



Arkansas Department of Human Services

Division of Medical Services

Program Overview

State Fiscal Year 2004



Roy Jeffus, Director

DHS – Division of Medical Services

Donaghey Plaza South

P.O. Box 1437 Slot S401

(501) 682-8292

(800) 482-5431



**ARKANSAS
DEPARTMENT OF
HUMAN
SERVICES**

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 26% of Arkansas Medicaid **Program-related Costs**; the federal government funds approximately 74%. 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 75% or 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.

ARKANSAS MEDICAID

Program Costs

SFY	Total (in mill)	Unduplicated Recipients	Average Cost
1998	\$1,458	415,605	\$3,508
1999	\$1,522	459,782	\$3,310
2000	\$1,631	498,669	\$3,271
2001	\$1,852	535,322	\$3,460
2002	\$2,293	582,379	\$3,937
2003	\$2,464	626,036	\$3,936
2004	\$2,711	663,920	\$4,083
2005 (proj)	\$3,084	717,892	\$4,296

Arkansas Economics (SFY04)

		Medicaid Represents
Personal Healthcare Expenditures in AR	\$12.7 billion	21.3%
State of Arkansas Budget	\$15.6 billion	17.4%
State General Revenue Funded Budget	\$3.53 billion	15.1%

Arkansas Population*		% population served by Medicaid
All Ages	2,725,714	25%
Elderly	377,682	17%
Adult (20 - 64)	1,587,288	13%
Children (19 and under)	760,744	54%

*Source: Economic Analysis and Tax Research, DFA



Average Cost per prescription in SFY04 was \$56.77



74.82% of all Nursing Home residents in SFY03 were Medicaid Eligible



Provider Communications handled approximately 161,000 telephone inquiries in SFY04.

SFY05 Medicaid Operating Budget

(millions)

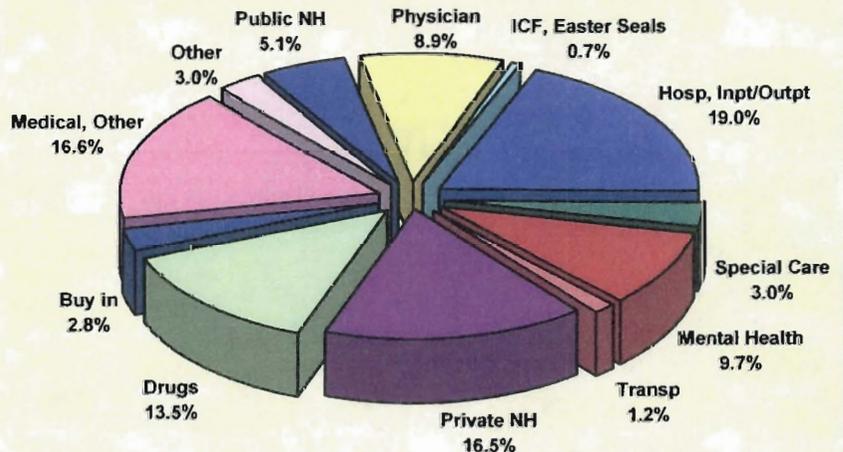
General Revenue	\$533.2
Other Revenue	\$145.0
Quality Assurance Fee	\$63.0
Trust Fund	\$52.0
Federal Revenue	\$2,291.1
Total Program	\$3,084.3



The medical cost for 55% of all babies born to Arkansas residents is paid for by Medicaid

Medicaid has approx. 25,100 actively ENROLLED providers, approx. 11,500 (45.8%) are PARTICIPATING Providers

Total Medicaid Expenditures SFY 2004



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.

26,758,849 claims were processed in SFY04
 Average processing time was 2.8 days

INNOVATIONS

Automated Eligibility Verification & Claims Submission System (AEVCS)

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

Assisted Living

This waiver offers certain individuals an alternative to remaining in their private dwelling or going to a nursing home

Non-Emergency Transportation Services

Regionalized transportation services at capitated rates to reduce costs and control fraud and abuse

ConnectCare Primary Care Case Management Program

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

TEFRA Waiver

Parents above a certain income level pay a premium for the Medicaid services for their child(ren)

Independence Choices

Waiver program that allows 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 cost-sharing 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
- ◆ Medical and Surgical Services of a Dentist
- ◆ Nurse Midwife
- ◆ Nurse Practitioner (Family and Pediatric)
- ◆ Nursing Facility Services (Age 21 or Older)
- ◆ Physician
- ◆ Rural Health Clinics

Optional Services Chosen by Arkansas:

