LOUISIANA DEPARTMENT OF HEALTH

09-305 Medical Vendor Administration

Vision
Medicaid envisions a future where every Louisianan has a fair and just opportunity to lead the healthiest life possible.

Mission
Our mission is to provide the right health care at the right time, reducing health disparities, and improving overall health outcomes in Louisiana.

Philosophy
Our philosophy is to operate the Medicaid program in a manner that achieves the Triple Aim of optimizing health system performance by improving the patient experience of care (including quality and satisfaction); improving the health of populations; and reducing the per capita cost of health care.

Executive Summary
The direction of health care nationally has been to improve care in ways that matter most to patients, families, and communities. It includes increased access to affordable, comprehensive, continuous health insurance coverage, which is essential to the ability to achieve and maintain good health. It emphasizes preventive and primary care and uses managed care delivery, quality initiatives, community partnerships, stakeholder engagement and other tools to improve health outcomes and reduce chronic diseases.

Louisiana Medicaid strives to:

1) Ensure those enrolled in Medicaid are eligible for Medicaid coverage by implementing regular eligibility determination checks.

2) Use the managed care delivery model to improve health outcomes.

3) Increase access to community-based services as an alternative to institutional care.

Agency Goals

Goal I:
To make comprehensive, coordinated care and quality health services available to all who qualify.

Goal II:
To increase access to community-based services as an alternative to institutional care.

Goal III:
Improve program integrity by ensuring only those who are eligible remain enrolled in Medicaid.

Statement of agency strategies for development and implementation of human resource policies that help and benefit women and families:

The Medical Vendor Administration is dedicated to the development and implementation of human resource policies that are helpful and beneficial to women and families and demonstrates its support through the following human resource policies: the Family Medical Leave Policy (8108-930), the Sexual Harassment Policy (8143-02) and the Equal Employment Opportunity Policy (8116-77). In addition, the allowance of flexibility in work schedules and the availability of Dependent Day Care Spending Accounts assist both women and their families.

LOUISIANA DEPARTMENT OF HEALTH

Program A: Medical Vendor Administration

Program A: Mission
The mission of the Medical Vendor Administration (MVA) Program A is to administer an efficient and effective Medicaid program in compliance with state and federal requirements.

Program A: Goals
I. Demonstrate good stewardship of public resources.

Activity 1 – Medicaid Eligibility Determination and Enrollment

Objective I: Optimize eligibility determination and enrollment processes to ensure timely access to Medicaid and CHIP, targeting 98.5% timely processing. Leverage data, automation, and integrated systems to improve efficiency, reduce administrative burden, and support equitable access.

Strategies:
1.1 Use advanced data integration, automation, and analytics to drive faster, more accurate eligibility decisions and renewals.
1.2 Simplify and align application processes across Medicaid and SNAP to create a single, resident-centered intake experience.

1.3 Expand Express Lane Eligibility and SNAP-Assisted Enrollment to reduce friction for eligible individuals.
1.4 Build automated pathways for pre-release enrollment of justice-involved individuals to ensure continuous coverage.
1.5 Implement process mining and AI-driven analytics to identify and eliminate bottlenecks in eligibility workflows.

Performance Indicators:

- Increase data sources to better verify eligibility at enrollment and renewal in accordance with SB 130 of the 2025 regular legislative session.
- Percentage of Medicaid applications received submitted and received through digital channels.
- Reduction in reliance on self-attestation of eligibility criteria through implementation of data integration for validation.
- Average time from submission to determination using digital verification.
- Percentage of calls received through the Medicaid & LaCHIP hotlines who hold for a representative less than five minutes.
- Number of justice-involved adults enrolled pre-release from incarceration.

Activity 2 – Medicaid Enterprise Systems (MES)

Louisiana's Medicaid providers deliver essential health care and long-term care supports and services to Medicaid recipients, and their continued participation is key to access to care and improved health outcomes. Medicaid Enterprise Systems (MES) handles most Medicaid provider relations functions, including the processing of provider claims and issuing payments for the FFS program, the processing of encounters (claims paid by managed care entities) for the managed care program, credentialing and enrolling providers in the Medicaid network, and combating fraud, waste and abuse in the Medicaid program.

Objective I: Transform Louisiana Medicaid's technology and data infrastructure into a cloud-based, modular, and intelligent enterprise platform that supports fast, accurate decision-making, improves operational efficiency, and enables scalable innovation.

Strategies:

1.1 Deploy a modern cloud-based Decision Support System (DSS) to replace the legacy mainframe and
data warehouse, enabling real-time analytics, forecasting, and performance management across all Medicaid functions.
1.2 Expand the use of AI to support predictive analytics, financial modeling, quality monitoring, and AI-assisted policy and code review.
1.3 Implement a scalable enterprise data sharing infrastructure to support interoperability with partners, other agencies, and Medicaid managed care entities.

1.4 Strengthen encounter data monitoring and program integrity using modern analytics platforms and machine learning to identify trends, gaps, and anomalies.
1.5 Promote data-driven decision-making by embedding dashboards, insights, and alerts directly into staff workflows and leadership reporting.

Performance Indicators:

- Launch of Medicaid DSS platform and legacy data warehouse retirement milestones
- Percentage of technologies transitioned to cloud-native architecture
- Provider and MCO access via self-service tools
- Reduction in manual effort and processing time through intelligent automation
- Mobile-first tools adopted by residents, stakeholders, and staff

Activity 3 – Financial Management

The federal government and the state jointly fund the Louisiana Medicaid program. States must ensure they can fund their share of Medicaid expenditures for the care and services available under their state plan and are responsible for safeguarding Medicaid funds by making proper payments to providers, recovering misspent funds, and accurately reporting costs for federal reimbursement. Sufficient financial controls, monitoring and reporting functions are necessary to enable program transparency and demonstrate accountability of public resources to Louisiana taxpayers, lawmakers, and other constituents. Financial management supports the agency's broader goals of ensuring cost effectiveness in the delivery of health care services by using efficient management practices and implementing measures that will constrain the growth in Medicaid expenditures.

Medicaid rate setting and audit functions decrease avoidable public expenditures in the Medicaid program and ensure that limited resources are for health care initiatives that have proven to be the most responsive to the needs of Medicaid members. These functions also ensure that funding allocated to institutional services, such as Nursing Homes and Intermediate Care Facilities (ICF) have proper expenditures. It also ensures that the development of Medicaid cost reports and analysis and audit of hospital records, as required by federal regulations assure that hospitals receive reimbursements in accordance with the provisions of state and federal law, rules, and regulations. Additionally, these functions include monitoring of Local Education Authorities (LEAs) participating in Medicaid for school-based health services to ensure access to Early Periodic Screening Diagnostic and Treatment (EPSDT) and other Medicaid allowable services for children and that reimbursement for these services through certified public expenditures are tracked and audited.

The purpose of establishing and maintaining an effective collections/recovery and cost avoidance program is to reduce Medicaid expenditures and improve program integrity. Monitoring of Third Party Liability (TPL) claims processing enables the Department to enforce that Medicaid is the payer of last resort. Maximizing recoveries will result in the most efficient use of Medicaid funds.

Collections:

- **TPL Collections** - Third parties are legally liable individuals, institutions, corporations (including insurers), and public or private agencies who are or may be responsible for paying medical claims of Medicaid enrollees. Medicaid pays only after a known third party has met its legal obligation to pay, with the exception of claims for prenatal, preventive pediatrics, and medical support enforcement, where Medicaid pays first and then pursues the third party payment, referred to as "pay and chase." Liable third parties include other health insurers and parties liable for accidents and injuries to Medicaid enrollees.

Cost Avoidance:

- **Cost Avoidance** - Cost Avoidance is the main goal of the TPL program. Once other insurance information is in MES, the system will begin cost-avoiding claims by denying them back to the provider with a message that the beneficiary has other insurance on that date of service and he or she should file the claim there first. If the provider has already billed the other insurance, Medicaid will only consider making payment up to the Medicaid allowed amount.

Objective I: Through the Financial Management Activity, administer the Medicaid program and ensure that financial operations are in accordance with federal and state statutes, rules, and regulations.

Strategy:

1.1 Monitor total expenditures to ensure costs do not exceed available resources for administering the Medicaid Program.

Performance Indicator:

- Administrative cost as a percentage of total cost

Objective II: Through the Financial Management Activity, pursue collections from third party sources legally responsible for health care costs of Medicaid and CHIP enrollees.

Strategies:

2.1 Maintenance of the Resource File in order to assure that the most accurate, up-to-date third party liability information for enrollees is in the MES (payment) system that results in higher collection of funds due.

2.2 Monitor the logic of the Medicaid claims payment system and update as needed to ensure that TPL edits are correct.

Performance Indicators:

- Number of TPL claims processed
- Number of claims available for TPL processing
- Percentage of TPL claims processed and cost-avoided

- Percentage of TPL claims processed through edits
- Funds recovered from third parties with a liability for services provided by Medicaid

Activity 4 – Program Integrity (PI)

The Department is committed to combating fraud, waste, and abuse in the Medicaid program in compliance with state and federal laws and regulations. Louisiana Medicaid focuses resources on specific Medicaid activities, such as provider enrollment compliance, managed care compliance, Unified Program Integrity Contractor (UPIC), Payment Error Rate Measurement (PERM), Surveillance and Utilization Review (SURS), and beneficiary fraud investigations.

- **Managed Care Compliance**: Medicaid is responsible for ensuring the integrity of all Louisiana Medicaid managed care entities. Medicaid tracks contract compliance across a number of measures including quarterly Program Integrity/Medicaid Fraud Control Unit meetings, reporting all providers terminated for cause, compliance with mandatory exclusions, concurrent reporting of suspected or confirmed fraud to Medicaid, and MCO reporting contract requirements. Medicaid ensures MCO adherence to contract requirements through the issuance of notices of action and monetary penalty assessments for non-compliance.

- **Unified Program Integrity Contractor (UPIC)**: UPIC vendors contracted with CMS to identify and prevent overpayments in Medicaid and Medicare.

- **Payment Error Rate Measurement (PERM)**: PERM measures state payment error rates on a 3-year cycle and determines the national error rate. Louisiana has ranked fifth, third, and eighth lowest in each of the past three PERM cycles, starting in 2008.

- **Surveillance and Utilization Review System (SURS)**: SURS analyzes data from fee-for-service program and encounter data from Louisiana Medicaid MCOs to detect fraud and abuse by providers.

- **Medicaid Beneficiary Fraud**: Medicaid Beneficiary Fraud (MBF) Unit investigates Medicaid beneficiary eligibility. MBF receives tips and referrals of Medicaid Beneficiaries and determines if there is an ineligible individual receiving benefits.

Objective I: Program Integrity will processes provider terminations and exclusions.

Strategy:

1.1 Identify providers for termination, mandatory, and permissive exclusion from the Medicaid program

Performance Indicator:

- Annual number of provider terminations and exclusions

Objective II: Through the Program Integrity Activity, rigorously oversee Medicaid MCOs to ensure overall contract compliance in the managed care program.

Strategy:

2.1 Assess MCO compliance with contract requirements

Performance Indicators:

- Number of notices of action issued for contract non-compliance
- Amount of monetary penalties assessed for contract non-compliance

Objective III: Through the Program Integrity Activity, prevent and detect claims-based fraud and abuse through data analysis, coordination with MCOs and participation in external audit (UPIC and PERM) activities.

Strategies:

3.1 Increase use of predictive analytics in the SURS activity.
3.2 Coordinate fraud, waste, and abuse activities across MCOs through shared reporting for improved compliance.
3.3 Coordinate with the CMS Unified Program Integrity Contractor (UPIC) in identifying and recovering overpayments.
3.4 Participate in CMS Payment Error Rate Measurement (PERM) cycles and incorporate apply PERM findings to reduce improper payments.

Performance Indicators:

- Number of audits/reviews
- Amount of overpayments identified post and pre-pay
- Number of notices and referrals sent to the Attorney General

Objective IV: Through the Program Integrity Activity, identify and review beneficiary eligibility.

Strategies:

4.1 Conduct targeted reviews to identify suspected beneficiary fraud
4.2 Refer suspected beneficiary fraud cases to law enforcement

Performance Indicators:

- Number of reviews conducted
- Number of referrals to law enforcement

LOUISIANA DEPARTMENT OF HEALTH

09-305 MEDICAL VENDOR ADMINISTRATION

APPENDIX

FY 2026-2031

5-YEAR STRATEGIC PLAN

Program A: Medical Vendor Administration

Principal Customers/Users of the Program and Benefits: There are two principal customers/users of the Medicaid Program: recipients of Medicaid services and providers of Medicaid services. Recipients generally fall into three categories: mothers and children (including pregnant women), elderly people, and persons with disabilities and chronic conditions. Medicaid providers are purveyors of covered medically necessary services to Medicaid recipients and may be individual owners, group-owned, a governmental entity, or an incorporated business.

A brief description of how the strategic planning process was implemented in your organization: Upon the Medicaid Executive Management Team (EMT) review of the Strategic Plan, Medicaid concluded that while progress towards goals and objectives is occurring as expected and we are achieving anticipated results, Medicaid needed to reaffirm its goals, objectives, strategies, and performance indicators. Strategic Plan adjustments reflect the current environment, current and future priorities, and enable the agency to continue to grow progress. Performance Indicator (PI) Documentation Sheets are complete for all new performance indicators.

Statement of Agency Strategies for Development and Implementation of Human Resource Policies That Are Helpful and Beneficial to Women and Families: The Medical Vendor Administration (MVA Agency 09-305) is dedicated to the development and implementation of human resource policies that are helpful and beneficial to women and families. MVA also demonstrates its support through the following human resource policies: the Family Medical Leave Policy (8108-930), the Sexual Harassment Policy (8143-02) and the Equal Employment Opportunity Policy (8116-77). In addition, the allowance of flexibility in work schedules and the availability of Dependent Day Care Spending Accounts assist both women and their families.

Maintenance of Agency Performance-Based Budgeting Records: The maintenance and preservation of all documents used in the development of strategic and operational plans, as well as data used for the completion of quarterly performance progress reports through the Louisiana Performance Accountability System (LaPAS), are in accordance with the state's record retention laws (R.S. 44:36). The agency maintains records for at least three (3) years from the origination date.

Potential Internal/External Factors That Could Significantly Affect the Achievement of Goals or Objectives in this Program: Internal factors that could affect the achievement of goals and objectives include the level and qualifications of staff, agency priorities, and coordination/cooperation between agencies of the Department.

Several external factors have significant influence on our ability to achieve the goals and objectives as stated. Primary factors are the appropriation of funding; changes in federal rules and regulations; utilization of services by recipients; growth or expansion of the eligible population shifts in state demographics; state economy and unemployment rates; medical inflation rates; participation rates of medical providers; new and increasingly expensive medical procedures and drugs; and changes in Legislative priorities.

Methods Used to Avoid Duplication of Effort: The Bureau of Health Services Financing (BHSF) is the sole entity in the state of Louisiana responsible for the administration of Medicaid funds. In this role, the Bureau coordinates the use of these funds across several agencies within the Department of Health and a few outside of the Department. In all cases federal rules, regulations and guidelines, as well as, policies issued by the BHSF, govern the use of funds and the BHSF oversees implementation. Consequently, the Bureau is able to assure coordination of effort and avoidance of duplication.

Within BHSF, there are a number of programs and functions. The Medicaid Director and Deputy Directors (collectively the Medicaid Executive Management Team) work closely with each other and are responsible for the coordination of the activities of BHSF between Medicaid programs. Medicaid Section Chiefs administer and oversee Medicaid programs, who work together in a complementary manner. Meetings of the Executive Management Team

and Section Chiefs occur on a weekly basis, and as-needed, for the purposes of coordinating work, identifying touchpoints and dependencies, and addressing issues and potential conflicts between programs.

Medicaid EMT members also meet regularly with other LDH program office leadership including the Office of Public Health (OPH), Office of Behavioral Health (OBH), Office of Citizens with Developmental Disabilities (OCDD), and the Office of Aging and Adult Services (OAAS). These meetings are necessary to coordinate work across programs, identify touchpoints and dependencies, and address issues and potential conflicts between programs.

Collectively, this process enables leaders and managers to work together to examine and solve issues critical to the administration of funds and minimize opportunities for potential program duplication.

Program Evaluations used to Develop Goals, Objectives, and Strategies:

- Review and evaluations of management reports
- Conferences with recipient and provider association
- Bureau planning and policy development sessions
- Customer service surveys
- Ongoing assessment to review progress in meeting performance standards

Agency Goals:

Goal I
To make comprehensive, coordinated care and quality health services available to all who qualify

Goal II
To increase access to community-based services as an alternative to institutional care

Goal III
To reduce the per capita cost of care by balancing health care and prevention spending

Statutory Authority for Goal: The Constitution of Louisiana (1974), Article 12, Section 8, declares that the Legislature may establish a system of economic security and social welfare, unemployment compensation, and public health. Louisiana Revised Statutes 36:251 and the following. Louisiana Revised Statute 46:976 gives the Louisiana Department of Health (LDH) secretary authority to direct and be responsible for the Medical Assistance Program and the Children's Health Insurance Program (Title XIX and XXI of the Social Security Act). The secretary also acts as the sole agent of the state, designates an office within the department, or its assistant secretary to cooperate with the federal government and other state and local agencies in the administration of federal funds granted to the state, department, or office to aid in the furtherance of any function of the department or its offices.

Primary Persons Who Will Benefit From or Be Significantly Affected by Objectives: Louisiana citizens, with the vast majority of the services provided to Medicaid eligible recipients. Additionally, there is an economic impact upon medical services provided within the State of Louisiana resulting from the reimbursements made to the medical community for the delivery of medically necessary services.

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Medicaid Eligibility Determination & Enrollment

Objective: Through the Medicaid Eligibility Determination activity, maximize the efficiency and accuracy of enrolling eligible individuals in Medicaid and CHIP by processing at least 98.5% of applications timely through continuous improvement that is technology driven, simplifies administrative processes, and eliminates waste.

Indicator Name: Percentage of Medicaid applications received online

Indicator LaPAS PI Code: 25540

1. **Type and Level**: Efficiency and Key (K)

2. **Rationale**: This indicator was selected because by increasing the number of online applications, we are able to utilize tools that streamline the entry of the information into our Louisiana Medicaid Eligibility Determination System (LaMEDS) and perform immediate verifications through data hubs. This eliminates work that would normally be performed by eligibility staff thus improving processing times and reducing some operational costs.

3. **Use**: This indicator will be used to help management know if outreach or other measures need to be taken to increase the number of Louisiana residents applying online.

4. **Clarity**: This indicator clearly identifies what is being measured.

5. **Accuracy, Maintenance, and Support**: the Office of the Legislative Auditor has not audited this indicator. LaMEDS tracks the number of on- line applications received.

6. **Data Source, Collection, and Reporting**: The Department of Health and Hospitals LaMEDS is used to pull numbers for all applications received. The numbers pulled from the system are then compiled into an on-going report that is updated monthly. This report is posted to a SharePoint site for Management review.

7. **Calculation Methodology**: The sum of all applications received divided by the sum of all applications received online that gives us the percentage of applications received online.

8. **Scope**: This indicator is an aggregate of the number of applications received online and can be broken down by online (telephone), online (in-house), and incomplete on-line applications.

9. **Caveats**: There are no known limitations or weaknesses related to this indicator.

10. **Responsible Persons**: Rhett Decoteau, Medicaid Program Manager 4, 225-342-9044, Rhett.Decoteau@la.gov and Octavius Youngblood, Medicaid Program Manager 3, 225-342-8404, Octavius.Youngblood@la.gov

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Medicaid Eligibility Determination & Enrollment

Objective: Through the Medicaid Eligibility Determination activity, maximize the efficiency and accuracy of enrolling eligible individuals in Medicaid and CHIP by processing at least 98.5% of applications timely through continuous improvement that is technology driven, simplifies administrative processes, and eliminates waste.

Indicator Name: Number of children enrolled through Express Lane Eligibility (ELE)

Indicator LaPAS PI Code: 25539

1. **Type and Level**: Efficiency and Key (K)

2. **Rationale**: The department exercised the federal Medicaid "Express Lane Eligibility" option for children who receive Supplemental Nutrition Assistance Program (SNAP) benefits to reach and retain eligible children. This process helps remove barriers to enrollment, reduce duplicative effort by applicants, and improve operational efficiencies. This indicator was selected because it tracks the number of children who are enrolled automatically based on decisions made by other government agencies thus reducing the number of manual applications that Medicaid staff must process. It is a valid measure of performance for this Objective.

3. **Use**: This indicator will assist management in determining if the program should continue and be expanded to include other government agencies beyond those currently involved in this process.

4. **Clarity**: This indicator clearly identifies what is being measured.

5. **Accuracy, Maintenance, and Support**: The Office of the Legislative Auditor has not audited this indicator. The Louisiana Medicaid Eligibility Determination System (LaMEDS) compiles data needed to produce a monthly report. There are also other ELE reports that management has created which are downloaded monthly to a SharePoint site to track ELE statistics.

6. **Data Source, Collection, and Reporting**: The LaMEDS compiles data needed to produce the monthly report. There are also other ELE reports that management has created which are downloaded monthly to a SharePoint site to track ELE statistics.

7. **Calculation Methodology**: ELE certifications added is used to determine the number of children enrolled through Express Lane Eligibility.

8. **Scope**: This indicator is aggregated sum of children enrolled through the ELE process and can be broken down by State, Region, and Parish.

9. **Caveats**: There are no known limitations or weaknesses related to this indicator.

10. **Responsible Persons**: Rhett Decoteau, Medicaid Program Manager 4, 225-342-9044, Rhett.Decoteau@la.gov and Octavius Youngblood, Medicaid Program Manager 3, 225-342-8404, Octavius.Youngblood@la.gov

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Medicaid Eligibility Determination & Enrollment

Objective: Through the Medicaid Eligibility Determination activity, maximize the efficiency and accuracy of enrolling eligible individuals in Medicaid and CHIP by processing at least 98.5% of applications timely through continuous improvement that is technology driven, simplifies administrative processes, and eliminates waste.

Indicator Name: Percentage of applications for pregnant women approved within five (5) calendar days

Indicator LaPAS PI Code: 24036

1. **Type and Level**: Outcome and Key (K)

2. **Rationale**: One of the key factors in low birth weight babies is lack of prenatal care. In an effort to improve the quality of health care for pregnant women, the Department's goal is to enroll pregnant women earlier to ensure healthier babies. As part of this initiative to expedite the pregnant women applications, the agency has implemented procedures to reduce the number of days that it takes to process these applications. This indicator was selected to help monitor productivity and enrollment activity of this high-risk population.

3. **Use**: This indicator will be used in management decisions involving staff allocation, productivity, work hours, outreach, and out stationing. It will also be used for internal management and budgeting purposes.

4. **Clarity**: The name clearly identifies what we are trying to measure, and it does not contain unclear terms. This measurement does not include Pregnant Woman applications that are denied.

5. **Accuracy, Maintenance, and Support**: The Office of the Legislative Auditor has not audited this indicator. The Louisiana Medicaid Eligibility Determination System (LaMEDS) compiles data needed to produce the monthly reports.

6. **Data Source, Collection, and Reporting**: The data comes from LaMEDS. The data collection source is the monthly Pregnant Woman Application Processing Time Frames calculated at the parish, region, and statewide level. The data is gathered monthly and the report is generated on the night of the first working day of the following month.

7. **Calculation Methodology**: The sum of all Medicaid Pregnant Woman applications processed within 5 days obtained from the divided by the sum of all Pregnant Woman applications processed gives us the percentage of Pregnant Women applications processes within 5 days.

8. **Scope**: The indicator is aggregated. The processing time for approved Pregnant Woman applications is calculated at the statewide as well as the region and parish levels and breakdowns are available. The agency does not intend to combine reports for this group with other groups that have a federal application processing time of 45 days for children and families related and 90 days for disability related because of the urgency placed on this population.

9. **Caveats**: There are no known limitations or weaknesses related to this indicator.

10. **Responsible Persons**: Rhett Decoteau, Medicaid Program Manager 4, 225-342-9044, Rhett.Decoteau@la.gov and Octavius Youngblood, Medicaid Program Manager 3, 225-342-8404, Octavius.Youngblood@la.gov

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Medicaid Eligibility Determination & Enrollment

Objective: Through the Medicaid Eligibility Determination activity, maximize the efficiency and accuracy of enrolling eligible individuals in Medicaid and CHIP by processing at least 98.5% of applications timely through continuous improvement that is technology driven, simplifies administrative processes, and eliminates waste.

Indicator Name: Percentage of applications for LaCHIP & Medicaid programs for children approved within 15 calendar days

Indicator LaPAS PI Code: 25541

1. **Type and Level**: Outcome and Key (K)

2. **Rationale:** This indicator was selected to better monitor our productivity through the eligibility activity, to inform, identify, and enroll eligible children into LaCHIP/Medicaid by processing applications timely and to improve access to health care for uninsured children through the LaCHIP program. It is also cost effective to the Department to provide periodic and early screening to children.

3. **Use**: This indicator will be used in management decisions concerning staff performance, over time as deemed necessary, and for internal management and budgeting purposes.

4. **Clarity**: The name uses the acronym: LaCHIP to refer to 'Louisiana Children Health Insurance Program'. It clearly identifies what we are trying to measure, and it does not contain unclear terms. This measurement does not include applications for children that are denied.

5. **Accuracy, Maintenance, and Support**: The Office of the Legislative Auditor has not audited this indicator. The Louisiana Medicaid Eligibility Determination System (LaMEDS) compiles data needed to produce the monthly reports.

6. **Data Source, Collection, and Reporting**: The data comes from LaMEDS. The data is gathered monthly and the report is generated on the night of the first working day of the following month.

7. **Calculation Methodology**: The sum of all LaCHIP and Medicaid applications for children processed within 15 days divided by the sum of all LaCHIP and Medicaid applications for children processed gives us the percentage of LaCHIP and Medicaid applications for children processed within 15 days.

8. **Scope**: The indicator is aggregated. Due to the aggressive efforts to reach this goal, this indicator is not likely to be combined with indicators for other client groups, which applications have a period of 45 days –including CHIP and CHAMP- for Children and family related and 90 days for disability related because of the importance to insure this population.

9. **Caveats**: There are no known limitations or weaknesses related to this indicator.

10. **Responsible Persons**: Rhett Decoteau, Medicaid Program Manager 4, 225-342-9044, Rhett.Decoteau@la.gov and Octavius Youngblood, Medicaid Program Manager 3, 225-342-8404, Octavius.Youngblood@la.gov

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Medicaid Eligibility Determination & Enrollment

Objective: Through the Medicaid Eligibility Determination activity, maximize the efficiency and accuracy of enrolling eligible individuals in Medicaid and CHIP by processing at least 98.5% of applications timely through continuous improvement that is technology driven, simplifies administrative processes, and eliminates waste.

Indicator Name: Total number of children enrolled

Indicator LaPAS PI Code: 10013

1. **Type and Level**: Output and Key (K)

2. **Rationale:** This indicator was selected because it tracks total number of children currently enrolled in Louisiana's Medicaid program and Louisiana Children's Health Insurance Program (LaCHIP). This information is vital to outreach and retention efforts as well as administrative and budget costs and projections. It is a valid measure of performance targeted in this objected.

3. **Use**: This indicator will be used in management decision making. This indicator will help management determine and monitor the number of children enrolled in Medicaid and LaCHIP and make decisions on administration and budget issues necessary to support this population. This indicator may be used for performance-based budgeting purposes.

4. **Clarity**: This indicator name clearly identifies what is being measured and "children" includes all eligibles under the age of 19.

5. **Accuracy, Maintenance, and Support**: The Office of the Legislative Auditor has not audited this indicator. The source of this indicator is the Children under 19 Recipient Statistic Report (RS -O-92) report, developed from the Medicaid Enterprise Systems (MES) mainframe and its accuracy and reliability, relies on the MES mainframe data.

6. **Data Source, Collection, and Reporting**: The source of this indicator is a VSAM file (table in a database) that is pulled from the MES mainframe. A subset is then made from this table to create the monthly RS- O-92 report that specifically reports on total children's enrollment.

7. **Calculation Methodology**: This indicator is calculated at Unisys by extracting enrollment data from the MES mainframe and creating the RS-O-92 report using that data. The total children's enrollment is comprised of all eligibles under age 19.

8. **Scope**: This indicator is the aggregated sum of all children enrolled in Medicaid and LaCHIP and can be broken down into any type case that contains an eligible child.

9. **Caveats**: There are no known limitations or weaknesses related to this indicator.

10. **Responsible Persons**: Rhett Decoteau Medicaid Program Manager 4, 225-342-9044, Rhett.Decoteau@la.gov and Octavius Youngblood, Medicaid Program Manager 3, 225-342-8404, Octavius.Youngblood@la.gov

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Medicaid Eligibility Determination & Enrollment

Objective: Through the Medicaid Eligibility Determination activity, maximize the efficiency and accuracy of enrolling eligible individuals in Medicaid and CHIP by processing at least 98.5% of applications timely through continuous improvement that is technology driven, simplifies administrative processes, and eliminates waste.

