations when funding Medicaid in Arkansas. The following pages break down the three appropriations, to detail services covered and the historical costs of each.



# ARKANSAS MEDICAID

12-18-95

## Medicaid Overview

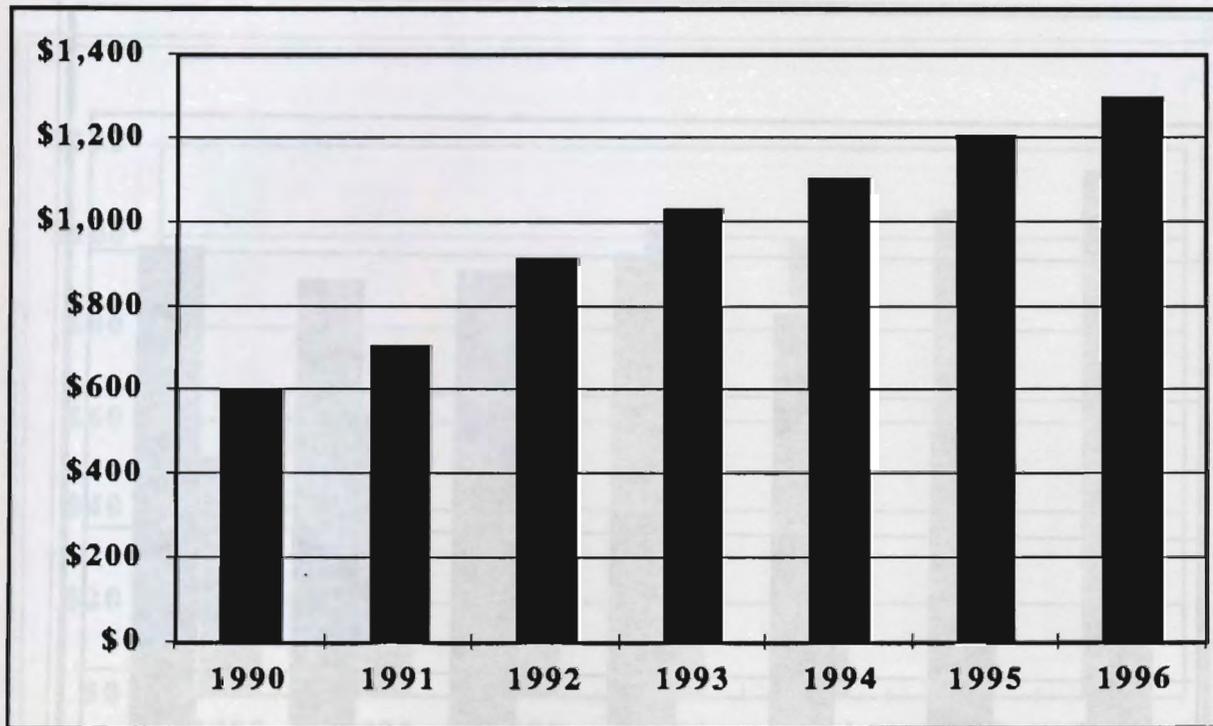
### Total Arkansas Medicaid Payments (In Millions of Dollars)

	<u>1990</u>	<u>1991</u>	<u>1992</u>	<u>1993</u>	<u>1994</u>	<u>1995</u>	<u>Budgeted 1996</u>
<b>Hospital/Medical</b>	300	367	517	616	647	722	769
<b>Prescription Drugs</b>	55	65	77	75	82	95	111
<b>Long Term Care</b>	244	275	317	338	364	388	419
<b>Total Expenditures</b>	599	707	911	1,029	1,093	1,205	1,299
<b>% of Increase</b>	18.14	18.03	28.85	12.95	6.22	10.25	7.80