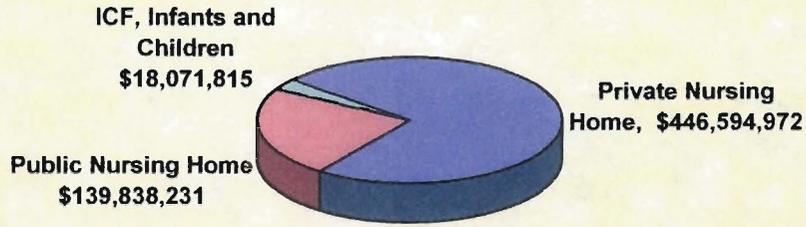
- ❖ Alternatives for Adults with Physical Disabilities Waiver
- ❖ Ambulatory Surgical Center Services
- ❖ Audiological Services (EPSDT, Under Age 21)
- ❖ Certified Registered Nurse Anesthetist (CRNA)
- ❖ Child Health Management Services (EPSDT, Under Age 21)
- ❖ Chiropractic Services
- ❖ DDS Alternative Community Services Waiver
- ❖ Dental Services (EPSDT, Under Age 21)
- ❖ Developmental Day Treatment Clinic Services (DDTCS) (Preschool and Age 18 or Older)
- ❖ Developmental Rehabilitation Services (Under Age 3)
- ❖ Domiciliary Care Services
- ❖ Durable Medical Equipment
- ❖ ElderChoices Waiver
- ❖ End-Stage Renal Disease (ESRD) Facility Services
- ❖ Hearing Aid Services (Under Age 21)
- ❖ Hospice Services
- ❖ Hyperalimentation Services
- ❖ Inpatient Psychiatric Services Under Age 21
- ❖ Intermediate Care Facility Services for Mentally Retarded
- ❖ Licensed Mental Health Practitioner Services (Under Age 21)
- ❖ Medical Supplies
- ❖ Nursing Facility Services (Under Age 21)
- ❖ Occupational, Physical, Speech Therapy Services (Under Age 21)
- ❖ 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 Hospital Services
- ❖ Rehabilitative Services for Persons with Mental Illness (RSPMI)
- ❖ Rehabilitative Services for Persons with Physical Disabilities (RSPD) (Under Age 21)
- ❖ Rehabilitative Services for Youth and Children (RSYC) (Under Age 21)
- ❖ Respiratory Care Services (EPSDT, Under Age 21)
- ❖ Respite Care Waiver (Under Age 19)
- ❖ 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 of Children's Medical Services
- ❖ Targeted Case Management for Recipients in the Division of Children and Family Services (Under Age 21)
- ❖ Targeted Case Management for Recipients of the Division of Youth Services (Under Age 21)
- ❖ Targeted Case Management Services for Recipients (EPSDT, Under Age 21)
- ❖ Targeted Case Management for Recipients Under Age 21 with a Developmental Disability
- ❖ Targeted Case Management Services for Recipients Age 60 and Older
- ❖ Targeted Case Management for SSI Recipients and TEFRA Waiver Recipients (Under Age 17)
- ❖ Transportation Services (Ambulance, Non-Emergency)
- ❖ Ventilator Equipment
- ❖ Visual Services

Major Benefit Limitations on Services:

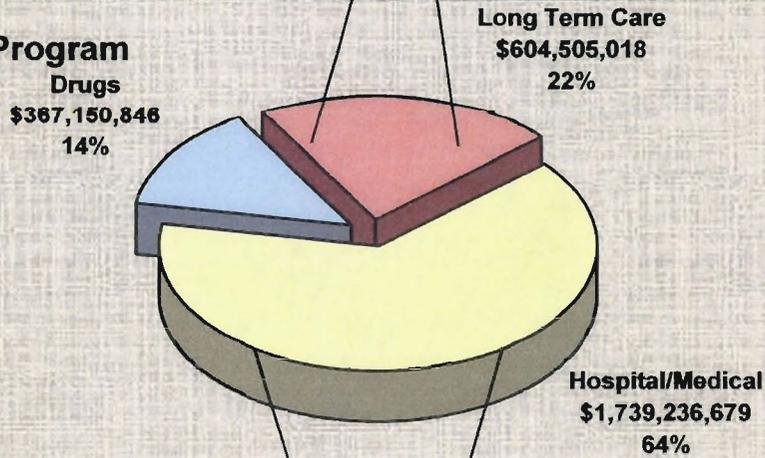
- Twelve visits to physicians, clinics and/or hospital outpatient departments allowed per state fiscal year.
- One basic family planning visit and three (3) periodic family planning visits per state fiscal year, in addition to the twelve (12) outpatient visits.
- Lab and x-ray services limited to total 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 certain organ transplant patients.
- Co-insurance: Some recipients must pay 10% of first Medicaid covered day of hospital stay. Arkids B recipients and certain recipients in the Working Disabled aid category must pay a higher percent for inpatient hospital services (20% and 25% respectively) and must also pay co-insurance for some additional services.
- Co-Pay: Some recipients must pay \$1 - \$3 of every prescription, and \$2 on the dispensing fee for prescription services for eyeglasses. Arkids B recipients and certain recipients in the Working Disabled aid category must pay a higher co-payment for these services and also must pay co-payments for some additional services.
- Premiums: Certain TEFRA recipients must pay a premium.
Any and all exceptions to benefit limits are based on medical necessity.