Indicator Name: Percentage of renewals processed and not closed for procedural reasons

Indicator LaPAS PI Code: 17038

1. **Type and Level**: Outcome and Key (K)

2. **Rationale:** This indicator measures the effectiveness of the agency's efforts to decrease the number of otherwise eligible children who lose eligibility at annual renewals solely due to procedural reasons.

3. **Use**: This indicator measures the effectiveness of the Agency's efforts to simplify not only the enrollment process, but the renewal process as well. This has been identified as one of the keys to reducing the number of uninsured children in the state. It also provides critical information on how many children are losing public health care coverage (Medicaid) for procedural reasons.

4. **Clarity**: Procedural closures are those closures of cases in which ineligibility has not been established. The sole reason for closure is failure to follow administrative procedures necessary for renewal.

5. **Accuracy, Maintenance, and Suppor**t: The Office of the Legislative Auditor has not audited this indicator. The Louisiana Medicaid Eligibility Determination System (LaMEDS) compiles data needed to produce the monthly reports.

6. **Data Source, Collection, and Reporting**: LaMEDS compiles data needed to produce the monthly reports. The reports are available to Medical Vendor Administration staff for tracking, monitoring, and programmatic decision-making.

7. **Calculation Methodology**: Three months of data for both programs is used in determining the monthly average (3-month total divided by 3). The quarterly average is then divided by the two (2) programs to provide the quarterly percentage. This Performance Indicator reports quarterly percentage and it is not cumulative.

8. **Scope**: This indicator is an aggregate of all eligible and can be displayed by region and parish.

9. **Caveats**: We do not predict to have limitations or weaknesses. This indicator is not a replacement or an alternative and it has been reported for a reasonable time. The source of the data does not contain partialities and includes all closures at renewal for CHIP and CHAMP.

10. **Responsible Persons**: Rhett Decoteau, Medicaid Program Manager 4, 225-342-9044, Rhett.Decoteau@la.gov and Octavius Youngblood, Medicaid Program Manager 3, 225-342-8404, Octavius.Youngblood@la.gov

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Medicaid Eligibility Determination & Enrollment

Objective: Through the Medicaid Eligibility Determination activity, maximize the efficiency and accuracy of enrolling eligible individuals in Medicaid and CHIP by processing at least 98.5% of applications timely through continuous improvement that is technology driven, simplifies administrative processes, and eliminates waste.

Indicator Name: Percentage of calls received through the Medicaid and LaCHIP hotlines who hold for a representative less than 5 minutes

Indicator LaPAS PI Code: 24041

1. **Type and Level**: Efficiency and Key (K)

2. **Rationale:** This indicator was selected because it tracks the percentage of calls received through the Medicaid and LaCHIP hotlines that are placed on hold for a representative less than 5 minutes. This information is vital to determining administrative and budget costs, as well as projections regarding the number of staff necessary to support these hotlines. It is a valid measure of performance targeted in this objective.

3. **Use**: This indicator will be used in management decision making. This indicator will help management determine and monitor the number of calls and wait times, and make decisions on administration, staffing and budget issues necessary to support this population. This indicator will not be used for performance- based budgeting purposes.

4. **Clarity**: This indicator name clearly identifies what is being measured and LaCHIP is defined as Louisiana Children's Health Insurance Program.

5. **Accuracy, Maintenance, and Support**: The Office of the Legislative Auditor has not audited this indicator. The source of this indicator is the automatic call distribution (ACD) hotline operated by the Medicaid/LaCHIP Customer Service Unit, and the accuracy and reliability relies on those reports.

6. **Data Source, Collection, and Reporting**: This source for this indicator is a report generated by the Medicaid Customer Service Unit. The report is generated on a nightly basis.

7. **Calculation Methodology**: This indicator is calculated by taking the daily number of calls handled following less than a 5-minute wait time and dividing it by the total number of calls received that day.

8. **Scope**: This indicator is the statewide aggregated sum of the total number of calls handled following less than a 5-minute wait time.

9. **Caveats**: There are no known limitations or weaknesses related to this indicator.

10. **Responsible Persons**: Rhett Decoteau, Medicaid Program Manager 4, 225-342-9044, Rhett.Decoteau@la.gov and Octavius Youngblood, Medicaid Program Manager 3, 225-342-8404, Octavius.Youngblood@la.gov

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Medicaid Eligibility Determination & Enrollment

Objective: Through the Medicaid Eligibility Determination activity, maximize the efficiency and accuracy of enrolling eligible individuals in Medicaid and CHIP by processing at least 98.5% of applications timely through continuous improvement that is technology driven, simplifies administrative processes, and eliminates waste.

Indicator Name: Number of children renewed through Express Lane Eligibility (ELE)

Indicator LaPAS PI Code: 25542

1. **Type and Level**: Efficiency and Key (K)

2. **Rationale:** The department exercised the federal Medicaid "Express Lane Eligibility" option for children who receive Supplemental Nutrition Assistance Program (SNAP) benefits to reach and retain eligible children. This process helps remove barriers to enrollment, reduce duplicative effort by applicants, and improve operational efficiencies. This indicator was selected because it tracks the number of children who are renewed automatically based on decisions made by other government agencies thus reducing the number of manual renewals that Medicaid staff must process. It is a valid measure of performance for this Objective.

3. **Use**: This indicator will assist management in determining if the program should continue and be expanded to include other government agencies beyond those currently involved in this process.

4. **Clarity**: This indicator clearly identifies what is being measured.

5. **Accuracy, Maintenance, and Support**: The Office of the Legislative Auditor has not audited this indicator. The Louisiana Medicaid Eligibility Determination System (LaMEDS) compiles data needed to produce a monthly report. There are also other ELE reports that management has created which are downloaded monthly to a SharePoint site to track ELE statistics.

6. **Data Source, Collection, and Reporting**: LaMEDS compiles data needed to produce the monthly report. There are also other ELE reports that management has created which are downloaded monthly to a SharePoint site to track ELE statistics.

7. **Calculation Methodology**: ELE renewals approved is used to determine the number of children renewed through Express Lane Eligibility.

8. **Scope**: This indicator is aggregated sum of children renewed through the ELE process and can be broken down by State, Region, and Parish.

9. **Caveats**: There are no known limitations or weaknesses related to this indicator.

10. **Responsible Persons**: Rhett Decoteau, Medicaid Program Manager 4, 225-342-9044, Rhett.Decoteau@la.gov and Octavius Youngblood, Medicaid Program Manager 3, 225-342-8404, Octavius.Youngblood@la.gov

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Medicaid Eligibility Determination & Enrollment

Objective: Through the Medicaid Eligibility Determination activity, maximize the efficiency and accuracy of enrolling eligible individuals in Medicaid and CHIP by processing at least 98.5% of applications timely through continuous improvement that is technology driven, simplifies administrative processes, and eliminates waste.

Indicator Name: Number of children enrolled as Title XXI Eligibles (LaCHIP)

Indicator LaPAS PI Code: 2241

1. **Type and Level**: Output and Supporting (S)

2. **Rationale:** This indicator was selected because it tracks number of children currently enrolled in Title XXI, which is the State Children's Health Insurance Program (CHIP). This information is vital to outreach and retention efforts as well as administrative and budget costs and projections. It is a valid measure of performance targeted in this objective.

3. **Use**: This indicator will be used in management decision making. This indicator will help management determine and monitor the number of children enrolled in Louisiana Children's Health Insurance Program (LaCHIP) and make decisions on administration and budget issues necessary to support this population. This indicator may be used for performance-based budgeting purposes.

4. **Clarity**: This indicator name clearly identifies what is being measured. Title XXI of the Social Security Act is the State Children's Health Insurance Program and "children" includes all eligibles under the age of 19.

5. **Accuracy, Maintenance, and Support**: The Office of the Legislative Auditor has not audited this indicator. The source of this indicator is the Recipient Chip Quarterly Statistic Report (RS-O-91) report, developed from the Medicaid Enterprise Systems (MES) mainframe and its accuracy and reliability relies on the MES mainframe.

6. **Data Source, Collection, and Reporting**: The source of this indicator is a Virtual Storage Access Method (VSAM) file (table in a database) that is pulled from the MES mainframe. A subset is then made from this table to create the monthly RS- O-91 report that specifically reports on LaCHIP enrollment.

7. **Calculation Methodology**: This indicator is calculated at Unisys by extracting enrollment data from the MES mainframe and creating the RS-O-91 report using that data. The total LaCHIP enrollment is comprised of the 5 phases of LaCHIP which are Phase I (type case 007), Phase II and Phase III (type case 015), Phase IV (type case 127), and Phase V (type case 134) and can be broken down by each phase.

8. **Scope**: This indicator is the aggregated sum of children enrolled in the five different phases of LaCHIP. Phase I (covers children up to 147% Federal Poverty Level (FPL)), Phase II and Phase III (covers children from 148-217% FPL), Phase IV (covers pregnant, citizen and non-citizen women up to 214% FPL), and Phase V (covers children from 218-250% FPL).

9. **Caveats**: There are no known limitations or weaknesses related to this indicator.

10. **Responsible Persons**: Rhett Decoteau, Medicaid Program Manager 4, 225-342-9044, Rhett.Decoteau@la.gov and Octavius Youngblood, Medicaid Program Manager 3, 225-342-8404, Octavius.Youngblood@la.gov

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Medicaid Eligibility Determination & Enrollment

Objective: Through the Medicaid Eligibility Determination activity, maximize the efficiency and accuracy of enrolling eligible individuals in Medicaid and CHIP by processing at least 98.5% of applications timely through continuous improvement that is technology driven, simplifies administrative processes, and eliminates waste.

Indicator Name: Number of children enrolled as Title XIX Eligibles (traditional Medicaid)

Indicator LaPAS PI Code: 2242

1. **Type and Level**: Output and Supporting (S)

2. **Rationale:** This indicator was selected because it tracks number of children (under age 19) currently enrolled in Title XIX which is the Medicaid. This information is vital to outreach and retention efforts as well as administrative and budget costs and projections. It is a valid measure of performance targeted in this objected.

3. **Use**: This indicator will be used in management decision making. This indicator will help management determine and monitor the number of children enrolled in Louisiana's Medicaid Program and make decisions on administration and budget issues necessary to support this population. This indicator may be used for performance-based budgeting purposes.

4. **Clarity**: This indicator name clearly identifies what is being measured. Title XIX of the Social Security Act establishes the Federal/State Medicaid program and "children" includes all eligible under the age of 19.

5. **Accuracy, Maintenance, and Support**: The Office of the Legislative Auditor has not audited this indicator. The source of this indicator is the Recipient Chip Quarterly Statistic Report (RS-O-91) and Children under 19 Recipient Statistic Report (RS -O-92) which are developed from the Medicaid Enterprise Systems (MES) mainframe and their accuracy and reliability relies on the MES mainframe data.

6. **Data Source, Collection, and Reporting**: The source of this indicator is a VSAM file (table in a database) that is pulled from the MES mainframe. A subset is then made from this table to create the monthly RS- O-91 and RS-O-92 reports that specifically report on children enrollment in Medicaid and Louisiana Children's Health Insurance Program (LaCHIP).

7. **Calculation Methodology**: This indicator is calculated at Unisys by extracting enrollment data from the MES mainframe and creating the RS-O-91 and RS-O-92 reports using that data. The RS-O-91 report shows the total number of children enrolled in LaCHIP and the RS-O-92 report shows the total number of children enrolled in both Medicaid and LaCHIP. Therefore, to calculate the Medicaid enrollment number only, the LaCHIP total enrollment is subtracted from the RS-O-92 total.

8. **Scope**: This indicator is the aggregated sum of all children enrolled in Medicaid and LaCHIP minus the number of children enrolled in LaCHIP. This indicator can be broken down into any type of case that contains an eligible child.

9. **Caveats**: There are no known limitations or weaknesses related to this indicator.

10. **Responsible Persons**: Rhett Decoteau, Medicaid Program Manager 4, 225-342-9044, Rhett.Decoteau@la.gov and Octavius Youngblood, Medicaid Program Manager 3, 225-342-8404, Octavius.Youngblood@la.gov

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Medicaid Eligibility Determination & Enrollment

Objective: Through the Medicaid Eligibility Determination activity, maximize the efficiency and accuracy of enrolling eligible individuals in Medicaid and CHIP by processing at least 98.5% of applications timely through continuous improvement that is technology driven, simplifies administrative processes, and eliminates waste.

Indicator Name: Percentage of applications for the New Adult program approved within 15 calendar days

Indicator LaPAS PI Code: 26084

1. **Type and Level**: Outcome and Key (K)

2. **Rationale:** This indicator was selected to better monitor our productivity through the eligibility activity, to inform, identify, and enroll eligible Adults into Medicaid by processing applications timely and to improve access to health care for uninsured adults through the Adult Group program.

3. **Use**: This indicator will be used in management decisions concerning staff performance, over time as deemed necessary, and for internal management and budgeting purposes.

4. **Clarity**: It clearly identifies what we are trying to measure, and it does not contain unclear terms. This measurement does not include applications for adults that are denied.

5. **Data Source, Collection, and Reporting**: The data comes from LaMEDS. The data is gathered monthly and the report is generated on the night of the first working day of the following month.

6. **Calculation Methodology**: The sum of all New Adult applications for adults processed within 15 days divided by the sum of all New Adult applications for processed gives us the percentage of New Adult applications for adults processed within 15 days.

7. **Scope**: The indicator is aggregated. Due to the aggressive efforts to reach this goal, this indicator is not likely to be combined with indicators for other client groups, which applications have a period of 45 days–including CHIP and CHAMP for Children and family related and 90 days for disability-related because of the importance to insure this population.

8. **Caveats**: We do not predict to have limitations or weaknesses because the report has been in production for a reasonable time and this is only a further step to measure the results by putting it into an indicator. The source of the data does not contain partialities and includes all type of applications without any kind of favoritism.

9. **Accuracy, Maintenance, and Support**: The Office of the Legislative Auditor has not audited this indicator. The Louisiana Medicaid Eligibility Determination System (LaMEDS) compiles data needed to produce the monthly reports.

10. **Responsible Persons**: Rhett Decoteau, Medicaid Program Manager 4, 225-342-9044, Rhett.Decoteau@la.gov and Octavius Youngblood, Medicaid Program Manager 3, 225-342-8404, Octavius.Youngblood@la.gov

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Medicaid Eligibility Determination & Enrollment

Objective: Through the Medicaid Eligibility Determination activity, maximize the efficiency and accuracy of enrolling eligible individuals in Medicaid and CHIP by processing at least 98.5% of applications timely through continuous improvement that is technology driven, simplifies administrative processes, and eliminates waste.

Indicator Name: Number of justice-involved adults enrolled pre-release from incarceration

Indicator LaPAS PI Code: 26085

1. **Type and Level**: Outcome and Key (K)

2. **Rationale:** This indicator was selected because it tracks total number of adults enrolled in Louisiana's Medicaid program pre-release from incarceration. This information is vital to outreach and retention efforts as well as administrative and budget costs and projections. It is a valid measure of performance targeted in this objective.

3. **Use**: This indicator will be used in management decision making. This indicator will help management determine and monitor the number of adults enrolled in Louisiana's Medicaid program pre-release from incarceration and make decisions on administration and budget issues necessary to support this population. This indicator may be used for performance-based budgeting purposes.

4. **Clarity**: This indicator name clearly identifies what is being measured.

5. **Data Source, Collection, and Reporting**: The Louisiana Medicaid Eligibility Determination System (LaMEDS) produces the data needed to populate the monthly reports in the Pre-release Application Transfer File.

6. **Calculation Methodology**: The calculation is the total of all justice involved adults enrolled pre-release from incarceration in an active certification in LaMEDS that month regardless of age or type case.

7. **Scope**: This indicator is the aggregated sum of justice-involved adults enrolled pre-release from incarceration in Medicaid and can be broken down into any type case as well as by region and parish.

8. **Caveats**: There are no known limitations or weaknesses related to this indicator.

9. **Accuracy, Maintenance, and Support**: The Office of the Legislative Auditor has not audited this indicator. The source of this indicator is the Pre-release Application Transfer File listing persons certified in 51-550 and 50-550.

10. **Responsible Persons**: Rhett Decoteau, Medicaid Program Manager 4, 225-342-9044, Rhett.Decoteau@la.gov and Octavius Youngblood, Medicaid Program Manager 3, 225-342-8404, Octavius.Youngblood@la.gov

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Medicaid Eligibility Determinations and Enrollment

Objective: Through the Medicaid Eligibility Determination activity, maximize the efficiency and accuracy of enrolling eligible individuals in Medicaid and CHIP by processing at least 98.5% of applications timely through continuous improvement that is technology driven, simplifies administrative processes, and eliminates waste.

Indicator Name: Percentage of Medicaid applications with a real-time eligibility decision

Indicator LaPAS PI Code: 26563

1. **Type and Level**: Outcome and Key (K)

2. **Rationale:** This indicator measures the percentage of applications approved or denied within 24 hours without requiring the intervention of a Medicaid analyst. Under the Affordable Care Act, the Agency must seek to verify eligibility criteria based on electronic data matches with reliable sources of data. This indicator is a valid measure of performance for this objective.

3. **Use**: This indicator measures the effectiveness of the Agency's efforts to improve technology, simplify administrative processes, and eliminate waste. Management for resource planning will primarily use the measurement internally and identifying data source needs if Real-Time Eligibility Decisions are not meeting expectations.

4. **Clarity**: This indicator name clearly identifies what is being measured.

5. **Data Source, Collection, and Reporting**: The Louisiana Medicaid Eligibility Determination System (LaMEDS) generates the data needed to produce this report. The Medicaid Data Analytics team has created an Application Tracking Dashboard in Tableau, which includes Real-Time Eligibility (RTE) results so Medical Vendor Administration staff can track, monitor, and make programmatic decisions.

6. **Calculation Methodology**: The Tableau Application Tracking Dashboard is used to determine the percentage of real-time eligibility decisions completed monthly or yearly. The total automated approvals, denials, and mix will be divided by the total applications to derive the percentage of real-time eligibility decisions.

7. **Scope**: This indicator is a part of a larger whole. It's a subset of applications based on total applications received.

8. **Caveats**: There are no known limitations or weaknesses related to this indicator.

9. **Accuracy, Maintenance, and Support**: Real-Time Eligibility refers to eligibility decisions made in a real-time manner by the LaMEDS system after hitting electronic data sources to verify data needed for eligibility determinations.

10. **Responsible Persons**: Rhett Decoteau, Medicaid Program Manager 4, 225-342-9044, Rhett.Decoteau@la.gov and Octavius Youngblood, Medicaid Program Manager 3, 225-342-8404, Octavius.Youngblood@la.gov

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Medicaid Eligibility Determinations & Enrollment

Objective: Through the Medicaid Eligibility Determination activity, maximize the efficiency and accuracy of enrolling eligible individuals in Medicaid and CHIP by processing at least 98.5% of applications timely through continuous improvement that is technology driven, simplifies administrative processes, and eliminates waste.

Indicator Name: Percentage of renewals streamlined

Indicator LaPAS PI Code: 26564

1. **Type and Level**: Outcome and Key (K)

2. **Rationale:** This indicator measures the percentage of renewals completed without requiring the intervention of a Medicaid analyst. Under the Affordable Care Act, the Agency must seek to verify eligibility criteria based on electronic data matches with reliable sources of data. This indicator is valid measure of performance for this objective.

3. **Use**: This indicator measures the effectiveness of the Agency's efforts to improve technology, simplify administrative processes, and eliminate waste through the renewal process. This metric allows us gauge the success of our automated processes at renewal and adjust where possible.

4. **Clarity**: Yes, this indicator name clearly identifies what is being measured.

5. **Data Source, Collection, and Reporting**: The Louisiana Medicaid Eligibility Determination System (LaMEDS) generates the data needed for this report. The Medicaid Data Analytics team has created a Renewals Dashboard in Tableau for Medical Vendor Administration (MVA) staff to track, monitor, and make programmatic decisions.

6. **Calculation Methodology**: The Tableau Renewal Dashboard managed by Data Analytics is used to determine the percentage of renewals streamlined completed by month or by year. The total renewed certifications streamlined will be divided by the total due certifications to derive the percentage of renewals streamlined.

7. **Scope**: This indicator is the total renewed certifications streamlined divided by the total due certifications in that time period to derive the percentage of renewals streamlined. This calculation can be done by month or year as well and can be broken down by type of assistance.

8. **Caveats**: There are no known limitations or weaknesses related to this indicator.

9. **Accuracy, Maintenance, and Support**:

10. **Responsible Persons**: Rhett Decoteau, Medicaid Program Manager 4, 225-342-9044, Rhett.Decoteau@la.gov and Octavius Youngblood, Medicaid Program Manager 3, 225-342-8404, Octavius.Youngblood@la.gov

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Medicaid Eligibility Determination & Enrollment

Objective: Through the Medicaid Eligibility Determination activity, maximize the efficiency and accuracy of enrolling eligible individuals in Medicaid and CHIP by processing at least 98.5% of applications timely through continuous improvement that is technology driven, simplifies administrative processes, and eliminates waste.

Indicator Name: Number of certified Medicaid Application Centers

Indicator LaPAS PI Code: 12027

1. **Type and Level**: Output and General (G)

2. **Rationale:** Medicaid eligibility is a vital component of this section. Medicaid Application Centers are extensions to the communities we serve, which make Medicaid accessible to all. These centers assist individuals and families with their initial application for Medicaid. This indicator reports how many community partners help with our primary mission.

3. **Use**: Management uses the number of application centers to gauge potential Medicaid presence statewide. The number of application centers assisted management with recent Medicaid office closures and consolidations. This indicator is used internally, but shared with others when requested.

4. **Clarity**: This indicator name clearly identifies what is being measured. Application centers are often referred to as ACs.

5. **Accuracy, Maintenance, and Support**: The Office of the Legislative Auditor has not audited this indicator. Assurance in the validity, reliability, and accuracy of this indicator is through thorough documentation in the Online Application and Louisiana Medicaid Eligibility Determination System (LaMEDS). These systems are continuously updated to reflect real-time information.

6. **Data Source, Collection, and Reporting**: The source of data is the Online Application Center Certified Application Center Report. The report can be generated at any time the number of application centers is needed. These systems are continuously updated to reflect real-time information. The indicator is reported on a state fiscal year, most current data available at request date and the frequency is consistent.

7. **Calculation Methodology**: This indicator is derived from the total number of application centers reported by the Online Application Certified AC Report.

8. **Scope**: This indicator is aggregated. The total reflects a statewide figure, which can be broken down into region and parish.

9. **Caveats**: There are centers with trained staff available to assist with Medicaid applications if needed; however, some are not as active as others are.

10. **Responsible Persons**: Rhett Decoteau, Medicaid Program Manager 4, 225-342-9044, Rhett.Decoteau@la.gov and Octavius Youngblood, Medicaid Program Manager 3, 225-342-8404, Octavius.Youngblood@la.gov

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Medicaid Eligibility Determination & Enrollment

Objective: Through the Medicaid Eligibility Determination activity, maximize the efficiency and accuracy of enrolling eligible individuals in Medicaid and CHIP by processing at least 98.5% of applications timely through continuous improvement that is technology driven, simplifies administrative processes, and eliminates waste.

Indicator Name: Number of individuals enrolled in all Medicaid and LaCHIP programs

Indicator LaPAS PI Code: 25543

1. **Type and Level**: Output and General (G)

2. **Rationale:** This indicator was selected because it tracks total number of individuals currently enrolled in Louisiana's Medicaid program and Louisiana Children's Health Insurance Program (LaCHIP). This information is vital to outreach and retention efforts as well as administrative and budget costs and projections. It is a valid measure of performance targeted in this objective.

3. **Use**: This indicator will be used in management decision making. This indicator will help management determine and monitor the number of individuals enrolled in Medicaid and LaCHIP and make decisions on administration and budget issues necessary to support this population. This indicator may be used for performance-based budgeting purposes.

4. **Clarity**: This indicator name clearly identifies what is being measured.

5. **Accuracy, Maintenance, and Support**: The Office of the Legislative Auditor has not audited this indicator. The Louisiana Medicaid Eligibility Determination System (LaMEDS) compiles data needed to produce the monthly reports.

6. **Data Source, Collection, and Reporting**: LaMEDS produces data needed to populate the monthly reports. The data is then complied in an Enrollment Trends report on a monthly basis.

7. **Calculation Methodology**: The calculation is the total of all individuals in an active certification in the Louisiana Medicaid Eligibility Determination System (LaMEDS) that month regardless of age or type case.

8. **Scope**: This indicator is the aggregated sum of all individuals enrolled in both Medicaid and LaCHIP and can be broken down into any type case as well as by region and parish.

9. **Caveats**: There are no known limitations or weaknesses related to this indicator.

10. **Responsible Persons**: Rhett Decoteau, Medicaid Program Manager 4, 225-342-9044, Rhett.Decoteau@la.gov and Octavius Youngblood, Medicaid Program Manager 3, 225-342-8404, Octavius.Youngblood@la.gov

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Medicaid Eligibility Determination & Enrollment

Objective: Through the Medicaid Eligibility Determination activity, maximize the efficiency and accuracy of enrolling eligible individuals in Medicaid and CHIP by processing at least 98.5% of applications timely through continuous improvement that is technology driven, simplifies administrative processes, and eliminates waste.

Indicator Name: Number of applications processed annually

Indicator LaPAS PI Code: 25545

1. **Type and Level**: Output and General (G)

2. **Rationale:** This indicator was selected because it tracks the total number of Medicaid and Louisiana Children's Health Insurance Program (LaCHIP) applications that were processed and a decision was rendered. This information is vital to the administration of the Medicaid Eligibility Division. It is beneficial to management in determining staffing needs and planning for the organizational structure of the division.

3. **Use**: Management will use this indicator to understand staffing needs, where efficiencies may be realized, identify if procedural changes are needed and the type of training required based on the types of applications being processed will use this indicator.

4. **Clarity**: This indicator clearly identifies what is being measured.

5. **Accuracy, Maintenance, and Support**: The Office of the Legislative Auditor has not audited this indicator. The source of this indicator is the Louisiana Medicaid Eligibility Determination System (LaMEDS). LaMEDS compiles data needed to produce the monthly reports.

6. **Data Source, Collection, and Reporting**: LaMEDS provides data on the number of applications received, the type of case that was processed, and the number of applications processed in the month.

7. **Calculation Methodology**: LaMEDS provides data on the number of applications received during the month, as well as how many applications were approved or rejected as well as still pending a decision.

8. **Scope**: This indicator is an aggregate of the number of applications received statewide during the month.

9. **Caveats**: There are no known limitations or weaknesses related to this indicator.

10. **Responsible Persons**: Rhett Decoteau, Medicaid Program Manager 4, 225-342-9044, Rhett.Decoteau@la.gov and Octavius Youngblood, Medicaid Program Manager 3, 225-342-8404, Octavius.Youngblood@la.gov

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Medicaid Eligibility Determinations & Enrollment

Objective: Through the Medicaid Eligibility Determination activity, maximize the efficiency and accuracy of enrolling eligible individuals in Medicaid and CHIP by processing at least 98.5% of applications timely through continuous improvement that is technology driven, simplifies administrative processes, and eliminates waste.

Indicator Name: Total number of adults enrolled (in Medicaid)

Indicator LaPAS PI Code: 26764

1. **Type and Level**: Output and General (G)

2. **Rationale:** This indicator was selected because it tracks the total number of adult individuals enrolled in Louisiana's Medicaid Program. This information is used for outreach and retention efforts as well as administrative and budget costs and projections. It is a valid measure of performance targeted in this objective.

3. **Use**: This indicator will be used in management decision making. This indicator will help management determine and monitor the number of adults enrolled in Medicaid and make decisions on outreach activities, administration, and budget issues necessary to support this population.

4. **Clarity**: Yes, this indicator name clearly identifies what is being measured.

5. **Accuracy, Maintenance, and Support**: None

6. **Data Source, Collection, and Reporting**: The source of the indicator is Medicaid Enrollment Report available in Pentaho. The Louisiana Medicaid Eligibility Determination System (LaMEDS) compiles the data needed to produce the report by month.

7. **Calculation Methodology**: The calculation is the total of all adult individuals enrolled in Medicaid and can be broken down by type of assistance as well as by region.

8. **Scope**: This indicator is the aggregated sum of all adult individuals enrolled in Medicaid by month or current year as well as by type of assistance.

9. **Caveats**: There are no known limitations or weaknesses related to this indicator.

10. **Responsible Persons**: Rhett Decoteau Medicaid Program Manager 4, 225-342-9044, Rhett.Decoteau@la.gov and Octavius Youngblood, Medicaid Program Manager 3, 225-342-8404, Octavius.Youngblood@la.gov

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Medicaid Enterprise Systems (MES)

Objective: Through the MES Activity, operate an efficient and effective MES mainframe.