**SOURCE: DFA AFGM Reports**



**Total Medicaid Expenditures**  
(In Millions of Dollars)

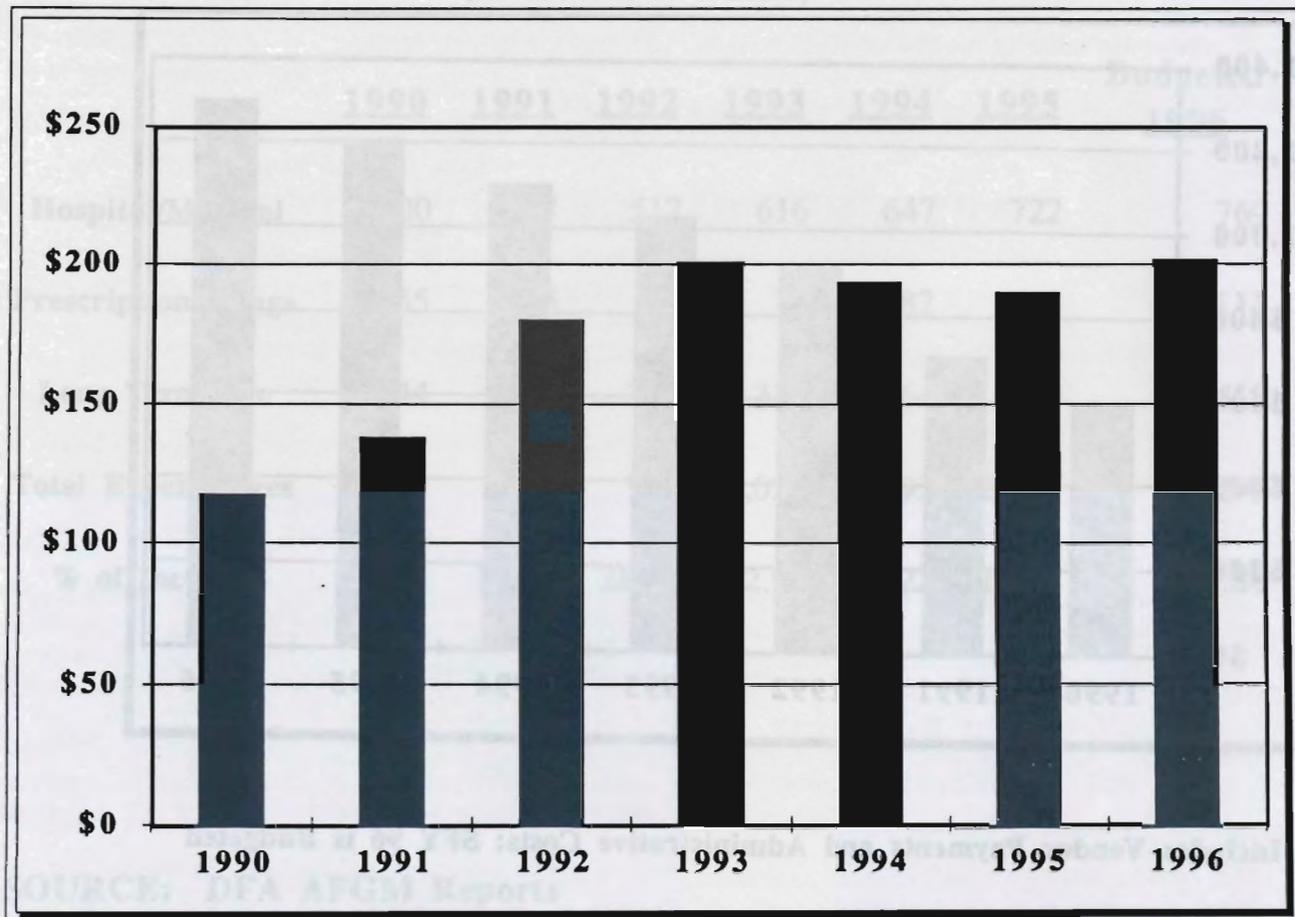


Includes Vendor Payments and Administrative Costs; SFY 96 is Budgeted



Medicaid Overview

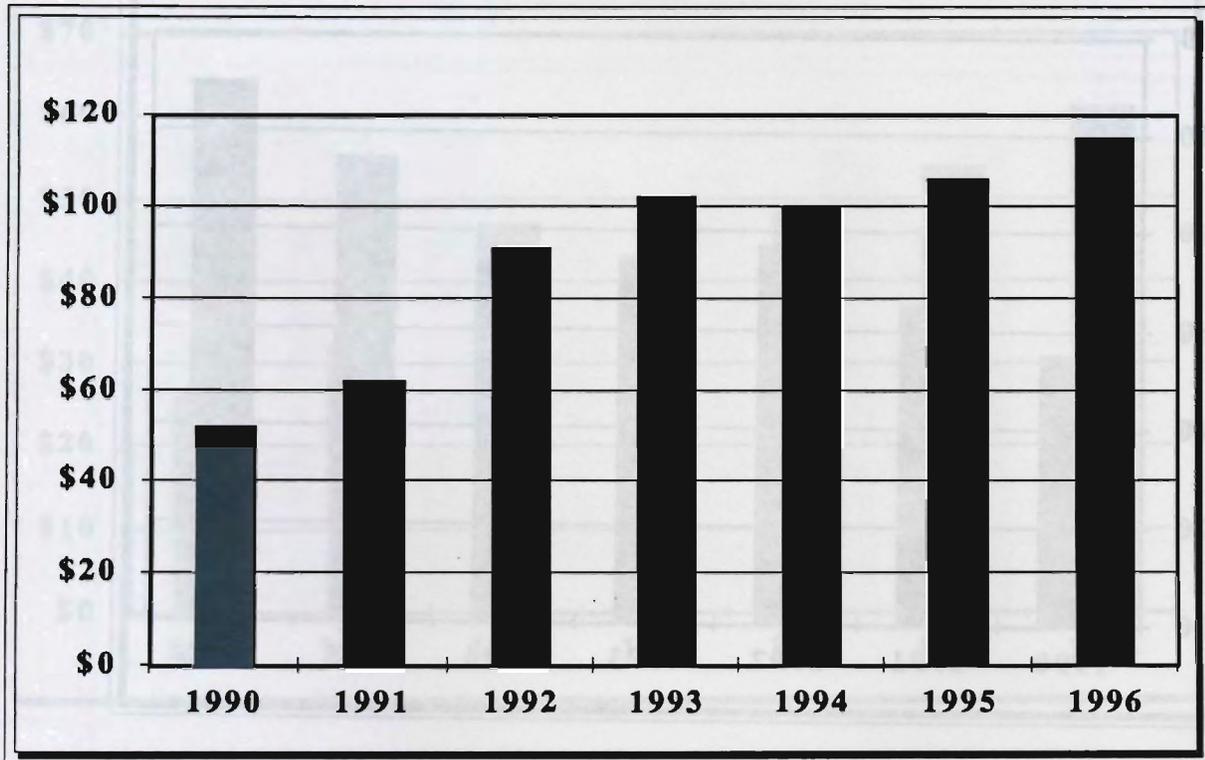
**Inpatient Hospital Vendor Payments**  
(In Millions of Dollars)



