



*Arkansas Department of Human Services
Division of Medical Services*

Program Overview State Fiscal Year 2007



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MEDICAID PROGRAM OVERVIEW

Medicaid is a joint federal-state program of medical assistance for eligible individuals based on financial need and/or health status.

LEGAL STRUCTURE AND HISTORY

Title XIX of the Social Security Act created grant programs popularly called “Medicaid” in 1965.

Medicaid furnishes **medical assistance** to those who have insufficient incomes and resources to meet the costs of necessary medical services.

Medicaid provides **rehabilitation and other services** to help families and individuals become or remain independent and able to care for themselves.

Section 7 of Arkansas Act 280 (1939) and Act 416 (1977) authorized the State of Arkansas to establish and maintain a medical care program for the indigent and vested responsibility for regulating and administering the program in the **Department of Health and Human Services DHHS**.

ADMINISTRATION

Arkansas Medicaid was implemented on January 1, 1970.

- DHHS 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

Non-SSI individuals are certified as eligible for Medicaid Services by **DHHS Field Staff** located in **County Offices**, SSI individuals are deemed Medicaid eligible 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 25.98% of Arkansas Medicaid **Program-related Costs**; the federal government funds approximately 74.02%. 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.
- **Waiver and Demonstration Services** are CMS approved services that are not optional or mandatory and/or can be targeted to specific populations.

ARKANSAS MEDICAID

Program Costs

State Fiscal Year (SFY)	Total (in mill)	Unduplicated Recipients	Average Cost
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	\$3,007	688,150	\$4,370
2006	\$3,137	729,800	\$4,298
2007	\$3,299	742,965	\$4,440
2008 (proj)	\$3,687	786,506	\$4,688

Arkansas Economics SFY07

		Medicaid Represents
Personal Healthcare Expenditures in AR	\$16.7 billion	18.6%
State of Arkansas Budget	\$20.0 billion	16.5%
State General Revenue Funded Budget	\$4.0 billion	13.7%

Arkansas Population*		% population served by Medicaid
All Ages	2,810,872	26%
Elderly	390,421	16%
Adult (20 - 64)	1,654,016	12%
Children (19 and under)	766,435	64%

*Source: Economic Analysis and Tax Research, DFA



Average Cost per prescription in SFY07 was approximately \$66.00



71.71% of all Nursing Home residents in SFY06 were Medicaid Eligible

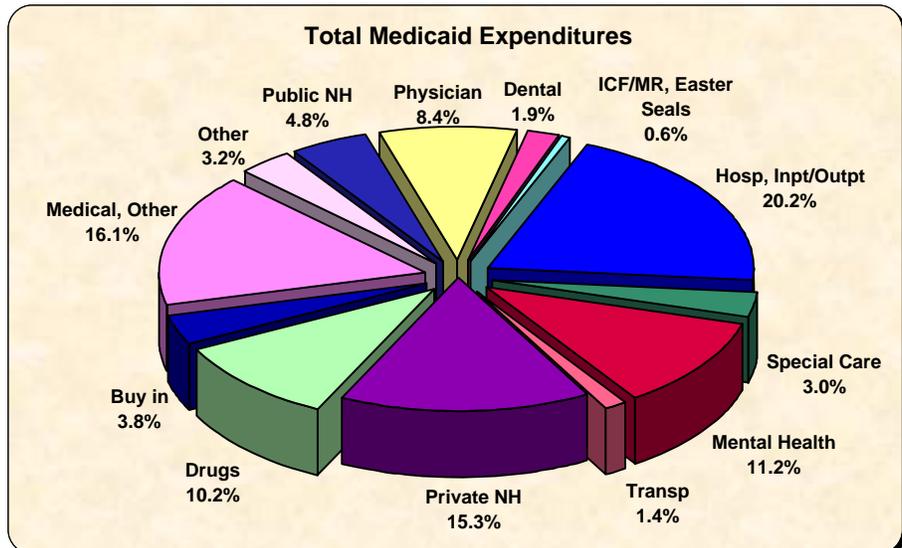


Provider Communications handled approximately 144,040 telephone inquiries in SFY07

SFY08 Medicaid Operating Budget

(millions)

General Revenue	\$668.5
Other Revenue	\$171.1
Quality Assurance Fee	\$64.3
Trust Fund	\$123.4
Federal Revenue	\$2,659.7
Total Program	\$3,687.0



- 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.



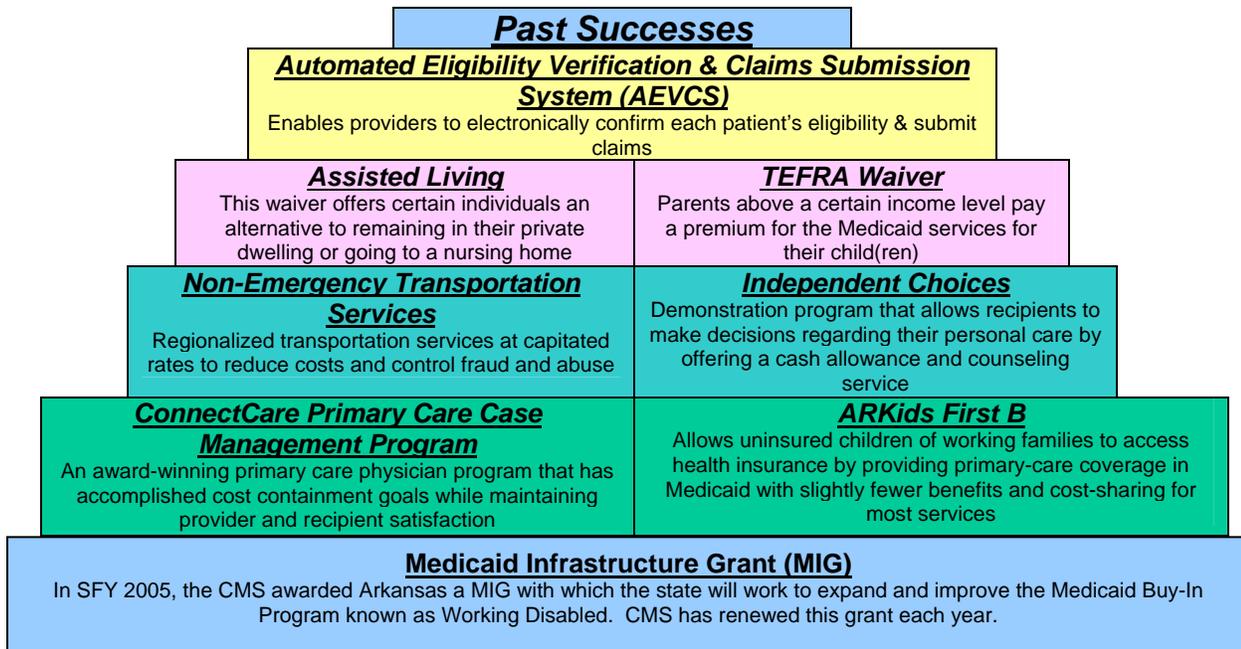
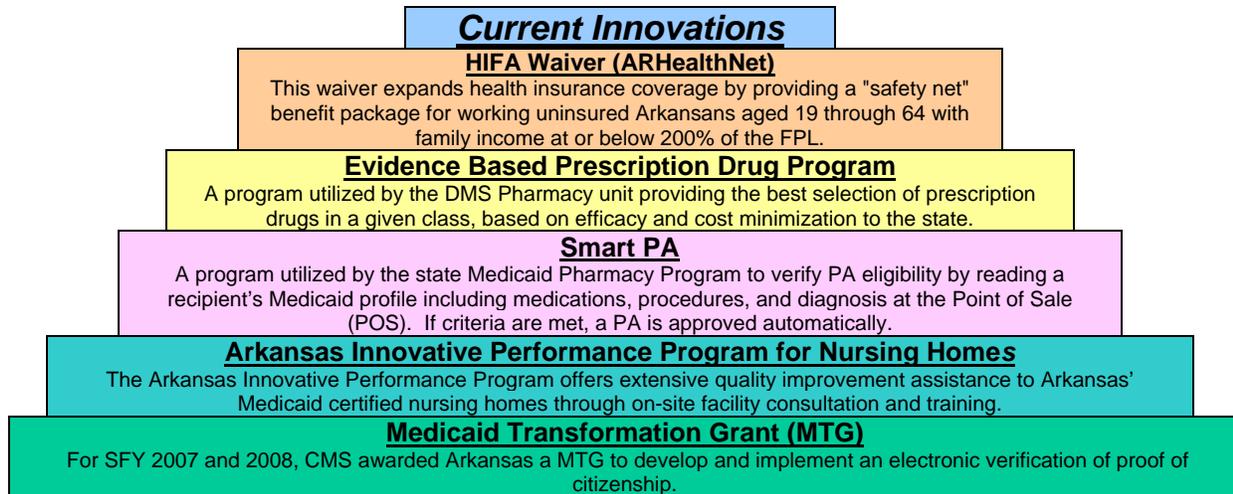
The medical cost for 62% of all babies born to Arkansas residents is paid for by Medicaid