Indicator Name: Percentage of total claims processed within 30 days of receipt

Indicator LaPAS PI Code: 2219

1. **Type and Level**: Outcome and Key (K)

2. **Rationale:** This PI measures Fiscal Intermediary performance against the Center for Medicare and Medicaid Services (CMS) and Fiscal Intermediary (FI) contract requirement that all clean claims be processed within 30 days. This standard is a Systems Performance Review criterion for CMS. Retention of the 75% Federal Funds match for the cost of claims processing is dependent upon meeting these criteria.

3. **Use**: This indicator will be used to assess the Fiscal Intermediary's Performance. Failure of the FI to meet the criteria could result in fiscal sanctions.

4. **Clarity**: "Claims processed" refer to all claims that completed adjudication and been paid or denied. "Clean claims" refer to error-free claims that do not require further resolution before adjudication. CMS refers to the federal agency that administers Medicaid.

5. **Accuracy, Maintenance, and Support**: The Office of the Legislative Auditor reviews this performance indicator on a yearly basis and they found it reliable and accurate.

6. **Data Source, Collection, and Reporting**: The information is obtained from the MES Processing Assessment Report CP-0-21, which is drawn from the weekly claims processing cycle. It is available on CoinServe/ESP + desktop after the last check write of the current month.

7. **Calculation Methodology**: Processing time from claim receipt to final adjudication is measured. The CP-0-21 data from the "Paid within 30 Days" field is divided by the "Clean Claims Adjudicated" field to obtain a percentage of those within the guidelines. Monthly figures for the last 3 months are then averaged to obtain a quarterly average.

8. **Scope**: The monthly report is averaged for the quarter. It is a statewide figure.

9. **Caveats**: The indicator is affected by the age and volume of recycled (reprocessed) claims.

10. **Responsible Person:** Jonathan Wesley, Medicaid Program Manager 3, Medicaid Enterprise Systems, 225.342.0259, Jonathan.Wesley@la.gov

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Medicaid Enterprise Systems (MES)

Objective: Through the MES Activity, operate an efficient and effective MES mainframe.

Indicator Name: Average claim processing time in days

Indicator LaPAS PI Code: 2217

1. **Type and Level**: Outcome and Supporting (S)

2. **Rationale:** This PI measures Fiscal Intermediary performance against the CMS and FI contract requirement that all clean claims be processed within 30 days. This standard is a Systems Performance Review criterion for CMS. Retention of the 75% Federal Funds match for the cost of claims processing is dependent upon meeting these criteria. It is also helpful when evaluating provider complaints regarding the length of time it takes for Medicaid to process a claim.

3. **Use**: This indicator will be used to assess the Fiscal Intermediary's performance. Failure of the FI to meet the criteria could result in fiscal sanctions.

4. **Clarity**: Claims processed refer to all claims that completed adjudication and been paid or denied. "Clean Claims" refer to error-free claims that do not require further resolution before adjudication. CoinServe is the system used to provide online versions of Medicaid Administrative Reports. CMS –Center for Medicare and Medicaid Services refers to the federal agency that administers Medicaid. FI – Fiscal Intermediary/Contractor is responsible for processing Medicaid claims and producing reports.

5. **Accuracy, Maintenance, and Support**: This performance indicator is reviewed by the Office of the Legislative Auditor on a yearly basis and has been found reliable and accurate.

6. **Data Source, Collection, and Reporting**: The information is obtained from the MES Monthly Average Days Report and Claim Count MW-M-20 (formerly MR-0-02) which is drawn from the weekly claims processing cycle. It is available on CoinServe/ESP (desktop) on or before the 10th of the current month for the previous month data.

7. **Calculation Methodology**: The monthly figures on the reports for the prior six (6) months are averaged.

8. **Scope**: A six-month average is reported. It is a statewide figure.

9. **Caveats**: The indicator is affected by the age and volume of recycled (reprocessed) claims.

10. **Responsible Person:** Jonathan Wesley, Medicaid Program Manager 3, Medicaid Enterprise Systems, 225.342.0259, Jonathan.Wesley@la.gov

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Medicaid Enterprise Systems (MES)

Objective: Through the MES Activity, operate an efficient and effective MES mainframe.

Indicator Name: Total number of managed care encounters processed

Indicator LaPAS PI Code: 26086

1. **Type and Level**: Input/Efficiency and Key (K)

2. **Rationale:** This Performance Indicator tracks the total number of encounters processed on a quarterly basis. It will assist with providing information to MES Management regarding Fiscal Intermediary resource usage.

3. **Use**: This indicator will be used to apprise MES Management of the total number of encounters processed by the Fiscal Intermediary.

4. **Clarity**: This indicator is not the same as the chargeable transaction count, because this total count value includes Voids and Denied records that are not part of the chargeable transaction count.

5. **Accuracy, Maintenance, and Support**: There is no record of auditing by Office of Legislative Auditor.

6. **Data Source, Collection, and Reporting**: Record counts are sourced from Louisiana Medicaid's MARS Data Warehouse tables.

7. **Calculation Methodology**: Total numbers reported are a simple count of Louisiana Medicaid ICNs for Original, Adjustment and Void encounter transactions processed in each SFY quarter. The count total includes both Accepted and Denied records. The count total should not include auto generated Credit Offset records for the reversal part of adjustment processing. Encounters are defined as transaction records that use CLQ_Transaction_Type = 2.

8. **Scope**: Total record counts include all encounter transactions processed for Managed Care Organization (MCO) entities and Statewide Management Organization (SMO) entities.

9. **Caveats**: This Performance Indicator is actually an attempt to estimate how many health care transactions will occur for Medicaid Recipients enrolled with the Managed Care Organizations (MCOs), because the number of encounters processed directly relates to the number of health care transactions for Medicaid Recipients enrolled with the MCOs.

10. **Responsible Person:** Jonathan Wesley, Medicaid Program Manager 3, Medicaid Enterprise Systems, 225.342.0259, Jonathan.Wesley@la.gov

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Medicaid Enterprise Systems (MES)

Objective: Through the MES Activity, operate an efficient and effective MES mainframe.

Indicator Name: Total number of managed care capitation payments processed

Indicator LaPAS PI Code: 26087

1. **Type and Level**: Input/Efficiency and Key (K)

2. **Rationale:** This Performance Indicator tracks the total number of capitation payments processed on a quarterly basis. It will assist with providing information to MES Management regarding Fiscal Intermediary resource usage.

3. **Use**: This indicator will be used to apprise MES Management of the total number of capitation payments processed by the Fiscal Intermediary.

4. **Clarity**: For the purposes of this indicator, the term "managed care capitation payments" includes capitation payment records from both Managed Care Organization (MCO) entities and Statewide Management Organization (SMO) entities.

5. **Accuracy, Maintenance, and Support**: There is no record of auditing by Office of Legislative Auditor.

6. **Data Source, Collection, and Reporting**: Record counts are sourced from Louisiana Medicaid's MARS Data Warehouse tables.

7. **Calculation Methodology**: Total numbers reported are a simple count of Louisiana Medicaid ICNs for Original, Adjustment and Void capitation payments processed in each SFY quarter. The count total includes both Accepted and Denied records. The count total should not include auto generated Credit Offset records for the reversal part of adjustment processing. Capitation payments are defined as records that use Type of Service codes 45, 51 and 53.

8. **Scope**: Total record counts reported include both MCO and SMO capitation payments.

9. **Caveats**: This Performance Indicator is actually an attempt to estimate the number of Medicaid Recipients actively enrolled with the Healthy Louisiana MCOs, because the number of capitation payments processed is directly related to the number of Medicaid Recipients actively enrolled with the MCOs.

10. **Responsible Person:** Jonathan Wesley, Medicaid Program Manager 3, Medicaid Enterprise Systems, 225.342.0259, Jonathan.Wesley@la.gov

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Medicaid Enterprise Systems (MES)

Objective: Through the MES Activity, operate an efficient and effective MES mainframe.

Indicator Name: Dollar value of MES contract expenditures

Indicator LaPAS PI Code: 25556

1. **Type and Level**: Input and Key (K)

2. **Rationale:** This indicator gives insight on the quality of services provided by MES contractors. Typically, the Department will assess penalties on contractors after attempts for remediation have failed or in the case of a regular violations or unsatisfactory performance per contract specifications.

3. **Use**: Indicator will be used in management decision-making, impacting services performed by all MES contractors, but focusing primarily on services of the Fiscal Intermediary (FI). Services on which penalties are assessed may be removed from the contract and assumed by the Department or another Contractor. Data may also affect rigidity of service level agreements in future contractual agreements.

4. **Clarity**: Indicator captures all penalties assessed on all MES contractors in the reporting period.

5. **Accuracy, Maintenance, and Support**: The Office of the Legislative Auditor has not reviewed this indicator because it is new.

6. **Data Source, Collection, and Reporting**: Data is maintained on internal budget tracking reports and reported on an annual basis.

7. **Calculation Methodology**: Indicator is calculated based on the sum of assessed penalties on all MES contractors for reporting period.

8. **Scope**: Data is aggregated and reported annually.

9. **Caveats**: Indicator is influenced by level of oversight on contract activities and leniency granted to Contractors.

10. **Responsible Person**: Alicia Parker, Medicaid Program Manager 1B, Medicaid Enterprise Systems | Shared Services, 337-254-7569, Alicia.Parker2@la.gov

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Medicaid Enterprise Systems (MES)

Objective: Through the MES Activity, operate an efficient and effective MES mainframe.

Indicator Name: Percentage of MES contract expenditures with federal funds

Indicator LaPAS PI Code: 25557

1. **Type and Level**: Input and Supporting (S)

2. **Rationale:** This indicator reports on the ability by the MES Section to maximize funding sources, particularly enhanced federal financial participation, for systems development and operations.

3. **Use**: Indicator will be used for budget planning and may affect the approach taken for system modifications and operational changes. As system technologies advance and manual processes are reduced, the likelihood of approval by the Centers for Medicare & Medicaid Services (CMS) for enhanced federal financial participation (75% to 90% FFP) increases.

4. **Clarity**: Indicator name is self-explanatory.

5. **Accuracy, Maintenance, and Support**: Indicator is new and has not been audited by the Office of the Legislative Auditor.

6. **Data Source, Collection, and Reporting**: Expenditures and the percentage of federal financial participation are maintained on internal budget tracking reports and are reported to CMS on the CMS-64 Quarterly Expense Report. Indicator is reported on an annual basis.

7. **Calculation Methodology**: Indicator is calculated as the sum of MES contract expenditures approved for federal funding (numerator) divided by the sum of all MES contract expenditures (denominator) for reporting period (SFY).

8. **Scope**: Data is aggregated and reported annually.

9. **Caveats**: Adjustments to federal reimbursements after the reporting period may not be not reflected in the indicator.

10. **Responsible Person**: Alicia Parker, Medicaid Program Manager 1B, Medicaid Enterprise Systems | Shared Services, 337-254-7569, Alicia.Parker2@la.gov

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Medicaid Enterprise Systems (MES)

Objective: Through the MES Activity, operate an efficient and effective MES mainframe.

Indicator Name: Number of competitive procurements issued for IT services and software for modular MES functions

Indicator LaPAS PI Code: 26572

1. **Type and Level**: Outcome and General (G)

2. **Rationale:** This Performance Indicator measures the number of procurements to meet the CMS requirements of a modular MES with multiple vendors.

3. **Use**: This indicator will be used to measure the movement away from our MES, sole-source vendor to smaller, more outcome-based vendors and to insure as they mature to encompass the business, information, and technical capabilities that embody the Medicaid Enterprise. It will be used for internal management purposes.

4. **Clarity**: CMS requires states to move to an MES made of up reusable and interchangeable modules that are simple, inexpensive, and small. The aim is to increase Medicaid programs' ability to update and change their systems as well as allow earlier access to enhanced rates for implementing IT systems.

5. **Accuracy, Maintenance, and Support**: This is a newly proposed indicator. There is no record of auditing by the Office of Legislative Auditor.

6. **Data Source, Collection, and Reporting**: This information will be obtained from searching or referencing the OSP procurement systems.

7. **Calculation Methodology**: Using the total number of approved, published RFPs for services previously encompassed in the existing, sole-source MES vendor's contract.

8. **Scope**: This indicator is the sum of new RFPs approved by Office of State Procurement (OSP) per state fiscal year.

9. **Caveats**: There is no caveat or qualifier for this new Performance Indicator.

10. **Responsible Person**: Kendal Scheidt, Medicaid Program Manager 4, Project Portfolio Management Office (PPMO), (225) 436-2604, Kendal.Scheidt@la.gov

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Medicaid Enterprise Systems (MES)

Objective: Through the MES Activity, operate an efficient and effective MES mainframe.

Indicator Name: Number of contracts executed for IT services and software for modular MES functions

Indicator LaPAS PI Code: 26573

1. **Type and Level**: Outcome and General (G)

2. **Rationale:** This Performance Indicator measures the number of contracts awarded to meet the CMS requirements of a modular MES with multiple vendors.

3. **Use**: This indicator will be used to measure the movement away from our MES, sole-source vendor to smaller, more outcome-based vendors and to insure as they mature to encompass the business, information, and technical capabilities that embody the Medicaid Enterprise. It will be used for internal management purposes

4. **Clarity**: CMS requires states to move to an MES made of up reusable and interchangeable modules that are simple, inexpensive, and small. The aim is to increase Medicaid programs' ability to update and change their systems as well as allow earlier access to enhanced rates for implementing IT systems.

5. **Accuracy, Maintenance, and Support**: This is a newly proposed indicator. There is no record of auditing by the Office of Legislative Auditor.

6. **Data Source, Collection, and Reporting**: This information will be obtained from searching or referencing the OSP procurement systems for awarded contracts.

7. **Calculation Methodology**: Using the total number of approved, awarded contracts for services and the resulting services scheduled to be excluded from the existing, sole-source MES vendor.

8. **Scope**: This indicator is the sum of new contracts approved by Office of State Procurement (OSP) and CMS per state fiscal year, and consequently signed and executed.

9. **Caveats**: There is no caveat or qualifier for this new Performance Indicator.

10. **Responsible Person**: Kendal Scheidt, Medicaid Program Manager 4, Project Portfolio Management Office (PPMO), (225) 436-2604, Kendal.Scheidt@la.gov

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Medicaid Enterprise Systems (MES)

Objective: Through the MES Activity, operate an efficient and effective MES mainframe.

Indicator Name: Number of IT services and software designed, developed, or deployed for modular MES functions

Indicator LaPAS PI Code: 26574

1. **Type and Level**: Outcome and General (G)

2. **Rationale:** This Performance Indicator measures the number of modules implemented to meet the CMS requirements of a modular MES with multiple vendors.

3. **Use**: This measure will describe the overall health of a project in terms of the schedule. If used in conjunction with the system requirements and the overall project plan, the DDI phase should depict milestones that display if the project is on target with its scheduled completion date and if it conforms to the overall project plan. It will be used for internal management purposes.

4. **Clarity**: The term "Design, Development, and Implementation (DDI) Phase" refers to the phase where requirements are gathered and validated; design documents are constructed; systems and solutions built and integrated; unit, system, and user acceptance testing are performed; and cutover activity and system implementation are performed.

5. **Accuracy, Maintenance, and Support**: The data for this indicator will be gathered throughout the lifecycle of the project. Tracking of this indicator commences after the execution of contract with a vendor/contractor who develops/constructs/integrates a system or sub-system tailored to the Medicaid Enterprise business needs. This is a newly proposed indicator. There is no record of auditing by the Office of Legislative Auditor.

6. **Data Source, Collection, and Reporting**: This information will be obtained from searching or referencing the project implementation systems JAMA and JIRA for documentation to support DDI and deployment of new MES systems. This information will be in a publication on a monthly basis but reported on an annual basis.

7. **Calculation Methodology**: Using the total number of in progress and/or completed modularity projects for MES services and the resulting services excluded from the existing, sole-source MES vendor.

8. **Scope**: This indicator is the sum of new, MES projects started or completed per state fiscal year.

9. **Caveats**: Tracking of this indicator commences after the execution of contract with a vendor/contractor.

10. **Responsible Person**: Kendal Scheidt, Medicaid Program Manager 4, Project Portfolio Management Office (PPMO), (225) 436-2604, Kendal.Scheidt@la.gov

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Medicaid Enterprise Systems (MES)

Objective: Through the MES Activity, operate an efficient and effective MES mainframe.

Indicator Name: Total number of claims processed

Indicator LaPAS PI Code: 12020

1. **Type and Level**: Output and General (G)

2. **Rationale:** This PI gives the total number of claims processed (adjudicated) an important measure of the performance of the Fiscal Intermediary and the MES Claims Processing System.

3. **Use**: This indicator evaluates the performance of the Fiscal Intermediary and is for performance-based budgeting. The Fiscal Intermediary contract bases payment for the Claims Processing function on the number of paid claims each month.

4. **Clarity**: "Claims processed" refer to all claims that completed adjudication and been paid or denied. CoinServe is a system that provides online versions of Medicaid Administrative Reports.

5. **Accuracy, Maintenance, and Support**: This performance indicator is reviewed by the Office of the Legislative Auditor on a yearly basis and has been found reliable and accurate.

6. **Data Source, Collection, and Reporting**: The information is obtained from the MES Monthly Average Days Report and Claim Count MW-M-20 (formerly MR-0-02) which is drawn from the weekly claims processing cycle. It is available on CoinServe/ESP + desktop on or before the 10th of the current month for the previous month data.

7. **Calculation Methodology**: The data comes directly from the "Current Year Claim Count" field.

8. **Scope**: The sum of total claims paid and total claims denied.

9. **Caveats**: The volume of recycled (reprocessed) claims affects the indicator.

10. **Responsible Person**: Jonathan Wesley, Medicaid Program Manager 3, Medicaid Enterprise Systems, 225.342.0259, Jonathan.Wesley@la.gov

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Financial Management

Objective: Through the Financial Management Activity, administer the Medicaid program and ensure that financial operations are in accordance with federal and state statutes, rules, and regulations.

Indicator Name: Administrative cost as a percentage of total cost

Indicator LaPAS PI Code: 24045

1. **Type and Level**: Efficiency and Key (K)

2. **Rationale:** This indicator reports the percentage of total Medicaid cost to administer the Medicaid Program in relationship to the total Medicaid Program cost for the delivery of service.

3. **Use**: Management will use the results to adjust administrative cost to avoid exceeding the performance standard that has been set. This report is for internal management use. It will also be used for performance based budgeting to identify ways to cost effectively administer the Medicaid Program.

4. **Clarity**: Yes, the indicator name clearly identifies what is being measured.

5. **Accuracy, Maintenance, and Support**: This is a new indicator for FY2011 and has not yet been audited by the Office of the Legislative Auditor. Calculations are made using information reported by the Division of Administration ISIS system.

6. **Data Source, Collection, and Reporting**: The source of data for the indicator is the Division of Administration Financial database and internal databases which tracks the Existing Operating Budgets for Medical Vendor Administration and Medical Vendor Payments. Data collection reports occur on a SFY basis for the current year.

7. **Calculation Methodology**: The indicator is calculated by dividing the total Medicaid Administrative cost by the total Medicaid Program cost.

8. **Scope**: This indicator is aggregated. The calculation is based on the total cost.

9. **Caveats**: This indicator does not have any limitations or weaknesses

10. **Responsible Persons**: Caleb Dunbar, Medicaid Program Manager 1A, (225) 342-3975, Caleb.Dunbar3@la.gov and Katrina MaGee, Medicaid Program Manager 2, (225) 342-9492, Katrina.Magee@la.gov

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Financial Management

Objective: Through the Financial Management Activity, administer the Medicaid program and ensure that financial operations are in accordance with federal and state statutes, rules, and regulations.

Indicator Name: Percentage of State Plan amendments approved

Indicator LaPAS PI Code: 24046

1. **Type and Level**: Output and General (G)

2. **Rationale:** This indicator reports the percentage of State Plan amendments approved by CMS.

3. **Use**: The results are used by internal management to evaluate the performance of the personnel who are responsible for developing the State Plan amendments, writing, negotiating, and obtaining CMS approval of the proposed amendments.

4. **Clarity**: This indicator provides evidence of our State Plan Amendment submission clarity and our level of understanding of CMS requirements and regulations by calculating our approval rate.

5. **Accuracy, Maintenance, and Support**: The Office of the Legislative Auditor with positive results has audited this indicator.

6. **Data Source, Collection, and Reporting**: The source of the data is correspondence received from CMS indicating amendment approvals and the internal database. Quarterly data collection reports occur annually on a State Fiscal Year basis.

7. **Calculation Methodology**: The percentage is calculated by dividing the number of State Plan amendments approved by CMS by the total number of State Plan amendments that CMS has rendered a decision (approved or denied) on during the fiscal year.

8. **Scope**: This indicator is aggregated. The calculation is based on the total number of State Plan amendments approved.

9. **Caveats**: Not all amendments submitted in the current State Fiscal Year will receive approval in the same year. Those amendments remain in a pending status and are counted in the year of approval or withdrawal.

10. **Responsible Persons**: Marjorie Jenkins, Policy & Compliance, Medicaid Program Manager 4, (225) 342-5924, Marjoirie.Jenkins@la.gov

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Financial Management

Objective: Through the Financial Management Activity, administer the Medicaid program and ensure that financial operations are in accordance with federal and state statutes, rules, and regulations.

Indicator Name: Number of State Plan amendments submitted

Indicator LaPAS PI Code: 24047

1. **Type and Level**: Output and General (G)

2. **Rationale:** This indicator reports the percentage of State Plan amendments approved by CMS.

3. **Use**: Internal management will use the results to evaluate the performance of the personnel who are responsible for developing the State Plan amendments uses the results.

4. **Clarity**: The indicator name clearly identifies what is being measured.

5. **Accuracy, Maintenance, and Support**: The Office of the Legislative Auditor with positive results has audited this indicator.

6. **Data Source, Collection, and Reporting**: The source of the data is correspondence, State Plan pages, fiscal impacts, and supporting documents submitted to CMS indicating the plan of the State to adopt federal regulations. The data is collected quarterly and reported annually on a State Fiscal Year basis.

7. **Calculation Methodology**: The indicator is calculated by taking a count of the number of State Plan amendments submitted to CMS.

8. **Scope**: This indicator is aggregated. The calculation is based on the total number of State Plan amendments submitted.

9. **Caveats**: Not all amendments submitted in the current State Fiscal Year may complete the approval process; a very low number of them may be withdrawn due to changes on State decision to pursue the federal requirements.

10. **Responsible Persons**: Marjorie Jenkins, Policy & Compliance, Medicaid Program Manager 4, (225) 342-5924, Marjoirie.Jenkins@la.gov

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Financial Management

Objective: Through the Financial Management Activity, reduce the incidence of inappropriate Medicaid expenditures and annually perform a minimum of 95% of the planned monitoring visits to Local Education Authorities (LEA) participating in the Medicaid School-Based Administrative Claiming Program or the Early Periodic Screening Diagnostic and Treatment (EPSDT) Direct Services Program.

Indicator Name: Number of LEA quarterly claims targeted for monitoring

Indicator LaPAS PI Code: 13375

1. **Type and Level**: Output and Supporting (S)

2. **Rationale:** This indicator measures the number of LEAs participating in the Medicaid Administrative Claiming (MAC) Program, the Direct Services Program, the Nursing Program, and the Behavioral Health program that are targeted. This indicator was selected because it is measurable and accurately describes the intent of the performance reporting.

3. **Use**: This performance indicator is used to assess the monitoring activity of the school boards participating in Medicaid programs. These programs are under scrutiny nationwide and require in-depth monitoring to control.

4. **Clarity**: None

5. **Accuracy, Maintenance, and Support**:

6. **Data Source, Collection, and Reporting**: Postlethwaite and Netterville will be performing the monitoring activities.

7. **Calculation Methodology**: Figures are the number of LEAs monitored by Postlethwaite and Netterville (Jason Coker). It is about a third of the LEAs. Postlethwaite and Netterville does all of the monitoring in Quarters 3 and 4.

8. **Scope**: Aggregated

9. **Caveats**: This indicator does not have any limitations or weaknesses

10. **Responsible Person**: Lindsey Nizzo, Program Manager 2, Rate Setting & Audit, (225) 342-3613, Lindsey.Nizzo@LA.GOV

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Financial Management

Objective: Through the Financial Management Activity, reduce the incidence of inappropriate Medicaid expenditures and annually perform a minimum of 95% of the planned monitoring visits to Local Education Authorities (LEA) participating in the Medicaid School-Based Administrative Claiming Program or the Early Periodic Screening Diagnostic and Treatment (EPSDT) Direct Services Program.

Indicator Name: Percentage of targeted Local Education Agencies monitored

Indicator LaPAS PI Code: 13376

1. **Type and Level**: Output and Key (K)

2. **Rationale:** This indicator measures the percentage of school board claims monitored that were targeted for monitoring. This indicator was selected because it is measurable and accurately describes the intent of the monitoring performance indicator.

3. **Use**: This performance indicator is used to assess the monitoring activity of the school boards participating in Medicaid programs. These programs are under scrutiny nationwide and require in-depth monitoring to control.

4. **Clarity**: None

5. **Accuracy, Maintenance, and Support**:

6. **Data Source, Collection, and Reporting**: Postlethwaite and Netterville will be performing the monitoring activities.

7. **Calculation Methodology**: Figures are calculated by getting the number of LEAs monitored by Postlethwaite and Netterville. The number of LEAs targeted for monitoring then divides this total. Multiply this figure by 100. Postlethwaite and Netterville targets about one-third of the LEAs.

8. **Scope**: Aggregated

9. **Caveats**: This indicator does not have any limitations or weaknesses

10. **Responsible Person**: Lindsey Nizzo, Program Manager 2, Rate Setting & Audit, (225) 342-3613, Lindsey.Nizzo@LA.GOV

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Financial Management

Objective: Through the Financial Management Activity, reduce the incidence of inappropriate Medicaid expenditures and annually perform a minimum of 95% of the planned monitoring visits to Local Education Authorities (LEA) participating in the Medicaid School-Based Administrative Claiming Program or the Early Periodic Screening Diagnostic and Treatment (EPSDT) Direct Services Program.

Indicator Name: Number of Nursing Home cost reports targeted for monitoring

Indicator LaPAS PI Code: 25549

1. **Type and Level**: Output and Supporting (S)

2. **Rationale:** This indicator measures the number of nursing home cost reports monitored that were targeted for monitoring. This indicator was selected because it is measurable and accurately describes the intent of the monitoring performance indicator.

3. **Use**: This performance indicator is used to assess the monitoring activity of the nursing homes participating in Medicaid programs.

4. **Clarity**: None

5. **Accuracy, Maintenance, and Support**: None

6. **Data Source, Collection, and Reporting**: Contractor status report (located on server at: P&N (Postlethwaite & Netterville)/Monthly Status Report/FY XX). In report, select "Queries": "NH201X audited." (Note: If status report for previous month is not in yet, get estimate for previous month from P&N (Missy Peroyea), and add to total from status report for the month before.)

7. **Calculation Methodology**: It is the number of full scope and limited scope audits done by the contractor.

8. **Scope**: Aggregated.

9. **Caveats**: This indicator does not have any limitations or weaknesses

10. **Responsible Person**: Lindsey Nizzo, Program Manager 2, Rate Setting & Audit, (225) 342-3613, Lindsey.Nizzo@LA.GOV

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Financial Management

Objective: Through the Financial Management Activity, reduce the incidence of inappropriate Medicaid expenditures and annually perform a minimum of 95% of the planned monitoring visits to Local Education Authorities (LEA) participating in the Medicaid School-Based Administrative Claiming Program or the Early Periodic Screening Diagnostic and Treatment (EPSDT) Direct Services Program.

Indicator Name: Percentage of Nursing Home cost reports monitored

Indicator LaPAS PI Code: 25550

1. **Type and Level**: Output and Key (K)

2. **Rationale:** This indicator measures the percentage of Nursing Home cost reports monitored that were targeted for monitoring. This indicator was selected because it is measurable and accurately describes the intent of the monitoring performance indicator.

3. **Use**: This performance indicator is used to assess the monitoring activity of the nursing homes participating in Medicaid programs.

4. **Clarity**: None

5. **Data Source, Collection, and Reporting**: Contractor status report.

6. **Calculation Methodology**: It is (the number of full scope and limited scope audits done by the contractor (PI 25549) divided by the total number of facilities (Rate Calculation sheet from Myers and Stauffer)) x 100.

7. **Scope**: Aggregated.

