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 Centers for Medicare and Medicaid Services (CMS) administers the Medicaid Program for the U.S. Department of Health and Human Services. CMS authorizes federal funding levels and approves each state’s State Plan, ensuring compliance with human services federal regulations.

Eligibility
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 CMS and are funded at the same level as mandatory services.
<table>
<thead>
<tr>
<th>SFY</th>
<th>Total Cost (in million)</th>
<th>Total Recipients</th>
<th>Average Cost Per Recipient</th>
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<td>2003 (proj)</td>
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**Arkansas Economics (SFY02)**

- **Personal Healthcare Expenditures in AR**: $10.66 billion (21.5%)
- **State of Arkansas Expenditures**: $11.6 billion (19.8%)
- **State General Revenue Funded Budget**: $3.24 billion (includes trust fund)
- **Arkansas Population**: 2,682,818 (22%), 385,317 (16%), 1,568,006 (11%), 729,495 (49%)

*Source: Economic Analysis and Tax Research, DFA*

- **Average Cost per Prescription**: $49.31 in SFY02
- **Provider Communications**: Handled approximately 140,700 telephone inquiries in SFY02.
- **75.59% of all Nursing Home residents in SFY01 were Medicaid Eligible**

**Total Medicaid Expenditures SFY 2002**

- **Hosp, Inpt/Outpt**: 22.1%
- **Special Care**: 3.6%
- **Mental Health**: 3.6%
- **Drugs**: 11.0%
- **Private NH**: 16.0%
- **Transp**: 1.1%
- **ICF, Easter Seals**: 0.7%
- **Other**: 2.8%
- **Physician**: 7.3%
- **Public NH**: 5.5%
- **Medical, Other**: 17.1%
- **Buy In**: 2.8%

**Medicaid has approx. 22,700 actively ENROLLED providers, approx. 10,300 (45.4%) are PARTICIPATING Providers**

**23,912,935 claims were processed in SFY02**

Average processing time was 2.3 days

**INNOVATIONS**

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

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

- **Non-Emergency Transportation Services**: Regionalized transportation services at capitated rates to reduce costs and control fraud and abuse
- **ConnectCare Managed Care Program**: An award-winning primary care physician program that has accomplished cost containment goals while maintaining provider and recipient satisfaction
- **Independent Choices**: Waiver program allowing recipients to make decisions regarding their personal care by offering a cash allowance and counseling service
- **ARKids First B**: Allows uninsured children of working families to access health insurance by providing primary-care coverage in Medicaid with slightly fewer benefits and copayments for most services

DHS: Division of Medical Services
Arkansas Medicaid Services

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
- Laboratory and X-Ray

Optional Services Chosen by Arkansas:

- Alternatives for Adults with Physical Disabilities Waiver
- Ambulatory Surgical Center Services
- Audiological Services (EPSDT, Under Age 21)
- Certified Registered Nurse Anesthetist (CRNA)
- Child Health Management Services (EPSDT, Under Age 21)
- Chiropractic Services
- DDS Alternative Community Services Waiver
- Dental Services (EPSDT, Under Age 21)
- Developmental Day Treatment Clinic Services (DDTCS)
- Developmental Rehabilitation Services
- Domiciliary Care Services
- Durable Medical Equipment
- ElderChoices Waiver
- End-Stage Renal Disease (ESRD) Facility Services
- Hearing Services
- Hospice Services
- Hyperalimentation Services
- Inpatient Psychiatric Services Under Age 21
- Inpatient Rehabilitative Hospital Services
- Intermediate Care Facility Services for Mentally Retarded
- Licensed Mental Health Practitioner Services (Under Age 21)
- Medical Supplies
- Medicare/Medicaid Crossover Only
- Nursing Facility Services (Under Age 21)
- Occupational, Physical, Speech Therapy Services
- Orthotic Appliances
- Personal Care Services
- Podiatrist Services
- Portable X-Ray Services
- Prescription Drugs
- Private Duty Nursing Services for Ventilator-Dependent All Ages and High-Tech Non-Ventilator Dependent Persons (EPSDT, Under 21)
- Prosthetic Devices
- Radiation Therapy Center
- Rehabilitative Services for Persons with Mental Illness (RSPMI)
- Rehabilitative Services for Persons with Physical Disabilities (RSPD)
- Rehabilitative Services for Youth and Children (RSYC)
- Respiratory Care Services (EPSDT, Under Age 21)
- School-Based Mental Health Services (Under Age 21)
- Targeted Case Management for Pregnant Women
- Targeted Case Management for Recipients Age 21 and Over With a Developmental Disability
- Targeted Case Management for Recipients (Under Age 21 with a Developmental Disability)
- Targeted Case Management Services for Recipients (EPSDT, Under Age 21)
- Targeted Case Management Services for Recipients Age 60 and Older
- Transportation Services (Ambulance, Non-Emergency)
- Ventilator Equipment
- Visual Services