Medicaid has approx. 27,300 actively ENROLLED providers, approx. 12,300 (45%) are PARTICIPATING Providers



31,634,693 claims were processed in SFY07 with an average processing time of 2.1 days.

Arkansas Medicaid (Continued)



Arkansas Medicaid Services

Services Mandated by Federal Government:

- ◆ Child Health Services (Early and Periodic Screening, Diagnosis and Treatment [EPSDT])
- ◆ 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

Approved Medicaid Waivers:

- Alternatives for Adults with Physical Disabilities
- AR HealthNet
- ARKids First-B
- Division of Developmental Disabilities Alternative Community Services
- ElderChoices
- IndependentChoices
- Living Choices Assisted Living
- Non-Emergency Transportation
- TEFRA
- Women's Health (Family Planning)

Optional Services Chosen by Arkansas:

- ❖ Ambulatory Surgical Center Services
- ❖ Audiological Services (Under Age 21)
- ❖ Certified Registered Nurse Anesthetist (CRNA)
- ❖ Child Health Management Services (CHMS) (Under Age 21)
- ❖ Chiropractic Services
- ❖ 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
- ❖ 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
- ❖ 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.

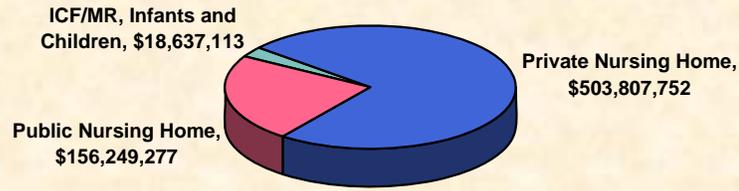
Additional Information for Children's Services:

- Some parents/guardians of 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.

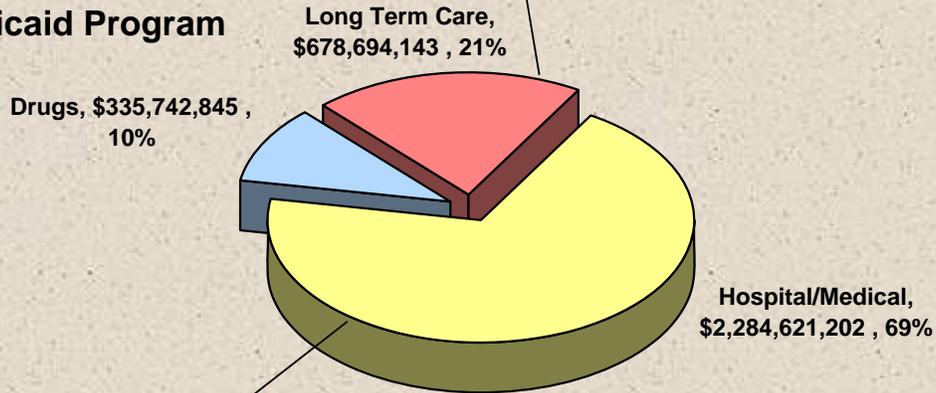
Any and all exceptions to benefit limits are based on medical necessity.