8. **Caveats**: This indicator does not have any limitations or weaknesses

9. **Accuracy, Maintenance, and Support**: None

10. **Responsible Person**: Lindsey Nizzo, Program Manager 2, Rate Setting & Audit, (225) 342-3613, Lindsey.Nizzo@LA.GOV

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Financial Management

Objective: Through the Financial Management Activity, reduce the incidence of inappropriate Medicaid expenditures and annually perform a minimum of 95% of the planned monitoring visits to Local Education Authorities (LEA) participating in the Medicaid School-Based Administrative Claiming Program or the Early Periodic Screening Diagnostic and Treatment (EPSDT) Direct Services Program.

Indicator Name: Number of Intermediate Care Facility (ICF) cost reports targeted for monitoring

Indicator LaPAS PI Code: 25551

1. **Type and Level**: Output and Supporting (S)

2. **Rationale:** This indicator measures the number of Intermediate Care Facilities (ICF) cost reports monitored that were targeted for monitoring. This indicator was selected because it is measurable and accurately describes the intent of the monitoring performance indicator.

3. **Use**: This performance indicator assesses the monitoring activity of the Intermediate Care Facilities (ICF) participating in Medicaid programs.

4. **Clarity**: None

5. **Data Source, Collection, and Reporting**: Contractor's invoices.

6. **Calculation Methodology**: It is the number of full scope and limited scope audits done by the contractor. Get total from the P&N invoices (on Rate Setting and Audit server). Yes. (P&N will be doing all, or the majority, of these audits in Quarters 3 & 4.).

7. **Scope**: Aggregated.

8. **Caveats**: This indicator does not have any limitations or weaknesses

9. **Accuracy, Maintenance, and Support**:

10. **Responsible Person**: Lindsey Nizzo, Program Manager 2, Rate Setting & Audit, (225) 342-3613, Lindsey.Nizzo@LA.GOV

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Financial Management

Objective: Through the Financial Management Activity, reduce the incidence of inappropriate Medicaid expenditures and annually perform a minimum of 95% of the planned monitoring visits to Local Education Authorities (LEA) participating in the Medicaid School-Based Administrative Claiming Program or the Early Periodic Screening Diagnostic and Treatment (EPSDT) Direct Services Program.

Indicator Name: Percentage of Intermediate Care Facilities (ICF) cost reports monitored

Indicator LaPAS PI Code: 25552

1. **Type and Level**: Output and Supporting (S)

2. **Rationale:** This indicator measures the percentage of Intermediate Care Facilities (ICF) cost reports monitored that were targeted for monitoring. This indicator was selected because it is measurable and accurately describes the intent of the monitoring performance indicator.

3. **Use**: This performance indicator is used to assess the monitoring activity of the nursing homes participating in Medicaid programs.

4. **Clarity**: None

5. **Data Source, Collection, and Reporting**: Contractor status report.

6. **Calculation Methodology**: It is (the number of full scope and limited scope audits done by the contractor (PI 25551) divided by the total number of facilities ("Tables": "ICFDD 201X")) x 100.

7. **Scope**: Aggregated.

8. **Caveats**: This indicator does not have any limitations or weaknesses

9. **Accuracy, Maintenance, and Support**: None

10. **Responsible Person**: Lindsey Nizzo, Program Manager 2, Rate Setting & Audit, (225) 342-3613, Lindsey.Nizzo@LA.GOV

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Financial Management

Objective: Through the Financial Management Activity, reduce the incidence of inappropriate Medicaid expenditures and annually perform a minimum of 95% of the planned monitoring visits to Local Education Authorities (LEA) participating in the Medicaid School-Based Administrative Claiming Program or the Early Periodic Screening Diagnostic and Treatment (EPSDT) Direct Services Program.

Indicator Name: Number of hospital cost reports reviewed and audited

Indicator LaPAS PI Code: 25553

1. **Type and Level**: Output and Supporting (S)
2. **Rationale:** This monitors the contractor's performance.
3. **Use**: This indicator will be for internal management purposes.
4. **Clarity**: It is clear.
5. **Data Source, Collection, and Reporting**: This number is produced on a monthly basis and provided to the department by the contractor.
6. **Calculation Methodology**: The number is calculated by adding the number of hospital partial settlements completed and the final settlements completed in the reporting period.
7. **Scope**: The number represents the total number of hospital cost reports reviewed and audited which consists of partial settlements and final settlements for in-state hospitals.
8. **Caveats**: Due to the timing of cost reports received from the hospitals, the numbers that are reported will vary from quarter to quarter.
9. **Accuracy, Maintenance, and Support**: This is a number that is reported to the legislative auditor.
10. **Responsible Person:** Sonya Webb-Forbes, Medicaid Program Manager 3, Rate Setting & Audit, (225) 342-0325, Sonya.Webb-Forbes@la.gov

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Financial Management

Objective: Through the Financial Management Activity, reduce the incidence of inappropriate Medicaid expenditures and annually perform a minimum of 95% of the planned monitoring visits to Local Education Authorities (LEA) participating in the Medicaid School-Based Administrative Claiming Program or the Early Periodic Screening Diagnostic and Treatment (EPSDT) Direct Services Program.

Indicator Name: Number of LEA claims adjusted because of monitoring activities

Indicator LaPAS PI Code: 16539

1. **Type and Level**: Efficiency and General (G)

2. **Rationale:** This indicator measures the accuracy of reporting cost of LEAs participating in the Medicaid Administrative Claiming (MAC) Program, the Direct Services Program, the Nursing Program and the Behavioral Health Program that are targeted. This indicator was selected because it is measurable and accurately describes the intent of the performance reporting.

3. **Use**: This performance indicator assesses the monitoring activity of the school boards participating in Medicaid programs. These programs are under scrutiny nationwide and require in-depth monitoring to control.

4. **Clarity**: None

5. **Accuracy, Maintenance, and Support**: None

6. **Data Source, Collection, and Reporting**: Total number of claims adjusted from Jason Coker, P&N.

7. **Calculation Methodology**: The number of the claims audited by Postlethwaite and Netterville.

8. **Scope**: Aggregated.

9. **Caveats**: This indicator does not have any limitations or weaknesses

10. **Responsible Person**: Lindsey Nizzo, Program Manager 2, Rate Setting & Audit, (225) 342-3613, Lindsey.Nizzo@LA.GOV

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Financial Management

Objective: Through the Financial Management Activity, reduce the incidence of inappropriate Medicaid expenditures and annually perform a minimum of 95% of the planned monitoring visits to Local Education Authorities (LEA) participating in the Medicaid School-Based Administrative Claiming Program or the Early Periodic Screening Diagnostic and Treatment (EPSDT) Direct Services Program.

Indicator Name: Amount identified as over claimed by LEAs because of monitoring

Indicator LaPAS PI Code: 13540

1. **Type and Level**: Efficiency and General (G)

2. **Rationale:** This indicator measures the total expenditures paid to participating school boards inappropriately but identified by LDH during the auditing process. This indicator is necessary because it is measurable and accurately describes the intent of the monitoring activity.

3. **Use**: This performance indicator assesses the monitoring activity of the school boards participating in Medicaid programs. These programs are under scrutiny nationwide and require in-depth monitoring to control.

4. **Clarity**: None

5. **Accuracy, Maintenance, and Support**: None

6. **Data Source, Collection, and Reporting**: The source is our contractor, Jason Coker, with Postlethwaite and Netterville.

7. **Calculation Methodology**: Total amount identified as overpayment.

8. **Scope**: Aggregated.

9. **Caveats**: Sometimes monitoring results in increasing the amount due to the LEAs. LEAs often understate their cost and that is corrected as well during the monitoring process. The goal of his monitoring is accuracy.

10. **Responsible Person**: Lindsey Nizzo, Program Manager 2, Rate Setting & Audit, (225) 342-3613, Lindsey.Nizzo@LA.GOV

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Financial Management

Objective: Through the Financial Management Activity, reduce the incidence of inappropriate Medicaid expenditures and annually perform a minimum of 95% of the planned monitoring visits to Local Education Authorities (LEA) participating in the Medicaid School-Based Administrative Claiming Program or the Early Periodic Screening Diagnostic and Treatment (EPSDT) Direct Services Program.

Indicator Name: Number of Nursing Home cost reports adjusted because of monitoring activities

Indicator LaPAS PI Code: 25554

1. **Type and Level**: Efficiency and General (G)

2. **Rationale:** This indicator measures the accuracy of reporting cost of Nursing Homes participating in the Medicaid Program. This indicator was selected because it is measurable and accurately describes the intent of the performance reporting.

3. **Use**: This performance indicator assesses the monitoring activity of the nursing homes participating in Medicaid programs.

4. **Clarity**: None

5. **Accuracy, Maintenance, and Support**: None

6. **Data Source, Collection, and Reporting**: Contractor status report and contractor database.

7. **Calculation Methodology**: It is (the number of full scope and limited scope audits done by the contractor listed on the Status Report (PI 25549)) minus (the number of limited scope audits that did not have adjustments listed on the Database).

8. **Scope**: Aggregated

9. **Caveats**: This indicator does not have any limitations or weaknesses

10. **Responsible Person**: Lindsey Nizzo, Program Manager 2, Rate Setting & Audit, (225) 342-3613, Lindsey.Nizzo@LA.GOV

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Financial Management

Objective: Through the Financial Management Activity, reduce the incidence of inappropriate Medicaid expenditures and annually perform a minimum of 95% of the planned monitoring visits to Local Education Authorities (LEA) participating in the Medicaid School-Based Administrative Claiming Program or the Early Periodic Screening Diagnostic and Treatment (EPSDT) Direct Services Program.

Indicator Name: Number of Intermediate Care Facilities (ICF) cost reports adjusted because of monitoring activities

Indicator LaPAS PI Code: 25555

1. **Type and Level**: Efficiency and General (G)
2. **Rationale:** This indicator measures the accuracy of reporting cost of Intermediate Care Facility (ICF participating in the Medicaid Program. This indicator was selected because it is measurable and accurately describes the intent of the performance reporting.
3. **Use**: This performance indicator assesses the monitoring activity of the nursing homes participating in Medicaid programs.
4. **Clarity**: None
5. **Accuracy, Maintenance, and Support**: None
6. **Data Source, Collection, and Reporting**: Contractor status report.
7. **Calculation Methodology**: Contractor's invoices.
8. **Scope**: Aggregated
9. **Caveats**: This indicator does not have any limitations or weaknesses
10. **Responsible Person**: Lindsey Nizzo, Program Manager 2, Rate Setting & Audit, (225) 342-3613, Lindsey.Nizzo@LA.GOV

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Financial Management

Objective: Through the Financial Management Activity, pursue collections from third party sources legally responsible for health care costs of Medicaid and CHIP enrollees.

Indicator Name: Number of TPL claims processed

Indicator LaPAS PI Code: 2215

1. **Type and Level**: Output and Key (K)

2. **Rationale:** All claims that enter the system pass through the third party liability (TPL) edits. Measure the procedures in place to identify all TPL claims.

3. **Use**: Report will become the report card for appropriately subjecting all claims to the TPL edits and will serve to identify system defects or inconsistencies.

4. **Clarity**: None

5. **Accuracy, Maintenance, and Support**: This Performance Indicator is subject to audit by the Office of the Legislative Auditor.

6. **Data Source, Collection, and Reporting**: Figures come from the TP-F-68Q, which provides the number of TPL claims processed. The fiscal intermediary produces the reports.

7. **Calculation Methodology**: The TP-F-68Q is a quarterly report, which gives the number of claims edited for third party coverage in a given quarter.

8. **Scope**: Statewide

9. **Caveats**: Downtime for the claims processing system would affect all claims.

10. **Responsible Persons**: Delvina Drewery, TPL & Coordination of Benefits Analyst, 225-747-4567, Delvina.Drewery@LA.GOV; Sadrina Clayton, Medicaid Program Manager 2, Medicaid Vendor Payments, (225) 219-4016, Sadrina.Clayton@la.gov; and Jackie Cummings, Medicaid Program Manager 4, Medicaid Vendor Payments, (225) 342-7505, Jackie.Cummings2@la.gov

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Financial Management

Objective: Through the Financial Management Activity, pursue collections from third party sources legally responsible for health care costs of Medicaid and CHIP enrollees.

Indicator Name: Percentage of TPL claims processed through edits

Indicator LaPAS PI Code: 7957

1. **Type and Level**: Output and Key (K)

2. **Rationale:** All claims that enter the system pass through the third party liability edits. Measure the procedures in place to identify all third party liability (TPL) claims.

3. **Use**: Report will become the "report card" for appropriately subjecting all claims to the TPL edits and will serve to identify system defects or inconsistencies.

4. **Clarity**: None

5. **Accuracy, Maintenance, and Support**: This Performance Indicator is subject to audit by the Office of the Legislative Auditor.

6. **Data Source, Collection, and Reporting**: Figures are taken from report number CNTL-2M600. All non-exempt claims that enter the system for processing access the Medicaid recipient file. This file reflects indicators that tell the system whether there is third party coverage. If coverage exists, the system then accesses the TPL resource file to determine if a third party (health insurance, Medicare A and/or B) is responsible for payment prior to a Medicaid payment.

7. **Calculation Methodology**: The CNTL-2M600 is a monthly report which gives the percentage of claims edited for third party coverage in a given month. The number of claims edited to date for the reporting period is divided by the number of claims available for editing for that same period. The result is a cumulative average for each quarterly reporting period.

8. **Scope**: Statewide information can be broken down into Medicare and private insurance amounts cost-avoided.

9. **Caveats**: Downtime for the claims processing system would affect all claims.

10. **Responsible Persons**: Delvina Drewery, TPL & Coordination of Benefits Analyst, 225-747-4567, Delvina.Drewery@LA.GOV; Sadrina.Clayton, Medicaid Program Manager 2, Medicaid Vendor Payments, (225) 219-4016, Sadrina.Clayton@la.gov; and Jackie Cummings, Medicaid Program Manager 4, Medicaid Vendor Payments, (225) 342-7505, Jackie.Cummings2@la.gov

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Financial Management

Objective: Through the Financial Management Activity, pursue collections from third party sources legally responsible for health care costs of Medicaid and CHIP beneficiaries.

Indicator Name: TPL trauma recovery amount

Indicator LaPAS PI Code: 7958

1. **Type and Level**: Output and Supporting (S)

2. **Rationale:** This indicator gives the Recovery and Premium Assistance (RPA) Unit's state fiscal year total of dollars recovered from liable third parties for injury/accident-related Medicaid beneficiary expenditures.

3. **Use**: Accumulation of data for this indicator produces current recoveries and future estimations of funds recovered by the RPA Unit.

4. **Clarity**: Total collections consist of: (a) Trauma Recovery; (b) Accident/Injury Report (A/IR) collections; (c) Health Recovery; and (d) Global Settlements.

5. **Accuracy, Maintenance, and Support**: This Performance Indicator is subject to audit by the Office of the Legislative Auditor. Related data is verifiable via monthly reports providing recovery amounts.

6. **Data Source, Collection, and Reporting**: Collections are obtained from the monthly reports produced by the Louisiana Medicaid Management Information System (LMMIS)/Third Party Liability (TPL) Recovery Report Archive.

7. **Calculation Methodology**: This figure is calculated by adding the reported monthly totals for A/IR collections, miscellaneous health recoveries, and global settlements to the monthly total reported for Trauma Recovery.

8. **Scope**: The scope is statewide. Information can be broken down by the individual Trauma Recovery Program Specialist's, Supervisor's, or Manager's caseload, each of which is comprised of several parishes.

9. **Caveats**: The reports are dependent upon claims processed through the Fiscal Intermediary's claims processing system. The RPA Unit's collection reports also depend upon the precision of the TPL Recovery application of LMMIS. Any breakdown or variation in these systems could directly affect this total. Staffing consequences (i.e. prolonged absence, staff shortage, etc.) and volume associated with increased settlement disbursements may result in uneven and fluctuating collections.

10. **Responsible Persons**: Becky Bach, Medicaid Program Manager 1B, Medicaid Vendor Payments, (225) 342-5059, Becky.Bach@la.gov; Sadrina Clayton, Medicaid Program Manager 2, Medicaid Vendor Payments, (225) 219-4016, Sadrina.Clayton@la.gov; and Jackie Cummings, Medicaid Program Manager 4, Medicaid Vendor Payments, (225) 342-7505, Jackie.Cummings2@la.gov

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Financial Management

Objective: Through the Financial Management Activity, pursue collections from third party sources legally responsible for health care costs of Medicaid and CHIP enrollees.

Indicator Name: Number of claims available for TPL processing

Indicator LaPAS PI Code: 12021

1. **Type and Level**: Output and General (G)

2. **Rationale:** This indicator gives the total number of claims available for third party liability processing to assist in determining the effectiveness of the program.

3. **Use**: Gives management the exact number of claims that should result in third party liability processing.

4. **Clarity**: Number of claims available for third party liability processing

5. **Accuracy, Maintenance, and Support**: This Performance Indicator is subject to audit by the Office of the Legislative Auditor.

6. **Data Source, Collection, and Reporting**: This figure comes from the monthly MM-0-33 report of Year-to-Date claims payments statistics, which may be found on the LMES CoinServe. The contractor that serves as the fiscal intermediary produces the reports.

7. **Calculation Methodology**: Claims available - The total number of pay and chase claim types 08 (non-emergency medical transportation), 13 (EPSDT), and 16 (adult day care) processed are subtracted from the grand total of all claims types processed to produce the number of claims available for TPL processing.

8. **Scope**: Statewide

9. **Caveats**: The MM-0-33 is dependent on claims processed through the Fiscal Intermediary Claims Processing System. Any breakdown or variation in the system could directly affect this count. In addition, mailing loss of a claims tape or problems processing a claims tape from Medicare could affect the count.

10. **Responsible Person**: Delvina Drewery, TPL & Coordination of Benefits Analyst, 225-747-4567, Delvina.Drewery@LA.GOV; Sadrina.Clayton, Medicaid Program Manager 2, Medicaid Vendor Payments, (225) 219-4016, Sadrina.Clayton@la.gov; and Jackie Cummings, Medicaid Program Manager 4, Medicaid Vendor Payments, (225) 342-7505, Jackie.Cummings2@la.gov

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Financial Management

Objective: Through the Financial Management Activity, pursue collections from third party sources legally responsible for health care costs of Medicaid and CHIP enrollees.

Indicator Name: Percentage of TPL claims processed and cost-avoided

Indicator LaPAS PI Code: 12022

1. **Type and Level**: Output and General (G)

2. **Rationale:** This indicator gives the total number of claims available for third party liability processing to assist in determining the effectiveness of the program.

3. **Use**: Gives management the exact number of claims that should result in third party liability processing.

4. **Clarity**: Number of claims available for third party liability processing.

5. **Accuracy, Maintenance, and Support**: This Performance Indicator is subject to audit by the Office of the Legislative Auditor.

6. **Data Source, Collection, and Reporting**: This figure comes from the monthly MM-0-33 report that provides the claims available for TPL editing and the MRO68 that provides the number of TPL claims processed. The fiscal intermediary produces the reports.

7. **Calculation Methodology**: The total number of pay and chase claim types 08 (non-emergency medical transportation), 13 (EPSDT), and 16 (adult day care) processed are subtracted from the grand total of all claims types processed to produce the number of claims available for TPL processing. Claims processed - information extracted from the MR068. Percentage calculated by dividing claims processed by the claims available.

8. **Scope**: Statewide

9. **Caveats**: The MM-0-33 is dependent on claims processed through the Fiscal Intermediary Claims Processing System. Any breakdown or variation in the system could directly affect this count. In addition, mailing loss of a claims tape or problems processing a claims tape from Medicare could affect the count.

10. **Responsible Person**: Delvina Drewery, TPL & Coordination of Benefits Analyst, 225-747-4567, Delvina.Drewery@LA.GOV; Sadrina.Clayton, Medicaid Program Manager 2, Medicaid Vendor Payments, (225) 219-4016, Sadrina.Clayton@la.gov; and Jackie Cummings, Medicaid Program Manager 4, Medicaid Vendor Payments, (225) 342-7505, Jackie.Cummings2@la.gov

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Financial Management

Objective: Through the Financial Management Activity, pursue collections from third party sources legally responsible for health care costs of Medicaid and CHIP enrollees.

Indicator Name: Funds recovered from third parties with a liability for services provided by Medicaid

Indicator LaPAS PI Code: 24044

1. **Type and Level**: Output and General (G)

2. **Rationale:** This indicator gives the total dollars collected from various third parties.

3. **Use**: This indicator gives management the amount collected from various third parties to arrive at a full picture of LDH's and its vendors' collection/recovery performance.

4. **Clarity**: Total collections consist of: (a) collection efforts of the Recovery and Premium Assistance Unit - Trauma, Recipient, & Estate; (b) Medicare Recovery projects performed by the Fiscal Intermediary (FI); and (c) collection efforts of the Third Party Liability (TPL) contractor.

5. **Accuracy, Maintenance, and Support**: This Performance Indicator is subject to audit by the Office of the Legislative Auditor. Related data is verifiable via monthly reports and invoices providing recovery amounts and activity.

6. **Data Source, Collection, and Reporting**: This figure comes from multiple sources: (a) monthly reports produced by the Fiscal Intermediary (LMMIS/TPL Recovery, Report Archive - Trauma, Recipient, and Estate Recovery; and LMMIS/Report Viewer (Coinserv), CP-0-12A, and CP-0-12B - Medicare Recovery) and (b) monthly invoice documentation (collections from the TPL contractor).

7. **Calculation Methodology**: The funds recovered are the sum of the various reports.

8. **Scope**: The indicator's scope is statewide.

9. **Caveats**: The reports are dependent upon claims processed through the Fiscal Intermediary's claims processing system. The RPA Unit's collection reports also depend upon the precision of the TPL Recovery application of LMMIS. Activity reported for work performed by the TPL contractor is depended upon the precision of invoice reporting/payment, as provided by the TPL contractor and contract monitor. Any breakdown or variation in these systems/reports could directly affect this total. Problems processing a claim file from Medicare could also affect this total.

10. **Responsible Persons**: Sadrina Clayton, Medicaid Program Manager 2, Medicaid Vendor Payments, (225) 219-4016, Sadrina.Clayton@la.gov; Becky Bach, Medicaid Program Manager 1B, Medicaid Vendor Payments, (225) 342-5059, Becky.Bach@la.gov; and Jackie Cummings, Medicaid Program Manager 4, Medicaid Enterprise Systems, (225) 342-7505, Jackie.Cummings2@la.gov

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Financial Management

Objective: Through the Financial Management Activity, increase collections through the Collections/Recovery and Cost Avoidance activity by 1% from estates of individuals who were aged 55 or older when Medicaid paid long-term care facility services, home and community-based services, and related hospital and prescription drug services.

Indicator Name: Estate recovery amount

Indicator LaPAS PI Code: 25567

1. **Type and Level**: Output and Supporting (S)

2. **Rationale:** This indicator gives the Recovery and Premium Assistance (RPA) Unit's state fiscal year total of dollars recovered from the estates of deceased Medicaid beneficiaries that were age 55 or older, were in a nursing home or received home and community-based services (HCBS), and related hospital and prescription drug services paid by Medicaid – after consideration of applicable offsets.

3. **Use**: Accumulation of data for this indicator produces current recoveries and future estimations of funds recovered by the RPA Unit.

4. **Clarity**: None

5. **Accuracy, Maintenance, and Support**: This Performance Indicator is subject to audit by the Office of the Legislative Auditor. Related data is verifiable via monthly reports providing recovery amounts.

6. **Data Source, Collection, and Reporting**: Collections come from the monthly reports produced by the LMMIS/TPL Recovery Report Archive.

7. **Calculation Methodology**: This figure calculates from the monthly reports the Fiscal Intermediary produces via the LMMIS/TPL Recovery Report Archive.

8. **Scope**: The scope is statewide. Information can be broken down by the individual Estate Recovery Program Specialist's, Supervisor's, or Manager's caseload, each of which is comprised of several parishes.

9. **Caveats**: The reports are dependent upon claims processed through the Fiscal Intermediary's claims processing system. The RPA Unit's collection reports also depend upon the precision of the TPL Recovery application of LMMIS. Any breakdown or variation in these systems could directly affect this total. The following may result in uneven and fluctuating collections: staffing consequences (i.e. prolonged absence, staff shortage, etc.), volume associated with the sale of homes for which LDH has filed its proof of claim, and unmeasurable variables resulting in eventual reimbursement to the State, after applicable offsets.

10. **Responsible Persons**: Gwendolyn Williams, Medicaid Program Manager 1B, Medicaid Vendor Payments, (225) 342-9041, Gwendolyn.Williams2@la.gov; Sadrina.Clayton, Medicaid Program Manager 2, Medicaid Vendor Payments, (225) 219-4016, Sadina.Clayton@la.gov; and Jackie Cummings, Medicaid Program Manager 4, Medicaid Vendor Payments, (225) 342-7505, Jackie.Cummings2@la.gov

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Financial Management

Objective: Through the Financial Management Activity, increase collections through the Collections/Recovery and Cost Avoidance activity by 1% from Medicaid beneficiaries' annuities and Special Needs Trusts (SNT) subject to recovery, as well as from offenders court-ordered to pay restitution to LDH for payments made on behalf of Medicaid beneficiaries. .

Indicator Name: Recipient recovery amount

Indicator LaPAS PI Code: 25568

1. **Type and Level**: Output and Supporting (S)

2. **Rationale:** This indicator gives the Recovery and Premium Assistance (RPA) Unit's state fiscal year total of dollars recovered from:

   - Annuities of deceased Medicaid beneficiaries/their spouses (State/LDH assigned beneficiary)
   - Special Needs Trust (SNTs) of deceased Medicaid beneficiaries/their spouses (SNTs with Medicaid payback clause); and,
   - Offenders court-ordered to pay restitution to LDH (i.e. expenses paid on behalf of beneficiary), as facilitated by the LA Department of Corrections/Probation and Parole, or court-ordered reimbursement from individuals, as facilitated by LDH's Medicaid Recipient Fraud Investigative Unit (MRFIU) and the Attorney General's Office.

3. **Use**: Accumulation of data for this indicator produces current recoveries and future estimations of funds recovered/collected by the RPA Unit.

4. **Clarity**: This performance indicator does not include retrospective recovery of Medicaid overpayments and ineligible payments made on a Medicaid recipient's behalf, except as pursued by MRFIU (Medicaid Recipient Fraud Investigative Unit) and the Attorney General.

5. **Accuracy, Maintenance, and Support**: This Performance Indicator is subject to audit by the Office of the Legislative Auditor. Related data is verifiable via monthly reports providing recovery amounts and supporting documentation.

6. **Data Source, Collection, and Reporting**: Collections come from the monthly reports produced by the LMMIS/TPL Recovery Report Archive.

7. **Calculation Methodology**: This amount is calculated from the monthly reports the Fiscal Intermediary produces via the LMMIS/TPL Recovery Report Archive. Restitution amounts due are provided by Department of Corrections/Probation & Parole, MRFIU, and/or the Attorney General's Office.

8. **Scope**: The scope is statewide. Information can be broken down by the individual Recipient Recovery Program Specialist's, Supervisor's, or Manager's caseload, each of which is comprised of several parishes.

9. **Caveats**: The reports are dependent upon claims processed through the Fiscal Intermediary's claims processing system. The RPA Unit's collection reports also depend upon the precision of the TPL Recovery application of LMMIS and documentation of restitution amounts due, as provided to RPA. Any breakdown or variation in these systems and restitution amounts provided could directly affect this total.

   The following may result in uneven and fluctuating collections:

   - Volume associated with death of beneficiaries/their spouses with annuities and/or SNTs subject to recovery,
   - Volume and other variables associated with LDH's MRFIU workload and resulting AG decisions,
   - Staffing consequences (i.e. prolonged absence, staff shortage, etc.), and
   - Unmeasurable variables resulting in eventual reimbursement to the State

10. **Responsible Persons**: Gwendolyn Williams, Medicaid Program Manager 1B, Medicaid Vendor Payments, (225) 342-9041, Gwendolyn.Williams2@la.gov; Sadrina Clayton, Medicaid Program Manager 2, Medicaid Vendor Payments, (225) 219-4016, Sadrina,Clayton@la.gov; and Jackie Cummings, Medicaid Program Manager 4, Medicaid Vendor Payments, (225) 342-7505, Jackie.Cummings2@la.gov

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Program Integrity

Objective: Through the Program Integrity Activity, prevent and detect claims-based fraud and abuse through data analysis, coordination with MCOs and participation in external audit (UPIC and PERM) activities.

Indicator Name: Number of audits/reviews

Indicator LaPAS PI Code: 26580

1. **Type and Level**: Output and Key (K)

2. **Rationale:** CMS requires states to have mechanisms in place to combat fraud, waste, and abuse in medical assistance programs. These mechanisms are necessary to ensure that fund disbursements are according to rules, regulations, and policies. In order to enforce the rules, regulations and policies, LDH utilizes audits/reviews to detect, deter, and recover overpayments from aberrant billing patterns. LDH has a contract with the fiscal intermediary to perform fraud, waste and abuse (referred to as Surveillance and Utilization Review Subsystem or SURS) reviews of managed care and fee-for-service providers. The contract requires Gainwell close a minimum of 600 surveillance and utilization reviews per year. LDH also works in conjunction with the Unified Program Integrity Contractor (UPIC). The UPIC has a contract with CMS to assist states with data mining and audits/reviews of providers participating in medical assistance programs funded with Medicaid dollars. The Managed Care Organizations (MCOs) are also required to have staff perform fraud, waste and abuse audits/reviews. This indicator allows LDH to track and monitor the fraud, waste, and abuse audits/reviews.

