

*Arkansas Department of Health and Human
Services*

Division of Medical Services

Program Overview

State Fiscal Year 2005



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DHHS – Division of Medical Services

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**ARKANSAS DEPARTMENT OF
HEALTH & 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 Health and Human Services (DHHS)**.

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 **DHHS 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 25.27% of Arkansas Medicaid **Program-related Costs**; the federal government funds approximately 74.73%. 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 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
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	\$3,006	688,150	\$4,368
2006 (proj)	\$3,344	734,033	\$4,556

Arkansas Economics (SFY05)

	Medicaid Represents
Personal Healthcare Expenditures in AR	\$15.5 billion / 21.6%
State of Arkansas Budget	\$17.2 billion / 18.2%
State General Revenue Funded Budget	\$3.61 billion / 14.9%

Arkansas Population*		% population served by Medicaid
All Ages	2,752,629	26%
Elderly	381,106	17%
Adult (20 - 64)	1,616,092	13%
Children (19 and under)	755,431	58%

*Source: Economic Analysis and Tax Research, DFA



Average Cost per prescription in SFY05 was \$61.80



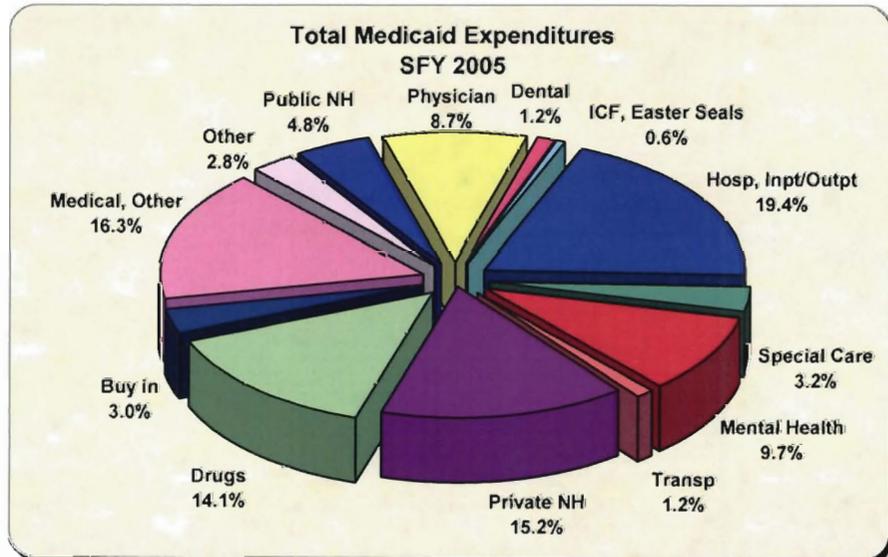
74.22% of all Nursing Home residents in SFY04 were Medicaid Eligible



Provider Communications handled approximately 171,431 telephone inquiries in SFY05.

SFY06 Medicaid Operating Budget

(millions)	
General Revenue	\$555.3
Other Revenue	\$183.6
Quality Assurance Fee	\$54.1
Trust Fund	\$84.8
Federal Revenue	\$2,466.4
Total Program	\$3,344.2



- 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.



The medical cost for 56.3% of all babies born to Arkansas residents is paid for by Medicaid

Medicaid has approx. 24,660 actively ENROLLED providers, approx. 10,154 (41.2%) are PARTICIPATING Providers

30,078,091 claims were processed in SFY05
Average processing time was 2.4 days

ARKANSAS MEDICAID, Continued

Current Innovations

Evidence Based Prescription Drug Program

A program utilized by the DMS Pharmacy unit providing the best selection of prescription drugs in a given class, based on efficacy and cost minimization to the state.

Smart PA

A program utilized by the state Medicaid Pharmacy Program to verify PA eligibility by reading a recipient's Medicaid Profile, including medications, procedures, and diagnosis, at the (POS) Point of Sale. If criteria is met a PA is setup automatically.

Arkansas Innovative Performance Program for Nursing Homes

The Arkansas Innovative Performance Program offers extensive quality improvement assistance to Arkansas' Medicaid certified nursing homes through on-site facility consultation and training.

Medicaid Infrastructure Grant (MIG)

In State Fiscal Year 2005, the Centers for Medicare and Medicaid Services (CMS) awarded Arkansas a Medicaid Infrastructure Grant (MIG) with which the State will work to expand and improve the Medicaid Buy-in program known as Working Disabled.

Past Successes

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

TEFRA Waiver

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

Non-Emergency Transportation Services

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

Independent Choices

Waiver program that allows recipients to make decisions regarding their personal care by offering a cash allowance and counseling service

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

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

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 (Under Age 21)
- ❖ Certified Registered Nurse Anesthetist (CRNA)
- ❖ Child Health Management Services (CHMS) (Under Age 21)
- ❖ Chiropractic Services
- ❖ DDS Alternative Community Services Waiver
- ❖ Dental Services (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 (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 (Under Age 21)
- ❖ School-Based Mental Health Services (Under Age 21)
- ❖ Targeted Case Management for Pregnant Women
- ❖ Targeted Case Management Beneficiaries Age 60 and Older
- ❖ Targeted Case Management for Beneficiaries of Children's Services (Under 21)
- ❖ Targeted Case Management for Beneficiaries of Children's Services who are SSI Beneficiaries or TEFRA Waiver Beneficiaries (Under Age 16)
- ❖ Targeted Case Management for Beneficiaries in the Division of Children and Family Services (Under Age 21)
- ❖ Targeted Case Management for Beneficiaries in the Division of Youth Services (Under Age 21)
- ❖ Targeted Case Management for Beneficiaries Age 21 and under with a Developmental Disability
- ❖ Targeted Case Management for Beneficiaries Age 22 and over with a Developmental Disability
- ❖ Targeted Case Management Services for other Beneficiaries Under Age 21
- ❖ Transportation Services (Ambulance, Non-Emergency)
- ❖ Ventilator Equipment
- ❖ Visual Services