Arkansas Medicaid Program Benefit Expenditures SFY07

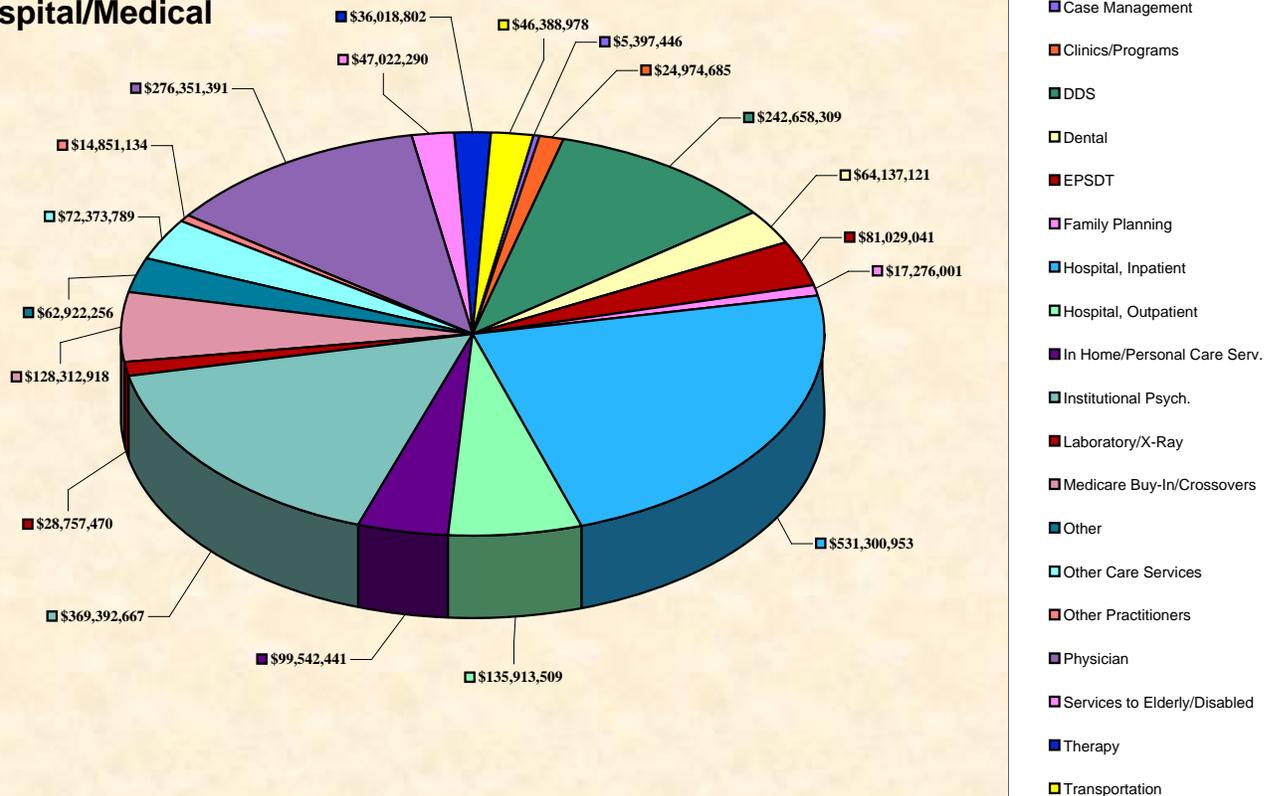
Long Term Care



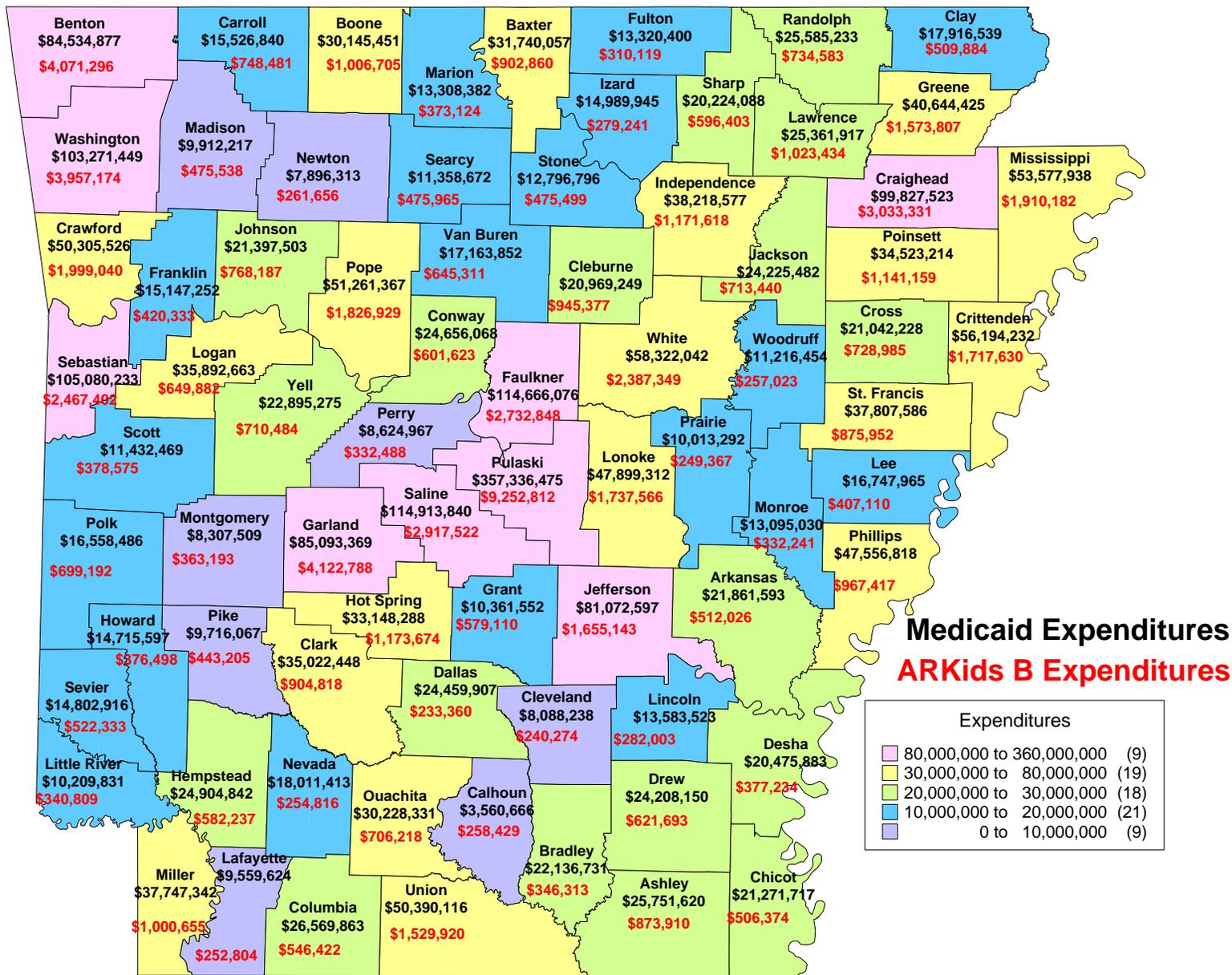
Total Medicaid Program



Hospital/Medical



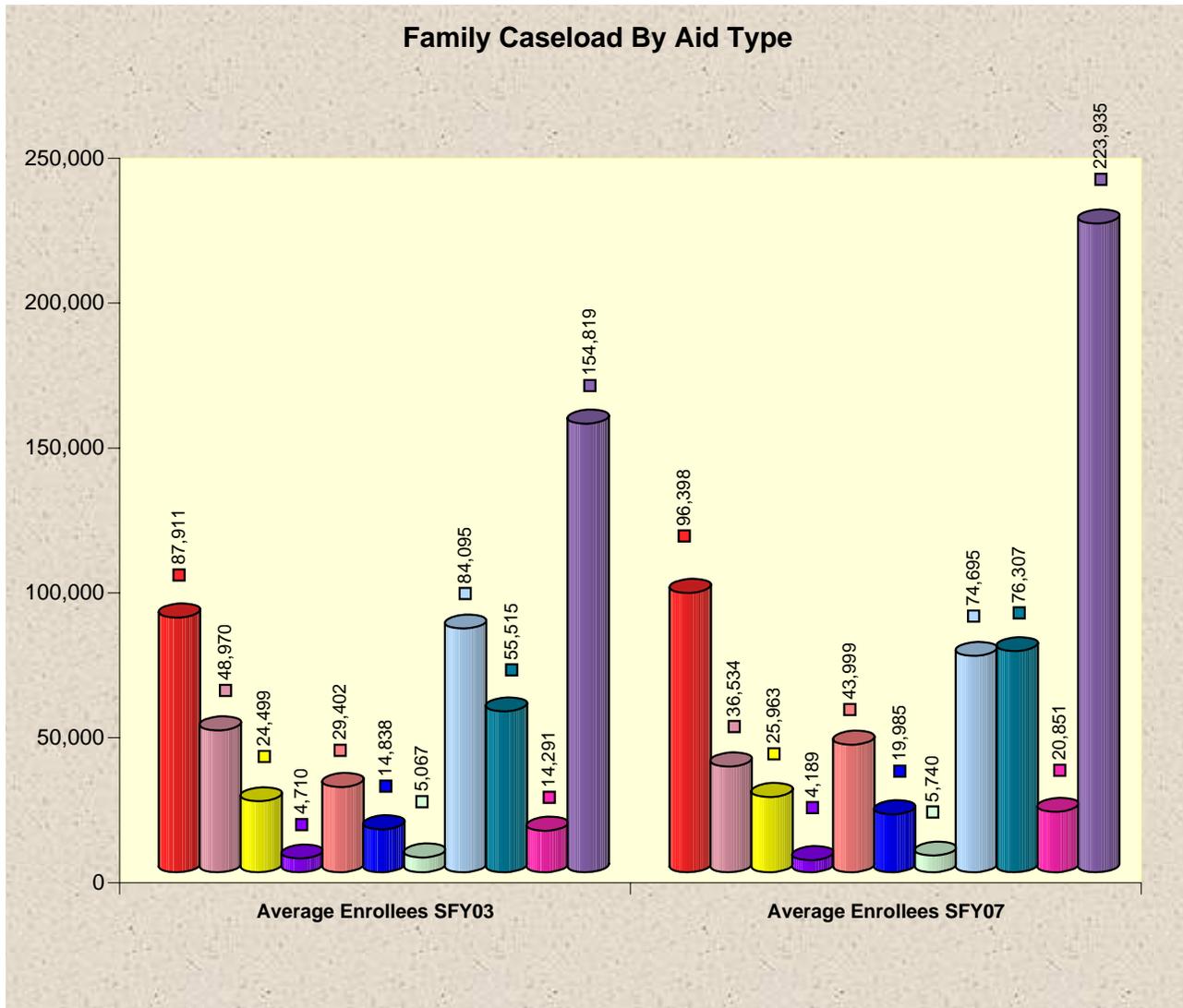
Expenditures by County SFY 2007



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

MEDICAID ENROLLEES

Family Caseload By Aid Type



Aid Categories

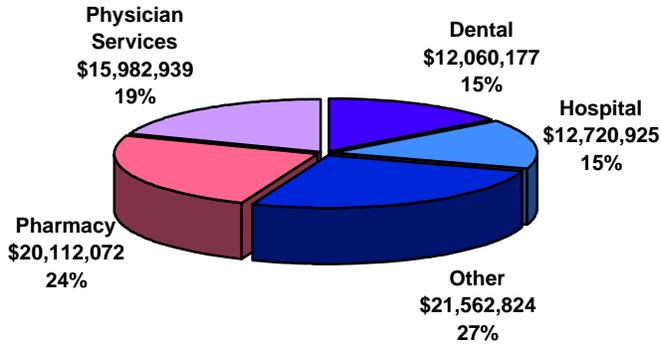
- SSI Supplemental Security Income
- AFDC Aid to Families with Dependent Children
- AABD Aid to the Aged, Blind and Disabled
- MN Medically Needy
- QMB Qualified Medicare Beneficiary
- U-18 Under Age 18
- FC Foster Care
- FP Family Planning
- ARKids B ARKids Group
- PW Adults Pregnant Women
- PW Children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

There was an average of 1 enrolled refugee per month in SFY03 and 0 per month in SFY07.