Major Benefit Limitations on Services:

- Twelve visits to physicians, clinics and/or hospital outpatient departments allowed per state fiscal year.
- One basic family planning visit and three (3) periodic family planning visits per state fiscal year, in addition to the twelve (12) outpatient visits.
- Lab and x-ray services limited to total benefit payment of $500 per state fiscal year, except for EPSDT recipients.
- Three pharmaceutical prescriptions, including refills, allowed per month (family planning prescriptions are 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 (6) prescriptions per month for recipients at risk of institutionalization.
- Inpatient hospital days limited to 24 per state fiscal year, except for EPSDT recipients and organ transplant patients.
- Co-Pay: Some recipients must pay 10% of first Medicaid covered day of hospital stay, $1 - $3 of every prescription, and $2 on the dispensing fee for prescription services for eyeglasses.

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

FAMILY CASELOAD BY AID TYPE

There were an average of 9 enrolled refugees per month in SFY96 and 1 per month in SFY02.

Aid Categories

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

Source: Division of County Operations
Aces IM 2414
DHS; Division of Medical Services
Enrollees By County
SFY 2002

Polk 4,438 1,205
Montgomery 1,974 539
Carroll 4,073 744
Boone 6,060 990
Marion 3,397 464
Baxter 5,585 954
Fulton 2,948 434
Randolph 4,748 797
Sharp 4,402 631
Izard 2,892 416
Stone 2,799 614
Lawrence 4,708 730
Greene 8,069 962
Craighead 16,161 2,256
Mississippi 16,072 1,622

Montgomery 1,974 539
Newton 2,068 421
Searcy 2,188 534
Van Buren 3,336 778
Conway 4,533 660
Feulkner 12,667 2,041
White 12,860 2,330
Woodruff 2,858 338

Fulton 2,948 434
Poinsett 7,465 1,100

*Unduplicated Count for the State Fiscal Year

Source: DHS; Division of Medical Services
Medicaid Decision Support

Medicaid Enrollees*
ARKids B Enrollees*

Total # of Medicaid Enrollees
- 50,000 to 75,000 (1)
- 7,500 to 50,000 (20)
- 4,000 to 7,500 (25)
- 2,500 to 4,000 (19)
- 0 to 2,500 (11)
Provider Types of Paid Claims

- Physician Services: $10,082,962 (25%)
- Dental: $5,008,528 (12%)
- Hospital: $7,894,555 (20%)
- Other: $8,670,959 (22%)
- Pharmacy: $8,631,481 (21%)

Enrollees by Age for Arkansas

Median Age for Arkids B Enrollees in Arkansas was 8 years 11 months.

Monthly Expenditures per Enrollee for Arkansas
The Office of Long Term Care prior authorizes nursing facility services 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.

Children's Medical Services (CMS) is the Title V program for children with special health care needs (CSHCN). CMS is a community-based program and CMS staff work actively with consumers, community providers and other agencies in meeting the needs of CSHCN. Services provided by CMS include service coordination and payment for limited services for children who have no Medicaid coverage. The total number of children served in SFY02 was 18,382.
FIELD AUDIT UNIT:

The Field Audit Unit is responsible for performing on-site/in-house audits of Medicaid providers to ensure 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 ensuring quality medical care for recipients and protecting the integrity of both state and federal funds.

UTILIZATION REVIEW:

The Utilization Review Section identifies, monitors quality of service, investigates, and initiates recoupments of possible fraudulent and abusive billing practices by Arkansas Medicaid providers. The Utilization Review Section prior authorizes medical services such as prosthetics, hearing aid repairs, hyperalimentation and out of state transportation. The Arkansas Medicaid Primary Care Physician (PCP) Program is monitored by the Utilization Review Section. In State Fiscal Year 2002, Utilization Review processed 31,447 requests for extension of benefits from providers for recipients. A total of 18,126 extensions were granted and 13,321 requests denied based on lack of medical necessity. In State Fiscal Year 2002, the Utilization Review Section processed 33,199 requests for prior authorization of services. Of these 19,208 requests were approved and 13,991 requests were denied based on program guidelines. The Surveillance Utilization Review System (SURS) Unit and the Peer Review Organization (PRO) Unit identified $5,207,275 in provider overpayments. The Utilization Review Section also serves as a liaison for Electronic Data Systems (EDS), Arkansas for Medical Care Inc (AFMC) and First Health to the provider/recipient communities. The Utilization Review Section does a random sample questionnaire to recipients to assure that paid benefits were received. Referrals of questionable responses are then made to the Field Audit Section. The Utilization Review Section 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. UR also processed 15,677 telephone inquiries and 39,042 worksheets.

PHARMACY:

In SFY02 the Arkansas Medicaid Pharmacy Unit managed a $266 million prescription drug program. Over 765 pharmacy providers were reimbursed for more than 54 million prescriptions provided to Medicaid recipients. Additionally, the Pharmacy Program oversees the collection of drug rebates from pharmaceutical manufacturers. Collections in SFY02 totaled $53,924,107.