3. **Use**: LDH management will use this indicator to ensure that the audits/reviews selected are the cases that have the biggest financial risk/loss to the Medicaid program. Post-payment audit activity reported by MCOs is used by Program Integrity to identify problem providers for further review; monitor MCO fraud prevention and detection activity for effectiveness; and ensure accurate and complete reporting of MCO audit activity, particularly regarding financial information that may affect MCO rates, such as provider recoveries and settlements.

4. **Clarity**: The indicator clearly identifies what is being measured. For MCO reporting, an audit is any review that occurs when a plan or its subcontractor makes contact with a provider to verify services, or performs a review of a provider's data due to an internal or external tip, profiling or monitoring.

5. **Accuracy, Maintenance, and Support**: This Performance Indicator is subject to audit by the Office of the Legislative Auditor. Related data is verifiable via monthly reports providing recovery amounts.

6. **Data Source, Collection, and Reporting**: All audits/reviews are tracked. The SURS and UPIC reviews are entered in a database and reports are generated monthly; however, ad hoc reports can be produced as needed. The MCOs provide LDH with quarterly reports of their audits/reviews.

7. **Calculation Methodology**: This indicator is a count of audits/reviews for all of Program Integrity efforts. The count includes UPIC, SURS and MCO oversight and is tracked monthly by the closing date for each audit/review.

8. **Scope**: The indicator is an aggregate. The SURS, UPIC and MCO audits are combined into one number.

9. **Caveats**: The number of audits/reviews can include cases that are comprehensive or focused. A comprehensive review involves a general review of the provider's billing for a certain period. A focused review involves a specific billing issue.

10. **Responsible Persons**: Amara Blust, Amara.Blust2@la.gov Program Integrity, 225-278-2346; Marsha Ourso, SURS Business Analyst, Program Integrity, (225) 342-0005, Marsha.Ourso@LA.GOV

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Program Integrity

Objective: Through the Program Integrity Activity, prevent and detect claims-based fraud and abuse through data analysis, coordination with MCOs and participation in external audit (UPIC and PERM) activities.

Indicator Name: Amount of monetary penalties assessed for contract non-compliance

Indicator LaPAS PI Code: 26640

1. **Type and Level**: Outcome and General (G)

2. **Rationale:** Healthy Louisiana contractors (or Medicaid Managed Care Organizations) must meet the requirements of their contract with LDH. If a contractor is deficient or non-compliant with contract requirements, LDH may assess monetary penalties to obtain the level of performance required for successful operation of the Healthy Louisiana program. Penalties are set forth in the Department's contract with the Medicaid MCOs (Section 20 – Table of Monetary Penalties).

3. **Use**: This indicator will be used assist with the monitoring and oversight of Medicaid MCOs to ensure overall contract compliance in the managed care program and will be for internal management purposes and documenting contract compliance with a focus on transparency. This indicator provides a means for LDH to obtain the services and level of performance required for successful operation of the contract.

4. **Clarity**: The indicator clearly identifies what is being measured – a monetary penalty for a failure to adhere to the requirements in the contract.

5. **Accuracy, Maintenance, and Support**: The Office of Legislative Auditor has not audited the indicator. This is a new performance indicator and data is retrieved from which allows for accuracy and verifiability.

6. **Data Source, Collection, and Reporting**: Data obtained will be for monetary penalties assessed and paid by Medicaid MCOs. Annual reports will occur in the Department's annual Transparency Report with the measurement period being by state fiscal year on the Department's website. This measure is also an administrative action reported to the public via the Department's website.

7. **Calculation Methodology**: This is a straightforward set dollar amount of monetary penalties assessed for contract non-compliance in accordance with the Table of Monetary Penalties found in the contract with the Medicaid MCOs. There are other factors taken into consideration with each penalty assessed such as the duration of the non-compliance, whether it is reoccurring or the severity of the non- compliance. Each factor applies consistently for each penalty assessed.

8. **Scope**: This is a statewide wide figure.

9. **Caveats**: The measure is for monetary penalties assessed by LDH and paid by Medicaid MCOs due to contract non-compliance.

10. **Responsible Persons**: Kristie Robinson, Medicaid Program Manager 2, Program Operations & Compliance; Kristie.Robinson2@LA.GOV; Whitney Martinez, Provider Enrollment Program Manager 2, 225-975-3595, Whitney.Martinez@LA.GOV; Carmen Valliere, Medicaid Program Manager 3, Program Operations & Compliance;

225-342-1862, Carmen.Valliere@LA.GOV and Brandon Bueche, Medicaid Program Manager 4, Program Operations & Compliance; 225-384-0460, Brandon.Bueche@LA.GOV

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Program Integrity

Objective: Through the Program Integrity Activity, prevent and detect claims-based fraud and abuse through data analysis, coordination with MCOs and participation in external audit (UPIC and PERM) activities.

Indicator Name: Annual number of provider exclusions

Indicator LaPAS PI Code: 26100

1. **Type and Level**: Outcome and General (G)

2. **Rationale:** By way of federal mandate, the state Medicaid Agency is required to exclude and terminate providers that fail to meet certain eligibility requirements outlined by law, rules, regulations, and policy. Program Integrity is responsible for the execution of exclusions and terminations, tracking and reporting this information.

3. **Use**: This indicator is for internal management and by our partner agencies for reporting.

4. **Clarity**: Exclusion and terminations are an adverse sanction imposed against an individual or entity that directly or indirectly owns 5% or more of the subject provider entity or directly has managerial input on the subject provider. The adverse action is usually a result of a criminal offense involving the Medicare, Medicaid, or title XXI program, or current and previous activities of the individual or entity pose a financial risk to the program(s).

5. **Accuracy, Maintenance, and Support**: The Office of the Legislative Auditor to date has not audited the indicator.

6. **Data Source, Collection, and Reporting**: The Program Integrity section maintains a tracking log and an Adverse Actions website (https://adverseactions.LDH.la.gov/).

7. **Calculation Methodology**: This indicator is an unduplicated count of all exclusions and terminations.

8. **Scope**: This measure comes from the entirety of exclusion and termination adverse actions imposed by the Program Integrity section.

9. **Caveats**: New enrollment system may affect the reporting of these metrics.

10. **Responsible Person**: Nick Diez; Nicholas.Diez@la.gov Program Integrity Section Chief, 225-219-4150, Amara Blust; Amara.Blust2@la.gov Program Integrity, 225-278-2346

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Program Integrity

Objective: Through the Program Integrity Activity, prevent and detect claims-based fraud and abuse through data analysis, coordination with MCOs and participation in external audit (UPIC and PERM) activities.

Indicator Name: Number of notices of action issued for contract non-compliance

Indicator LaPAS PI Code: 26581

1. **Type and Level**: Outcome and General (G)

2. **Rationale:** Healthy Louisiana contractors must meet the requirements of their contract with LDH. If a contractor is deficient or non-compliant with contract requirements, LDH may issue notices of action to obtain the level of performance required for successful operation of the Healthy Louisiana program. Medicaid ensures MCO adherence to contract requirements through the issuance of notices of action. The notices address, in writing, a determination of contract non-compliance, the remedial action(s) that must be taken, and of any other conditions related such as the length of time the remedial actions shall continue and of the corrective actions that the MCO must perform. The notice will also include administrative actions that LDH will take should the MCO not demonstrate compliance by performing the corrective actions.

3. **Use**: This indicator will be used assist with obtaining the level of performance required for successful operation of the Medicaid program to be used for internal management purposes and documenting contract compliance.

4. **Clarity**: The indicator clearly identifies what is being measured.

5. **Accuracy, Maintenance, and Support**: This is a new performance indicator and data is retrieved from which allows for accuracy and verifiability.

6. **Data Source, Collection, and Reporting**: Data obtained will be based on data retrieved from internal logs maintained in real time by MVA staff. This measure will be collected and reported in real time to the public via the Department website.

7. **Calculation Methodology**: This is a straightforward number of notices of action issued to the Medicaid MCOs.

8. **Scope**: This is a statewide wide figure.

9. **Caveats**: The measure is for data obtained from internal logs maintained in real time.

10. **Responsible Persons**: Kristie Robinson, Medicaid Program Manager 2, Program Operations & Compliance; Kristie.Robinson2@LA.GOV; Whitney Martinez, Provider Enrollment Program Manager 2, 225-975-3595, Whitney.Martinez@LA.GOV; Carmen Valliere, Medicaid Program Manager 3, Program Operations & Compliance; 225-342-1862, Carmen.Valliere@LA.GOV and Brandon Bueche, Medicaid Program Manager 4, Program Operations & Compliance; 225-384-0460, Brandon.Bueche@LA.GOV

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Program Integrity

Objective: Through the Program Integrity Activity, prevent and detect claims-based fraud and abuse through data analysis, coordination with MCOs and participation in external audit (UPIC and PERM) activities.

Indicator Name: Amount of overpayments identified post and pre-pay

Indicator LaPAS PI Code: 26582

1. **Type and Level**: Outcome and General (G)

2. **Rationale:** Program Integrity within LDH is tasked with protecting the fiscal integrity of the medical assistance programs in the state. LDH is required to identify and collect overpayments made to providers. LDH has a contract with the fiscal intermediary to perform fraud, waste and abuse (referred to as Surveillance and Utilization Review Subsystem or SURS) reviews of managed care and fee-for-service providers. The SURS contract requires the closure a minimum of 600 surveillance and utilization reviews per year. LDH also works in conjunction with the Unified Program Integrity Contractor (UPIC). The UPIC has a contract with CMS to assist states with data mining and audits/reviews of providers participating in medical assistance programs funded with Medicaid dollars. The Managed Care Organizations (MCOs) are also required to have staff perform fraud, waste and abuse audits/reviews. This indicator allows LDH to track and monitor the overpayments identified post and prepay because of fraud, waste, and abuse audits/reviews.

3. **Use**: LDH management will use this indicator to ensure that the overpayments identified in the audits/reviews completed are recovered, and funds are returned to the state and federal government, including being accounted for in rate setting for MCO-identified overpayments.

4. **Clarity**: The indicator clearly identifies what is being measured. LDH and its agents may review any claims payment for up to five years from the date of service. Services must be properly documented, actually performed, and medically necessary to be reimbursed. Payment in excess of what is due is an overpayment.

5. **Accuracy, Maintenance, and Support**: The Office of the Legislative Auditor does audit LDH's fraud, waste, and abuse efforts. The audits check to see if overpayments identified are accurate and that the funds are returned to the state and federal government.

6. **Data Source, Collection, and Reporting**: The results of all audits/reviews are tracked and reported. The results including overpayments identified from SURS and UPIC reviews are entered in a database and reports are generated monthly; however, ad hoc reports can be produced as needed. The MCOs provide LDH with quarterly reports of their audits/reviews.

7. **Calculation Methodology**: This indicator is a straightforward sum of the overpayments identified in the audits/reviews completed.

8. **Scope**: The indicator is an aggregate. The overpayment from SURS, UPIC and MCO audits are combined into one number.

9. **Caveats**: Audits/reviews are generally not closed until the identified overpayments are collected which may involve a payment plan. Providers who failed to pay back the overpayments are referred to collections. Overpayments identified by the MCOs are included in a report that routes to Program Integrity.

10. **Responsible Persons**: **Responsible Persons**: Amara Blust, Amara.Blust2@la.gov Program Integrity, 225-278-2346; Marsha Ourso, SURS Business Analyst, Program Integrity, (225) 342-0005, Marsha.Ourso@la.gov

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Program Integrity

Objective: Through the Program Integrity Activity, prevent and detect claims-based fraud and abuse through data analysis, coordination with MCOs and participation in external audit (UPIC and PERM) activities.

Indicator Name: Number of notices and referrals sent to the Attorney General

Indicator LaPAS PI Code: 26583

1. **Type and Level**: Outcome and General (G)

2. **Rationale:** Program Integrity within LDH is tasked with protecting the fiscal integrity of the medical assistance programs in the state. Program Integrity is required to make referrals to the Attorney General when a credible allegation of fraud is identified. LDH has a contract with the fiscal intermediary to perform fraud, waste and abuse (referred to as Surveillance and Utilization Review Subsystem or SURS) reviews of managed care and fee-for-service providers. SURS makes referrals to the Medicaid Fraud Control Unit (MFCU) in the Attorney General's Office. The Managed Care Organizations (MCOs) are also required to make referrals to LDH and MFCU. This indicator allows LDH to track and monitor the referrals to MFCU because of fraud, waste, and abuse audits/reviews.

3. **Use**: LDH management will use this indicator to ensure that suspected and confirmed instances of fraud and abuse are referred to MFCU timely, and to ensure all referrals are screened for credible allegations of fraud, so that financial risk/loss to the Medicaid program is limited.

4. **Clarity**: Yes, the indicator clearly identifies what is being measured. For MCOs, all suspected provider fraud and abuse that has been substantiated through investigation is reported to LDH and MFCU as a referral. All preliminary reports of suspected provider fraud and abuse that has not yet been investigated are sent to LDH and MFCU as a notice. MCOs also make referrals to LDH for suspected member fraud and abuse.

5. **Accuracy, Maintenance, and Support**: The Office of the Legislative Auditor does audit LDH's fraud, waste, and abuse efforts. The audits check to see if credible allegations of fraud are referred to MFCU in accordance with the SURS Rule and Federal Regulation 42 CFR 455.23. Copies of all referrals are retained and once a quarter, a verification, or certification is obtained from MFCU to ensure that an active investigation is ongoing.

6. **Data Source, Collection, and Reporting**: The referrals are made by SURS and the MCOs. All referrals are tracked in a database and spreadsheet. Reports are generated monthly (SURS) and quarterly (MCOs); however, ad hoc reports can be produced as needed. According to 42 CFR 455.23, for credible allegations of fraud resulting in provider payment suspensions, LDH is required verify with MFCU that the referral is accepted and certify quarterly that the MFCU investigation is ongoing.

7. **Calculation Methodology**: This indicator is a straightforward count of the referrals made to MFCU.

8. **Scope**: The indicator is an aggregate count of referrals made by SURS and the MCOs.

9. **Caveats**: Referrals to MFCU are made based on credible allegations of fraud. Acceptance of the referrals is determined by MFCU.

10. **Responsible Persons**: **Responsible Persons**: Amara Blust, Amara.Blust2@la.gov Program Integrity, 225-278-2346; Marsha Ourso, SURS Business Analyst, Program Integrity, (225) 342-0005, Marsha.Ourso@la.gov

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Program Integrity

Objective: Through the Program Integrity Activity, prevent and detect claims-based fraud and abuse through data analysis, coordination with MCOs and participation in external audit (UPIC and PERM) activities.

Indicator Name: Number of referrals to law enforcement

Indicator LaPAS PI Code: 26584

1. **Type and Level**: Outcome and General (G)

2. **Rationale:** Number of referrals of recipient eligibility cases to law enforcement is an indicator of the quality of the state's eligibility determination process and is a deterrent for recipients to obtain Medicaid eligibility fraudulently. Number of referrals reduces ineligible Medicaid recipients from receiving Medicaid benefits.

3. **Use**: Management will review recipient referral cases to make necessary changes to the eligibility determination process to reduce fraud. LDH management will use this indicator to ensure that credible allegations of fraud are referred to MFCU so that financial risk/loss to the Medicaid program is limited.

4. **Clarity**: The indicator clearly identifies what is being measured.

5. **Accuracy, Maintenance, and Support**: The LDH recipient fraud unit and the sister unit within the AG are both new. Monthly meetings occur with the AG to ensure they received all referrals and discuss ongoing cases.

6. **Data Source, Collection, and Reporting**: All audits/reviews are tracked and logged manually on an internal spreadsheet and reports are generated monthly.

7. **Calculation Methodology**: It's a standard calculation of the referrals made to law enforcement.

8. **Scope**: The indicator is an aggregate count of referrals made by LDH recipient fraud unit to law enforcement.

9. **Caveats**: Referrals to law enforcement are made based on credible allegations of fraud. Acceptance and decision to pursue criminal charges is determined by law enforcement.

10. **Responsible Persons**: Nick Diez, Medicaid Program Manager 4, Program Integrity, Nicholas.Diez@la.gov 225-219-4150; Amara Blust, Amara.Blust2@la.gov Program Integrity, 225-278-2346Burton "BJ" Meche; Medicaid Program Manager 3; Burton.Meche@LA.GOV; 225-219-2575; and Chittana "Kit" Keophommavong-Bradford, Kit.Bradford@la.gov 225-219-7398

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Program Integrity

Objective: Through the Program Integrity Activity, identify and review recipient eligibility.

Indicator Name: Number of reviews conducted

Indicator LaPAS PI Code: 26585

1. **Type and Level**: Outcome and Key (K)

2. **Rationale:** CMS requires states to have mechanisms in place to combat fraud, waste, and abuse in medical assistance programs. These mechanisms are necessary to ensure that funds are paid according to rules, regulations, and policies. In order to enforce the rules, regulations and policies, LDH utilizes audits/reviews to detect, deter, and combat fraud, waste, and abuse within the recipient eligibility determination process. The Medicaid Recipient Fraud Investigation Unit (MRFIU) was developed within LDH to perform case reviews on all Fraud allegations. This indicator allows LDH to track and monitor the fraud, waste, and abuse audits/reviews.

3. **Use**: LDH management will use this indicator to ensure that the audits/reviews selected are the cases that have the biggest financial risk/loss to the Medicaid program. In addition, every recipient fraud tips are reviewed and the outcome is tracked to assist with possible training needs or to develop methods to improve the eligibility process.

4. **Clarity**: The indicator clearly identifies what is being measured.

5. **Accuracy, Maintenance, and Support**: The Office of the Legislative Auditor does audit LDH's fraud, waste, and abuse efforts. The audits check to determine that all complaints received are reviewed. Copies of all complaints received are retained in case records and the report data maintained in within the agency's database.

6. **Data Source, Collection, and Reporting**: All audits/reviews are tracked and logged manually on an internal spreadsheet and reports are generated monthly.

7. **Calculation Methodology**: This indicator is a straightforward count of audits/reviews. There is an open date and close date for each audit/review.

8. **Scope**: The indicator is an aggregate of all fraud complaints received throughout the state of Louisiana and audits are performed on the entire Medicaid population.

9. **Caveats**: The number of audits/reviews can include preliminary or full investigation. A preliminary investigation involves a general review of the case to determine if the recipient originally reported the change in eligibility factor. A full investigation involves a more in depth review of the entire case record to determine when the change in eligibility factor took place and if the agency provided the recipient an opportunity to report the change.

10. **Responsible Persons**: Nick Diez, Medicaid Program Manager 4, Program Integrity, Nicholas.Diez@la.gov 225-219-4150; Amara Blust, Amara.Blust2@la.gov Program Integrity, 225-278-2346Burton "BJ" Meche; Medicaid Program Manager 3; Burton.Meche@LA.GOV; 225-219-2575; and Chittana "Kit" Keophommavong-Bradford, Kit.Bradford@la.gov 225-219-7398

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Medicaid Enterprise Systems (MES)

Objective: Through the MES Activity, credential and enroll qualified providers in the Medicaid program.

Indicator Name: Total number of providers credentialed and enrolled in the Medicaid program

Indicator LaPAS PI Code: NEW (Strategic Plan)

1. **Type and Level**: Output and General (G)

2. **Rationale:** This indicator was selected because it demonstrates that the number of credentialed providers being monitored by the state. It also indicates whether there are large decreases or increases in the number so that the state can investigate and report the source of the change and if a contract's activity caused it.

3. **Use**: This indicator is for internal management purposes and it will not serve as an indicator of a goal or target. This indicator may be used in management decision-making as it relates to workload for LDH and contractor staff.

4. **Clarity**: The indicator clearly identifies what is being measured and does not include jargon, acronyms, initializations, or unclear terms.

5. **Accuracy, Maintenance, and Support**: The Office of the Legislative Auditor has audited Provider enrollment processes, but has not audited the number of credentialed and enrolled Medicaid providers. The Auditors' office has audited provider enrollment processes to ensure that only eligible and qualified providers are enrolled. The Office of the Legislative Auditor has also audited the accuracy of the provider registry, which lists the enrolled managed care providers. The Auditor's office found evidence that the provider registry's accuracy could be improved.

6. **Data Source, Collection, and Reporting**: The sources of data for this indicator are the provider registry file and DXC's provider enrollment reporting. The provider registry file is updated every Wednesday and Friday, and DXC's enrollment reporting is updated monthly. The frequency and timing is consistent.

7. **Calculation Methodology**: This indicator is a sum of the number of enrolled fee-for-service providers and the number of enrolled managed-care only providers. This indicator is not used by more than one agency or program.

8. **Scope**: The indicator is an aggregate. The number of MCO-only providers and FFS providers combines into one number for the indicator. The figure could be broken down into region/parish or provider type/specialty.

9. **Caveats**: The indicator has a weakness in its reliance on the provider registry to determine the number of MCO-only providers. The provider registry includes non-credentialed providers (like single case agreements) without an indication of their credentialing status. There are also duplicates on the registry that cannot be easily identified. In addition, the monthly report from DXC is not an automatic report generated from their system. DXC staff manually enters it into an Excel document, which is updated and distributed to LDH monthly. There is not an appreciable bias because there is not a goal for contractors for the number of credentialed and enrolled providers. These weaknesses will be resolved as part of the upcoming Provider Management Module.

10. **Responsible Persons**: Stacy Guidry, Medicaid Program Manager 2, Program Operations & Compliance; 337-857-6115, Stacy.Guidry@LA.GOV; Whitney Martinez, Provider Enrollment Program Manager 2, 225-975-3595, Whitney.Martinez@LA.GOV; and Brandon Bueche, Medicaid Program Manager 4, Program Operations & Compliance; 225-384-0460, Brandon.Bueche@LA.GOV

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Medicaid Enterprise Systems (MES)

Objective: Through the MES Activity, credential and enroll qualified providers in the Medicaid program.

Indicator Name: Average length of time to complete enrollment from date of receipt of a properly completed provider enrollment packet

Indicator LaPAS PI Code: NEW (Strategic Plan)

1. **Type and Level**: Output and General (G)

2. **Rationale:** This indicator was selected to identify the role of MES system in completing enrollment in the provider enrollment system. The average time is a measure to track system performance to determine how long a provider takes to input the enrollment information.

3. **Use**: This indicator will be used for internal management purposes and will not serve as an indicator of a goal or target. This indicator may be used in management decision-making as it relates to workload for LDH and contractor staff.

4. **Clarity**: The indicator clearly identifies what is being measured and does not include jargon, acronyms, initializations, or unclear terms.

5. **Accuracy, Maintenance, and Support**: The Office of the Legislative Auditor has audited Provider enrollment processes, but has not audited the number of credentialed and enrolled Medicaid providers. The Auditors' office has audited provider enrollment processes to ensure that only eligible and qualified providers are enrolled. The Office of the Legislative Auditor has also audited the accuracy of the provider registry, which lists the enrolled managed care providers. The Auditor's office found evidence that the provider registry's accuracy could be improved.

6. **Data Source, Collection, and Reporting**: The sources of data for this indicator are from the Verysis Provider Enrollment system report on key indicators. The frequency and timing is to be determined.

7. **Calculation Methodology**: This indicator is a determined by using the data set of providers with successful enrollment and calculating begin and end dates of enrollment for each. The information is then averaged based on the number of providers who have successfully enrolled.

8. **Scope**: The indicator is an average. The number of MCO-only providers and FFS providers combines into one number for the indicator. The figure could be broken down into region/parish or provider type/specialty.

9. **Caveats**: System implementation is ongoing and the process of getting data is fluid. There may be some manual calculations of the average time from Verisys call center metrics if the system is not implemented to pull metrics for reporting performance indicators.

10. **Responsible Persons**: Stacy Guidry, Medicaid Program Manager 2, Program Operations & Compliance; 337-857-6115, Stacy.Guidry@LA.GOV; Whitney Martinez, Provider Enrollment Program Manager 2, 225-975-3595, Whitney.Martinez@LA.GOV; and Brandon Bueche, Medicaid Program Manager 4, Program Operations & Compliance; 225-384-0460, Brandon.Bueche@LA.GOV

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Medicaid Enterprise Systems (MES)

Objective: Through the MES Activity, credential and enroll qualified providers in the Medicaid program.

Indicator Name: Average monthly receipts of enrollment requests

Indicator LaPAS PI Code: NEW (Strategic Plan)

1. **Type and Level**: Output and Key (K)

2. **Rationale:** This indicator was selected to identify the role of MES system in completing enrollment in the provider enrollment system. The average time is a measure to track system performance to determine how long a provider takes to input the enrollment information.

3. **Use**: This indicator will be used for internal management purposes and will not serve as an indicator of a goal or target. This indicator may be used in management decision-making as it relates to workload for LDH and contractor staff.

4. **Clarity**: The indicator clearly identifies what is being measured and does not include jargon, acronyms, initializations, or unclear terms.

5. **Accuracy, Maintenance, and Support**: The Office of the Legislative Auditor has audited Provider enrollment processes, but has not audited the number of credentialed and enrolled Medicaid providers. The Auditors' office has audited provider enrollment processes to ensure that only eligible and qualified providers are enrolled. The Office of the Legislative Auditor has also audited the accuracy of the provider registry, which lists the enrolled managed care providers. The Auditor's office found evidence that the provider registry's accuracy could be improved.

6. **Data Source, Collection, and Reporting**: The sources of data for this indicator are from the Verisys Provider Enrollment system report on key indicators. The frequency and timing is to be determined.

7. **Calculation Methodology**: This indicator is a determined by using the data set of providers who have received enrollment request. The information is then averaged based on the number of providers for each month.

8. **Scope**: The indicator is an average. The number of MCO-only providers and FFS providers combines into one number for the indicator. The figure could be broken down into region/parish or provider type/specialty.

9. **Caveats**: System implementation is ongoing and the process of getting data is fluid. There may be some manual calculations of the average time from Verisys call center metrics if the system is not implemented to pull metrics for reporting performance indicators.

10. **Responsible Persons**: Stacy Guidry, Medicaid Program Manager 2, Program Operations & Compliance; 337-857-6115, Stacy.Guidry@LA.GOV; Whitney Martinez, Provider Enrollment Program Manager 2, 225-975-3595, Whitney.Martinez@LA.GOV; and Brandon Bueche, Medicaid Program Manager 4, Program Operations & Compliance; 225-384-0460, Brandon.Bueche@LA.GOV

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Financial Management

Objective: Through the Financial Management Activity, pursue collections from third party sources legally responsible for health care costs of Medicaid and CHIP beneficiaries.

Indicator Name: Percentage change of TPL trauma recovery amount

Indicator LaPAS PI Code: NEW (Strategic Plan)

1. **Type and Level**: Output and General (G)

2. **Rationale:** This measurement gives an indication of the amount of money identified and recovered and gives the total amount recovered from liable third parties and beneficiaries by the MES Recovery & Premium Assistance unit for Medicaid beneficiaries' injury/accident related expenditures for the reporting fiscal year, in comparison to the prior fiscal year's recoveries

3. **Use**: Accumulation of data for this indicator produces current recoveries and future estimations of funds recovered by the RPA Unit.

4. **Clarity**: The term "Design, Development, and Implementation (DDI) Phase" refers to the phase where requirements are gathered and validated; design documents are constructed; systems and solutions built and integrated; unit, system, and user acceptance testing are performed; and cutover activity and system implementation are performed.

5. **Accuracy, Maintenance, and Support**: This Performance Indicator is subject to audit by the Office of the Legislative Auditor. Related data is verifiable via monthly reports providing recovery amounts.

6. **Data Source, Collection, and Reporting**: The data source is the monthly report obtained from the LMMIS/TPL Recovery system's Report Archive.

7. **Calculation Methodology**: This figure is calculated by adding the reported FYTD (Fiscal Year to Date) total for June A/IR collections, miscellaneous health recoveries, and global settlements to the monthly total reported for Trauma Recovery. The percent change is calculated by subtracting the reporting fiscal year's total amount by the prior fiscal year's total amount, then dividing the difference by the prior fiscal year's total amount.

8. **Scope**: The scope is statewide. The data collection process will occur monthly and the data reports will occur annually. This number cannot be added to any other measure.