Source: HMDR 209 & 210; SFY 96 is Budgeted



**Physician Vendor Payments**  
(In Millions of Dollars)

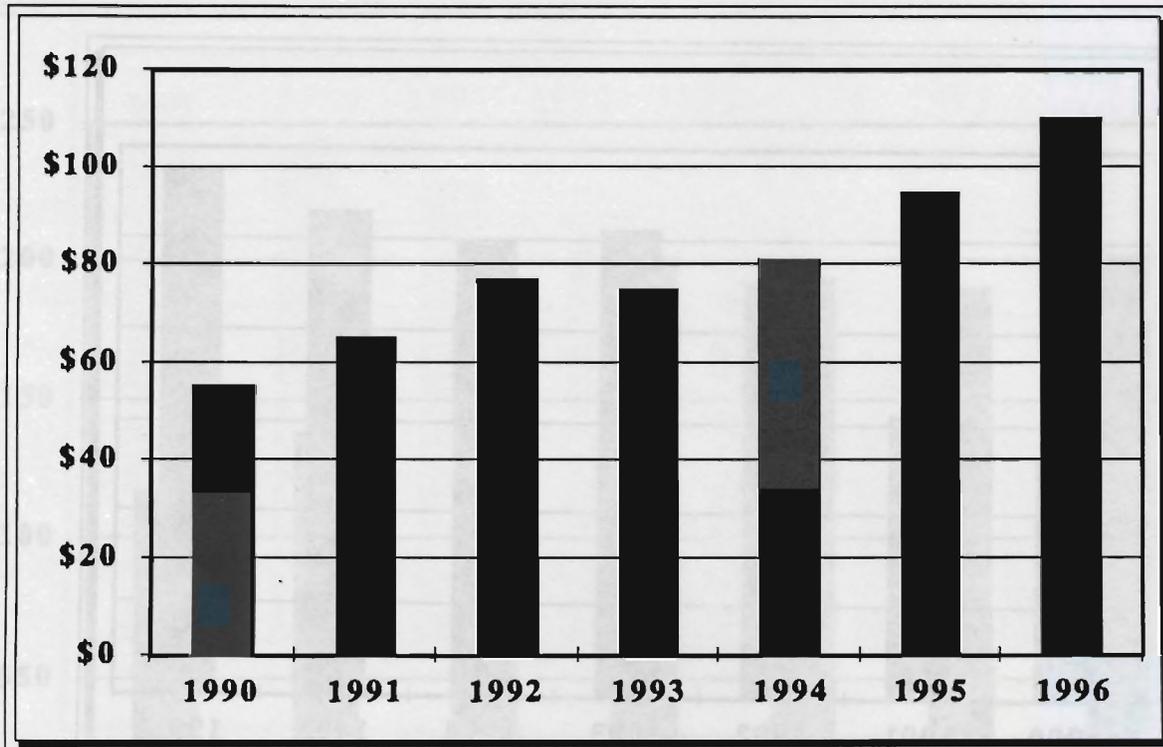


Source: HMDR 290 & 210; SFY 96 is Budgeted



Medicaid Overview

**Prescription Drug Vendor Payments**  
(In Millions of Dollars)

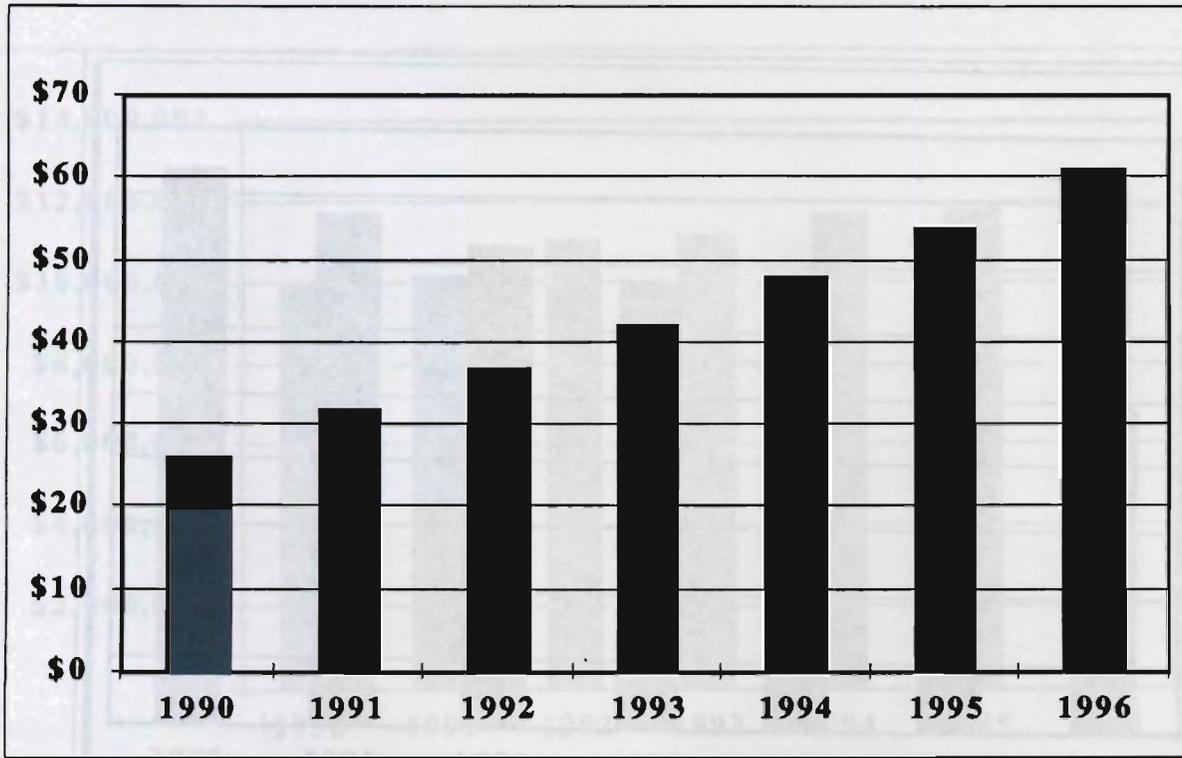


Source: HMDR 209 & 210; SFY 96 is Budgeted