Arkansas Medicaid Program Benefit Expenditures SFY04

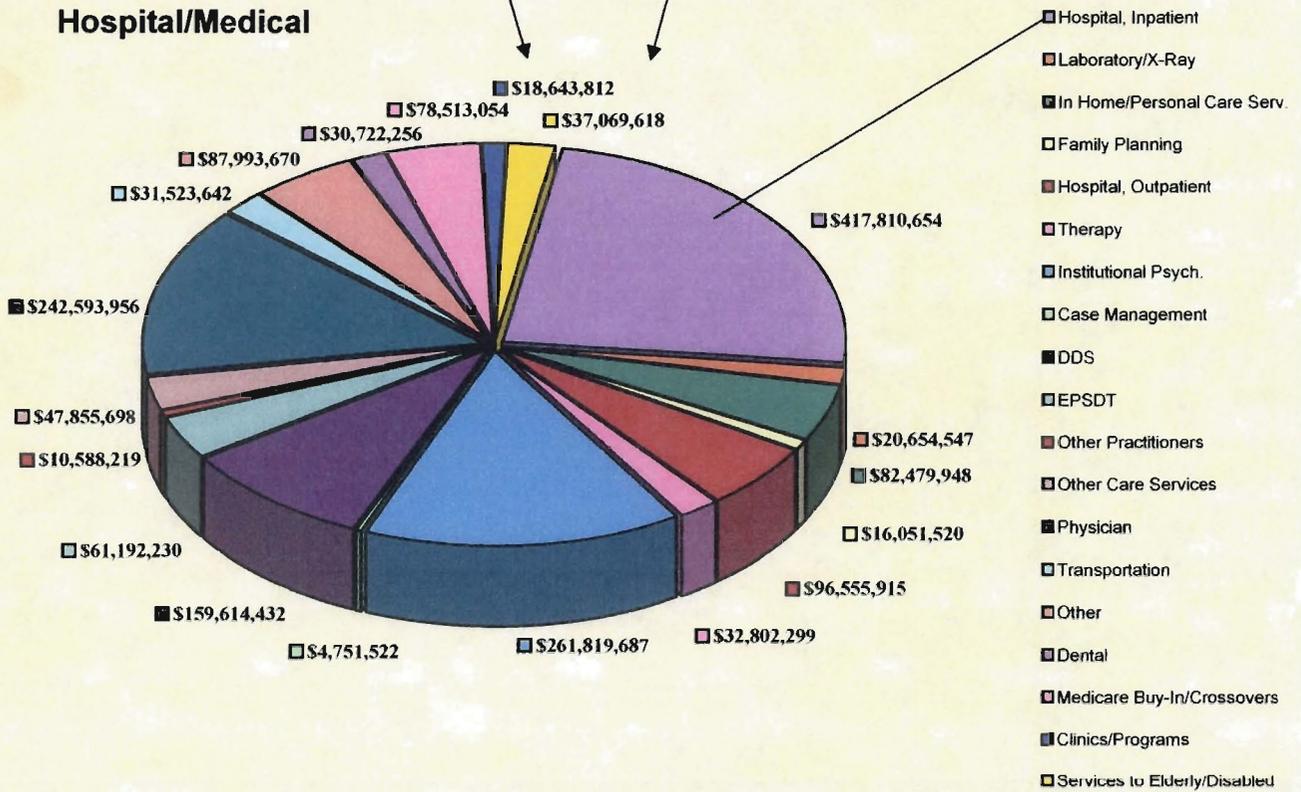
Long Term Care



Total Medicaid Program

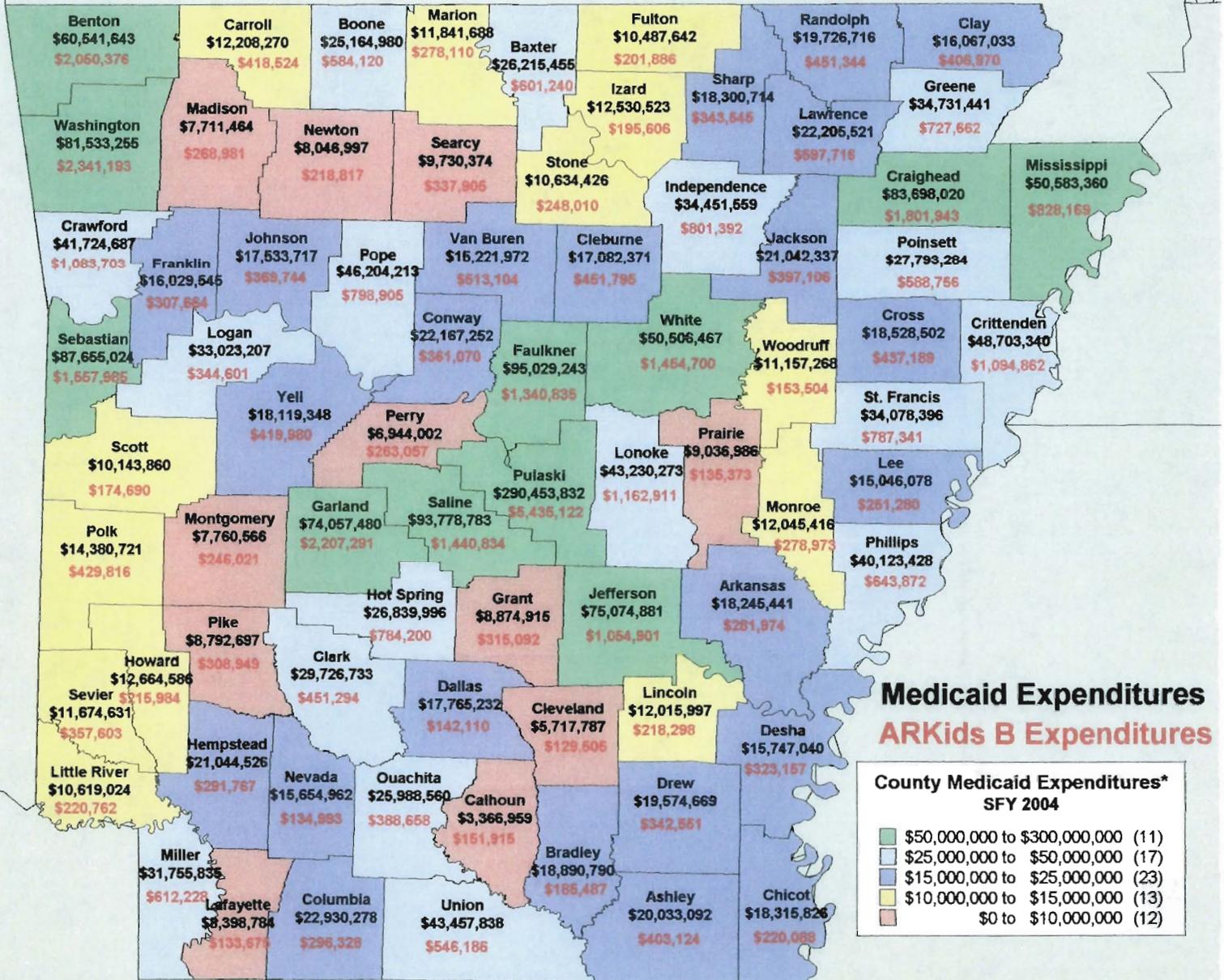


Hospital/Medical



Adjusted Paid Claims By County

SFY 2004



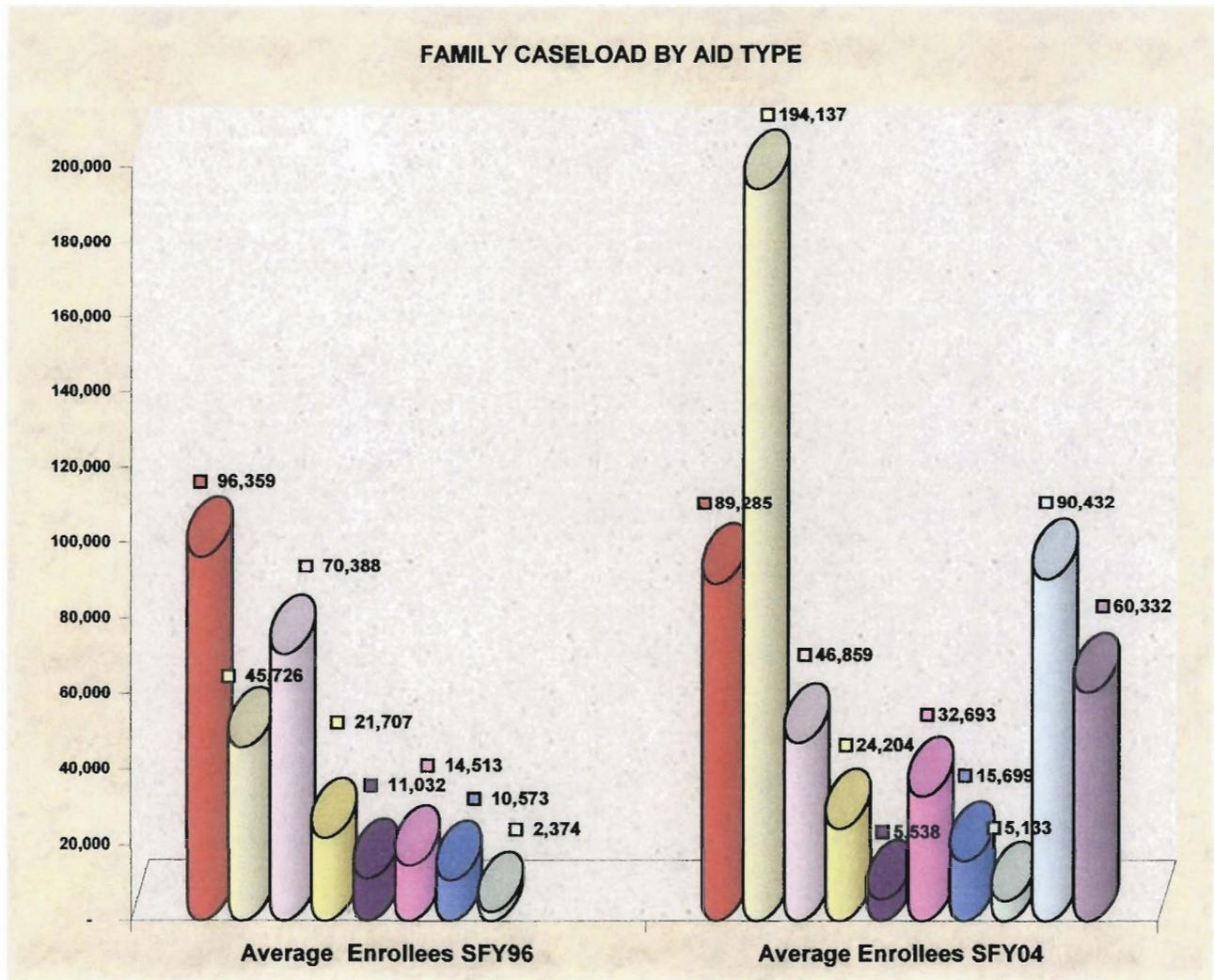
Medicaid Expenditures ARKids B Expenditures

**County Medicaid Expenditures*
SFY 2004**

█	\$50,000,000 to \$300,000,000 (11)
█	\$25,000,000 to \$50,000,000 (17)
█	\$15,000,000 to \$25,000,000 (23)
█	\$10,000,000 to \$15,000,000 (13)
█	\$0 to \$10,000,000 (12)

Source: DHS; Division of Medical Services
 Medicaid Decision Support System