Arkansas Medicaid Services

Major Benefit Limitations on Services for Adults (age 21 and older):

- Twelve visits to hospital outpatient departments allowed per state fiscal year.
- A total of twelve office visits allowed per state fiscal year for any combination of the following: certified nurse midwife, physician, medical services provided by a dentist, medical services furnished by an optometrist, and Rural Health Clinics.
- One basic family planning visit and three (3) periodic family planning visits per state fiscal year. Family planning visits are not counted toward other service limitations.
- Lab and x-ray services limited to total benefit payment of \$500 per state fiscal year, except for EPSDT beneficiaries.
- Three pharmaceutical prescriptions, including refills, allowed per month (family planning prescriptions are not counted against benefit limit; unlimited prescriptions for nursing facility beneficiaries and EPSDT beneficiaries under age 21). Extensions will be considered up to a maximum of six (6) prescriptions per month for beneficiaries at risk of institutionalization. Beneficiaries receiving services through the Independent Choices waiver may receive up to nine (9) medically necessary prescriptions per month.
- Inpatient hospital days limited to 24 per state fiscal year, except for EPSDT beneficiaries and certain organ transplant patients.
- Co-insurance: Some beneficiaries must pay 10% of first Medicaid covered day of hospital stay.
- Beneficiaries in the Working Disabled aid category must pay 25% of the charges for the first Medicaid covered day of inpatient hospital services and must also pay co-insurance for some additional services.
- Some beneficiaries must pay \$.50 - \$3 of every prescription, and \$2 on the dispensing fee for prescription services for eyeglasses. Beneficiaries 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.

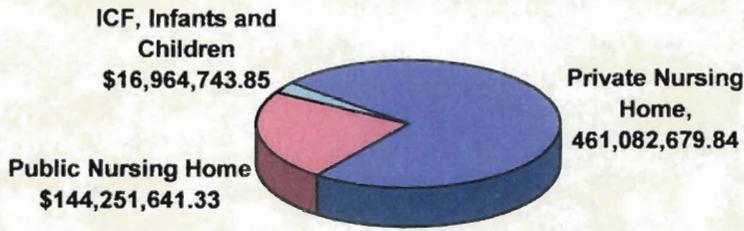
Additional Information for children's Services:

- Some children are responsible for coinsurance, co-payments, or premiums.
- Co-insurance: Arkids B beneficiaries must pay 20% of the charges for the first Medicaid covered day of inpatient hospital services and must also pay co-insurance for some outpatient services.
- Co-Pay: Arkids B beneficiaries must pay a higher co-payment for these services and also must pay co-payments for some outpatient services.
- Premiums: Based on family income certain TEFRA beneficiaries must pay a premium.

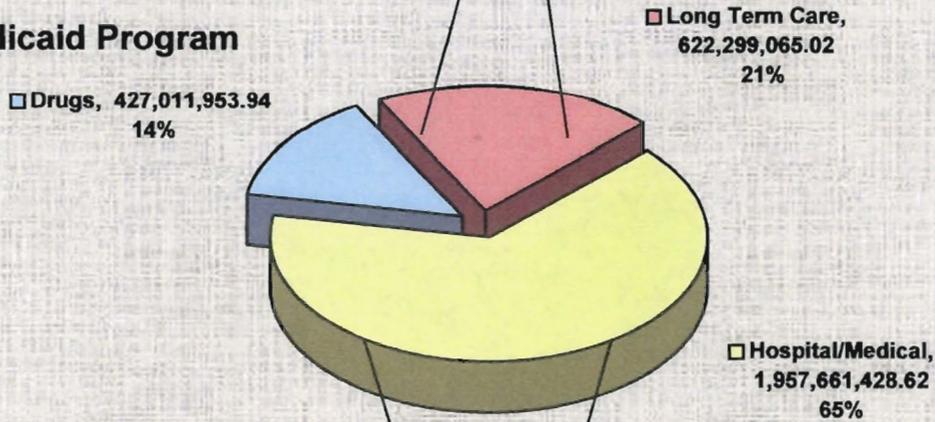
Any and all exceptions to benefit limits are based on medical necessity.