9. **Caveats**: The reports are dependent upon claims processed through the Fiscal Intermediary's claims processing system. The RPA Unit's collection reports also depend upon the precision of the TPL Recovery application of LMMIS' Report Archive. Any breakdown or variation in these systems could directly affect this figure. The following may result in uneven and fluctuating collections: a) volume associated with TPL incidents involving Medicaid beneficiaries and subsequent settlement and funds disbursement, b) staffing consequences (i.e. prolonged absence, staff shortage, etc.), and c) unmeasurable variables resulting in eventual reimbursement to the State. Tracking of this indicator commences after the execution of contract with a vendor/contractor.

10. **Responsible Persons**: Janelle Sparks, Medicaid Program Manager 2, Medicaid Enterprise Systems, (225) 342-0259, Janelle.Sparks@la.gov; Becky Bach, Medicaid Program Manager 1-B, Medicaid Enterprise Systems, (225) 342-5059, Becky.Bach@la.gov; and Mitzi Hochheiser, Medicaid Deputy Director, Medicaid Enterprise Systems, (225) 342-8935, Mitzi.Hochheiser@la.gov

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Financial Management

Objective: Through the Financial Management Activity, pursue collections from third party sources legally responsible for health care costs of Medicaid and CHIP beneficiaries.

Indicator Name: Number of requests generated for additional information relative to accidents or injuries

Indicator LaPAS PI Code: NEW (Strategic Plan)

1. **Type and Level**: Output and General (G)

2. **Rationale:** This indicator gives the total number of system-generated requests to Medicaid beneficiaries for information relative to accidents and/or injuries in order to determine if there is a legally responsible third party.

3. **Use**: To determine if there is a liable third party for accidents and/or injuries sustained by Medicaid beneficiaries.

4. **Clarity**: A request for additional information relative to accidents or injuries is equivalent to generation of an A/IR (Accident/Injury Report) case notice within the reporting fiscal year. The term "Design, Development, and Implementation (DDI) Phase" refers to the phase where requirements are gathered and validated; design documents are constructed; systems and solutions built and integrated; unit, system, and user acceptance testing are performed; and cutover activity and system implementation are performed.

5. **Accuracy, Maintenance, and Support**: This Performance Indicator is subject to audit by the Office of the Legislative Auditor. Related data is verifiable via monthly reports providing the count of A/IR notices issued.

6. **Data Source, Collection, and Reporting**: This A/IR notice count comes from monthly reports created in the LMMIS/TPL Recovery Report Archive.

7. **Calculation Methodology**: This figure is calculated by adding the total A/IR case notices generated, as indicated on the monthly reports produced by the Fiscal Intermediary via the LMMIS/TPL Recovery Report Archive and is derived from the total count of A/IR notices issued.

8. **Scope**: The scope is statewide. Information can be broken down by the individual trauma Specialist's caseload, which is comprised of several parishes each.

9. **Caveats**: Prolonged absence of a recovery Specialist may affect recoveries. System downtime and/or technical issues (i.e. file transfers, printing issues, etc.) could affect the automated generation of letters to beneficiaries. The reports used as the data source depend upon the precision of the TPL Recovery application of LMMIS, a breakdown of which could directly affect this figure. Tracking of this indicator commences after the execution of contract with a vendor/contractor.

10. **Responsible Persons**: Janelle Sparks, Medicaid Program Manager 2, Medicaid Enterprise Systems, (225) 342-0259, Janelle.Sparks@la.gov; Becky Bach, Medicaid Program Manager 1-B, Medicaid Enterprise Systems, (225) 342-5059, Becky.Bach@la.gov; and Mitzi Hochheiser, Medicaid Deputy Director, Medicaid Enterprise Systems, (225) 342-8935, Mitzi.Hochheiser@la.gov

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Financial Management

Objective: Through the Financial Management Activity, increase collections through the Collections/Recovery and Cost Avoidance activity by 1% from estates of individuals who were aged 55 or older when long term Medicaid paid long-term care facility services, home and community-based services, and related hospital and prescription drug services.

Indicator Name: Annual number of cases on which estate recovery initiations occurred

Indicator LaPAS PI Code: NEW (Strategic Plan)

1. **Type and Level**: Output and General (G)

2. **Rationale:** This indicator gives the Recovery and Premium Assistance (RPA) Unit's state fiscal year total of estate recovery cases initiated to recover from the estates of deceased Medicaid beneficiaries that were age 55 or older, were in a nursing home or received home and community-based services (HCBS), and related hospital and prescription drug services paid by Medicaid.

3. **Use**: Accumulation of data for this indicator produces number of cases for estate recovery initiated by the RPA Unit for the reporting fiscal year.

4. **Clarity**: Count of initiated cases is identified by count of new Estate Recovery referrals received/cases created. The term "Design, Development, and Implementation (DDI) Phase" refers to the phase where requirements are gathered and validated; design documents are constructed; systems and solutions built and integrated; unit, system, and user acceptance testing are performed; and cutover activity and system implementation are performed.

5. **Accuracy, Maintenance, and Support**: This Performance Indicator is subject to audit by the Office of **the** Legislative Auditor. Related data is verifiable via monthly reports providing new case counts.

6. **Data Source, Collection, and Reporting**: This number comes from the monthly reports produced by the LMMIS/TPL Recovery Report Archive.

7. **Calculation Methodology**: This count is obtained from the monthly reports the Fiscal Intermediary produces via the LMMIS/TPL Recovery Report Archive and is derived from the count of new referrals/cases reported FYTD (Fiscal Year to Date) on the June monthly report.

8. **Scope**: The scope is statewide. Information can be broken down by the individual Estate Recovery Program Specialist's, Supervisor's, or Manager's caseload, each of which is comprised of several parishes.

9. **Caveats**: Legislative constraints affect our efforts to collect. The reports used as the data source depend upon the precision of the TPL Recovery application of LMMIS, a breakdown of which could directly affect this figure. Tracking of this indicator commences after the execution of contract with a vendor/contractor.

10. **Responsible Persons**: Janelle Sparks, Medicaid Program Manager 2, Medicaid Enterprise Systems, (225) 342-0259, Janelle.Sparks@la.gov; Becky Bach, Medicaid Program Manager 1-B, Medicaid Enterprise Systems, (225) 342-5059; and Mitzi Hochheiser, Medicaid Deputy Director, Medicaid Enterprise Systems, (225) 342-8935, Mitzi.Hochheiser@la.gov

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Financial Management

Objective: Through the Financial Management Activity, increase collections through the Collections/Recovery and Cost Avoidance activity by 1% from estates of individuals who were aged 55 or older when long term Medicaid paid long-term care facility services, home and community-based services, and related hospital and prescription drug services.

Indicator Name: Annual number of estate recovery cases resulting in successful recovery

Indicator LaPAS PI Code: NEW (Strategic Plan)

1. **Type and Level**: Output and General (G)

2. **Rationale:** This indicator gives the Recovery and Premium Assistance (RPA) Unit's state fiscal year total number of estate recovery cases resulting in successful recovery from the estates of deceased Medicaid beneficiaries that were age 55 or older, were in a nursing home or received home and community-based services (HCBS), and related hospital and prescription drug services paid by Medicaid – after consideration of applicable offsets.

3. **Use**: Accumulation of data for this indicator produces current number of cases with successful estate recovery completed by the RPA Unit.

4. **Clarity**: This count reflects cases with receipt of payment in full and closure, after applicable offsets and other exclusions. The term "Design, Development, and Implementation (DDI) Phase" refers to the phase where requirements are gathered and validated; design documents are constructed; systems and solutions built and integrated; unit, system, and user acceptance testing are performed; and cutover activity and system implementation are performed.

5. **Accuracy, Maintenance, and Support**: This Performance Indicator is subject to audit by the Office of the Legislative Auditor. Related data is verifiable via monthly reports providing recovery case counts with payment in full and closure, after applicable offsets and other exclusions.

6. **Data Source, Collection, and Reporting**: This number comes from the monthly reports produced by the LMMIS/TPL Recovery Report Archive.

7. **Calculation Methodology**: This figure is the reported FYTD (Fiscal Year to Date) count of cases with payments received and case closure, after applicable offsets and other exclusions, as reported on the June monthly report the Fiscal Intermediary produces via the LMMIS/TPL Recovery Report Archive.

8. **Scope**: The scope is statewide. Information can be broken down by the individual Estate Recovery Program Specialist's, Supervisor's, or Manager's caseload, each of which is comprised of several parishes.

9. **Caveats**: Legislative constraints affect our efforts to collect. The reports used as the data source depend upon the precision of the TPL Recovery application of LMMIS, a breakdown of which could directly affect this figure. Tracking of this indicator commences after the execution of contract with a vendor/contractor.

10. **Responsible Persons**: Janelle Sparks, Medicaid Program Manager 2, Medicaid Enterprise Systems, (225) 342-0259, Janelle.Sparks@la.gov; Becky Bach, Medicaid Program Manager 1-B, Medicaid Enterprise Systems; and

Mitzi Hochheiser, Medicaid Deputy Director, Medicaid Enterprise Systems, (225) 342-8935, Mitzi.Hochheiser@la.gov

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Financial Management

Objective: Through the Financial Management Activity, increase collections through the Collections/Recovery and Cost Avoidance activity by 1% from estates of individuals who were aged 55 or older when Medicaid paid long-term care facility services, home and community-based services, and related hospital and prescription drug services.

Indicator Name: Percentage increase in estate recovery cases with successful recovery

Indicator LaPAS PI Code: NEW (Strategic Plan)

1. **Type and Level**: Output and General (G)

2. **Rationale:** This indicator gives the percentage increase in the Recovery and Premium Assistance (RPA) Unit's estate recovery cases with successful recovery from the estates of deceased Medicaid beneficiaries that were age 55 or older, were in a nursing home or received home and community-based services (HCBS), and related hospital and prescription drug services paid by Medicaid – after consideration of applicable offsets.

3. **Use**: Accumulation of data for this indicator produces percentage of increase in cases with successful estate recovery completed by the RPA Unit.

4. **Clarity**: **Clarity**: This count reflects cases with receipt of payment in full and closure, after applicable offsets and other exclusions. The term "Design, Development, and Implementation (DDI) Phase" refers to the phase where requirements are gathered and validated; design documents are constructed; systems and solutions built and integrated; unit, system, and user acceptance testing are performed; and cutover activity and system implementation are performed.

5. **Accuracy, Maintenance, and Support**: This Performance Indicator is subject to audit by the Office of the Legislative Auditor. Related data is verifiable via monthly reports providing recovery case counts with payment in full and closure, after applicable offsets and other exclusions.

6. **Data Source, Collection, and Reporting**: This number comes from the monthly reports produced by the LMMIS/TPL Recovery Report Archive.

7. **Calculation Methodology**: This figure is the reported FYTD (Fiscal Year to Date) count of cases with payments received and case closure, after applicable offsets and other exclusions, as reported on the June monthly report the Fiscal Intermediary produces via the LMMIS/TPL Recovery Report Archive. The percent change is calculated by subtracting the reporting fiscal year's count by the prior fiscal year's count, then dividing the difference by the prior fiscal year's total count.

8. **Scope**: The scope is statewide. Information can be broken down by the individual Estate Recovery Program Specialist's, Supervisor's, or Manager's caseload, each of which is comprised of several parishes.

9. **Caveats**: Legislative constraints affect our effort to collect. The reports used as the data source depend upon the precision of the TPL Recovery application of LMMIS, a breakdown of which could directly affect this figure. Tracking of this indicator commences after the execution of contract with a vendor/contractor.

10. **Responsible Persons**: Janelle Sparks, Medicaid Program Manager 2, Medicaid Enterprise Systems, (225) 342-0259, Janelle.Sparks@la.gov; Becky Bach, Medicaid Program Manager 1-B, Medicaid Enterprise Systems, (225) 342-5059, Becky.Bach@la.gov; and Mitzi Hochheiser, Medicaid Deputy Director, Medicaid Enterprise Systems, (225) 342-8935, Mitzi.Hochheiser@la.gov

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Financial Management

Objective: Through the Financial Management Activity, increase collections through the Collections/Recovery and Cost Avoidance activity by 1% from estates of individuals who were aged 55 or older when Medicaid paid long-term care facility services, home and community-based services, and related hospital and prescription drug services.

Indicator Name: Percentage of cases in which heirs claim hardship exemption

Indicator LaPAS PI Code: NEW (Strategic Plan)

1. **Type and Level**: Output and General (G)

2. **Rationale:** This indicator gives the percentage of estate recovery cases in which heirs claimed hardship exemptions from the recovery against the estates of deceased Medicaid beneficiaries that were age 55 or older, were in a nursing home, or received home and community-based services (HCBS), and related hospital and prescription drug services paid by Medicaid.

3. **Use**: Accumulation of data for this indicator produces current percentage of estate recovery cases in which heirs claimed hardship exemption.

4. The term "Design, Development, and Implementation (DDI) Phase" refers to the phase where requirements are gathered and validated; design documents are constructed; systems and solutions built and integrated; unit, system, and user acceptance testing are performed; and cutover activity and system implementation are performed.

5. **Accuracy, Maintenance, and Support**: This Performance Indicator is subject to audit by the Office of the Legislative Auditor. Related data is verifiable via monthly reports providing percentage of cases in which heirs claimed hardship exemption.

6. **Data Source, Collection, and Reporting**: This number comes from the June monthly report produced by the LMMIS/TPL Recovery Report Archive and is the reported FYTD (Fiscal Year to Date) count of case with hardship waivers claimed.

7. **Calculation Methodology**: This data element is calculated by dividing the reporting fiscal year's total count of closures due to hardship waiver by the total count of case closures for the reporting year, then multiplying that number by 100
8. **Scope**: The scope is statewide. Information can be broken down by the individual Estate Recovery Program Specialist's, Supervisor's, or Manager's caseload, each of which is comprised of several parishes.

9. **Caveats**: Legislative constraints affect our efforts to collect. The reports used as the data source depend upon the precision of the TPL Recovery application of LMMIS, a breakdown of which could directly affect this figure. Tracking of this indicator commences after the execution of contract with a vendor/contractor.

10. **Responsible Persons**: Janelle Sparks, Medicaid Program Manager 2, Medicaid Enterprise Systems, (225) 342-0259, Janelle.Sparks@la.gov; Becky Bach, Medicaid Program Manager 1-B, Medicaid Enterprise Systems, (225) 342-5059, Becky.Bach@la.gov; and Mitzi Hochheiser, Medicaid Deputy Director, Medicaid Enterprise Systems, (225) 342-8935, Mitzi.Hochheiser@la.gov

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Financial Management

Objective: Through the Financial Management Activity, increase collections through the Collections/Recovery and Cost Avoidance activity by 1% from estates of individuals who were aged 55 or older when Medicaid paid long-term care facility services, home and community-based services, and related hospital and prescription drug services.

Indicator Name: Louisiana's rank among states for amount of Estate Recovery

Indicator LaPAS PI Code: NEW (Strategic Plan)

1. **Type and Level**: Output and General (G)
2. **Rationale:** This indicator reports the ranking of Louisiana's estate recoveries compared to other states.
3. **Use**: This is a comparison among states to determine Louisiana's ranking.
4. **Clarity**: None
5. **Accuracy, Maintenance, and Support**: This Performance Indicator is subject to audit by the Office of the Legislative Auditor. There is currently no known data source to support this indicator.
6. **Data Source, Collection, and Reporting**: There is currently no known data source to support this indicator.
7. **Calculation Methodology**: There is currently no known data source to support this indicator.
8. **Scope**: This scope is nationwide.
9. **Caveats**: Legislative constraints affect our efforts to collect. National data on this topic is unavailable or outdated.
10. **Responsible Persons**: Janelle Sparks, Medicaid Program Manager 2, Medicaid Enterprise Systems, (225) 342-0259, Janelle.Sparks@la.gov; Becky Bach, Medicaid Program Manager 1-B, Medicaid Enterprise Systems, (225) 342-5059, Becky.Bach@la.gov; and Mitzi Hochheiser, Medicaid Deputy Director, Medicaid Enterprise Systems, (225) 342-8935, Mitzi.Hochheiser@la.gov

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Financial Management

Objective: Through the Financial Management Activity, increase collections through the Collections/Recovery and Cost Avoidance activity by 1% from individuals who were ineligible for Medicaid on the date(s) of service

Indicator Name: Annual number of cases on which recipient recovery initiations occurred

Indicator LaPAS PI Code: NEW (Strategic Plan)

1. **Type and Level**: Output and General (G)

2. **Rationale:** This indicator gives the Recovery and Premium Assistance (RPA) Unit's state fiscal year total number of cases initiated for:

   - Annuities of deceased Medicaid beneficiaries/their spouses (State/LDH assigned beneficiary)
   - SNTs of deceased Medicaid beneficiaries/their spouses (SNTs with Medicaid payback clause)
   - Offenders court-ordered to pay restitution to LDH (i.e. expenses paid on behalf of beneficiary), as facilitated by LA Department of Corrections/Probation and Parole, or court-ordered reimbursement from individuals, as facilitated by LDH's Medicaid Recipient Fraud Investigative Unit (MRFIU) and the Attorney General's Office.

3. **Use**: Accumulation of data for this indicator produces current number of recipient recovery cases initiated by the RPA Unit.

4. **Clarity**: This performance indicator does not include retrospective recovery of Medicaid overpayments and ineligible payments made on a Medicaid recipient's behalf, except as pursued by MRFIU (Medicaid Recipient Fraud Investigative Unit) and the Attorney General. The term "Design, Development, and Implementation (DDI) Phase" refers to the phase where requirements are gathered and validated; design documents are constructed; systems and solutions built and integrated; unit, system, and user acceptance testing are performed; and cutover activity and system implementation are performed.

5. **Accuracy, Maintenance, and Support**: This Performance Indicator is subject to audit by the Office of the Legislative Auditor. Related data is verifiable via monthly reports providing new case counts.

6. **Data Source, Collection, and Reporting**: This figure comes from the monthly reports produced by the LMMIS/TPL Recovery Report Archive.

7. **Calculation Methodology**: These counts come from the monthly reports the Fiscal Intermediary produces via the LMMIS/TPL Recovery Report Archive and are identified via the count of new referrals/cases.

8. **Scope**: The scope is statewide. Information can be broken down by the individual Recipient Recovery Program Specialist's, Supervisor's, or Manager's caseload, each of which is comprised of several parishes.

9. **Caveats**: The reports are dependent upon claims processed through the Fiscal Intermediary's claims processing system. The RPA Unit's collection reports also depend upon the precision of the TPL Recovery application of LMMIS and documentation of restitution due, as provided to RPA. Any breakdown or variation in these systems and restitution information provided could directly affect this total. The following may result in uneven and fluctuating collections: a) volume associated with death of beneficiaries/their spouses with annuities and/or SNTs subject to recovery, b) volume and other variables associated with LDH's MRFIU workload and resulting AG decisions, c) staffing consequences (i.e. prolonged absence, staff shortage, etc.), and d) unmeasurable variables resulting in eventual reimbursement to the State. Tracking of this indicator commences after the execution of contract with a vendor/contractor.

10. **Responsible Persons**: Janelle Sparks, Medicaid Program Manager 2, Medicaid Enterprise Systems, (225) 342-0259, Janelle.Sparks@la.gov; Becky Bach, Medicaid Program Manager 1-B, Medicaid Enterprise Systems, (225) 342-5059,

Becky.Bach@la.gov; and Mitzi Hochheiser, Medicaid Deputy Director, Medicaid Enterprise Systems, (225) 342-8935, Mitzi.Hochheiser@la.gov

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Financial Management

Objective: Through the Financial Management Activity, increase collections through the Collections/Recovery and Cost Avoidance activity by 1% from individuals who were ineligible for Medicaid on the date(s) of service

Indicator Name: Annual number of recipient recovery cases resulting in successful recovery

Indicator LaPAS PI Code: NEW (Strategic Plan)

1. **Type and Level**: Output and General (G)

2. **Rationale:** This indicator gives the Recovery and Premium Assistance (RPA) Unit's state fiscal year total number of cases for which recovery was successful from:

    - Annuities of deceased Medicaid beneficiaries/their spouses (State/LDH assigned beneficiary)
    - SNTs of deceased Medicaid beneficiaries/their spouses (SNTs with Medicaid payback clause)
    - Offenders court-ordered to pay restitution to LDH (i.e. expenses paid on behalf of beneficiary), as facilitated by LA Department of Corrections/Probation and Parole, or court-ordered reimbursement from individuals, as facilitated by LDH's Medicaid Recipient Fraud Investigative Unit (MRFIU) and the Attorney General's Office.

3. **Use**: Accumulation of data for this indicator produces current number of cases with successful recovery by the RPA Unit.

4. **Clarity**: This performance indicator does not include retrospective recovery of Medicaid overpayments and ineligible payments made on a Medicaid recipient's behalf, except as pursued by MRFIU and the Attorney General. The term "Design, Development, and Implementation (DDI) Phase" refers to the phase where requirements are gathered and validated; design documents are constructed; systems and solutions built and integrated; unit, system, and user acceptance testing are performed; and cutover activity and system implementation are performed.

5. **Accuracy, Maintenance, and Support**: This Performance Indicator is subject to audit by the Office of the Legislative Auditor. Related data is verifiable via monthly reports providing case counts and collection amounts.

6. **Data Source, Collection, and Reporting**: This figure is calculated from the monthly reports produced by the LMES/TPL Recovery Report Archive.

7. **Calculation Methodology**: The counts are taken from the monthly reports the Fiscal Intermediary produces via the LMMIS/TPL Recovery Report Archive. This figure is calculated from the monthly reports the Fiscal Intermediary produces via the LMMIS/TPL Recovery Report Archive and consists of case counts with payment in full and closure, after applicable offsets and other exclusions.

8. **Scope**: The scope is statewide. Information can be broken down by the individual Recipient Recovery Program Specialist's, Supervisor's, or Manager's caseload, each of which is comprised of several parishes.

9. **Caveats**: The reports are dependent upon claims processed through the Fiscal Intermediary's claims processing system. The RPA Unit's collection reports also depend upon the precision of the TPL Recovery application of LMMIS and documentation of restitution amount due, as provided to RPA. Any breakdown or variation in these systems and restitution information provided could directly affect this total. The following may result in uneven and fluctuating collections: a) volume associated with death of beneficiaries/their spouses with annuities and/or SNTs subject to recovery, b) volume and other variables associated with LDH"S MRFIU workload and resulting AG decisions, c) staffing consequences (i.e. prolonged absence, staff shortage, etc.), and d) unmeasurable variables resulting in eventual reimbursement to the State. Tracking of this indicator commences after the execution of contract with a vendor/contractor.

10. **Responsible Persons**: Janelle Sparks, Medicaid Program Manager 2, Medicaid Enterprise Systems, (225) 342-0259, Janelle.Sparks@la.gov; Becky Bach, Medicaid Program Manager 1-B, Medicaid Enterprise Systems, (225) 342-5059, Becky.Bach@la.gov; Mitzi Hochheiser, Medicaid Deputy Director, Medicaid Enterprise Systems, (225) 342-8935, Mitzi.Hochheiser@la.gov

PERFORMANCE INDICATOR DOCUMENTATION

Program: Medical Vendor Administration (Program A)

Activity: Financial Management

Objective: Through the Financial Management Activity, increase collections through the Collections/Recovery and Cost Avoidance activity by 1% from individuals who were ineligible for Medicaid on the date(s) of service.

Indicator Name: Percentage increase in recipient recovery cases with successful recovery

Indicator LaPAS PI Code: NEW (Strategic Plan)

1. **Type and Level**: Output and General (G)

2. **Rationale:** This indicator gives the percentage increase in cases with successful recovery performed by the Recovery and Premium Assistance (RPA) Unit from:

   - Annuities of deceased Medicaid beneficiaries/their spouses (State/LDH assigned beneficiary)
   - SNTs of deceased Medicaid beneficiaries/their spouses (SNTs with Medicaid payback clause)
   - Offenders court-ordered to pay restitution to LDH (i.e. expenses paid on behalf of a beneficiary), as facilitated by LA Department of Corrections/Probation and Parole, or court-ordered reimbursement from individuals, as facilitated by LDH's Medicaid Recipient Fraud Investigative Unit (MRFIU) and the Attorney General's Office

3. **Use**: Accumulation of data for this indicator produces percentage of increase in cases with successful recovery by the RPA Unit.

4. **Clarity**: This performance indicator does not include retrospective recovery of Medicaid overpayments and ineligible payments made on a Medicaid beneficiary's behalf, except as pursued by MRFIU and the Attorney General. The term "Design, Development, and Implementation (DDI) Phase" refers to the phase where requirements are gathered and validated; design documents are constructed; systems and solutions built and integrated; unit, system, and user acceptance testing are performed; and cutover activity and system implementation are performed.

5. **Accuracy, Maintenance, and Support**: This Performance Indicator is subject to audit by the Office of the Legislative Auditor. Related data is verifiable via monthly reports providing cases and recovery amounts.

6. **Data Source, Collection, and Reporting**: Case counts come from the monthly reports produced by the LMMIS/TPL Recovery Report Archive.

7. **Calculation Methodology**: The case counts come from the monthly reports the Fiscal Intermediary produces via the LMMIS/TPL Recovery Report Archive. The percent change is calculated by subtracting the reporting fiscal year's total count by the prior fiscal year's total count, then dividing the difference by the prior fiscal years' total count.

8. **Scope**: The scope is statewide. Information can be broken down by the individual Recipient Recovery Program Specialist's, Supervisor's, or Manager's caseload, each of which is comprised of several parishes.

9. **Caveats**: The reports are dependent upon claims processed through the Fiscal Intermediary's claims processing system. The RPA Unit's collection reports also depend upon the precision of the TPL Recovery application of LMMIS and documentation of restitution amount due, as provided to RPA. Any breakdown or variation in these systems and restitution information provided could directly affect this total. The following may result in uneven and fluctuating collections: a) volume associated with death of beneficiaries/their spouses with annuities and/or SNTs subject to recovery, b) volume and other variables associated with LDH"S MRFIU workload and resulting AG decisions, c) staffing consequences (i.e. prolonged absence, staff shortage, etc.), and d) unmeasurable variables resulting in eventual reimbursement to the State. Tracking of this indicator commences after the execution of contract with a vendor/contractor.

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Becky.Bach@la.gov: and Mitzi Hochheiser, Medicaid Deputy Director, Medicaid Enterprise Systems, (225) 342-8935, Mitzi.Hochheiser@la.gov

LOUISIANA DEPARTMENT OF HEALTH

09-306 Medical Vendor Payments

Vision

Medicaid envisions a future where every Louisianan has a fair and just opportunity to lead the healthiest life possible.

Mission

Our mission is to provide the right health care at the right time, reducing health disparities, and improving overall health outcomes in Louisiana.

Philosophy

Our philosophy is to operate the Medicaid program in a manner that achieves the Triple Aim of optimizing health system performance by improving the patient experience of care (including quality and satisfaction); improving the health of populations; and reducing the per capita cost of health care.

Executive Summary

The direction of health care nationally has been to improve care in ways that matter most to patients, families, and communities. It includes increased access to affordable, comprehensive, continuous health insurance coverage, which is essential to the ability to achieve and maintain good health. It emphasizes preventive and primary care to better identify problems, including non-medical drivers of health, and solutions further upstream and outside of acute care. With less complex and more coordinated care, the burden of illness is expected to decline and the per capita cost of care for populations to stabilize or decrease, lessening pressure on publicly funded health care budgets and providing communities with more flexibility to invest in activities, such as education, that increase vitality and economic wellbeing.

In keeping with the nation, Louisiana Medicaid strives to:

1) Ensure comprehensive coverage for eligible individuals

2) Increase access to preventive health screenings and decrease chronic illness for Medicaid members.

3) Increase access to community-based services as an alternative to institutional care.

4) Improve oversight of managed care compliance and enforce the management of care for recipients.

Agency Goals

Goal I
To make comprehensive, coordinated care and quality health services available to all who qualify.

Goal II
To increase access to community-based services as an alternative to institutional care.

Goal III
To reduce the per capita cost of care by balancing health care and prevention spending.

LOUISIANA DEPARTMENT OF HEALTH

Program A: Payments to Private Providers

Program A: Description
The Payments to Private Providers Program provides payments to private providers of health care services to Louisiana residents who are eligible for Title XIX (Medicaid), while ensuring that reimbursements to providers of medical services to Medicaid recipients are appropriate.

Program A: Mission
The mission of Payments to Private Providers is to administer a high-performing Medicaid program that maximizes high-value care and minimizes waste, paying for value over volume of services, and ensuring compliance with federal and state requirements regarding medically necessary services for eligible individuals.

Program A: Goals
I. To reduce health care costs by providing comprehensive coordinated care that balances health care and prevention spending
II. To increase access to community-based services as an alternative to institutional care

Activity 1 – Medicaid Managed Care

Louisiana's Medicaid managed care program is responsible for providing high-quality, innovative, and cost-effective health care to Medicaid recipients.

The Medicaid managed care objectives include:

- Improve access to care.