Source: Division of County Operations
Aces IM 2414

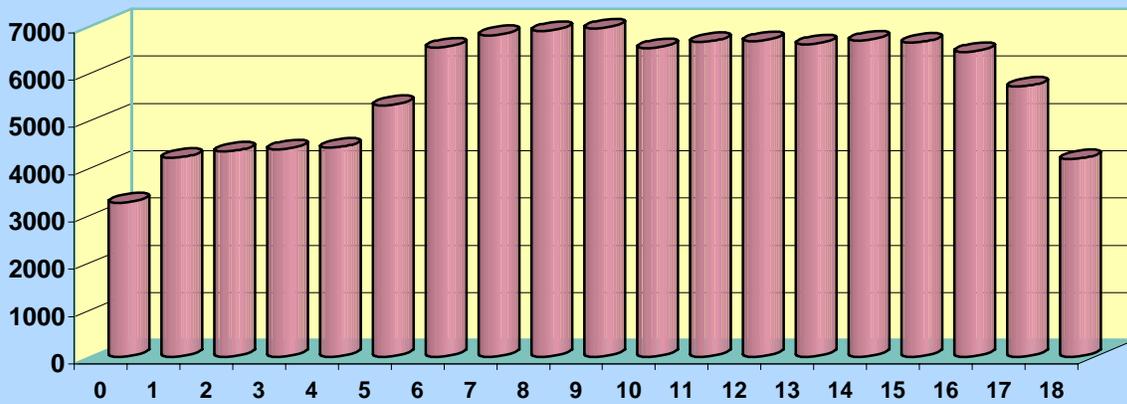
State of Arkansas SFY2007

Provider Types of Paid Claims

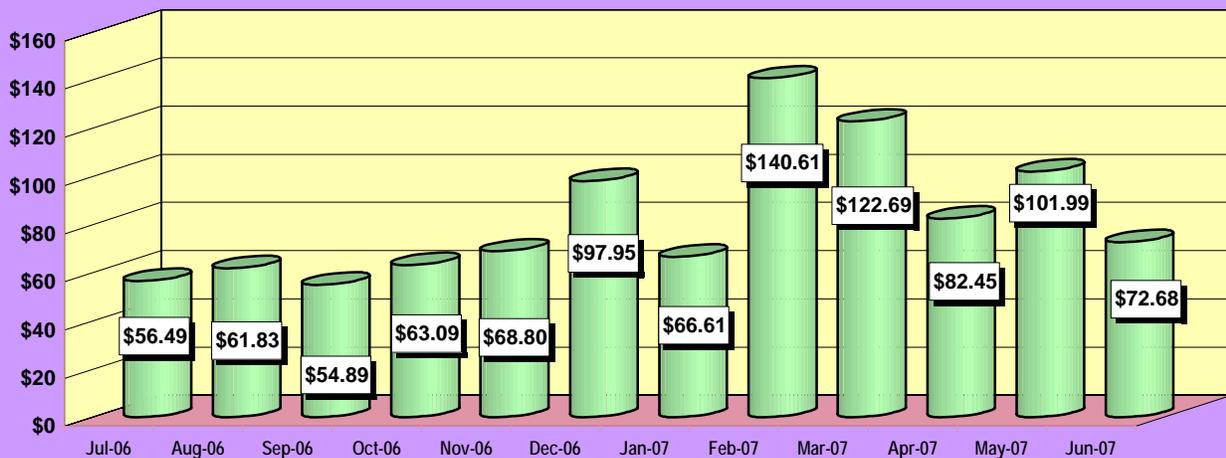


Median Age for
ARKids B Enrollees
in
Arkansas
was
11 years 9 months

Enrollees by Age for Arkansas

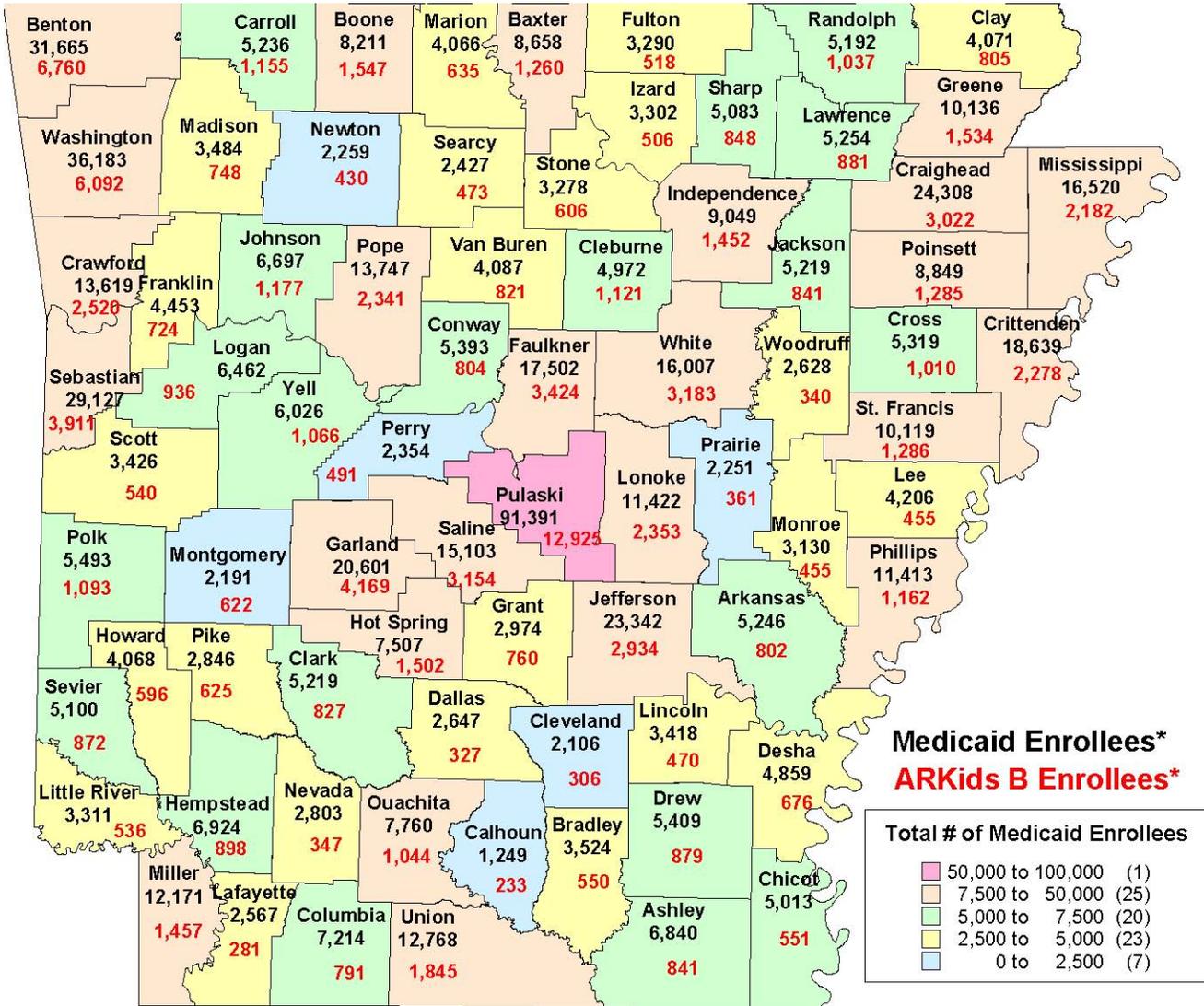


Monthly Expenditures per Enrollee for Arkansas



DSS Reports and Analysis

Enrollees by County SFY 2007

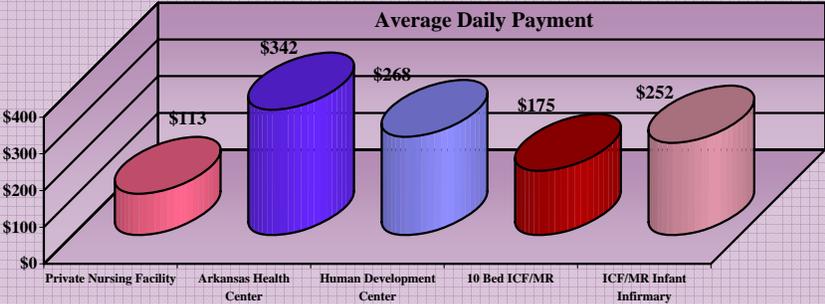
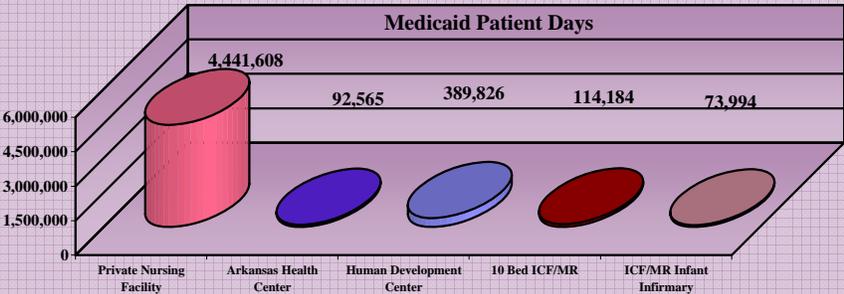


Source: DHS; Division of Medical Services
Medicaid Decision Support System

*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: DHHS Statistical Report

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 2007 (SFY 2007), there were more than 20,940 enrolled providers in the above programs. More than 9,300 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 2007, 71,462 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 12,000 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, Visual, Non-Emergency Transportation (NET), ARKids B and Ambulance programs.