 Medicaid totals include \$10,351 in CHIP payments
 *Doesn't include \$2,787,291 attributed to unspecified counties or non-claim related payments
 *Doesn't include cost settlements

MEDICAID ENROLLEES



Aid Categories

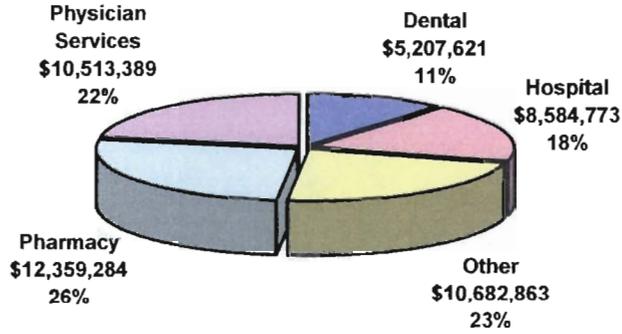
- SSI Supplemental Security Income
- PW Pregnant Women, Infants and Children
- AFDC Aid to Families with Dependent Children
- AABD Aid to the Aged, Blind and Disabled
- MN Medically Needy
- QMB Qualified Medicare Beneficiary
- U-18 Under Age 18
- FC Foster Care
- FP Family Planning
- ARKids ARKids Group

There were an average of 9 enrolled refugees per month in SFY96 and 1 per month in SFY04.