Medicaid Overview

**Medicare Buy In**  
(In Millions of Dollars)

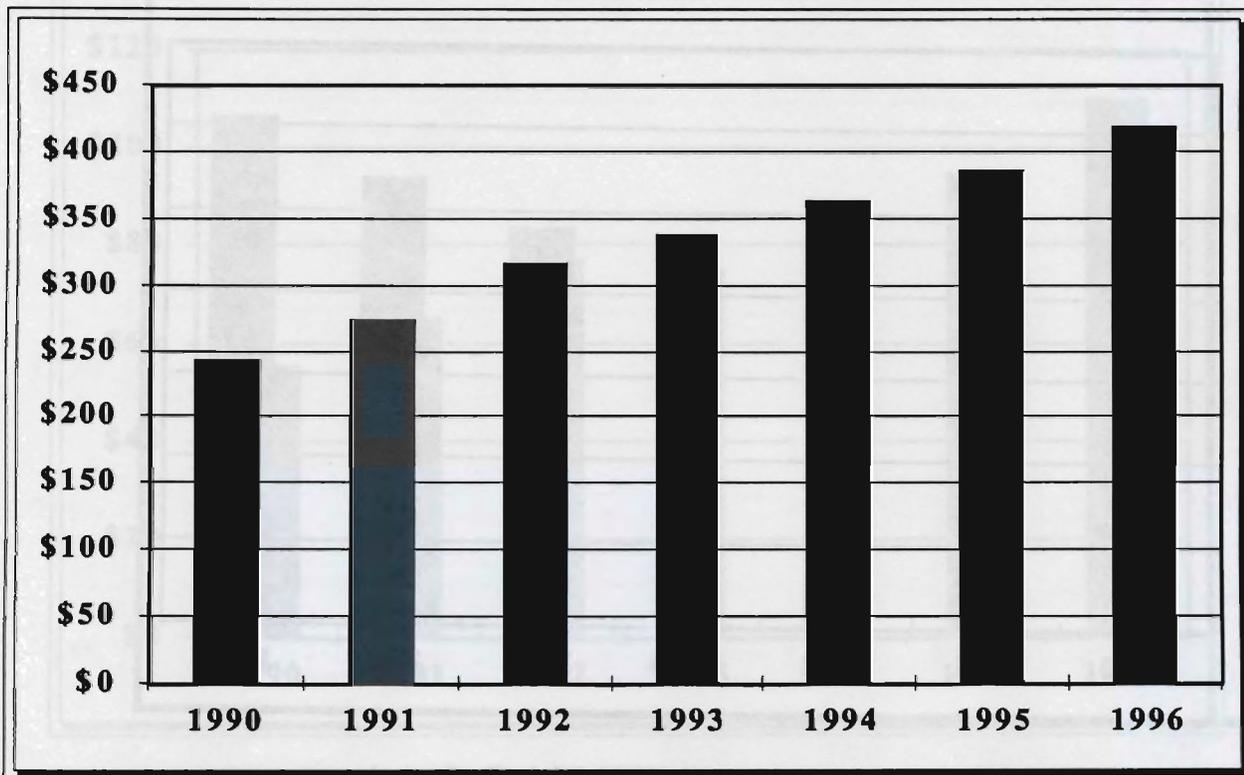


Source: HMDR 209 & 210; SFY 96 is Budgeted



Medicaid Overview

**Long Term Care Vendor Payments**  
(In Millions of Dollars)

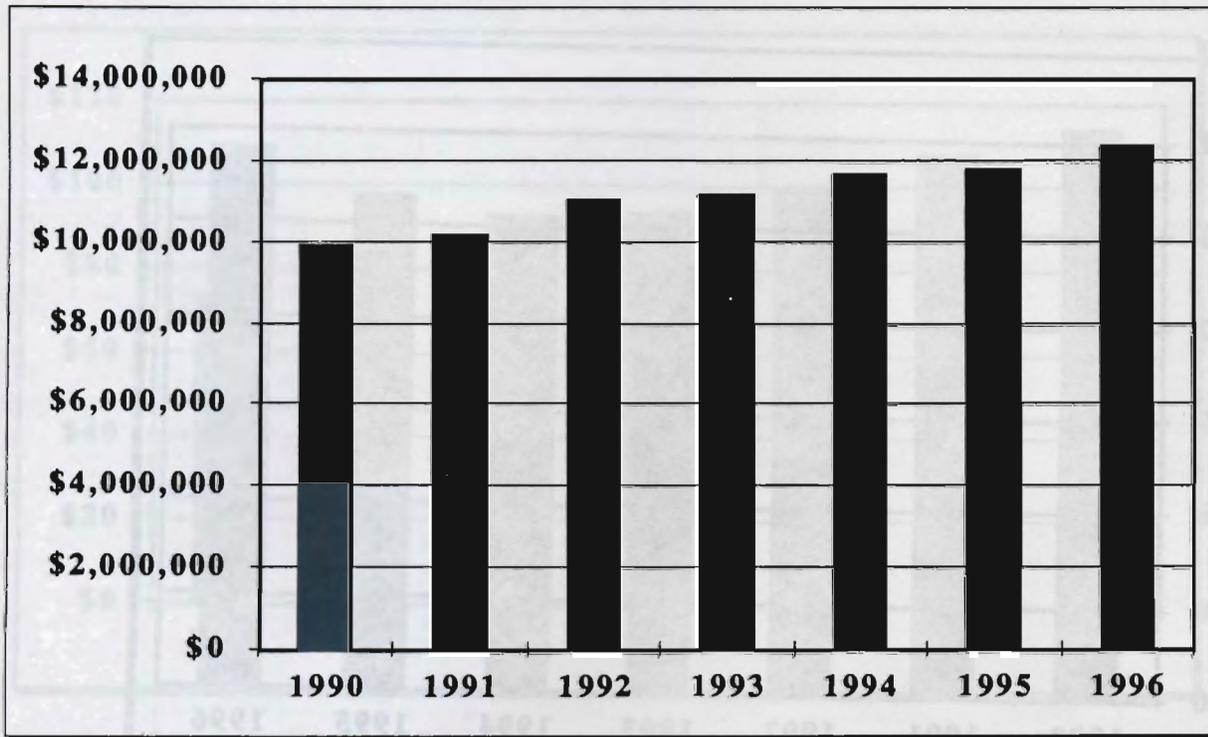


Source: HMDR 209 & 210; SFY 96 is Budgeted



Medicaid Overview