- Improve care coordination.
- Increase emphasis on disease prevention and the early diagnosis and management of chronic conditions.
- Improve health outcomes and quality of care.
- Supporting innovation and a culture of continuous quality improvement in Louisiana
- Decreasing fragmentation and increasing integration across providers and care settings particularly for enrollees with behavioral health needs.
- Aligning financial incentives and building shared capacity to improve health care quality through data and collaboration.
- Minimizing wasteful spending, unnecessary utilization, and fraud.

Today, Louisiana Medicaid serves approximately 35 percent of the state's population. Six (6) statewide Managed Care Organizations (MCOs), one (1) Behavioral Health Prepaid Inpatient Health Plan (PIHP), and two (2) Dental Prepaid Ambulatory Health Plans (PAHPs) pay for health care services for more than 90 percent of the Louisiana Medicaid population. The Louisiana Medicaid Managed Care program is a full risk-bearing, MCO health care delivery system responsible for providing specified Medicaid core benefits and services. An MCO assumes full risk for the cost of core benefits and services under the Contract and incurs loss if the cost of furnishing these core benefits and services exceeds the payment received for providing these services. The Louisiana Department of Health (LDH) establishes a Per Member per Month (PMPM) actuarially sound risk-adjusted rate for MCO payments. The rates are not subject to negotiation or dispute resolution. These managed care entities (MCEs) pay for Medicaid benefits and services included in the Louisiana Medicaid State Plan, state statutes and administrative rules, and Medicaid policy and procedure manuals. In addition, these MCEs also provide specified value-added Medicaid benefits and services.

In December 2015, LDH integrated specialized behavioral health services into the managed care program in an effort to improve care coordination for enrollees and facilitate provision of whole-person health care. Louisiana also continues to administer the Coordinated System of Care (CSoC), a single behavioral health PIHP to help children with behavioral health challenges that are at risk for out-of-home placement. Wraparound support and other services assist children with staying in or returning to their home.

The Dental Benefit Program (DPB) coordinates dental care for Medicaid recipients. The DBP provides children with preventive and diagnostic services such as regular exams and sealants as well as therapeutic services to treat dental medical problems. Adults receive denture services and comprehensive oral exams.

Objective I: Through the Medicaid Managed Care Activity, increase preventive and primary health care use, thereby improving quality, health outcomes, and patient experience for Louisiana Medicaid members.

Strategies:

1.1 Require Managed Care Entities to encourage Medicaid recipients to obtain appropriate preventive and primary care in order to improve their overall health and quality of life, and to ensure that those who care for them provide the coordinated care through managed care programs.

1.2 Provide health services in the most integrated setting possible, and emphasize community and home based alternatives where appropriate.

1.3 Reimburse for a cohesive service delivery model of high quality medically necessary behavioral health services, avoiding the use of services that are not medically necessary or evidence-based and maximizing the use of federal funding.

Performance Indicators:

- Percentage of enrolled children under age 21 who received a comprehensive or periodic oral evaluation within the measurement year
- Percentage of enrolled children ages one through under age 21 who received at least two dental topical fluoride applications within the measurement year
- Percentage of child and adolescent well care visits
- Percentage of well care visits for children in the first 15 months of age
- Percentage of well care visits for children15 to 30 months of age
- Percentage of adult access to preventive or ambulatory services

Activity 2 – Long-Term Services and Support (LTSS)

In 1981, the Federal Government created Title XIX, Home and Community-Based Services (HCBS), in order to provide home and community-based services to the elderly and persons with physical disabilities, developmental disabilities, and/or mental illnesses. Since this Act made an exception to the traditional Medicaid requirements, it required a waiver. Waivers give states flexibility to develop and test creative alternatives for operating their Medicaid programs that are cost neutral compared to what the federal government would have paid in absence of the waiver. These waiver programs allow Louisiana residents to receive Medicaid State Plan benefits while having greater flexibility to choose the services and supports that best suit their needs. They also allow individuals to preserve their independence by staying out of institutional settings and maintaining ties to families and friends.

Objective I: Through the Long-Term Services and Supports Activity, ensure the HCBS program remains in compliance with state and federal requirements so that Medicaid can continue to increase access for HCBS recipients.

Strategies:

1.1 Ensure compliance with CMS quality design and review processes for 1915(c) Waivers.

1.2 Ensure provider compliance with Medicaid's Electronic Visit Verification (EVV) system for in-home personal care service providers.

Performance Indicators:

- Percentage of LTSS recipients receiving Home and Community Based Services
- Percentage of providers compliant with the State's Electronic Visit Verification (EVV) standard

LOUISIANA DEPARTMENT OF HEALTH

Program B: Payments to Public Providers

Program B: Description

The Payments to Public Providers provides payments to public providers of health care services to Louisiana residents who are eligible for Title XIX (Medicaid), while ensuring that reimbursements to providers of medical services to Medicaid recipients are appropriate.

Program B: Mission

The mission of Payments to Public Providers is to administer the Medicaid Program to ensure operations are in accordance with federal and state statutes regarding medically necessary services to eligible recipients.

Program B: Goal

I. To provide cost effective and medically appropriate Medicaid covered services through public providers.

Activity 1 – Payments to Public Providers

This activity provides access to care through state and local governmental providers of health care services, including some services not readily available in the private sector, such as services provided to individuals with severe mental illness (Eastern Louisiana Mental Health System, Central Louisiana State Hospital) and developmental disabilities (Pinecrest Services and Support Center).

With the privatization of the Louisiana State University hospitals and clinics through Public-Private Partnerships, payments to public providers previously made to those entities shifted to the Payments to Private Providers Activity. Remaining public providers include the Office of Public Health (OPH), which bills for services provided at local health units, and Local Education Authorities (LEAs) that provide health care services to children attending public schools.

School-based services can improve access to care for children who may have difficulty in receiving services in a physician's office or clinic. This will result in earlier identification of certain medical conditions leading to earlier intervention. The school nurse will make necessary referrals to a physician when appropriate and assist the child's family in making

that appointment. School nurses must coordinate with the student's Medicaid managed care entity to assure continuity and coordination of care.

Objective I: Through the Payment to Public Providers Activity, track utilization of services provided by local school systems including nursing services, which allow important medical screenings to be provided by these school systems with Medicaid reimbursement.

Strategies:

1.1 Track utilization and growth of services that LEAs provide, including nursing services for screenings and referral to physicians for treatment.

1.2 Transition to roster billing for Medicaid school-based services to reduce the administrative burden to schools.

Performance Indicators:

- Number of LEAs participating in school nursing services
- Number of unduplicated recipients receiving school nursing services from LEAs
- Number of school nurses in participating LEAs

Program C: Buy-Ins & Supplements

Program C: Description

The Buy-Ins & Supplements Program provides medical insurance for eligible Medicaid and CHIP enrollees through the payment of premiums to other entities. This avoids potential additional Medicaid costs for those eligible individuals who cannot afford to pay their own "out-of-pocket" Medicare costs.

Program C: Mission

The mission of the Buy-Ins & Supplements Program is to purchase health care services through the payment of premiums to other entities on behalf of certain Louisiana Medicaid and CHIP enrollees. This program has two major components:

1. **Medicare Buy-Ins and Supplements** is the federal program that allows states to purchase Medicare coverage for individuals with limited income and resources by paying their monthly Medicare Part A and/or B premiums. By doing so, the state provides medical insurance protection to individuals with limited income and resources. For those individuals dually-eligible for Medicaid and Medicare, it has the effect of transferring some medical costs for this population from the Title XIX Medicaid program, which is partially state financed, to the Title XVIII Medicare program, which is fully financed by the federal government. Federal matching money is available through the Medicaid program to assist states with the premium payments for Medicare buy-in enrollees.

2. **Louisiana Health Insurance Premium Payment (LaHIPP)** is a program authorized under the authority of Section 1906 of the Social Security Act. It may reimburse all or a portion of an Employer Sponsored Insurance (ESI) or individual market premium on behalf of a Medicaid recipient, if purchasing such insurance is determined to be more cost effective than having Medicaid as the primary payer of medical expenses. Medicaid may also pay the out of pocket expenses (co-pays and deductibles) for LaHIPP eligibles enrolled in ESI or individual market coverage.

Program C: Goals

I. Medicaid cost avoidance through Buy-Ins (paying premiums) for Medicare and Medicaid dual eligibles.

II. To reduce Medicaid expenditures for Medicaid enrollees through reimbursement of employee's share of paid premiums for employer-based or individual market health insurance when cost effective to do so.

Activity 1 – Medicare Savings Program for Low-Income Seniors & Persons with Disabilities

The ultimate aim of the Medicare Savings Program (MSP) is to improve the health of its beneficiaries. Reducing financial barriers to health care can lead to better health outcomes, and expanding access to health care improves health status and mortality for those with the lowest incomes. The MSP has been shown to improve access to medical care services. Utilization of all medical service types is greater for MSP enrollees than for eligible non-enrollees, even when accounting for differences in health status and other characteristics. Data has shown that MSP enrollment increases access to preventative and primary care through use of outpatient hospital services and a higher frequency of office visits.

Objective I: The Medicare Savings Program for Low-Income Seniors & Persons with Disabilities Activity will avoid more expensive costs that Medicaid would otherwise fund. It ensures that eligible low-income senior citizens do not forego health coverage due to increasing Medicare premiums that make maintaining coverage increasingly difficult.

Strategies:

1.1 Continue outreach to promote the program to the public.

1.2 Improve timeliness and accuracy of information available to providers in Medicaid Eligibility Verification System (MEVS).

Performance Indicators:

- Total number of recipients (Part A)
- Total number of recipients (Part B)
- Total number of Buy-In eligibles (Part A and B)
- Buy-In Expenditures (Part A)
- Buy-In Expenditures (Part B)
- Total savings (cost of care less premium cost) for Medicare benefits

Activity 2 – Louisiana Health Insurance Premium Payment (LaHIPP) Program

The Louisiana Health Insurance Premium Payment (LaHIPP) Program Activity focuses on ensuring access to affordable and appropriate care to Medicaid & LaCHIP eligibles and their families who have access to Employer Sponsored Insurance (ESI) or individual market coverage. LDH reinstituted the LaHIPP program in April 2017 after it was retired in 2015. LaHIPP reimburses eligible Medicaid recipients for some costs related to ESI or individual market coverage, including premiums, copays, and deductibles when the provider bills Medicaid secondary. The program aims to reduce Medicaid costs by making it more affordable for eligible individuals to maintain private insurance coverage.

LaHIPP reduces the number of uninsured Louisiana residents and establishes a third party resource as the primary payer of medical expenses to reduce Medicaid costs, assuring that Medicaid pays only after the responsible third party has met its legal obligation to pay.

Objective I: Increase provider and member participation in the LaHIPP program.

Strategies:

1.1 Maximize the number of LaHIPP cases where it is determined to be cost effective to pay for employer sponsored health insurance or individual market coverage which becomes the primary payer of medical expenses for Medicaid enrollees.

Performance Indicators:

- Number of cases added in LaHIPP
- LaHIPP Total Savings in Millions
- Number of Medicaid enrollees with private coverage paid by LaHIPP
- Number of non-Medicaid family members with private coverage paid by LaHIPP

LOUISIANA DEPARTMENT OF HEALTH

09-306 MEDICAL VENDOR PAYMENTS

APPENDIX

FY 2026-2031

5-YEAR STRATEGIC PLAN

Program A: Payments to Private Providers
Program B: Payment to Public Providers
Program C: Program C: Buy-Ins & Supplements
Program D: Uncompensated Care Costs

The Medical Vendor Payments (MVP Agency 306) program combination is for planning purposes. In terms of services rendered, the programs and their goals, objectives, and indicators are identical. MVP will render payments for services to either public or private vendors and will report them along those lines. The service recipient's choice of vendors affects control over the amount of money that go to public versus private entities.

A brief description of how the strategic planning process was implemented in your organization: Upon Medicaid Executive Management Team review of the Strategic Plan, Medicaid concluded that while progress towards goals and objectives is being realized as expected and anticipated results are being achieved, it needed to reaffirm its goals, objectives, strategies, and performance indicators. Strategic Plan adjustments reflect the current environment, current and future priorities, and enable the agency to continue to grow progress. Performance Indicator (PI) Documentation Sheets are complete for all new performance indicators.

Statement of Agency Strategies for Development and Implementation of Human Resource Policies That Are Helpful and Beneficial to Women and Families: MVP is dedicated to the development and implementation of human resource policies that are helpful and beneficial to women and families. This program demonstrates its support through the following human resource policies: the Family Medical Leave Policy (8108-930), the Sexual Harassment Policy (8143-02) and the Equal Employment Opportunity Policy (8116-77). In addition, the allowance of flexibility in work schedules and the availability of Dependent Day Care Spending Accounts assist both women and their families.

Maintenance of Agency Performance-Based Budgeting Records: The maintenance and preservation of all documents used in the development of strategic and operational plans, as well as data used for the completion of quarterly performance progress reports through the Louisiana Performance Accountability System (LaPAS), are in accordance with the state's record retention laws (Revised Statute 44:36). The agency maintains records for at least three (3) years from the origination date.

Principal Customers/Users of the Program and Benefits: There are two principal customers/users of the Medicaid Program: recipients of Medicaid services and providers of Medicaid services. Recipients generally fall into three categories: mothers and children (including pregnant women), elderly people, and persons with disabilities and chronic conditions. Medicaid providers are purveyors of covered medically necessary services to Medicaid recipients and may be individual owners, group owned, a governmental entity, or an incorporated business.

Potential Internal/External Factors That Could Significantly Affect the Achievement of Goals or Objectives in this Program: Internal factors that could affect the achievement of goals and objectives include the level and qualifications of staff, agency priorities, and coordination/cooperation between agencies of the Department.

Several external factors have significant influence on our ability to achieve the goals and objectives as stated. Primary factors are the appropriation of funding; changes in federal rules and regulations; utilization of services by recipients; growth or expansion of the eligible population shifts in state demographics; state economy and unemployment rates; medical inflation rates; participation rates of medical providers; new and increasingly expensive medical procedures and drugs; and changes in Legislative priorities.

Methods Used to Avoid Duplication of Effort: The Bureau of Health Services Financing (BHSF) is the sole entity in the state of Louisiana responsible for the administration of Medicaid funds. In this role, the Bureau coordinates the use of these funds across several agencies within the Department of Health and a few outside of the Department. In all cases federal rules, regulations and guidelines, as well as, policies issued by the BHSF, govern the use of funds

and the BHSF oversees implementation. Consequently, the Bureau is able to assure coordination of effort and avoidance of duplication.

Within BHSF, there are a number of programs and functions. The Medicaid Director and Deputy Directors (collectively the Medicaid Executive Management Team) work closely with each other and are responsible for the coordination of the activities of BHSF between Medicaid programs. Medicaid Section Chiefs administer and oversee Medicaid programs, who work together in a complementary manner. Meetings of the Executive Management Team and Section Chiefs occur on a weekly basis, and as-needed, for the purposes of coordinating work, identifying touchpoints and dependencies, and addressing issues and potential conflicts between programs.

Medicaid EMT members also meet regularly with other LDH program office leadership including the Office of Public Health (OPH), Office of Behavioral Health (OBH), Office of Citizens with Developmental Disabilities (OCDD), and the Office of Aging and Adult Services (OAAS). These meetings are necessary to coordinate work across programs, identify touchpoints and dependencies, and address issues and potential conflicts between programs.

Collectively, this process enables leaders and managers to work together to examine and solve issues critical to the administration of funds and minimize opportunities for potential program duplication.

Program Evaluations used to Develop Goals, Objectives, and Strategies:

- Review and evaluations of management reports
- Conferences with recipient and provider association
- Bureau planning and policy development sessions
- Customer service surveys
- Ongoing assessment to review progress in meeting performance standards

Agency Goals:

Goal I
To make comprehensive, coordinated care and quality health services available to all who qualify

Goal II
To increase access to community-based services as an alternative to institutional care

Goal III
To reduce the per capita cost of care by balancing health care and prevention spending

Statutory Authority for Goal: The Constitution of Louisiana (1974), Article 12, Section 8, declares that the Legislature may establish a system of economic security and social welfare, unemployment compensation, and public health. Louisiana Revised Statutes 36:251 and the following. Louisiana Revised Statute 46:976 gives the Louisiana Department of Health (LDH) secretary authority to direct and be responsible for the Medical Assistance Program and the Children's Health Insurance Program (Title XIX and XXI of the Social Security Act). The secretary also acts as the sole agent of the state, designates an office within the department, or its assistant secretary to cooperate with the federal government and other state and local agencies in the administration of federal funds granted to the state, department, or office to aid in the furtherance of any function of the department or its offices.

Primary Persons Who Will Benefit From or Be Significantly Affected by Objective: Louisiana citizens, with the vast majority of the services provided to Medicaid eligible recipients. Additionally, there is an economic impact upon medical services provided within the State of Louisiana resulting from the reimbursements made to the medical community for the delivery of medically necessary services.

PERFORMANCE INDICATOR DOCUMENTATION

Program: Payments to Private Providers (Program A)

Activity: Medicaid Managed Care

Objective: Through the Medicaid Managed Care Activity, increase budget predictability while providing for a service delivery model of high quality, medically necessary health services, and avoiding unnecessary spending on duplication of services and low value care.

Indicator Name: Percentage of Medicaid enrollees enrolled in a managed care model

Indicator LaPAS PI Code: 25602

1. **Type and Level**: Output and Key (K)

2. **Rationale:** This indicator measures the extent to which the Medicaid population is enrolled in a managed care model for physical health services.

3. **Use**: This data will be used to assess the agency's performance in expanding Medicaid Managed Care to include currently excluded Medicaid enrollees, as feasible.

4. **Clarity**: Medicaid enrollees are those individuals who are: 1) determined eligible in accordance with the Louisiana Medicaid State Plan, both federally mandated or state legislatively approved optional groups, and CMS-approved Medicaid Waivers and Medicaid Eligibility Manual, and 2) certified in the Louisiana Medicaid Eligibility Data System (LaMEDS). Medicaid managed care enrollees are defined as those Medicaid enrollees for whom LDH pays a Per Member Per Month rate (PMPM) to a managed care plan as defined in 42 CFR Part 438. Only enrollees for whom LDH pays the comprehensive PMPM for physical health, specialized behavioral health (SBH), and NEMT are reported. Enrollees for whom LDH pays the limited SBH only PMPM are excluded from this measure.

5. **Accuracy, Maintenance, and Support**: The Office of the Legislative Auditor has not audited this measure. LDH compiles and verifies it internally.

6. **Data Source, Collection, and Reporting**: The source of this indicator is the MARS Data Warehouse (MDW), which is maintained by DXC and fed by the MES/LaMEDS mainframe.

7. **Calculation Methodology**: Managed Care Percentage of Medicaid enrollees enrolled in a managed care model = Number of Medicaid Healthy Louisiana managed care enrollees with a P linkage/ Number of Medicaid enrollees

8. **Scope**: Reporting is at an aggregate level.

9. **Caveats**: This indicator does not have any limitations or weaknesses.

10. **Responsible Person**: Carrie Jackson, Medicaid Program Manager 1B, Managed Care Finance, (225) 219-7058; carrie.jackson@la.gov; Cristian Nedelea, Economist 4-B, MVP Budget (225) 219-0192, cristian.nedelea@la.gov; Teresa Bravo, Medicaid Program Manager 4, Managed Care Finance, (225) 342-1862

PERFORMANCE INDICATOR DOCUMENTATION

Program: Payments to Private Providers (Program A)

Activity: Medicaid Managed Care

Objective: Through the Medicaid Managed Care Activity, increase budget predictability while providing for a service delivery model of high quality, medically necessary health services, and avoiding unnecessary spending on duplication of services and low value care.

Indicator Name: Percentage of Medicaid enrollee expenditures under a managed care model

Indicator LaPAS PI Code: 25603

1. **Type and Level**: Output and Key (K)

2. **Rationale:** This indicator measures the extent to which Medicaid covered services provide through a managed care model.

3. **Use**: This data will be used to assess the agency's performance in expanding Medicaid Managed Care to include currently excluded services, as feasible.

4. **Clarity**: Medicaid enrollee expenditures are all expenditures for Agency 09-306. Medicaid enrollee expenditures under a managed care model are defined as all expenditures for Medicaid enrollees enrolled in a managed care plan, exclusive of expenditures for services carved out of (not included in) managed care models. Medicaid enrollees are those individuals who are determined eligible in accordance with the Louisiana Medicaid State Plan, both federally mandated or state legislatively approved optional groups, and CMS-approved Medicaid Waivers and Medicaid Eligibility Manual; and certified in the Louisiana Medicaid Eligibility Determination System (LaMEDS).

   Medicaid managed care enrollees are defined as those Medicaid enrollees for whom LDH pays a Per Member Per Month rate (PMPM) to a managed care plan in any capacity including:

   A. Comprehensive PMPM payments for physical health, specialized behavioral health (SBH), and Non- Emergency Medical Transportation (NEMT)
   B. Limited SBH/NEMT Only PMPM payments
   C. Dental PAHP PMPM payments
   D. Coordinated System of Care (CSoC) PMPM payments
   E. Program for All-inclusive Care for the Elderly (PACE) payments
   F. Other non-PMPM payments made to managed care organizations such as Directed Payments and Managed Care Incentive Program (MCIP) payments

5. **Accuracy, Maintenance, and Support**: The Office of the Legislative Auditor has not audited this measure. LDH compile and verify it internally.

6. **Data Source, Collection, and Reporting**: Medicaid managed care rule and contracts relative to scope of covered services included and excluded. The MARS Data Warehouse (MDW), which is maintained by DXC and fed by the MES/LaMEDS mainframe. Payment memos tracking of other non-routine payments made to the managed care organizations.

7. **Calculation Methodology**: Percentage of Medicaid Healthy Louisiana enrollee expenditures under a managed care model = Medicaid expenditures for enrollees in a managed care plan, exclusive of expenditures for services carved out of (not included in) managed care / Total expenditures for all Medicaid enrollees.

8. **Scope**: Reporting is at an aggregate level.

9. **Caveats**: This indicator does not have any limitations or weaknesses.

10. **Responsible Person**: Carrie Jackson, Medicaid Program Manager 1B, Managed Care Finance, (225) 219-7058; carrie.jackson@la.gov; Cristian Nedelea, Economist 4-B, MVP Budget (225) 219-0192, cristian.nedelea@la.gov; Teresa Bravo, Medicaid Program Manager 4, Managed Care Finance, (225) 342-1862

PERFORMANCE INDICATOR DOCUMENTATION

Program: Payments to Private Providers (Program A)

Activity: Medicaid Managed Care

Objective: Through the Medicaid Managed Care Activity, increase budget predictability while providing for a service delivery model of high quality, medically necessary health services, and avoiding unnecessary spending on duplication of services and low value care.

Indicator Name: Annual amount of premium taxes paid by Medicaid managed care plans

Indicator LaPAS PI Code: 25604

1. **Type and Level**: Outcome and General (G)

2. **Rationale:** This indicator measures the State revenue impact of Medicaid Managed Care Organizations. Premium taxes levied by the State on Per Member per Month (PMPM) payments to Healthy Louisiana Prepaid Plans are collected by the Louisiana Department of Insurance and transferred to LDH to meet state matching requirements for federal financial participation in the Medicaid program.

3. **Use**: This data will inform future budgeting decisions relative to the financial requirements of the Medicaid program.

4. **Clarity**: Healthy Louisiana Prepaid Plans are define as insurance companies paying a license tax by the Louisiana Insurance Code and contracting with DHH to provide Medicaid benefits and services to Louisiana Medicaid Healthy Louisiana Program enrollees in exchange for a monthly-prepaid capitated amount per member.

5. **Accuracy, Maintenance, and Support**: The Office of the Legislative Auditor has not audited this measure.

6. **Data Source, Collection, and Reporting**: Data obtained from the Louisiana Department of Insurance Form 1061 Annual Premium Tax Statement filed by Medicaid Managed Care Organizations no later than March 1 of each year.

7. **Calculation Methodology**: As specified on the LA DOI Form 1061 http://www.ldi.state.la.us/Documents/FinancialSolvency/Surplus_Lines/Form1061.pdf

8. **Scope**: Reporting is at an aggregate level, summing the amount of tax paid by each Healthy Louisiana Prepaid Plan.

9. **Caveats**: This indicator does not have any limitations or weaknesses.

10. **Responsible Person**: Carrie Jackson, Medicaid Program Manager 1B, Manage Care Finance, (225) 304-0577; carrie.jackson@la.gov; Teresa Bravo, Medicaid Program Manager 4, Managed Care Finance (225) 342-1862, teresa.bravo@la.gov

PERFORMANCE INDICATOR DOCUMENTATION

Program: Payments to Private Providers (Program A)

Activity: Medicaid Managed Care

Objective: Through the Medicaid Managed Care Activity, increase preventive and primary health care use, thereby improving quality, health outcomes, and patient experience for Louisiana Medicaid members.

Indicator Name: Percentage of enrolled children under age 21 who received a comprehensive or periodic oral evaluation within the measurement year.

Indicator LaPAS PI Code: 3061004 (NEW)

1. **Type and Level**: Outcome and Key (K)

2. **Rationale:** This indicator was chosen to provide data regarding Medicaid Early Periodic Screening and Diagnostic (EPSDT) beneficiaries aged <1 through under 21, who received a comprehensive or periodic oral evaluation within the measurement year. This Child Core Set measure assist CMS and states in understanding the quality of oral health care provided in Medicaid and CHIP. Additionally, it helps to monitor and improve access to dental care, and aids in gaining an understanding of oral health disparities that beneficiaries may experience. CMS encourages states to use Core Set data to develop initiatives and policies to advance health equity and improve outcomes.

3. **Use**: This measure will be used for monitoring trends and inform management of areas needing improvement and assist with the policymaking process relative to budgeting and quality outcome improvement.

4. **Clarity**: The indicator clearly identifies what is being measured.

5. **Accuracy, Maintenance, and Support**: The Office of the Legislative Auditor has not audited the indicator. The indicator is a nationally accepted valid measure used by CMS for overseeing the provisions of oral health care in state Medicaid programs. The data specifications in this indicator were developed and supported by the American Dental Association on behalf of the Dental Quality Alliance (ADA/DQA) to improve performance measures for oral health care

6. **Data Source, Collection, and Reporting**: Data obtained for CMS Child Core Set measures are based on paid, suspended, pended, and denied Medicaid claims and encounters validated and housed in the data warehouse. These measures are reported quarterly during a calendar year as specified by CMS.

7. **Calculation Methodology**: Utilizing encounter data, the numerator and denominator are determined based on specifications for CMS Child Core Set reporting. Calculations for the measure is determined based on percentage. The denominator is the total number of children under age 21 as of December 31 of the measurement year. The numerator shows the unduplicated number of enrolled children who received a comprehensive or periodic dental oral evaluation service during the measurement year (CDT codes: D0120, D0150, D0145).

8. **Scope**: Reporting is at an aggregate level (the Performance indicator itself), but it has the capability to disaggregate to the Dental Benefit Program Manager (DBPM) level.

9. **Caveats**: Measures includes all paid, suspended, pending, and denied claims. Visits are limited diagnostic CDT codes D0120 or D0150 or D0145. Visits to all dental providers are included, regardless of specialty. Members used in the calculation of this data are required to meet continuous enrollment criteria of 180 days during the measurement year.

10. **Responsible Person**: The data collection and reports are completed by University of Louisiana at Monroe (ULM) and evaluated by program staff. LDH program contact: Andrea Perry, Medicaid Program Manager 1B, Program Operations & Compliance, 225-342-7476, Andrea.Perry@la.gov or Tiffany Hayes, Medicaid Program Monitor, Program Operations & Compliance, 225-342-7877, Tiffany.Hayes@la.gov

PERFORMANCE INDICATOR DOCUMENTATION

Program: Payments to Private Providers (Program A)

Activity: Medicaid Managed Care

Objective: Through the Medicaid Managed Care Activity, increase preventive and primary health care use, thereby improving quality, health outcomes, and patient experience for Louisiana Medicaid members.

Indicator Name: Percentage of enrolled children ages one through under age 21 who received at least two dental topical fluoride applications within the measurement year.

Indicator LaPAS PI Code: 3061005 (NEW)

1. **Type and Level**: Outcome and Key (K)

2. **Rationale:** This indicator was chosen to track trends and changes in Medicaid Early Periodic Screening and Diagnostic (EPSDT) dental program beneficiaries' ages 1 through under 21, who received at least two dental fluoride applications, within the measurement year. This modified Child Core Set measure assist CMS and states in understanding the quality of oral health care provided in Medicaid and CHIP. Additionally, it helps to monitor and improve access to dental care, and aids in gaining an understanding of oral health disparities that beneficiaries may experience. CMS encourages states to use Child Core Set data to develop initiatives and policies to advance health equity and improve outcomes.

3. **Use**: This measure will be used for monitoring trends and inform management of areas needing improvement and assist with the policymaking process relative to budgeting and quality outcome improvement.