ARKids 1st B

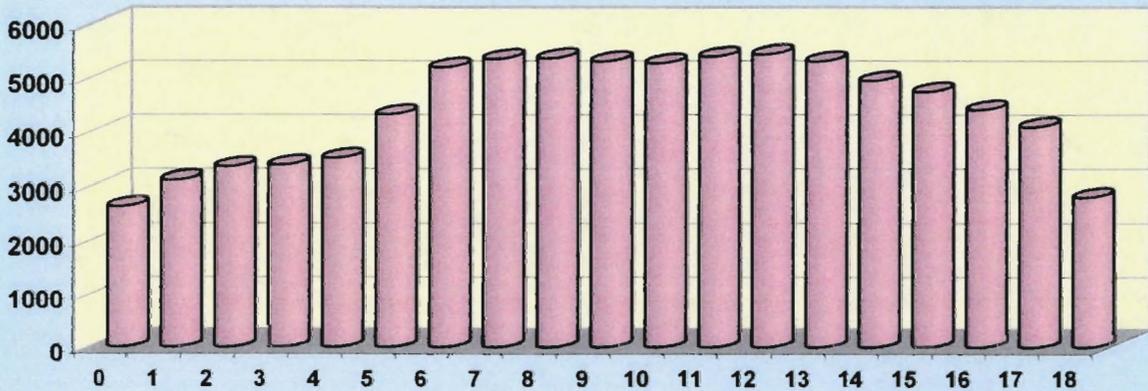
State of Arkansas
SFY2004

Provider Types of Paid Claims



Median Age for Arkids B Enrollees in Arkansas was 9 years 1 month.

Enrollees by Age for Arkansas

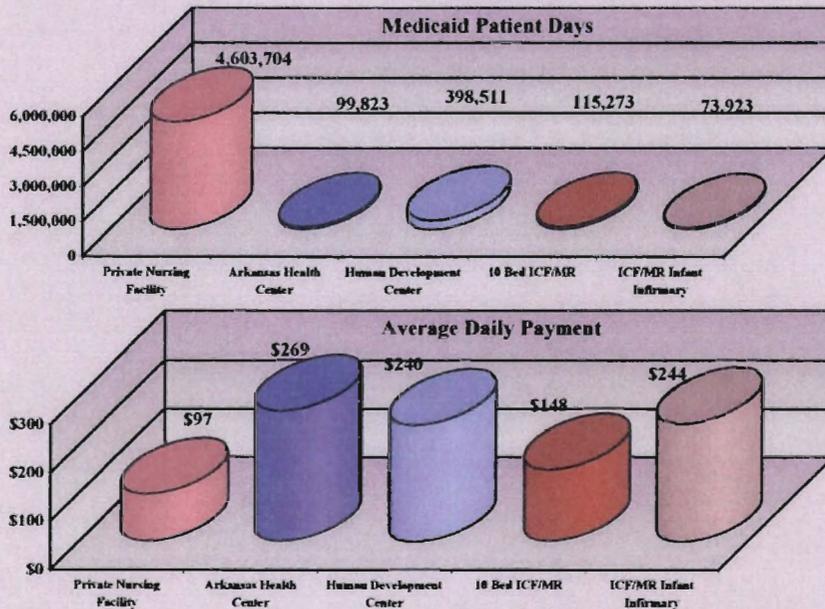


Monthly Expenditures per Enrollee for Arkansas



OFFICE OF LONG TERM CARE

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, Adult Day Care Facilities, and Assisted Living Facilities.



Source: Office of LTC

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 Non-Emergency 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 2004, Utilization Review processed 63,094 requests for extension of benefits from providers for recipients. A total of 42,725 extensions were granted and 20,369 requests denied based on lack of medical necessity. In State Fiscal Year 2004, the Utilization Review Section processed 26,019 requests for prior authorization of services. Of these 15,473 requests were approved and 10,546 requests were denied based on program guidelines. The Surveillance Utilization Review System (SURS) Unit and the Peer Review Organization (PRO) Unit identified \$4,379,742 in provider overpayments. The Utilization Review Section also serves as a liaison for Electronic Data Systems (EDS), Arkansas Foundation for Medical Care Inc (AFMC), First Health Services, and APS Healthcare Midwest 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 47,043 telephone inquiries and 46,330 worksheets.

PHARMACY:

In SFY04 the Arkansas Medicaid Pharmacy Unit managed a \$367 million prescription drug program. Over 800 pharmacy providers were reimbursed for more than 5.9 million prescriptions provided to Medicaid recipients. Additionally, the Pharmacy Program oversees the collection of drug rebates from pharmaceutical manufacturers. Collections in SFY04 totaled \$74,404,543.

MEDICAL ASSISTANCE UNIT:

The Medical Assistance Section is responsible for enrolling providers in Medicaid and the ARKids First Program. At the end of the State Fiscal Year 2004 (SFY 2004), there were more than 19,400 enrolled providers in the above programs. More than 8,500 of these providers were physicians and physician groups. The Medical Assistance Section also responds to the concerns and questions of providers and recipients of Medicaid and ARKids services. In SFY 2004, 86,937 telephone inquiries were handled in all the Medical Assistance Units with over 55,600 of those in the Program Communications Unit. In addition, since the start of the ARKids Program in September of 1997, over 171,000 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 Treatment (EPSDT) program and the Dental and Visual programs.