Infant Infirmery ICF/MR Medicaid Expenditures

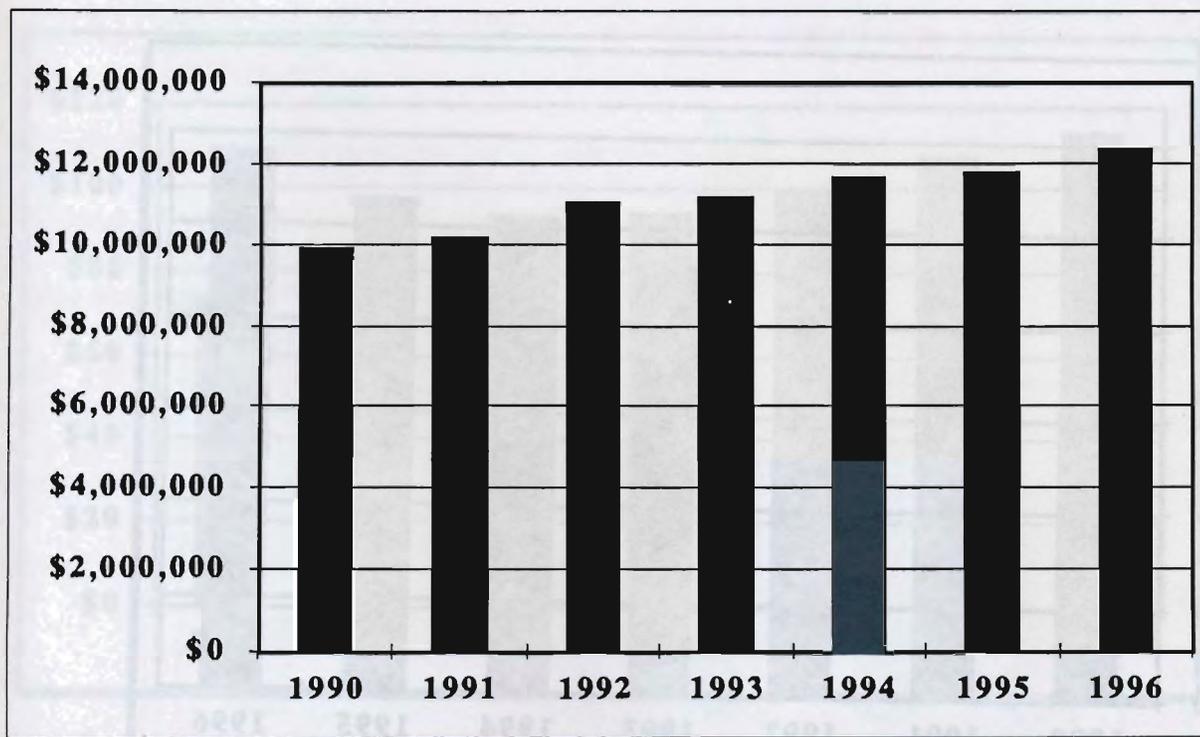


SFY 96 is Budgeted



Medicaid Overview

Infant Infirmery ICF/MR Medicaid Expenditures

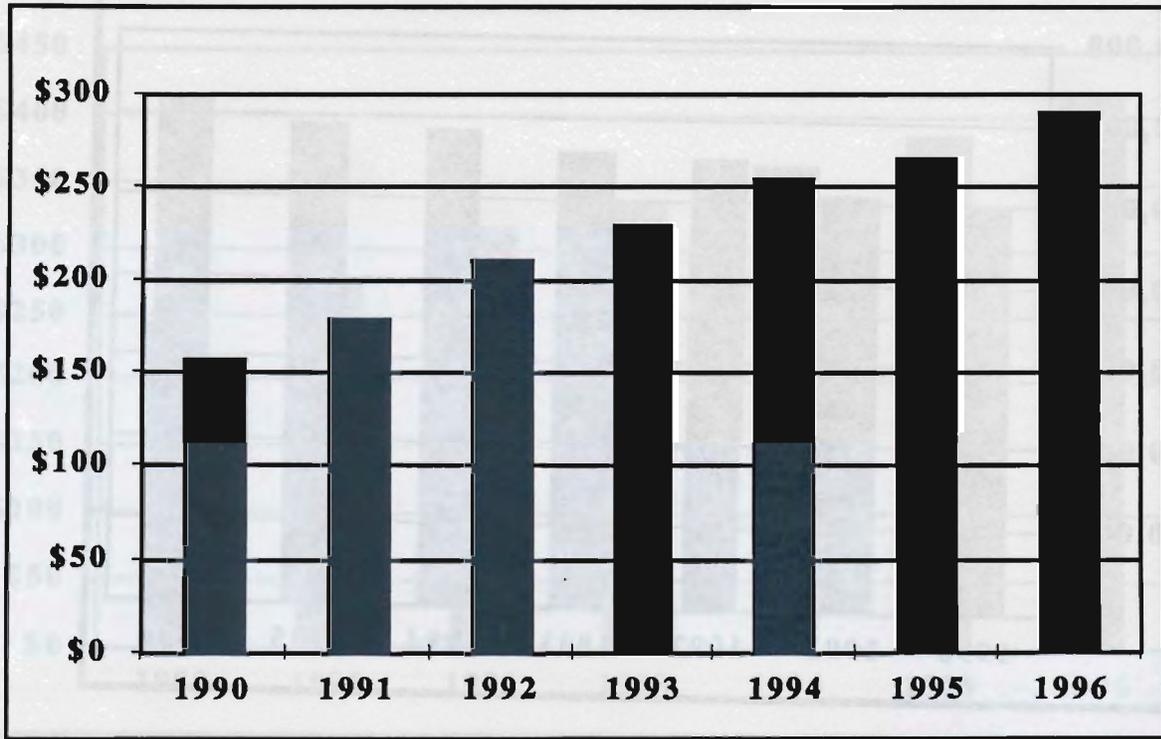


SFY 96 is Budgeted



Medicaid Overview

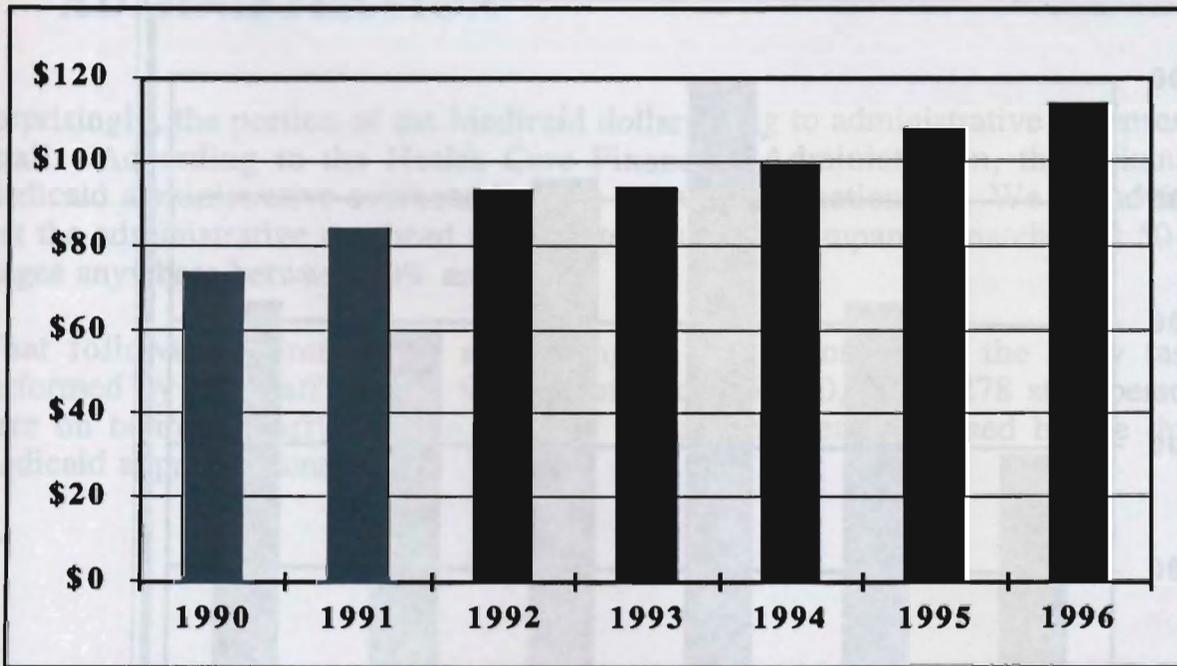
**Private Nursing Facilities Medicaid Expenditures**  
(In Millions of Dollars)