	SFY 2007	SFY 2006	SFY 2005	SFY2004	SFY2003
Telephone					
Inquiries	71,462	68,727	72,621	86,937	93,917
Written					
Correspondence	1,989	3,020	3,754	3,737	3,671
Fair					
Hearings	356	341	355	358	322

PHARMACY

The Prescription Drug Program, which is an optional Medicaid benefit, was implemented in Arkansas in 1973. Under this program, eligible recipients may obtain prescription medication through any of the 876 enrolled pharmacies in the state. During SFY 2007, a total of 415,352 Medicaid recipients used their prescription drug benefits. A total of 4.5 million prescriptions were reimbursed by Arkansas Medicaid for a cost of \$299.4 million dollars thus making the average cost per prescription approximately \$66. An average cost for a brand name prescription was \$116 dollars, although representing 46% of the claims, it accounted for 79% of our expenditures. The average cost for a generic prescription was \$27 dollars, representing 54% of Arkansas' claims and accounting for 21% of Arkansas' expenditures.

The Prescription Drug Program restricts each recipient to a maximum of three prescriptions per month, with the capability of getting up to six prescriptions by PA, except for recipients under 21 and certified Long Term Care recipients who receive unlimited prescriptions per month. Beginning January 1, 2006, full benefit dual eligibles began receiving drug coverage through the Medicare Prescription Drug Benefit (Part D) of the Medicare Modernization Act of 2003 rather than through Arkansas Medicaid. Persons eligible under the Assisted Living Waiver are allowed up to nine prescriptions per month.

Medicaid reimbursement for prescription drugs is based on the cost plus a dispensing fee. Drug costs are established and based upon a pharmacy's Estimated Acquisition Cost (EAC), the federally established Generic Upper Limit (GUL), or the state established Upper Limit (SUL). Arkansas Medicaid has a dispensing fee of \$5.51 as established by the DMS and approved by the CMS. The EAC and dispensing fee are based on surveys that determine an average cost for dispensing a prescription and the average ingredient cost. In March of 2002, a differential fee of \$2.00 applied to generic prescriptions for which no upper limit exists.

PROGRAM PLANNING AND DEVELOPMENT

The Program Planning and Development (PPD) Section develops and maintains the State's Medicaid Plan and the State's Child Health Insurance Program Plan. This section writes separate provider policy manuals for each of the forty-five (45) 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 B.

PROGRAM INTEGRITY SECTION

The Program Integrity Section is responsible for performing on-site/in-house reviews of Medicaid providers to ensure compliance with federal and state regulations and policy. The goal of the Program Integrity Section is to verify the nature and the 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. To ensure the goal is met, the Program Integrity Section is comprised of three units:

- Field Audit
- Surveillance and Utilization Reviews (SURs)
- Payment Error Rate Measurement (PERM)

The PERM unit is responsible for coordinating and performing recipient eligibility in conjunction with the CMS contractor to determine the payment error rate in the Medicaid program.

During state fiscal year 2007, the Program Integrity Section conducted 119 on-site reviews identifying \$1,709,300 in provider overpayments and collected \$253,039 in provider overpayments. Program Integrity also sanctioned 4 providers which resulted in a cost avoidance of \$4,952,674.

REIMBURSEMENT

Provider Reimbursement develops reimbursement methodologies and rates, identifies budget impacts for changes in reimbursement methodologies, 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 annual and semi-annual cost reports submitted by Nursing Facility and Intermediate Care Facilities for the Mentally Retarded (ICFs/MR). 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.

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.

Systems & Support performs the following:

- * Develops all Request for Proposals (RFPs) and 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
- * Approves production system modifications to MMIS
- * Performs quality assurance reviews on all edits and audits affecting claims processed by the MMIS
- * Develops and produces reports from the Medicaid data warehouse

THIRD PARTY LIABILITY

The Medicaid Program is required by federal and state regulations to utilize all third party sources and to seek reimbursement for services that have been paid by Medicaid. "Third Party" is identified as an individual, institution, corporation or public or private agency that is liable for payment of all or part of the medical cost of injury, disease or disability of a Medicaid beneficiary.

Medicaid is considered a "payor of last resort". Third Party Liability identifies Medicaid beneficiary's who have other medical insurance or payment sources that must pay first. These payment sources include but are not limited to health insurance, liability insurance, court settlements and indemnity policies.

The Third Party Liability collections for State Fiscal Year 2007 were \$13,591,445.72 for Health and Casualty collections and \$14,772,749.53 for Cost Avoidance (Cost Avoided Insurance Claims). The Third Party Liability grand total savings to the Medicaid Program were \$28,364,195.25.

UTILIZATION REVIEW

The Utilization Review Section of the Division of Medical Services is responsible for monitoring the quality of medically necessary services delivered and protecting the integrity of both state and federal funds supporting the Medicaid Program. This section evaluates the medical necessity of delivered services assuring quality medically necessary health care is delivered by eligible providers to Medicaid beneficiaries.