Arkansas Medicaid Program Benefit Expenditures SFY05

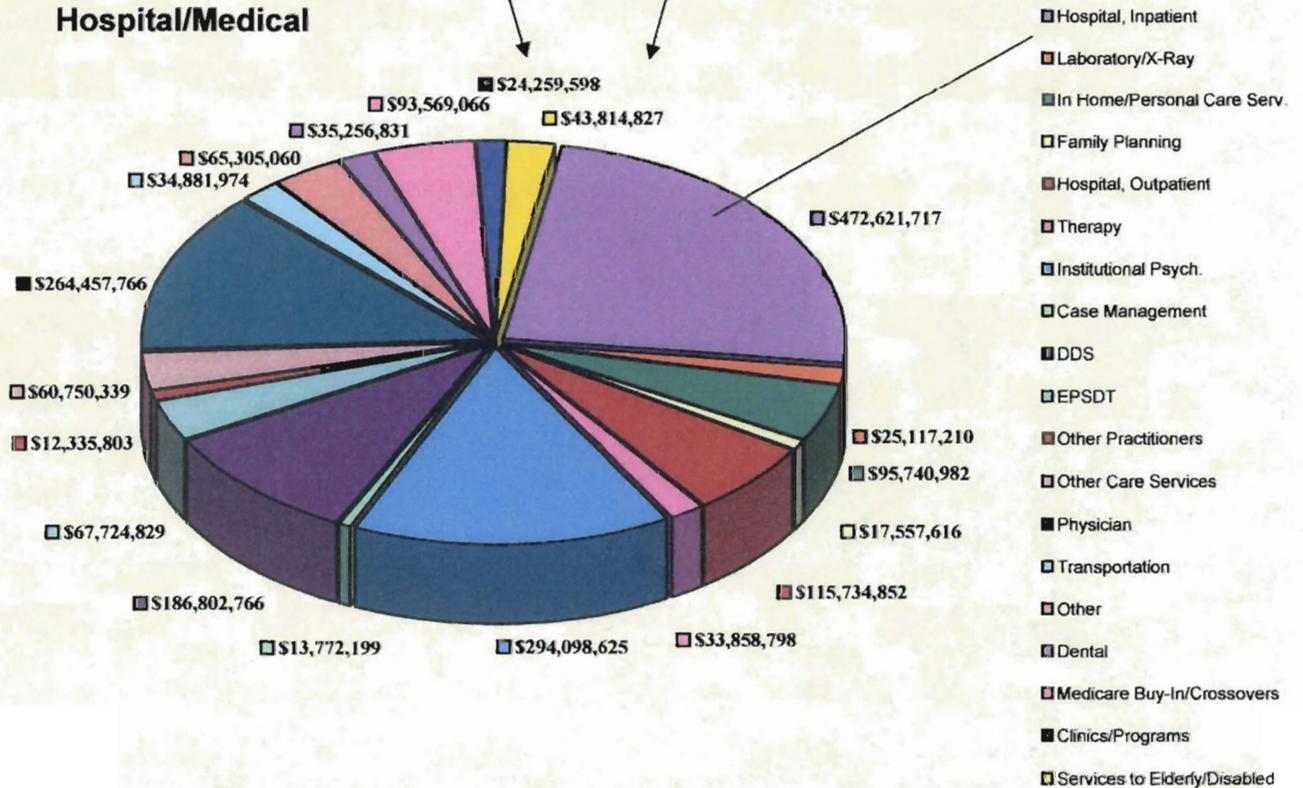
Long Term Care



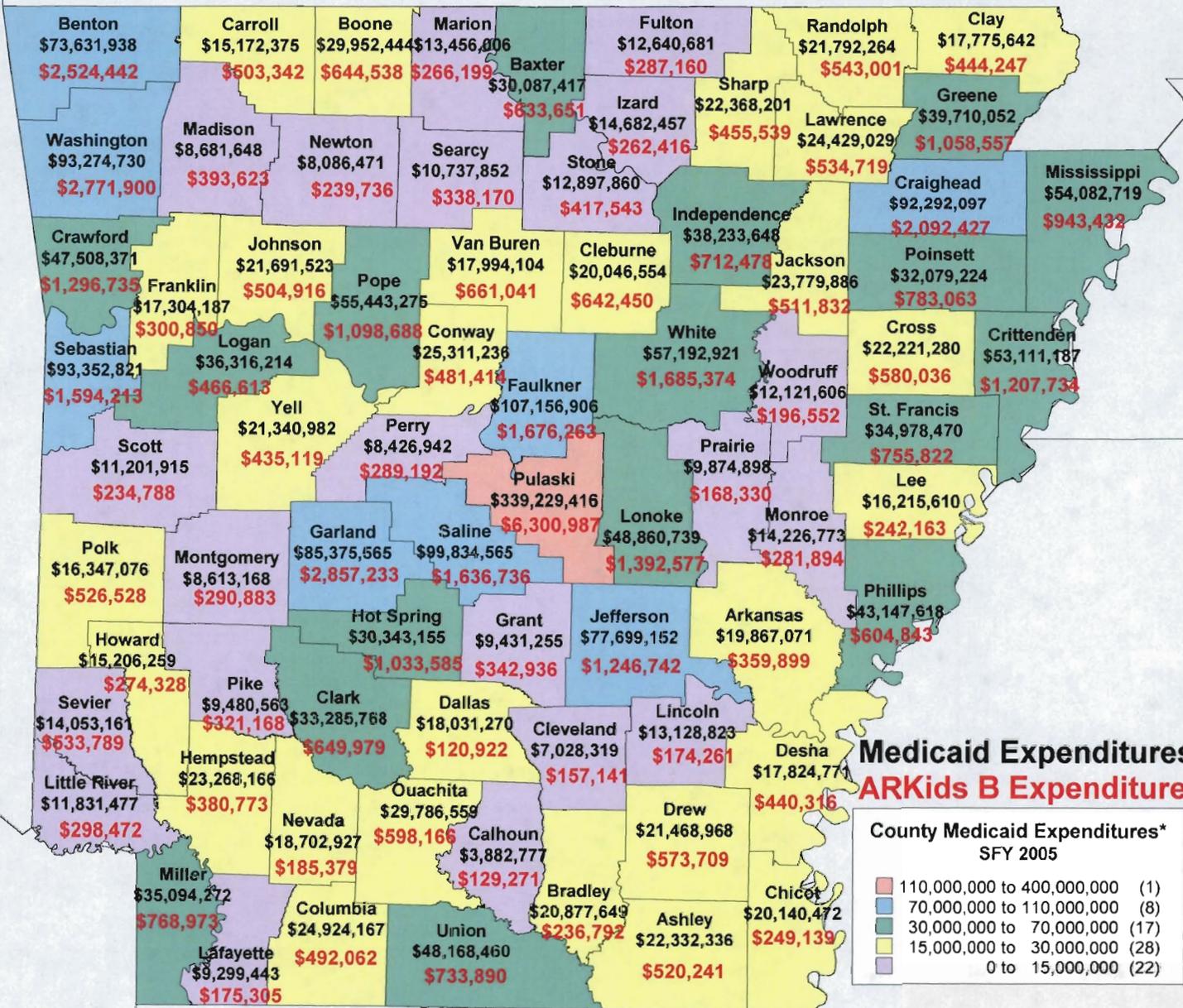
Total Medicaid Program



Hospital/Medical



Adjusted Paid Claims By County SFY 2005



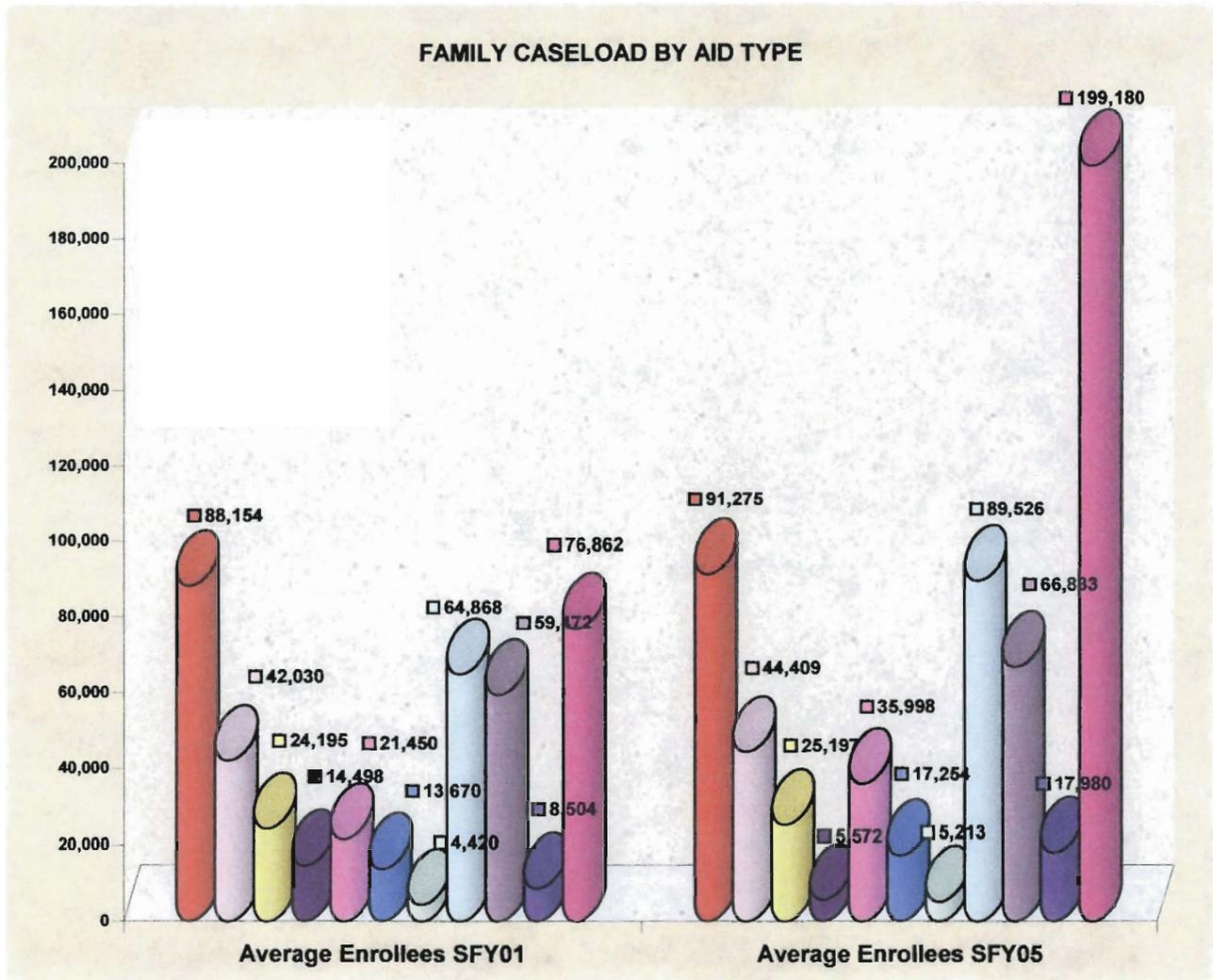
Medicaid Expenditures*
ARKids B Expenditures*

County Medicaid Expenditures*
SFY 2005

- 110,000,000 to 400,000,000 (1)
- 70,000,000 to 110,000,000 (8)
- 30,000,000 to 70,000,000 (17)
- 15,000,000 to 30,000,000 (28)
- 0 to 15,000,000 (22)

Source: DHHS; Division of Medical Services
Medicaid Decision Support System
*Doesn't include cost settlements