	<u>SFY 2004</u>	<u>SFY 2003</u>	<u>SFY 2002</u>
Telephone Inquiries	86,937	93,917	80,914
Written Correspondence	3,737	3,671	3,021
Recipient Denial Letters	129	139	129
Fair Hearings	358	322	315

PROGRAM PLANNING AND DEVELOPMENT :

The Program Planning and Development (PPD) Section develops and maintains the Medicaid State Plan and the State Child Health Insurance Program State Plan. This section writes separate provider policy manuals for each of the forty-four (44) 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 2004 were \$7,006,062.39. The amount cost avoided for State Fiscal Year 2004 was \$11,485,237.77. Grand total savings for SFY04 were \$18,491,300.16.

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:

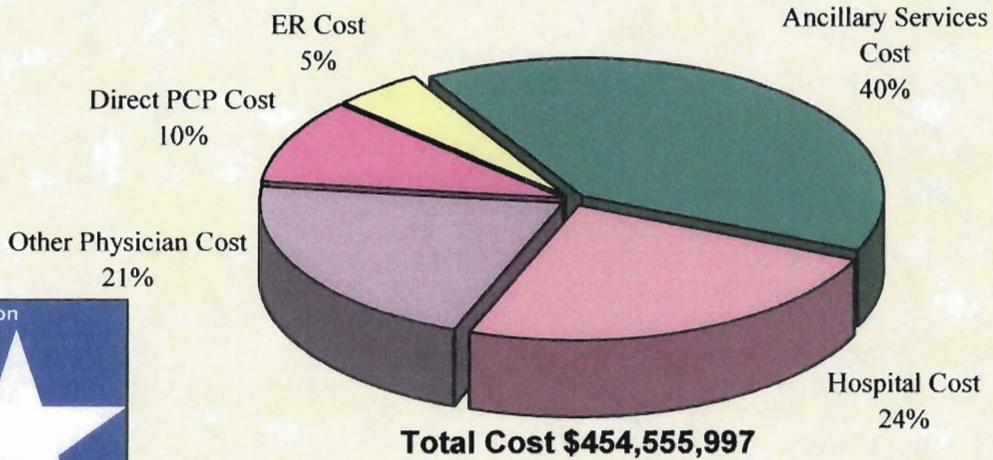
Provider Reimbursement develops reimbursement methodologies, identifies budget impacts for changes in reimbursement methodologies, develops reimbursement rates, coordinates payments with the Medicaid Fiscal Agent and provides reimbursement technical assistance for the following Medicaid providers:

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 diems, services, supplies, equipment purchases and equipment rental.

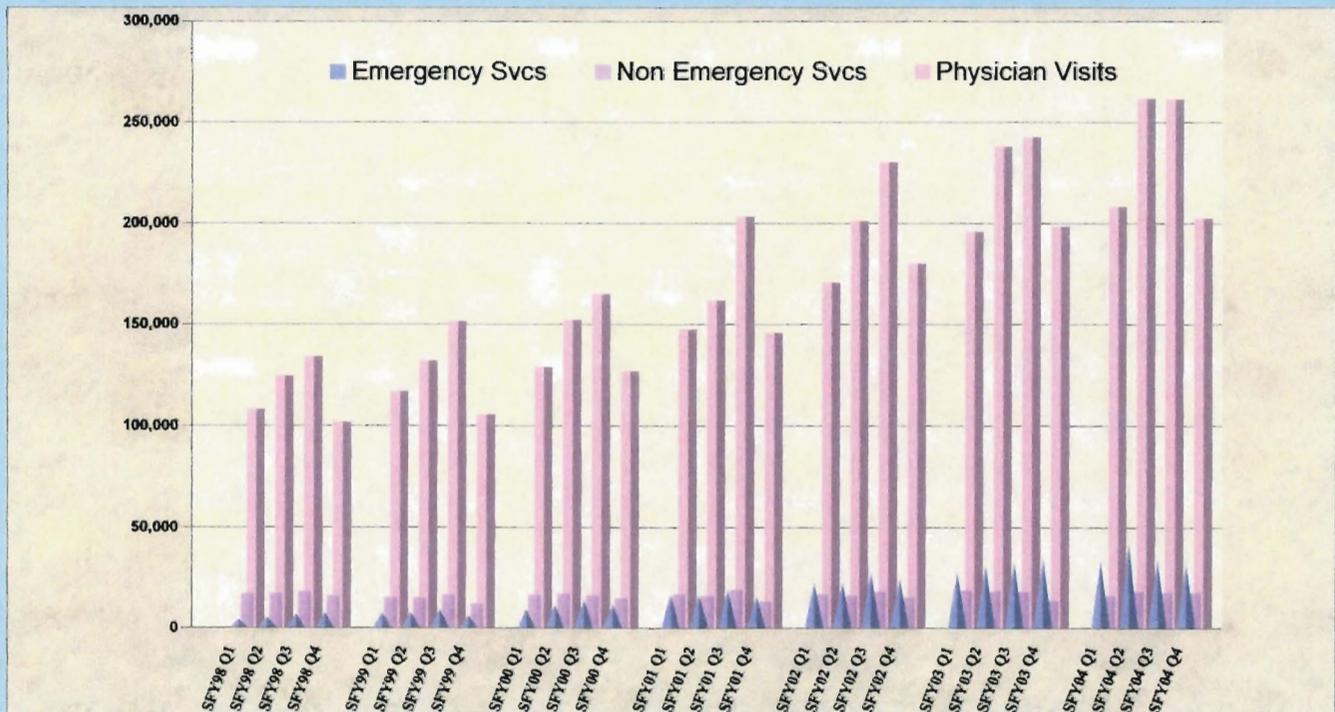
Long Term Care – This Section reviews Nursing Facility and Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) submitted annual and semi-annual cost reports. The cost reports are reviewed for compliance with applicable state and federal requirements and regulations, including both desk reviews 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.