SFY 96 is Budgeted



**Public Nursing Facilities Medicaid Expenditures**  
(In Millions of Dollars)

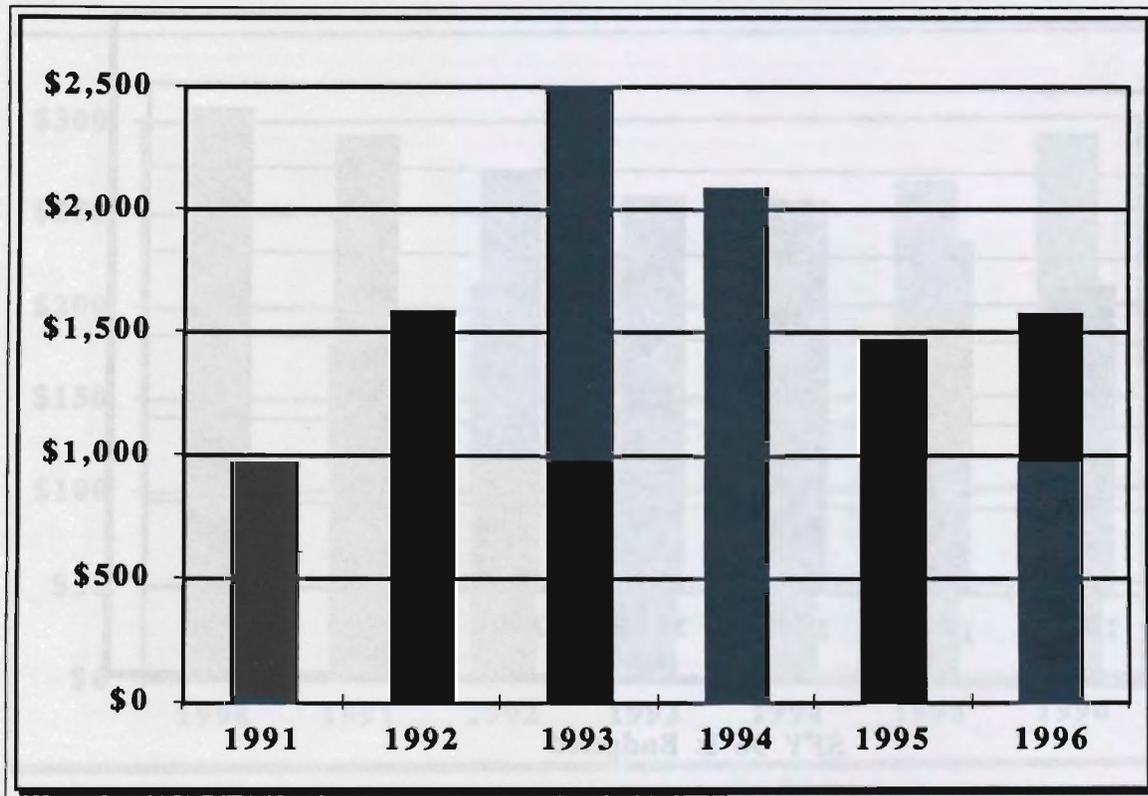


SFY 96 is Budgeted



Medicaid Overview

**Federally Qualified Health Care Centers Vendor Payments--  
(In Millions of Dollars)**



Source: HMDR 209 & 210; SFY 96 is Budgeted



### V. ADMINISTRATION

Surprisingly, the portion of the Medicaid dollar going to administrative expenses is small. According to the Health Care Financing Administration, the Arkansas Medicaid administrative overhead is 3.6% versus 4.6% nationally. We are advised that the administrative overhead for private insurance companies matched as 50-50 ranges anywhere between 10% and 30%.

What follows will reflect an accounting of but a portion of the daily tasks performed by our staff in SFY 95. As of December 30, 1995, 278 staff persons were on board to carry out the tasks of the program encompassed by the three Medicaid appropriations.



Medicaid Overview

Program Management Statistics

Medical Services  
SFY 95

Telephone inquiries handled.....	74,682
Correspondence produced.....	5,955
Provider visits made.....	344
Presentations or workshops.....	20
Third Party Liability collections.....	\$3.7 million
New providers enrolled.....	2,040
Dental Prior Authorizations processed.....	5,080
Dollar value of dental requests denied by consultants.....	\$488,578
Visual/Eyeware prior approvals.....	3,467
Visual/Eyeware requests denied.....	1,744

Medical Utilization Review  
SFY 95

Prior Authorizations approved.....	10,752
Prior Authorizations denied.....	2,930
Benefit extensions granted.....	1,629
Benefit extensions denied.....	922
Post payment reviews.....	847
Over payments identified.....	\$991,855
Over payments recovered.....	\$270,566
Medicaid recipients reviewed.....	309
Fraud referrals made.....	86

Systems Performance  
SFY 95

Paper Claims Processed.....	145,321
Electronic Claims Processed.....	1,307,894
Total Claims Processed.....	1,453,215
Average Claim Processing Time (in days from receipt to payment).....	2.5
Rate at which Claims are Paid in Error.....	<1%
Computer Service Requests Completed.....	173



Medicaid Overview

Long Term Care  
SFY 1995

Pre-Admission Screening/Annual Resident Review (PASARR)

	<b>TOTALS</b>
Pre-admission screening assessments .....	513
Annual resident reviews completed .....	1,907

Licensure and Certification Activity

Nursing facility (NF) surveys completed.....	308
Initial surveys complete.....	5
Follow-up surveys performed .....	294
Complaints investigated .....	1,020
Facility placed out-of-compliance .....	27

Nursing Assistant Training (NAT) Program

Recorded telephone inquired .....	12,495
Written inquiries to clear CNA registry status .....	12,073
Telephone inquiries on various issues .....	7,308
Individuals approved for CNA "exemption" registration.....	640
Cost reimbursement forms processed.....	872
Exemption status denials/returns received.....	294
Certified and Re-certified NAT Program .....	104
Out-of-state inquiries.....	1,116
Out-of-state responses received.....	601
Cost reimbursement statements returned .....	129
Written responses to other states .....	507

Licensure and Residential Care Facility (RCF) Section

RCF construction visit.....	11
RCF surveys completed .....	209
RCF pre-licensure visit .....	12
RCF follow-up surveys conducted.....	11
RCF complaints investigated.....	56
RCF survey for additional beds .....	1
RCF special visit .....	53
RCF unlicensed facility visit .....	11
RCF unlicensed follow-up visit .....	2
Adult Day Care (ADC) surveys completed.....	21
ADC pre-licensure visits.....	12
ADC pre-licensure survey.....	17
ADC special visits.....	3
NF Licensed - New/Change of status.....	16