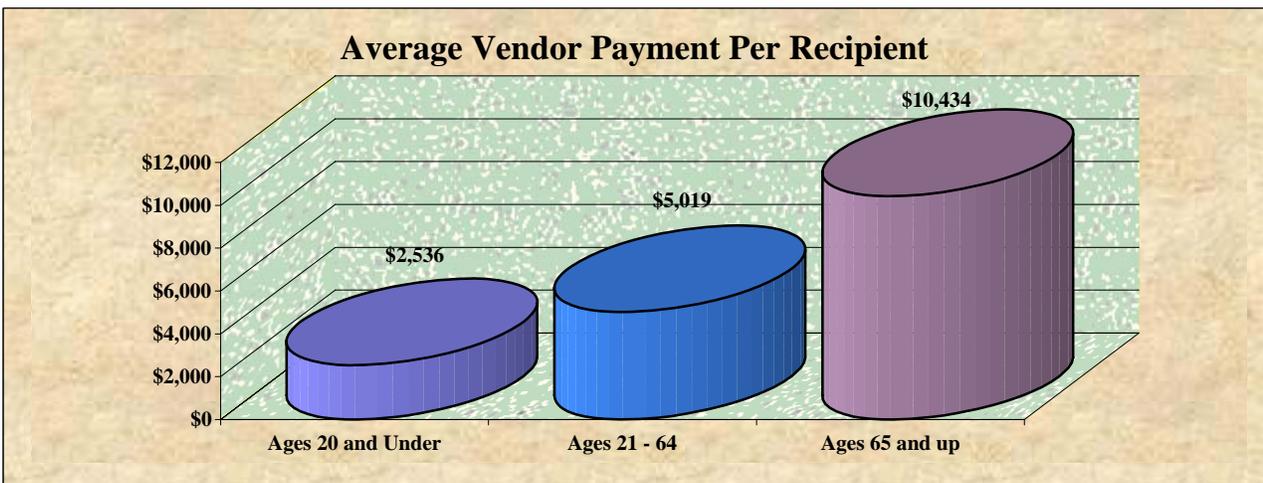
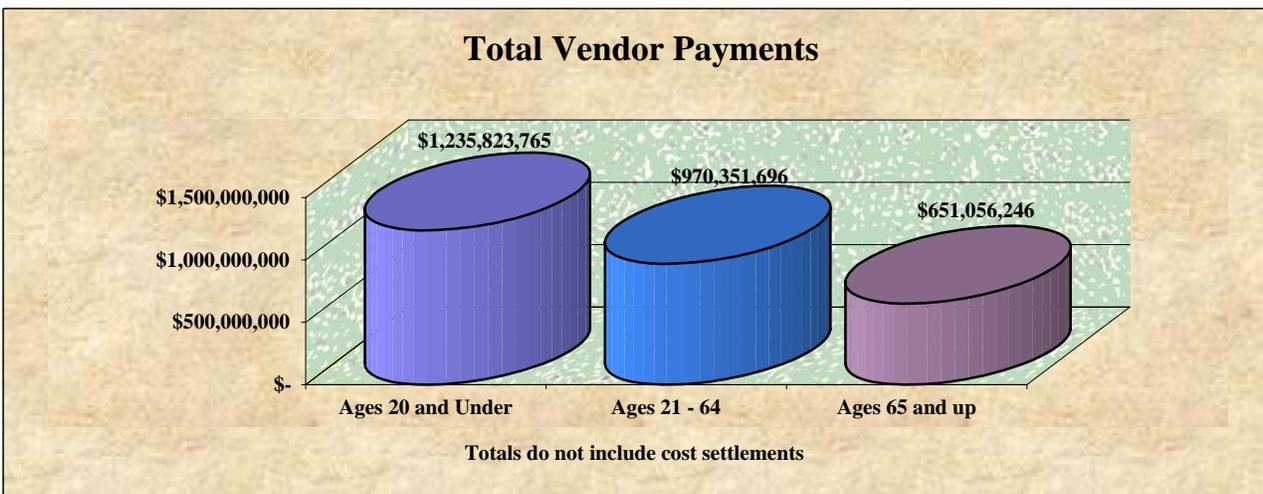
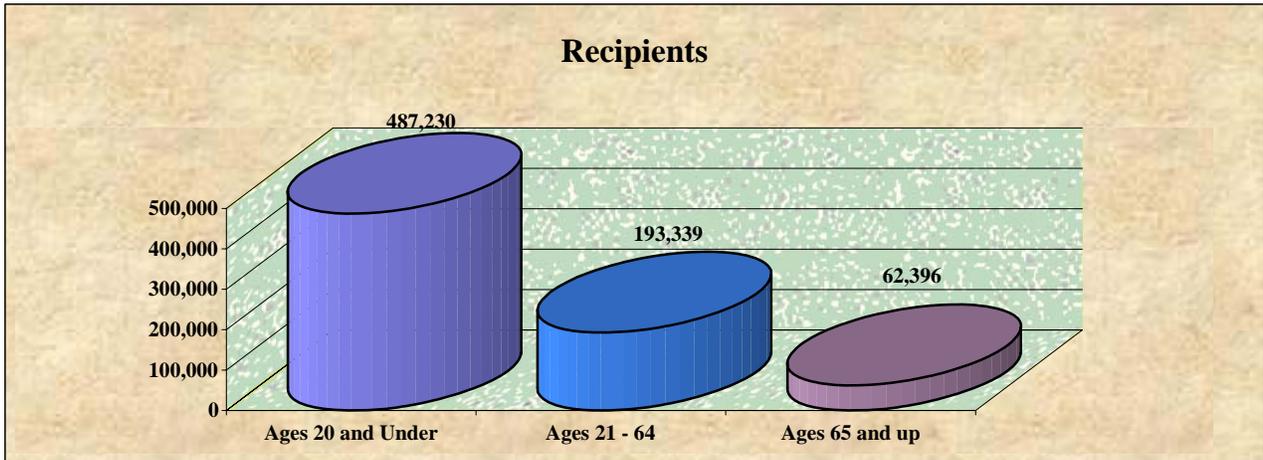
The Utilization Review Section is available to assist providers and beneficiaries regarding services. The Utilization Review Section is continually seeking new methods to eliminate waste and unnecessary services from the Medicaid program while assuring quality health care is provided to Arkansas Medicaid beneficiaries.

WAIVER QUALITY ASSURANCE UNIT

The DMS Waiver Quality Assurance (QA) Unit is responsible for monitoring operation of various Medicaid waiver and demonstration programs operated with approval from the Centers for Medicare and Medicaid Services (CMS). The Waiver QA Unit assures compliance with CMS requirements for operating the waivers and demonstrations. Activities include:

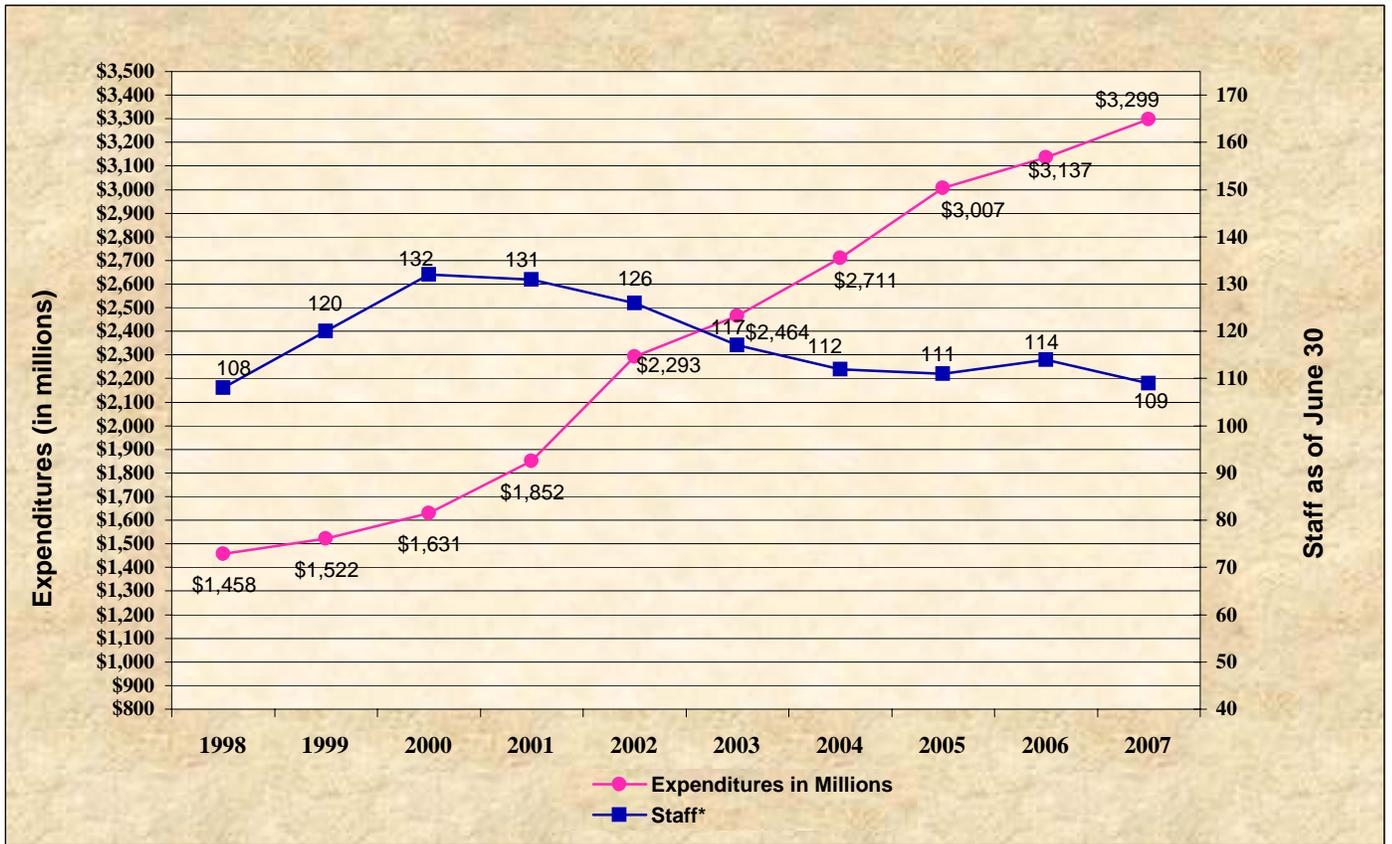
- Assisting operating agencies with development of new waivers and demonstrations
- Communicating and coordinating with CMS regarding waiver and demonstration activities and requirements
- Providing technical assistance to operating agencies regarding waiver and demonstration requirements and compliance
- Performing case reviews, data analysis, and oversight activities to help identify problems and assure remediation for compliance with CMS requirements
- Developing QA strategies and interagency agreements for the operation and administration of waivers and demonstrations.

Unduplicated Recipient Counts and Vendor Payments by Age SFY07

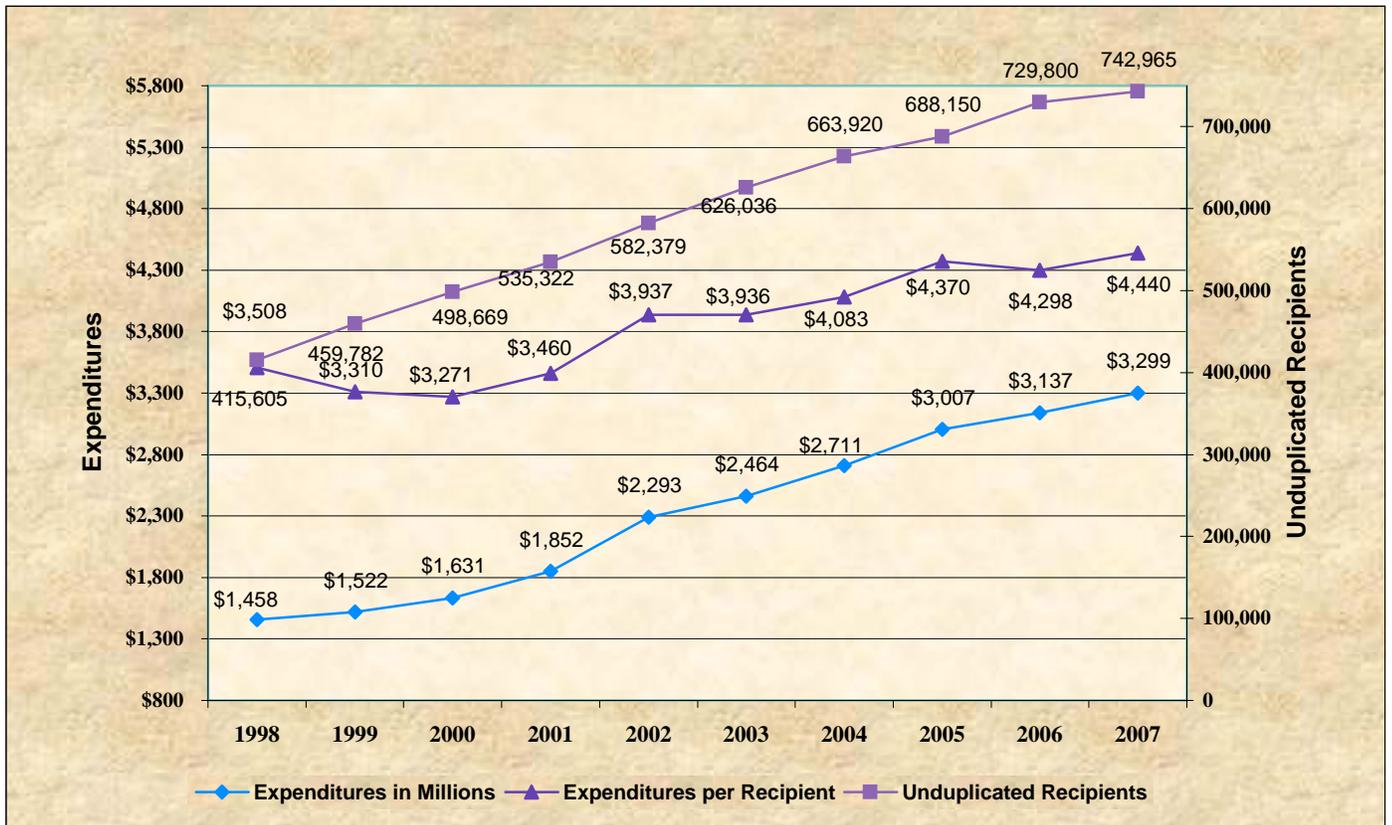


Source: HCFA2082

MEDICAID STAFFING COMPARED TO EXPENDITURES



MEDICAID UNDUPLICATED RECIPIENTS COMPARED TO EXPENDITURES



Source: HCFA2082; Medicaid Budget Reports

*Staff detail in above Chart reflects DMS filled positions excluding OLTC staff