PRIMARY CARE PHYSICIAN (PCP) PROGRAM EXPENDITURES SFY04
PCP PROGRAM ENTITLED ConnectCare



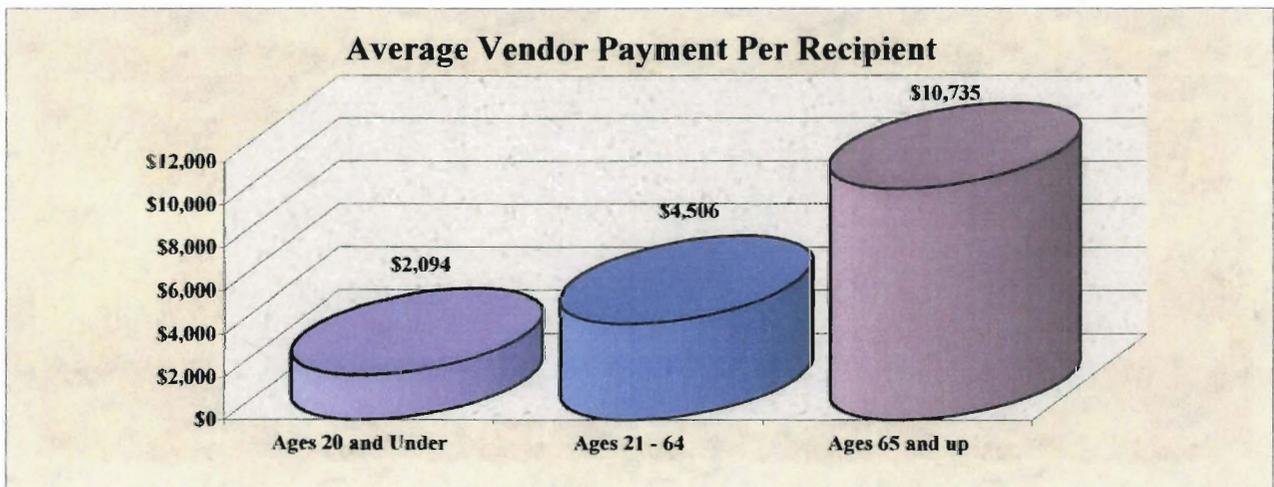
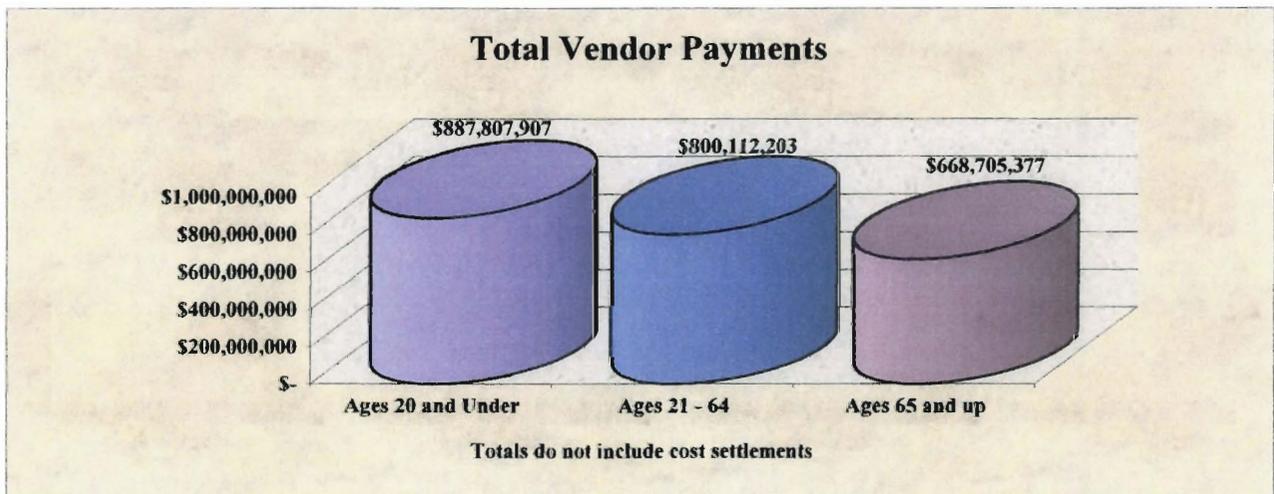
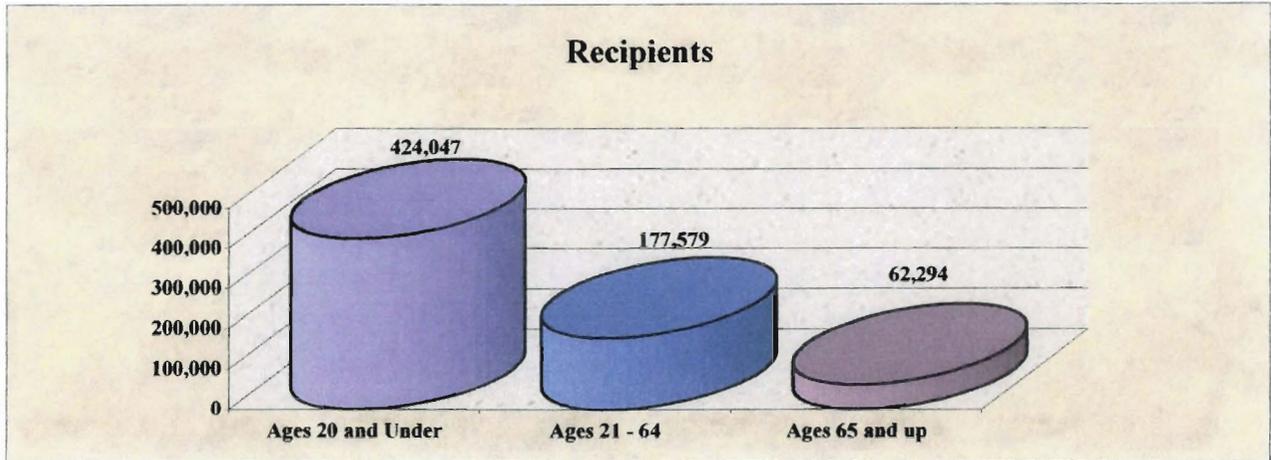
Arkansas Medicaid's *ConnectCare* program enables every eligible recipient to have his or her own primary care physician. The primary care physician is an advocate for the patient, coordinating care, making referrals when necessary, and minimizing the need to go to a hospital emergency department for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