# ARKANSAS MEDICAID

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## Medicaid Overview

NF Floor Plans for Additions/Renovation/Construction .....	17
NF LSC Licensure Visits.....	16

## Nursing Home Admissions and Reviews

Admission Applications processed .....	7,634
Applications denied .....	210
Continued Stay Reviews .....	43,513
TEFRA Applications processed .....	1,113
Medicaid Waiver - DDS .....	252
ElderChoices Applications received.....	7,460
Approved .....	6,073
Denied.....	1,297
Returned for Completion .....	89

## Medicaid Management Information Systems - MMIS

Billing Telephone Inquiries .....	4,698
Medicare Crossover Claims Processed .....	\$10,839,647.77



Medicaid Overview

Cost Containment

All too often, over the past few years, the demand for Medicaid services has outpaced available revenues. Reasons include recession, Federal mandates, increased numbers of eligibles and providers, as well as the effects of medical inflation. What follows is a chronology of the positive actions taken to contain Medicaid costs in recent years.

The leadership of Governor Tucker and the Legislature in the December 1992 special session helped stabilize Medicaid funding. Since then, we have implemented a series of program changes intended to foster wiser decision-making about funding resources. These measures included initiation of Managed Care, selective competitive bidding and targeted prior authorization -- all implemented with the goal of managing wisely and avoiding the need to eliminate programs and medically necessary care. It is our aim to avoid in the future the pattern of program cuts of the past by applying effective management to the utilization of available revenue sources (such as the Soft Drink tax).



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**Medicaid Overview****Cost Containment Measures**

- 08-01-80 Implemented a 30-day cost efficient supply for maintenance medications.
- 07-01-81 Inpatient hospital benefit limit was established at the 50th percentile of the Professional Activities Study (PAS) Southern Regional length of stay by diagnosis.
- 07-01-81 Reduced rural health clinic services from 18 to 12 visits per calendar year.
- 07-01-81 Reduced physician services from 18 to 12 visits per calendar year.
- 07-01-81 Reduced chiropractic services from 18 to 12 visits per year.
- 07-01-81 Eliminated dental services for recipients over 21 years of age.
- 07-01-81 Reduced prescriptions from 4 per month to 3 per month.
- 09-01-83 Decreased covered hospital days from the 75th percentile to the 50th percentile of the Professional Activities Study (PAS) average length of stay by diagnosis.
- 10-01-83 Implemented a "fee schedule" reimbursement methodology for physician services and laboratory and X-ray services.
- 02-13-84 Implemented a revision in inpatient hospital services to nine days for claims from 02-13-84 through 06-30-84.
- 07-01-84 Implemented a 35-day annual benefit limit for inpatient hospital services with extensions for EPSDT recipients who are considered to be in life threatening situations.
- 07-01-84 Significant changes in coverage, reimbursement and benefit limitations for inpatient, outpatient, and physician services in inpatient and outpatient hospital services.
- 07-01-84 Implemented a prospective payment system utilizing per diem rates for inpatient and outpatient hospital services.
- 12-15-84 Implemented a "fee schedule" reimbursement methodology for visual care services.
- 10-01-85 Implemented revisions in the amount, duration, scope and reimbursement methodology for mental health clinic services.
- 11-01-86 Decreased the inpatient PAS average length of stay from the 75th percentile to the 50th percentile.



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## Medicaid Overview

- 11-01-86 Decreased the annual benefit limit for inpatient hospital services from 35 to 20 days per state fiscal year for recipients 21 years of age and over.
- 11-01-86 Recipients age 21 and older excluded from the 20-day annual benefit limit for life threatening situations extension.
- 1-01-86 Decreased outpatient services from 18 to 12 visits per year. Limit was based on the state fiscal year.
- 11-01-86 Limited payment for Part A & B Medicare Coinsurance to 50% of Coinsurance amounts.
- 11-01-86 Reduced reimbursement rates by 5%.
- 12-01-86 Implemented generic drug policy in the prescription drug program.
- 01-01-87 Implemented a prior authorization requirement for personal care services.
- 02-01-87 Restricted certain surgery procedures to the outpatient setting unless prior authorized for inpatient service.
- 03-01-87 Implemented a restricted formulary in the prescription drug program.
- 04-01-87 Established a maximum of \$250.00 per month, per recipient for home health supplies.
- 07-01-87 Established a maximum of \$100.00 per month, per recipient for home health supplies.
- 01-01-88 Implemented a pre-certification for inpatient admissions involving Medicaid recipients.
- 11-01-88 Established an annual benefit limit of 35 days, per recipient per state fiscal year for inpatient rehabilitative services.
- 10-16-89 Implemented a pre-certification requirement for inpatient admissions to a rehabilitative hospital for alcohol, chemical dependency and psychiatric treatment.
- 01-01-90 Implemented an inpatient hospital benefit limit of 25 days per state fiscal year.
- 01-01-90 Implemented a 25-day benefit limit for home health benefits for the period January 1, 1990 through June 30, 1990.
- 08-01-90 Excluded persons age 21 and older from being eligible to receive dental, occupational, physical and speech therapy, chiropractor or psychology services.
- 08-01-90 Discontinued the medically needy category of service for persons age 21 and older with the exception of pregnant women and refugees.