MEDICAID ENROLLEES

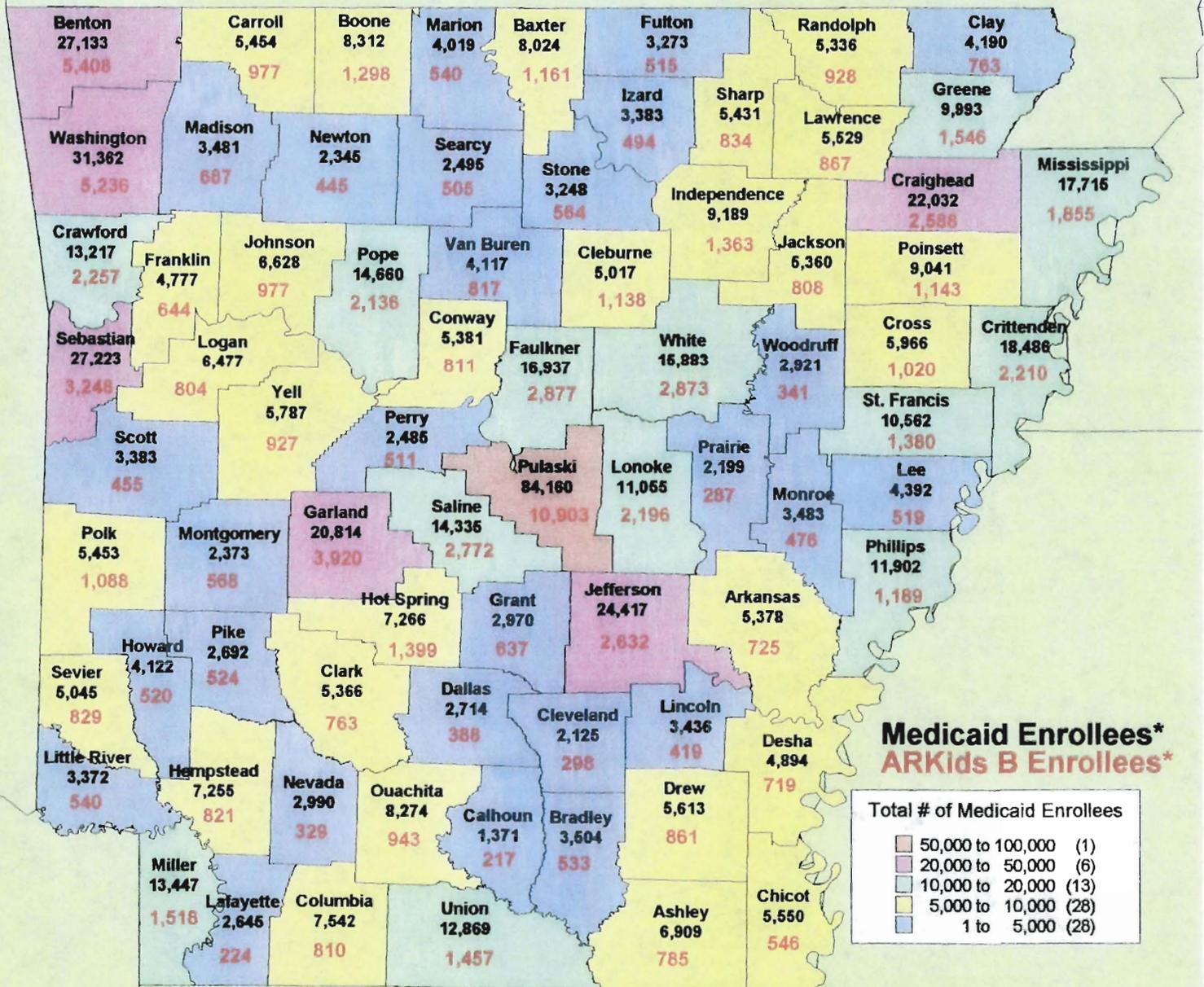


Aid Categories

- SSI Supplemental Security Income
- 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 B ARkids Group
- PW Adults Pregnant Women
- PW Children Infants and Children

There were an average of .33 enrolled refugees per month in SFY01 and 2.6 per month in SFY05.

Enrollees By County SFY 2005



Medicaid Enrollees*
ARKids B Enrollees*

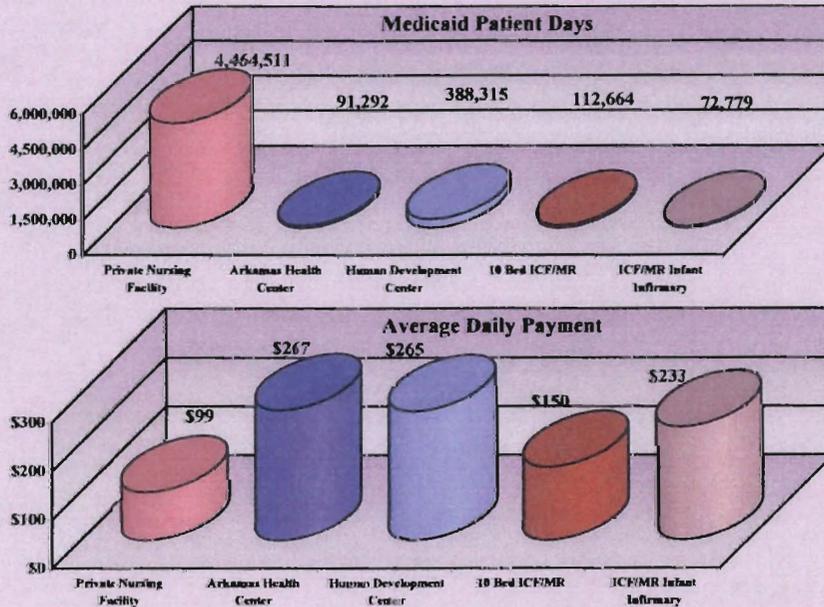
Total # of Medicaid Enrollees

50,000 to 100,000	(1)
20,000 to 50,000	(6)
10,000 to 20,000	(13)
5,000 to 10,000	(28)
1 to 5,000	(28)

Source: DHS; Division of Medical Services;
Medicaid Decision Support System
*Unduplicated Count for the State Fiscal Year

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 reviews of Medicaid providers to ensure compliance with federal and state regulations and policy. The Field Audit Unit conducts research and initiates recoupment of possible fraudulent billing practices. Staff of the Field Audit Unit during the State Fiscal year 2005 monitored and conducted surveys of Non-Emergency Transportation Brokers. In state fiscal year 2005, the Field Audit Unit also processed 1,597 TEFRA applications. The goal of the Unit is to verify the nature and extent of services paid by the Medicaid program while ensuring quality medical care for recipients and protecting the integrity of both state and federal funds. During the state fiscal year 2005, the Field Audit Unit identified \$113,419.73 in provider overpayments. \$6,821,838.88 was identified in Peer Review Organization (PRO). Field Audit collected \$170,330.20 in provider overpayments, Peer Review Organization (PRO) collection was \$6,866,780.12. The Field Audit Unit conducted 147 on-site/in-house reviews for this time period, of those reviews 61 were non-emergency transportation reviews.

PHARMACY:

In SFY05 the Arkansas Medicaid Pharmacy Unit managed a \$427 million prescription drug program. Over 800 pharmacy providers were reimbursed for more than 6.9 million prescriptions provided to Medicaid recipients. Additionally, the Pharmacy Program oversees the collection of drug rebates from pharmaceutical manufacturers. Collections in SFY05 totaled \$96,774,625.