ARKANSAS MEDICAID TREATMENT TRENDS

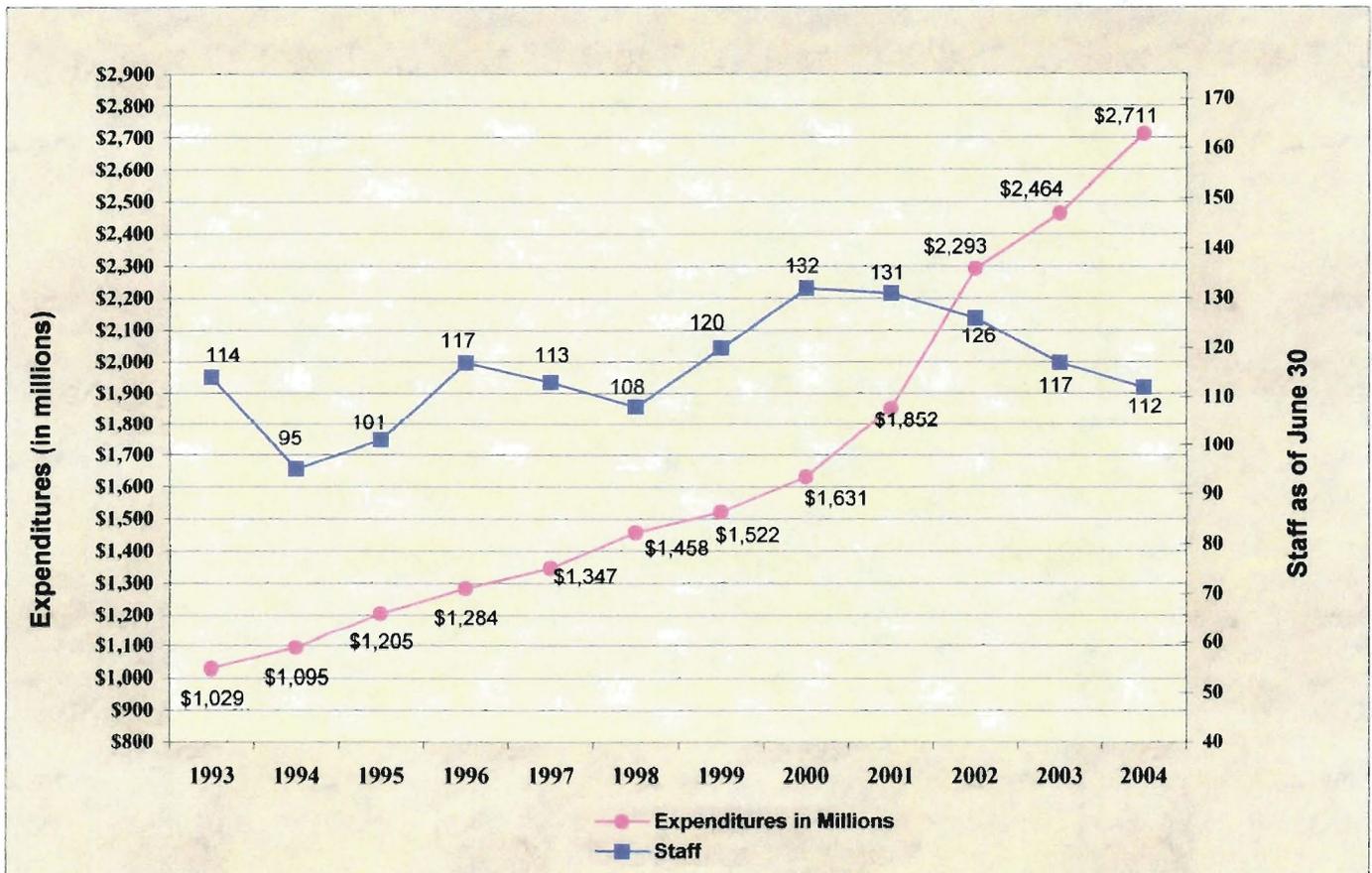


An analysis by the Arkansas Foundation for Medical Care illustrated a cost/benefit of the *ConnectCare* Program as the *nominal increase* in "less costly" physician office visits, with a *marked decrease* of approximately 60% in more expensive non-emergency visits to Hospital Emergency Rooms compared to levels prior to 1996 and virtually no growth since that time.

Unduplicated Recipient Counts and Vendor Payments by Age SFY04



MEDICAID STAFFING COMPARED TO EXPENDITURES



MEDICAID UNDUPLICATED RECIPIENTS COMPARED TO EXPENDITURES