# ARKANSAS MEDICAID

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## Medicaid Overview

- 08-01-90 Established a 25 day benefit limit for persons age 21 and older receiving inpatient rehabilitative hospital services.
- 12-01-91 Recipients age 21 and older excluded from receiving psychological, occupational, physical and speech therapy, chiropractic, dental services. (Benefits restored were 7-1-91).
- 12-01-91 Reduced the outpatient hospital services annual benefit limit from 18 visits to 12 visits per state fiscal year for recipients age 21 and older.
- 12-01-91 Combined the annual benefit limit of 12 visits per state fiscal year for recipients age 21 and older receiving physician, FQHC, RHC and podiatrist services.
- 01-01-92 Eliminated the "over the counter" category of medications from the Pharmacy Program.
- 01-01-92 Reinstated the Medicaid Utilization Management Program (MUMP) for all recipients regardless of age. In addition, a benefit limit of 20 days in the hospital per state fiscal year was established for recipients age 21 and older. No extensions were to be authorized.
- 01-01-92 Established a benefit limit of 25 visits per state fiscal year for all recipients receiving home health services.
- 01-01-92 Recipients age 21 and older limited to 4 prescriptions per calendar year.
- 01-01-92 Established a \$500.00 per state fiscal year benefit limit for recipients age 21 and older receiving lab and X-ray services.
- 02-01-92 Excluded the "cough and cold" category of medication for recipients age 21 and older.
- 05-01-92 Reduced prescriptions from 4 to 3 prescriptions per calendar month for recipients age 21 and older. No extensions were to be authorized.
- 07-01-92 The Title XIX maximum allowable reimbursement rates were reduced by 20% for the following programs: Ambulance, Chiropractic, Dental, End-State Renal Disease Facility, Certified Registered Nurse Anesthetist, Child Health Management Services, Child Health Services, Home Health, Hearing Services, Hospital, Nurse Midwife, Nurse Practitioner, Occupational, Physical and Speech Therapy, Physician and Lab and X-Ray, Podiatrist, Portable X-Ray, Private Duty Nursing, Profit/Non-Profit Transportation, Prosthetics, Psychology, Public Transportation and Visual Care.
- 09-01-92 A co-payment amount will be charged to recipients for the following services: Physician, Outpatient Hospital, Nurse Practitioner; Federally Qualified Health Center; Rural Health Clinic; Optometrists; Prosthetics; Public Transportation and Prescription Drugs. Except for the Prescription Drug Program, the co-payment



Medicaid Overview

amount will be based on the total amount paid by the Medicaid Program and applied to the following graduated scale:

\$10.00 or less - \$0.50, \$10.01 to \$25.00 - \$1.00, \$25.00 to \$50.00 - \$2.00, \$50.00 or more - \$3.00. The co-payment amount will not exceed \$3.00 per claim.

The co-payment amount for the Prescription Drug Program will be based on the same graduated scale but will be applied per prescription. The co-payment amount will not exceed \$3.00 per prescription. A \$25.00 maximum has been established for a family (budget unit) of one plus \$25.00 for each additional Medicaid eligible family member.

- 10-04-92 Consideration of resources as an eligibility factor for pregnant women, infants and children was implemented.
- 07-01-93 Arkansas Medicaid implemented a reimbursement methodology for residential treatment units within inpatient psychiatric hospitals, for services provided to individuals under 22 years of age. Medicaid will reimburse these units the allowable cost, based on audited cost reports, or \$316.00 per day.
- 04-01-95 Inpatient Obstetrical Care and Routine Newborn Services Waiver.

AEVCS Awards:

1993 Computer World Smithsonian Pinchot in the Category of Government and non-profit

1995 National Association of State Information Resource Executives-Recognition Award for Outstanding Achievement in the Field of Information Technology in the category of Innovative Use of Technology.

AEVCS Nominations:

Innovations 1994 - Funded by the Ford Foundation and administered through the John F. Kennedy School of Government at Harvard University. Ten programs each year receive widespread public recognition and Ford Foundation grants of \$100,000. Another fifteen programs receive \$20,000 grants.

1994 Payment Systems Excellence Award - presented annually to an individual or organization that have demonstrated leadership in the implementation and use of automated payments systems. Presented by the National Automated Clearing House Association.



Medicaid Overview

**Electronic Claims Processing**

**Automated Eligibility Verification & Claims Submission (AEVCS)**

It is estimated that each claim received electronically saves the claims payer between \$1 and \$4 in "inputting" costs.

Full implementation of Electronic Data Interchange at the transaction level would save anywhere from \$4 to \$10 billion annually of the more than \$30 billion currently being spent every year on administrative health care costs--

**ARKANSAS LEADS THE WAY FOR OTHER STATES AND PRIVATE INSURANCE MARKETS WITH ITS AEVCS.**





Medicaid Overview

**AEVCS Articles:**

Fortune magazine, Investor's Business Daily, Electronicity, Government Technology (December 93 & January 94 issues), Automated Medical Payments News, Clearinghouse Update, NACHO News, Washington Report on Health Care & Information Technology

**AEVCS Demonstrations:**

Vice-President Albert Gore at the Health Care Technology Forum, Health Information Modernization Press Conference at the request of Senators Bond & Riegle and Congressman Hobson.



1991 Congress World Leadership Award in the Category of Government and Non-Profit  
1992 National Association of State Information Resources Executive Recognition Award for Outstanding Achievement in the Field of Information Technology in the category of Innovative Use of Technology  
AEVCS Nominations  
Innovations 1991 - Funded by the Ford Foundation and administered through the John F. Kennedy School of Government at Harvard University. Ten programs each year receive widespread public recognition and Ford Foundation grants of \$100,000. Another fifteen programs receive \$20,000 grants  
1994 Payment System Excellence Award - presented annually to an individual or organization that has demonstrated leadership in the implementation and use of automated payment systems. Presented by the National Automated Clearing House Association



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Medicaid Overview

## Quotes From AEVCS Participating Providers:

### Obstetrics and Gynecology -- Little Rock, Arkansas

"I just wanted to drop you a note to tell you HOW MUCH the AEVCS systems has simplified my life. So many physicians in the area do not accept Medicaid simply because they found the claims processing problems overwhelming. This is certainly not the case any longer and I believe that as more and more providers become aware of the changes Medicaid and EDS have implemented, they will reconsider their withdrawal. I love my AEVCS and I want to submit everything through it."

### Pediatrician -- Arkadelphia, Arkansas

"The cut back in paper, postage and hand written claims and letters has been a great improvement. Thank you so much for your work on this most successful program."

### Primary Care Physician -- Warren, Arkansas

"The AEVCS system implemented by Arkansas has significantly enhanced the efficiency of processing Medicaid Claims in our office. A process that was once a nightmare has become the opposite."

### Radiologist -- Fayetteville, Arkansas

"We have noticed how quickly we are receiving payments on claims submitted through AEVCS. Also, the number of denials has decreased dramatically. It is very helpful that the system tells you if you have made an error so you can correct it immediately and submit a "clean" claim."

### Hospital -- Little Rock, Arkansas

"Claims processing, which was once a tedious, unending mass of paper forms to screen and edits, has become an almost totally unattended operation. As the 6th largest Children's Hospital in the country, we are enrolled in over 30 other states' Medicaid programs. None of these other programs offer a comprehensive billing process that proves efficient for large providers, as does AEVCS. Arkansas' plan should serve as a model for these other programs to streamline their processing."

### Billing Agent -- Louisiana

"This is a true improvement and I believe that this...will change the relationship between the Medical Practitioner and Medicaid in a positive way."