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 2005 (SFY 2005), there were more than 24,600 enrolled providers in the above programs. More than 8,600 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 2005, 72,621 telephone inquiries were handled in all Assistance Sections including the Early Periodic, Screening, Diagnosis and Treatment (EPSDT) program and other Medical Assistance Units with over 21,600 of those inquiries being handled by the Program Communications Unit. The ARKids Program for Arkansas children has become a model for similar programs in other states. Other areas administered by the Medical Assistance Section are the Dental and Visual programs.

	<u>SFY 2005</u>	<u>SFY 2004</u>	<u>SFY 2003</u>	<u>SFY 2002</u>
Telephone Inquiries	72,621	86,937	93,917	80,914
Written Correspondence	3,754	3,737	3,671	3,021
Recipient Denial Letters	129	129	139	129
Fair Hearings	355	358	322	315

UTILIZATION REVIEW:

The purposes of the Utilization Review section are to identify possible fraud or abuse, to monitor the quality of services delivered and to pre-authorize the necessary medical service. This section assures that both quality and efficient care are provided to the Medicaid clients through qualified providers. Utilization Review accomplishes its purpose through staff efforts directed in the following areas:

1. Pre-pay and Post-Payment reviews of medical services.
2. Prior authorization for Durable Medical Equipment (DME), Private Duty Nursing, Hyperalimentation, Hearing Aid Repairs, Out of State Emergencies and Extensions for Home Health, Personal Care for over 21 years of age.
3. Monitor contractors that perform prior authorizations and extension of benefits for quality assurance reviews for the following programs: In-patient Psych, In-patient and Out-patient Hospital, Primary Care Physician, Targeted Case Management, Therapy, RSPMI, Out Patient Mental Health Services, Child Health Management Services Personal Care Under-21 and Organ Transplants.
4. Review requests for extension of benefits for Out Patient Visits, Office Visits, Lab & X-ray, Speech & Physical for Under 21, Psychiatric Pharmacologic Management, Medical Supplies, Personal Care Over-21, Home Health and Diapers. In Jan 2005 these services were contracted: Out Patient Visits, Office Visits, Lab & X-ray, Speech & Physical for Under 21.
5. Arrange out-of-state transportation for recipients and their companions to receive medical service not available in-state.

The Utilization Review Section is continually seeking new methods to eliminate waste and unnecessary services from the Medicaid program while assuring that the quality of care provided is equal to that of privately insured Arkansans.

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 2005 were \$10,539,912.71. The amount cost avoided for State Fiscal Year 2005 was \$13,484,356.28. Grand total savings for SFY05 were \$24,024,268.99.

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 (RFPs) & Advance Planning Documents (APDs) 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
- * Approve production system modifications to MMIS
- * Performs quality assurance reviews on all edits and audits affecting claims processed by the MMIS

REIMBURSEMENT:

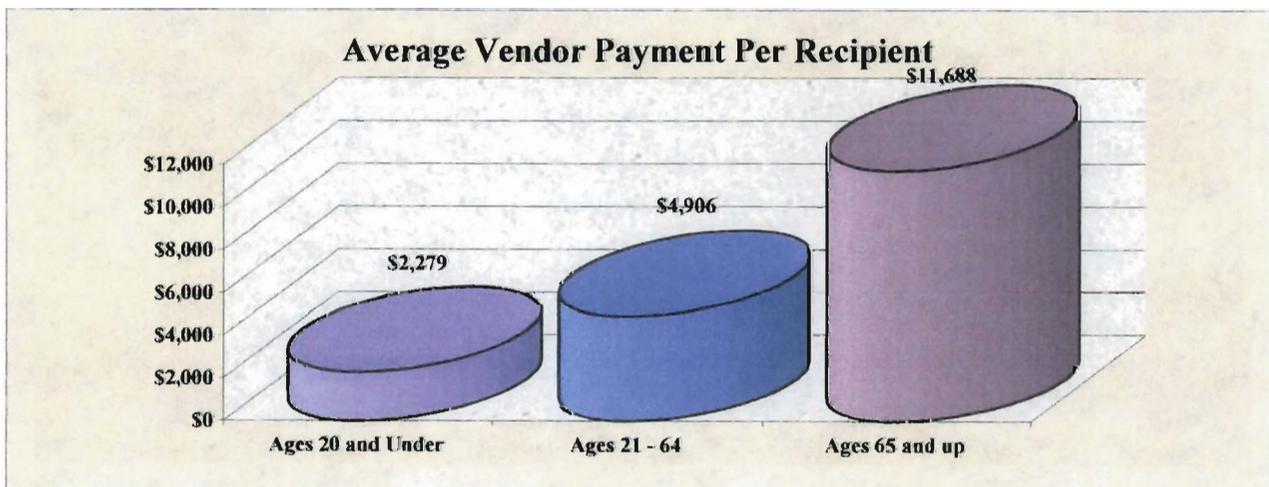
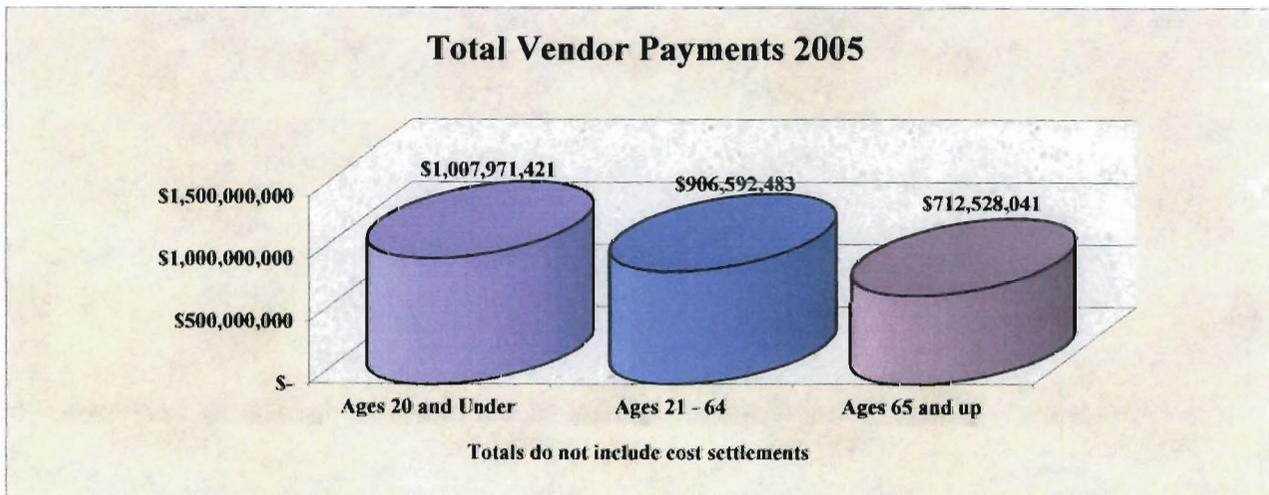
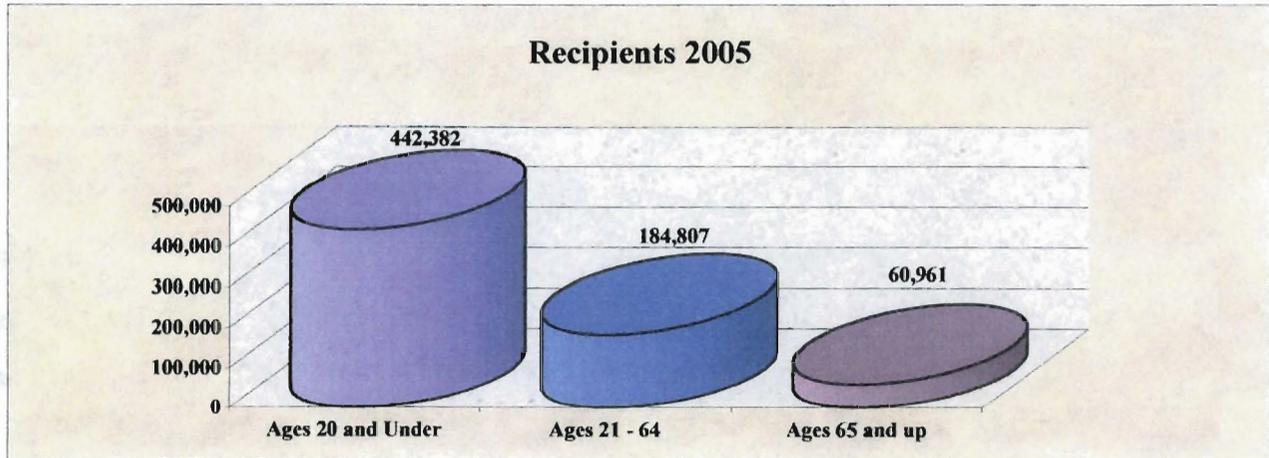
Provider Reimbursement develops reimbursement methodologies, identifies budget impacts for changes in reimbursement methodologies, develops reimbursement rates, coordinates payments with the Medicaid Fiscal Agent and provides reimbursement technical assistance for the following Medicaid providers:

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

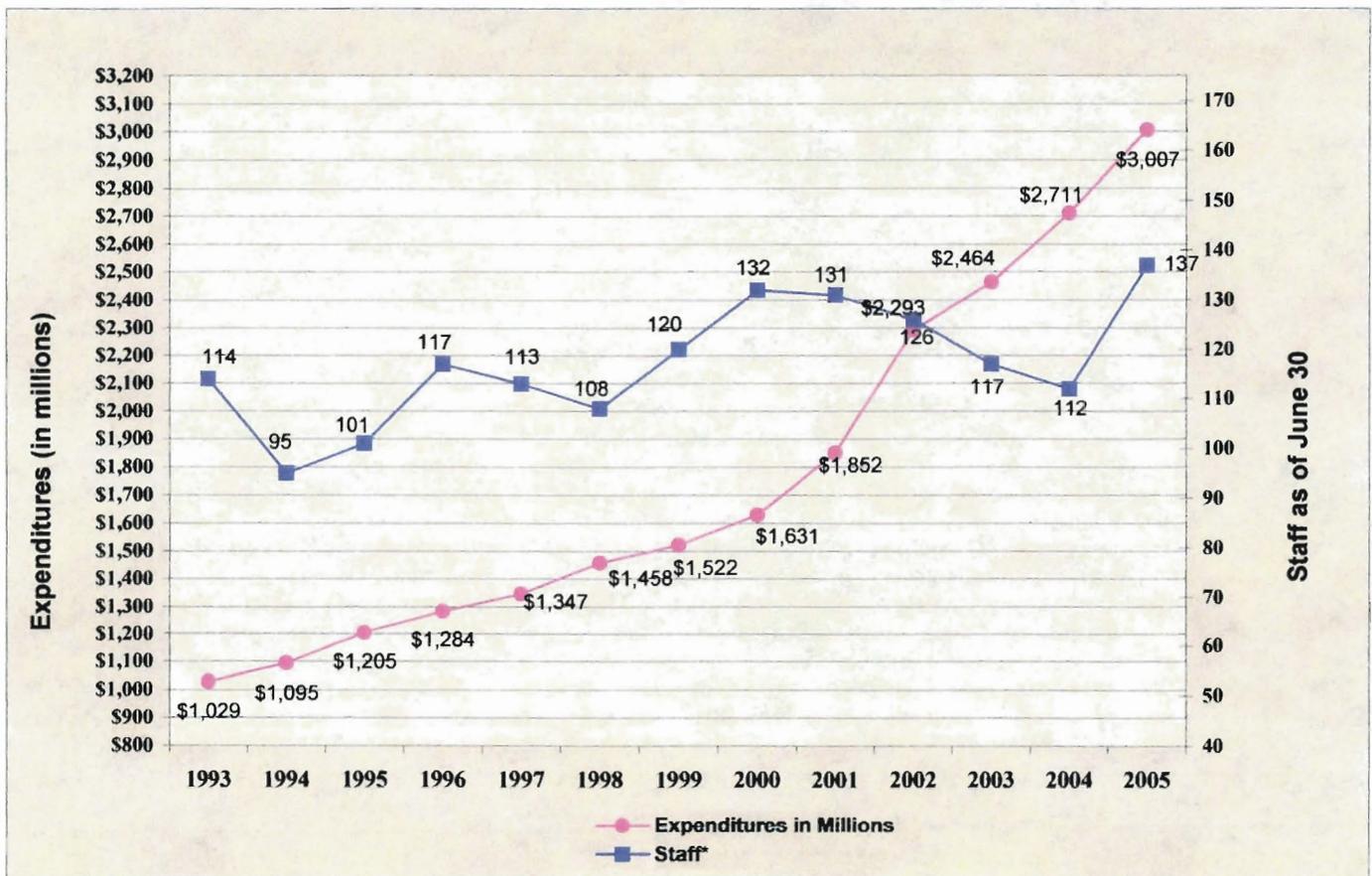
Non-Institutional – Physician, Dental, Durable Medical Equipment, ARKids, Nurse Practitioner, Nurse Midwife, CHMS, DDTCS, RSPMI, Other. The Non-Institutional Section is also responsible for the maintenance of reimbursement rates and assigning all billing codes for both institutional and non-institutional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