MEDICAL ASSISTANCE UNIT:

The Medical Assistance Section is responsible for enrolling providers in Medicaid and the ARKids First program. At the end of State Fiscal Year 2002 (SFY 2002), there were almost 18,000 enrolled providers in the above programs. More than 8,000 of these providers were physicians and physician groups. Five (5) new programs were added in SFY 2002. They were Critical Access Hospital effective 8-01-01, School Outreach effective 9-01-01, Gerontological Nurse Practitioner effective 12-01-01, Rehab Services for Youth/Children effective 1-01-02, and Developmental Rehab Services effective 2-01-02. The Medical Assistance Section also responds to the concerns and questions of providers and recipients of Medicaid and ARKids services. In SFY 2002, 80,914 telephone inquiries were handled in all Medical Assistance Units with over 40,000 of those in the Program Communications Unit. In addition, since the start of the ARKids Program in September of 1997, over 145,000 ARKids participants' telephone enrollment contacts were processed. The ARKids Program growth for Arkansas children has become a model for similar programs in other states. Other areas administered by the Medical Assistance Section are the Early Periodic, Screening, Diagnosis and Treatment (EPSDT) program and the Dental and Visual programs.

<table>
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<th>SFY 2002</th>
<th>SFY 2001</th>
<th>SFY 2000</th>
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*In SFY 2002, all telephone contacts to Medical Assistance Units were logged and counted.

DHS; Division of Medical Services
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 forty-one (41) 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.

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 2002 were $7,029,784.55. The amount cost avoided for State Fiscal Year 2002 was $13,183,006.34. Grand total savings for SFY02 were $20,212,790.89.

SYSTEMS & SUPPORT:

Systems & Support is the liaison for DMS and the contracted fiscal agent that operates the Medicaid Management Information System (MMIS) which processes all Medicaid claims.

- S & S develops all Request for Proposals and Advance Planning Documents related to the MMIS
- Develops the contract for the fiscal agent to operate the MMIS and monitors the contractor’s performance
- Maintains system documentation from the contractor
- Develops, tracks, and documents customer service requests for modifications to the MMIS
- Performs quality assurance reviews on all edits and audits affecting claims processed by the MMIS
- Conducts Claims Processing Assessment System reviews
- Provides network and hardware/software support and maintenance to DMS employees

REIMBURSEMENT:

Provider Reimbursement develops reimbursement methodologies, identifies budget impacts for changes in reimbursement methodologies, develops reimbursement rates, coordinates payments with the Medicaid Fiscal Agent and provides reimbursement technical assistance for the following Medicaid providers:

Institutional – Hospital, Residential Treatment Unit (RTU), Rural Health Clinic (RHC), Federally Qualified Health Center (FQHC), Residential Treatment Center (RTC), Other. The Institutional Section is also responsible for processing all necessary cost settlements for these providers.

Non-Institutional – Physician, Dental, Durable Medical Equipment, ARKids, Nurse Practitioner, Nurse Midwife, CHMS, DDTCS, Other. The Non-Institutional Section is also responsible for the maintenance of reimbursement rates and assigning all billing codes for both institutional and non-institutional per diem, services, supplies, equipment purchases and equipment rental.

Long Term Care – This Section reviews Nursing Facility and Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) submitted annual and semi-annual cost reports. The cost reports are reviewed for compliance with applicable state and federal requirements and regulations, including both desk reviews and on-site reviews. The Long Term Care Section maintains a database of the cost report information, which is used to evaluate cost and develop reimbursement methodologies and rates. The Long Term Care Section is also responsible for processing all necessary cost settlements for these providers.
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.

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.

Source: AFMC; ER Treatment Trends
Unduplicated Recipient Counts and Vendor Payments by Age SFY02

Recipients

- Ages 20 and Under: 363,552
- Ages 21 - 64: 155,220
- Ages 65 and up: 63,607

Source: HCFA2082

Total Vendor Payments

- Ages 20 and Under: $710,523,793
- Ages 21 - 64: $655,566,407
- Ages 65 and up: $586,723,853

Totals do not include cost settlements

Average Vendor Payment Per Recipient

- Ages 20 and Under: $1,954
- Ages 21 - 64: $4,223
- Ages 65 and up: $9,224

Source: HCFA2082

DHS, Division of Medical Services
MEDICAID STAFFING COMPARED TO EXPENDITURES

MEDICAID UNDUPLICATED RECIPIENTS COMPARED TO EXPENDITURES

Source: HCFA2082; Medicaid Budget Reports
DHS; Division of Medical Services
MEDICAID STAFFING COMPARED TO EXPENDITURES

MEDICAID UNDUPLICATED RECIPIENTS COMPARED TO EXPENDITURES

Source: HCFA2082; Medicaid Budget Reports

DHS, Division of Medical Services