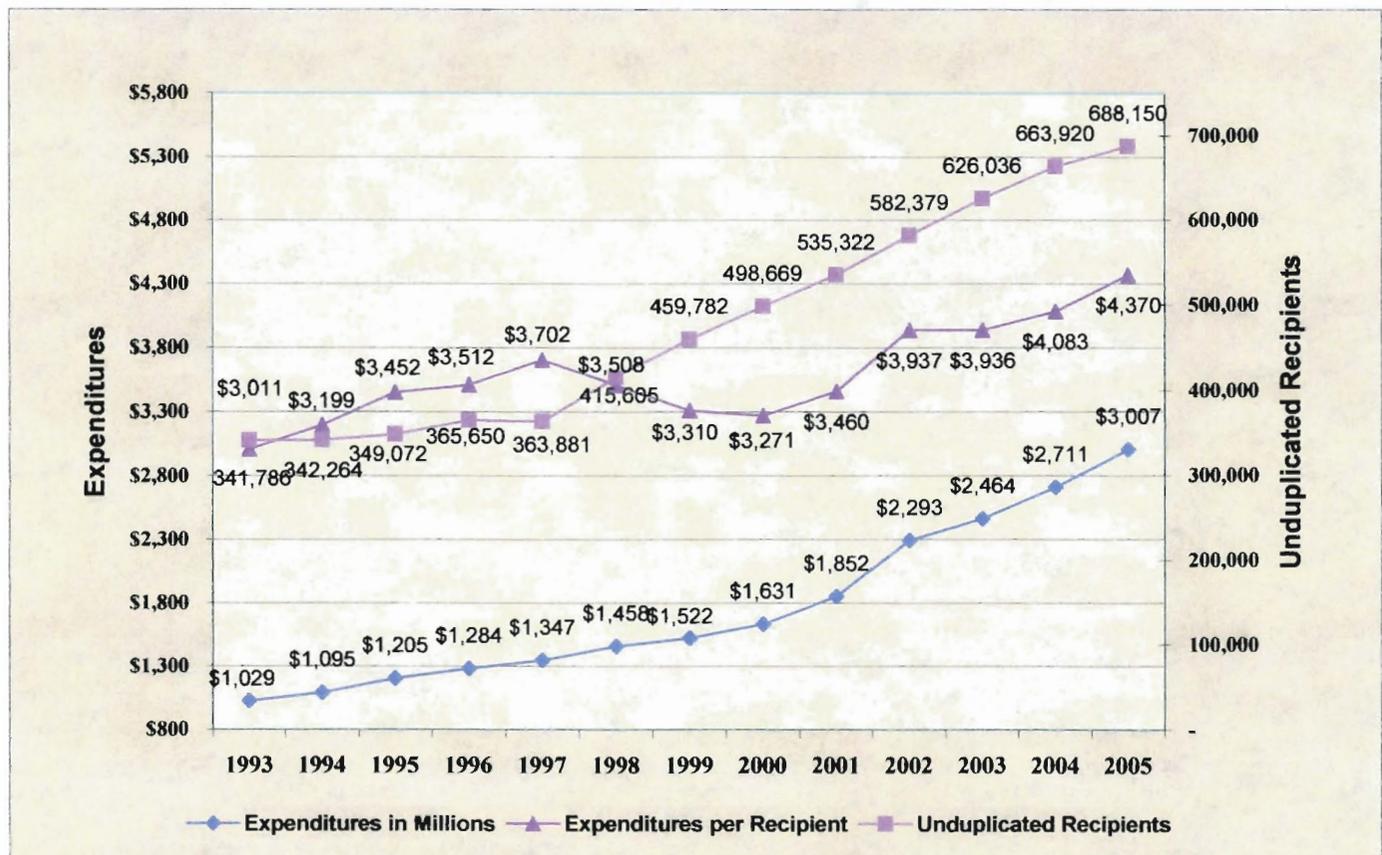
Unduplicated Recipient Counts and Vendor Payments by Age SFY05



MEDICAID STAFFING COMPARED TO EXPENDITURES



MEDICAID UNDUPLICATED RECIPIENTS COMPARED TO EXPENDITURES



Source: HCFA2082; Medicaid Budget Reports

*Staff detail in above Chart includes Office of LTC Staff

DHHS; Division of Medical Services