4. **Clarity**: The indicator clearly identifies what is being measured.

5. **Accuracy, Maintenance, and Support**: The Office of the Legislative Auditor has not audited this indicator. The indicator is a nationally accepted valid measure used by CMS for overseeing the provisions of oral health care in state Medicaid programs. The data specifications in this indicator are supported by the American Dental Association on behalf of the Dental Quality Alliance (ADA/DQA) to improve performance measures for oral health care.

6. **Data Source, Collection, and Reporting**: Data obtained for CMS Child Core Set measure are based on paid, suspended, pended, and denied Medicaid claims and encounters validated and housed in the data warehouse. These measures are reported quarterly during a calendar year specified by CMS.

7. **Calculation Methodology**: Utilizing encounter data, the numerator and denominator are determined based on specifications for CMS Child Core Set reporting. Calculations for this measure is based on percentage. The denominator is the total number of child ages 1-20 as of December 31 of the measurement year. The numerator is the unduplicated number of enrolled children who receive at least two fluoride applications (CDT Codes D1206 or D1208) during the measurement year. Applications must be provided on two unique dates of service.

8. **Scope**: Reporting is at an aggregate level (the Performance indicator itself), but it has the capability to disaggregate to the Dental Benefit Program Manager (DBPM) level.

9. **Caveats**: Measures were based on paid, unpaid, and denied claims and encounters. Visits are limited to topical fluoride applications by enrolled children ages one through 20. Members used in the calculation of this data are required to meet continuous enrollment criteria.

10. **Responsible Person**: The data collection and reports are completed and evaluated by University of Louisiana at Monroe (ULM) and evaluated by program staff. LDH program contact: Andrea Perry, Medicaid Program Manager 1B, 225-342-7476, Andrea.Perry@la.gov or Tiffany Hayes, Medicaid Program Monitor, Program Operations & Compliance, 225-342-7877, Tiffany.Hayes@la.gov

PERFORMANCE INDICATOR DOCUMENTATION

Program: Payments to Private Providers (Program A)

Activity: Medicaid Managed Care

Objective: Through the Medicaid Managed Care Activity, increase preventive and primary health care use, thereby improving quality, health outcomes, and patient experience for Louisiana Medicaid members.

Indicator Name: Percentage of enrolled children who have ever received a sealant on a permanent first molar tooth.

Indicator LaPAS PI Code: 3061006 (NEW)

1. **Type and Level**: Outcome and Key (K)

2. **Rationale:** This indicator is a part of the 2024 CHIP Child Core Set measures and monitors the percentage of enrolled children who have ever received a sealant on a permanent first molar tooth. The measure provides data on the children covered under the Medicaid Early Periodic Screening and Diagnostic (EPSDT) Program. This Child Core Set measure assists CMS and states in understanding the quality of health care provided in Medicaid and CHIP. Additionally, it helps to monitor and improve access to dental care, and aids in gaining an understanding of oral health disparities that beneficiaries may experience. CMS encourages states to use Child Core Set data to develop initiatives and policies to advance health equity and improve outcomes.

3. **Use**: This measure will be used for monitoring trends and disparities in sealant placement which will aid in informing management of areas needing improvement and assist with the policy making process relative to budgeting and quality outcome improvement.

4. **Clarity**: The indicator clearly identifies what is being measure.

5. **Accuracy, Maintenance, and Support**: The Office of the Legislative Auditor has not audited the indicator. The indicator is a nationally accepted valid measure used by CMS for overseeing the provisions of oral health care in state Medicaid programs. The data specifications in this indicator were developed and supported by the American Dental Association on behalf of the Dental Quality Alliance (ADA/DQA) to improve performance measures for oral health care.

6. **Data Source, Collection, and Reporting**: Data obtained for the CMS Child Core Set Measure is based on paid, suspended, pended, and denied Medicaid claims and encounters validated and housed in the data warehouse. This measure is reported quarterly during a calendar year specified by CMS.

7. **Calculation Methodology**: Utilizing encounter data, the numerator and denominator are determined based on specifications for the CMS Child Core Set reporting. A percentage for the measure is determined based on the numerator and denominator. The denominator is the number of members meeting the eligibility, and the treatment criteria. The numerator shows the number of unduplicated members in the population that received a dental sealant on a permanent first molar tooth with a dental practitioner during the measurement year.

8. **Scope**: Reporting is at an aggregate level (the Performance indicator itself), but it has the capability to disaggregate to the Dental Benefit Program Manager (DBPM) level.

9. **Caveats**: Measures are based on paid, suspended, pended, and denied Medicaid claims and encounters. Visits are limited to dental sealants placed on a permanent first molar. Members used in the calculation of this data are required to meet continuous enrollment criteria of 180 days. This measure will not delineate those whose teeth have not erupted, those who have already received sealants in prior years, and those with decayed/filled teeth not candidates for sealants. However, this measure is designed to identify the prevalence of sealant placement on a permanent first molar tooth during the reporting year for members at elevated risk for caries.

10. **Responsible Person**: The data collection and reports are completed and evaluated by University of Louisiana at Monroe (ULM) and evaluated by program staff | LDH program contact: Andrea Perry, Medicaid Program Manager 1B, Program Operations & Compliance, 225-342-7476, Andrea.Perry@la.gov or Tiffany Hayes, Medicaid Program Monitor, Program Operations & Compliance, 225-342-7877, Tiffany.Hayes@la.gov

PERFORMANCE INDICATOR DOCUMENTATION

Program: Payments to Private Providers (Program A)

Activity: Medicaid Managed Care

Objective: Through the Medicaid Managed Care Activity, increase preventive and primary health care use, thereby improving quality, health outcomes, and patient experience for Louisiana Medicaid members

Indicator Name: Percentage of adult access to preventive or ambulatory services

Indicator LaPAS PI Code: 26113

1. **Type and Level**: Outcome and General (G)

2. **Rationale:** This measure is an indicator of the availability of primary care services and if appropriate ambulatory and preventive care.

3. **Use**: This measure tracks and monitors the program progress in assuring access and utilization of primary and preventive services.

4. **Clarity**: This measure assesses the percentage of members 20 years of age and older who had an ambulatory or preventive care visit during the measurement year (total).

   This report includes three age stratification rates and a total rate:

   - 20-44 years
   - 45-64 years
   - 65 years and older
   - Total

   The numerator is members with one or more ambulatory or preventive care visits during the measurement year and the denominator is the eligible population.

5. **Accuracy, Maintenance, and Support**: The Office of the Legislative Auditor has not audited this measure. The National Committee for Quality Assurance (NCQA) reporting process requires that standard methodologies are used, use of NCQA certified software or vendors is required and the data is submitted and processed through NCQA. In addition, the annual submission of all LDH required HEDIS measures is reviewed annually by the CMS required contracted External Quality Review Organization (EQRO).

6. **Data Source, Collection, and Reporting**: The primary data source for this measure is claims and encounter data as collected and reported by the Healthy Louisiana Plans and the state Fiscal Intermediary. Data supplements may occur through actual chart review to verify provision of services. The measures are calculated by each Healthy Louisiana Plan as submitted and certified by NCQA and subject to review by the CMS required contracted External Quality Review Organization (EQRO) The data are collected on a calendar year basis and reported through NCQA annually in the spring following year of collection.

7. **Calculation Methodology**: This measure calculates according to the NCQA defined standard methodology (see NCQA HEDIS 2022: Technical Specifications for Health Plans).

8. **Scope**: In addition to reporting through NCQA, the numerator, denominator, and percent calculations are submitted to LDH and the University of Louisiana Monroe (ULM) through the EQRO. LDH utilizes the services of the University of Louisiana Monroe (ULM) to assist with the analysis and reporting of Healthy Louisiana quality measures.

9. **Caveats**: This indicator does not have any limitations or weaknesses.

10. **Responsible Persons**: Herbert Twase, Medicaid Program Manager 2, Quality Improvement, Population Health and Health Equity, (225) 342-1272, Herbert.Twase@la.gov; Deonne Bailey, Medicaid Program Manager 1B, Quality Improvement, (225) 342-5042; Katherine Stewart, Medicaid Program Manager 3, Quality Improvement, (225) 219-4146, Kate.Stewart@LA.GOV; Timothy Williams, Medicaid Program Manager 4, Quality Improvement, (225) 342-0327, Tim.Williams@LA.GOV

PERFORMANCE INDICATOR DOCUMENTATION

Program: Payments to Private Providers (Program A)

Activity: Medicaid Managed Care

Objective: Through the Medicaid Managed Care Activity, increase preventive and primary health care use, thereby improving quality, health outcomes, and patient experience for Louisiana Medicaid members

Indicator Name: Percentage of well care visits for children in the first 15 months of age

Indicator LaPAS PI Code: 26943

1. **Type and Level**: Outcome and General (G)

2. **Rationale:** This measure is an indicator of the availability of primary care services and the actual utilization of appropriate primary and preventive care.

3. **Use**: This measure tracks and monitors the program progress in assuring access to and utilization of primary and preventive services.

4. **Clarity**: This measure assesses the percentage of members who had the following number of well-child visits with a PCP during the last 15 months: For children who turned 15 months old during the measurement year, six (6) or more well child visits.

5. **Accuracy, Maintenance, and Support**: None

6. **Data Source, Collection, and Reporting**: The primary data source for this measure is claims and encounter data as collected and reported by the Healthy Louisiana Plans and the state Fiscal Intermediary. Supplemental data reports may occur through actual chart review to verify provision of services. The measures calculate each Healthy Louisiana Plan as submitted and certified by NCQA and subject to review by the CMS required contracted External Quality Review Organization (EQRO). The data collections occur by calendar year and annual reports occur through NCQA in the spring following year of collection.

7. **Calculation Methodology**: This measure calculates according to NCQA defined standard methodology (see NCQA HEDIS 2022: Technical Specifications for Health Plans).

8. **Scope**: In addition to reporting through NCQA, The numerator, denominator, and percent calculations are submitted to LDH and the University of Louisiana Monroe (ULM) through the EQRO. LDH utilizes the services of the University of Louisiana Monroe (ULM) to assist with the analysis and reporting of Healthy Louisiana quality measures.

9. **Caveats**: This indicator does not have any limitations or weaknesses.

10. **Responsible Persons**: Herbert Twase, Medicaid Program Manager 2, Quality Improvement, Population Health and Health Equity, (225) 342-1272, Herbert.Twase@la.gov; Deonne Bailey, Medicaid Program Manager 1B, Quality Improvement, (225) 342-5042; Katherine Stewart, Medicaid Program Manager 3, Quality Improvement, (225) 219-4146, Kate.Stewart@LA.GOV; Timothy Williams, Medicaid Program Manager 4, Quality Improvement, (225) 342-0327, Tim.Williams@LA.GOV

PERFORMANCE INDICATOR DOCUMENTATION

Program: Payments to Private Providers (Program A)

Activity: Medicaid Managed Care

Objective: Through the Medicaid Managed Care Activity, increase preventive and primary health care use, thereby improving quality, health outcomes, and patient experience for Louisiana Medicaid members

Indicator Name: Percentage of well care visits for children15 to 30 months of age

Indicator LaPAS PI Code: 26944

1. **Type and Level**: Outcome and General (G)

2. **Rationale:** This measure is an indicator of the availability of primary care services and the actual utilization of appropriate primary and preventive care.

3. **Use**: This measure tracks and monitors the program progress in assuring access to and utilization of primary and preventive services.

4. **Clarity**: The percentage of members who had the following number of well child visits with a Primary Care Physician (PCP) during the last 15 months: For children who turned 30 months old during the measurement year, two (2) or more well child visits.

5. **Accuracy, Maintenance, and Support**: None

6. **Data Source, Collection, and Reporting**: The primary data source for this measure is claims and encounter data as collected and reported by the Healthy Louisiana Plans and the state Fiscal Intermediary. Supplemental data reports may occur through actual chart review to verify provision of services. The measures calculate each Healthy Louisiana Plan as submitted and certified by NCQA and subject to review by the CMS required contracted External Quality Review Organization (EQRO). The data collections occur by calendar year and annual reports occur through NCQA in the spring following year of collection.

7. **Calculation Methodology**: This measure calculates according to NCQA defined standard methodology (see NCQA HEDIS 2022: Technical Specifications for Health Plans).

8. **Scope**: In addition to reporting through NCQA, The numerator, denominator, and percent calculations are submitted to LDH and the University of Louisiana Monroe (ULM) through the EQRO. LDH utilizes the services of the University of Louisiana Monroe (ULM) to assist with the analysis and reporting of Healthy Louisiana quality measures.

9. **Caveats**: This indicator does not have any limitations or weaknesses.

10. **Responsible Persons**: Herbert Twase, Medicaid Program Manager 2, Quality Improvement, Population Health and Health Equity, (225) 342-1272, Herbert.Twase@la.gov; Deonne Bailey, Medicaid Program Manager 1B, Quality Improvement, (225) 342-5042; Katherine Stewart, Medicaid Program Manager 3, Quality Improvement, (225) 219-4146, Kate.Stewart@LA.GOV; Timothy Williams, Medicaid Program Manager 4, Quality Improvement, (225) 342-0327, Tim.Williams@LA.GOV

PERFORMANCE INDICATOR DOCUMENTATION

Program: Payments to Private Providers (Program A)

Activity: Medicaid Managed Care

Objective: Through the Medicaid Managed Care Activity, increase preventive and primary health care use, thereby improving quality, health outcomes, and patient experience for Louisiana Medicaid Members.

Indicator Name: Percentage of child and adolescent well care visits

Indicator LaPAS PI Code: 26945

1. **Type and Level**: Outcome and General (G)

2. **Rationale**: This measure is an indicator of the availability of primary care services and the actual utilization of appropriate primary and preventive care.

3. **Use**: This measure tracks and monitors the program progress in assuring access to and utilization of primary and preventive services.

4. **Clarity**: This measure assesses the percentage of members 3-21 years of age who had at least one comprehensive well-care visit with a primary care physician (PCP) or an Obstetrics-Gynecology (OB/GYN) Nurse Practitioner during the measurement year.

   Report includes three age stratification rates and a total rate:

   - 3-11 years
   - 12-17 years
   - 18-21 years
   - Total

   The numerator is one or more well-care visits (Well-Care Value Set) during the measurement year and the denominator is the eligible population. The well-care visit must occur with a PCP or an OB/GYN practitioner, but the practitioner does not have to be the practitioner assigned to the member.

5. **Data Source, Collection, and Reporting**: The primary data source for this measure is claims and encounter data as collected and reported by the Healthy Louisiana Plans and the state Fiscal Intermediary. Data supplements may occur through actual chart review to verify provision of services. The measures calculate each Healthy Louisiana Plan as submitted and certified by NCQA and subject to review by the Centers of Medicare & Medicaid Services (CMS) required contracted External Quality Review Organization (EQRO). The data are collected on a calendar year basis and reported through NCQA annually in the spring following year of collection.

6. **Calculation Methodology**: This measure calculates according to NCQA defined standard methodology (see NCQA HEDIS 2020-2021: Technical Specifications for Health Plans).

7. **Scope**: In addition to reporting through NCQA, The numerator, denominator, and percent calculations are submitted to LDH and the University of Louisiana Monroe (ULM) through the EQRO. LDH utilizes the services of the University of Louisiana Monroe (ULM) to assist with the analysis and reporting of Healthy Louisiana quality measures.

8. **Caveats**: This indicator does not have any limitations or weaknesses.

9. **Accuracy, Maintenance, and Support**: The Office of the Legislative Auditor has not audited this measure. The NCQA reporting process requires that standard methodologies are used, use of NCQA certified software or vendors is required and the data is submitted and processed through NCQA. In addition, the annual submission of all LDH required HEDIS measures is reviewed annually by the CMS required contracted External Quality Review Organization (EQRO).

10. **Responsible Persons**: Herbert Twase, Medicaid Program Manager 2, Quality Improvement, Population Health and Health Equity, (225) 342-1272, Herbert.Twase@la.gov; Deonne Bailey, Medicaid Program Manager 1B, Quality Improvement, (225) 342-5042; Katherine Stewart, Medicaid Program Manager 3, Quality Improvement, (225) 219-4146, Kate.Stewart@LA.GOV; Timothy Williams, Medicaid Program Manager 4, Quality Improvement, (225) 342-0327, Tim.Williams@LA.GOV

PERFORMANCE INDICATOR DOCUMENTATION

Program: Payments to Private Providers (Program A)

Activity: Long-Term Services and Supports (LTSS)

Objective: Through the Long-Term Services and Supports Activity, ensure the HCBS program remains in compliance with state and federal requirements so that Medicaid can continue to increase access for HCBS recipients.

Indicator Name: Percentage of providers compliant with the State's EVV standard

Indicator LaPAS PI Code: 26589

1. **Type and Level**: Outcome and Key (K)

2. **Rationale:** To ensure proper implementation of EVV, providers will continue to appropriately utilize the system according to LDH requirements. The indicator will identify what percentages of providers remain in compliance with each program's standard.

3. **Use**: The indicator will determine provider compliance going forward and may result in LDH withholding payment from providers when non-compliance is identified.

4. **Clarity**: Yes

5. **Accuracy, Maintenance, and Support**: To date, the Office of the Legislative Auditor has not analyzed data. Medicaid's contractor, Statistical Resources, Inc. (SRI), maintains the data for this report and is routinely reviewed by a LDH workgroup.

6. **Data Source, Collection, and Reporting**: The data source is an external database hosted by Medicaid's contractor (SRI). Reports are analyzed monthly by an internal workgroup. Data is updated nightly and reports reflect provider usage over a 90-day period.

7. **Calculation Methodology**: The indicator is calculated as a simple percentage: Numerator = number of providers compliant, Denominator = total number of providers reporting services in the measurement period.

8. **Scope**: The indicator is aggregate and may be broken down by provider, region, and waiver. The indicator includes all providers of in-home personal care services.

9. **Caveats**: Since service reporting is updated daily, the level of provider compliance may also change daily. Reports need to be pull on a consistent basis but with this caveat in mind.

10. **Responsible Persons**: Statistical Resources Inc. (SRI) is responsible for data collection, reporting, and quality and LDH's EVV workgroup for data analysis. For inquiries related to this indicator, Gustave Lehmann, Medicaid Program Manager 2, Program Support and Waivers, 225-342-9846, Gustave.Lehmann@LA.GOV, Toni Bennett, Medicaid Program Manager 4, Program Support and Waivers, 225-342-6332, Toni.Bennett@LA.GOV. Inquiries may also be made to Medicaid's contractor SRI: Steve Buco, President of SRI may be contacted by phone (225) 767-0501 or sbuco@statres.com.

PERFORMANCE INDICATOR DOCUMENTATION

Program: Payments to Private Providers (Program A)

Activity: Long-Term Services and Supports (LTSS)

Objective: Through the Long-Term Services and Supports Activity, ensure the HCBS program remains in compliance with state and federal requirements so that Medicaid can continue to increase access for HCBS recipients.

Indicator Name: Percentage of LTSS recipients receiving Home and Community Based Services

Indicator LaPAS PI Code: 26590

1. **Type and Level**: Outcome and Key (K)

2. **Rationale:** To assess the Department's efforts around rebalancing and shifting recipients away from more expensive care provided in institutional settings when appropriate.

3. **Use**: The indicator helps to inform management of progress towards one of the Department's goals of right care, right place, and right time.

4. **Clarity**: The indicator includes information on LTSS recipients that are served in home and community- based settings versus those served in institutional settings.

5. **Accuracy, Maintenance, and Support**: The Office of the Legislative Auditor has not audited this indicator. Data for this indicator is maintained in the MES data warehouse.

6. **Data Source, Collection, and Reporting**: The data will be retrieved from the data warehouse on an annual basis.

7. **Calculation Methodology**: The indicator is calculated as a simple percentage: Numerator = number of LTSS recipients receiving home and community-based services; Denominator = total number of LTSS recipients

8. **Scope**: This indicator is aggregated and may be broken down by geographical region and service. The indicator represents all Medicaid recipients receiving LTSS.

9. **Caveats**: This indicator does not have any limitations or weaknesses.

10. **Responsible Persons**: Gustave Lehmann, Medicaid Program Manager 2, Program Support and Waivers, 225-342-9846, Gustave.Lehmann@LA.GOV, Toni Bennett, Medicaid Program Manager 4, Program Support and Waivers, 225-342-6332, Toni.Bennett@LA.GOV

PERFORMANCE INDICATOR DOCUMENTATION

Program: Payments to Public Providers (Program B)

Activity: Payments to Public Providers

Objective: Through the Payment to Public Providers Activity, track utilization of services provided by local school systems including nursing services, which allow important medical screenings to be provided by these school systems with Medicaid reimbursement.

Indicator Name: Number of Local Education Agencies participating in School Nursing Services

LaPAS PI Code: 24092

1. **Type and Level**: Output and Key (K)

2. **Rationale:** This indicator will be a strong indicator as to depth of participation by the LEAs in this program.

3. **Use**: This proposal seeks to achieve the goals of better access to care by giving students in school easier access to care to nursing services. LEAs will use this indicator as an internal management tool to gauge participation.

4. **Clarity**: None

5. **Accuracy, Maintenance, and Support**:

6. **Data Source, Collection, and Reporting**: Source is an internal LDH file that is updated whenever there is a change in the number.

7. **Calculation Methodology**: The indicator is calculated by totaling the number of Local Education Agencies listed in the file. Rate Setting and Audit staff can get.

8. **Scope**: Aggregated.

9. **Caveats**: This indicator does not have any limitations or weaknesses.

10. **Responsible Person**: Lindsey Nizzo, Medicaid Program Manager 2; Rate Setting and Audit Section, (225) 342-3613, Lindsey.Nizzo@LA.GOV

PERFORMANCE INDICATOR DOCUMENTATION

Program: Payments to Public Providers (Program B)

Activity: Payments to Public Providers

Objective: Through the Payment to Public Providers Activity, track utilization of services provided by local school systems including nursing services, which allow important medical screenings to be provided by these school systems with Medicaid reimbursement.

Indicator Name: Number of unduplicated recipients Receiving School Nursing Services from Local Education Agencies

Indicator LaPAS PI Code: 25580

1. **Type and Level**: Output and Key (K)

2. **Rationale:** This indicator will be a strong indicator as to depth and amount of scope the services being provided by the LEAs in this program.

3. **Use**: This proposal seeks to achieve the goals of better access to care by giving students in school easier access to care to nursing services. This indicator will use as an internal management tool to gauge participation by LEAs as well as the utilization patterns of students in the schools.

4. **Clarity**: None

5. **Accuracy, Maintenance, and Support**: It has not been audited.

6. **Data Source, Collection, and Reporting**: The Louisiana Medicaid Data Warehouse will take the data from billing data.

7. **Calculation Methodology**: This is a simple calculation of a distinct count of the number of unique recipients utilizing nursing services from LEAs based on procedure code.

8. **Scope**: Aggregated.

9. **Caveats**: This indicator does not have any limitations or weaknesses.

10. **Responsible Person**: Lindsey Nizzo, Medicaid Program Manager 2; Rate Setting and Audit Section, (225) 342-3613, Lindsey.Nizzo@LA.GOV

PERFORMANCE INDICATOR DOCUMENTATION

Program: Payments to Public Providers (Program B)

Activity: Payments to Public Providers

Objective: Through the Payment to Public Providers Activity, track utilization of services provided by local school systems including nursing services, which allow important medical screenings to be provided by these school systems with Medicaid reimbursement.

Indicator Name: Number of school nurses in participating Local Education Agencies

Indicator LaPAS PI Code: 25582

1. **Type and Level**: Output and General (G)

2. **Rationale:** This indicator will be a strong indicator as to depth and amount of scope the services being provided by the LEAs in this program.

3. **Use**: This proposal seeks to achieve the goals of better access to care by giving students in school easier access to care to nursing services. LEAs will use this indicator as an internal management tool to gauge participation.

4. **Clarity**: None

5. **Accuracy, Maintenance, and Support**:

6. **Data Source, Collection, and Reporting**: File from each Local Education Agency each quarter.

7. **Calculation Methodology**: Total the number of nurses listed on each file. Rate Setting and Audit staff requests the figure from P&N.

8. **Scope**: Aggregated.

9. **Caveats**: This indicator does not have any limitations or weaknesses.

10. **Responsible Person**: Lindsey Nizzo, Medicaid Program Manager 2; Rate Setting and Audit Section, (225) 342-3613, Lindsey.Nizzo@LA.GOV

PERFORMANCE INDICATOR DOCUMENTATION

Program: Buy-Ins & Supplements (Program C)

Activity: Medicare Savings Programs for Low-Income Seniors & Persons with Disabilities

Objective: The Medicare Savings Program for Low-Income Seniors & Persons with Disabilities Activity will avoid more expensive costs that would otherwise be funded by Medicaid by ensuring that eligible low-income senior citizens do not forego health coverage due to increasing Medicare premiums that make maintaining coverage increasingly difficult...

Indicator Name: Total number of recipients (Part A)

Indicator LaPAS PI Code: 2261

1. **Type and Level**: Output and General (G)

2. **Rationale:** This indicator provides the number of Medicare Part A recipients eligible for Buy-In and supports the expenditures for Medicare premium payments through the Buy-In Program. The number of recipients is important to estimate future expenditures.

3. **Use**: This indicator determines the current cost and estimated future cost and participation for program budget development and monitoring. It is used for internal management purposes and performance- based budgeting purposes.

4. **Clarity**: The indicator name clearly identifies what is being measured. Part A is Medicare hospital insurance. The Buy-In program pays Medicare premiums for individuals eligible for Medicaid. Payment of Part A premiums is required for all individuals or their spouse who did not work the required number of quarters under the Social Security Program to qualify for no cost premiums for Part A.

5. **Accuracy, Maintenance, and Support**: The Office of the Legislative Auditor audits the indicator annually.

6. **Data Source, Collection, and Reporting**: The data source for this indicator is the CMS monthly buy-in report, "S19." CMS sends this with the monthly billing statement for premiums. Data is also stored and collected from LDH's LaMEDS system. LDH's Business Analytics team provides the number of cases. The report is provided monthly. The timing of collection and reporting varies, but are usually received in the beginning of each month.

7. **Calculation Methodology**: CMS reports the number of recipients as collected by the number of individuals who are recipients of Medicare Part A: Buy-In. On the S19 report, it is identified as "Code 11" and "Code 41."

8. **Scope**: This indicator's scope is aggregate. It is the statewide total for recipients of Medicare Part A: Buy-In for all Medicare Savings Programs.

9. **Caveats**: Counts will never totally match counts produced independently, as CMS controls processing of the data. There may be problems or inconsistencies in an individual's data. There is a difference in Medicaid deadlines of when an individual's Buy-In starts and ends. Unmeasurable variables that impact totals may cause uneven and fluctuating counts.

10. **Responsible Persons**: Jessica Wright, Premium Assistance Coordinator 2, (225) 342-9098, Jessica.Wright5@la.gov; Octavius Youngblood, Medicaid Program Manager 3, (225) 342-8404, Octavius.Youngblood@LA.GOV; and Rhett Decoteau, Medicaid Program Manager 4, (225) 342-9044, Rhett.Decoteau@LA.GOV

PERFORMANCE INDICATOR DOCUMENTATION

Program: Buy-Ins & Supplements (Program C)

Activity: Medicare Savings Programs for Low-Income Seniors & Persons with Disabilities

Objective: The Medicare Savings Program for Low-Income Seniors & Persons with Disabilities Activity will avoid more expensive costs that would otherwise be funded by Medicaid by ensuring that eligible low-income senior citizens do not forego health coverage due to increasing Medicare premiums that make maintaining coverage increasingly difficult.

Indicator Name: Total number of recipients (Part B)

Indicator LaPAS PI Code: 2262

1. **Type and Level**: Output and General (G)

2. **Rationale:** This indicator provides the number of Medicare Part B recipients eligible for Buy-In and supports the expenditures for Medicare premium payments through the Buy-In Program. The number of recipients is important to estimate future expenditures.

3. **Use**: This indicator determines the current cost and estimated future cost and participation for program budget development and monitoring. It is used for internal management purposes and performance- based budgeting purposes.

4. **Clarity**: The indicator name clearly identifies what is being measured. Medicare Part B pays for doctors, outpatient hospital care, and some other medical services not covered by Part A. The Buy-In program pays Medicare premiums for individuals eligible for Medicaid. A premium for Part B is billed to all individuals who participate in the Medicare program.

5. **Accuracy, Maintenance, and Support**: The Office of the Legislative Auditor audits the indicator annually.

6. **Data Source, Collection, and Reporting**: The data source is the CMS monthly buy-in report, "190." CMS sends this with the monthly billing statement for premiums. Data is also stored and collected from LDH's LaMEDS system. LDH's Business Analytics team provides the number of cases. The report is provided monthly. The timing of collection and reporting varies, but are usually received in the beginning of each month.

7. **Calculation Methodology**: CMS reports the number of recipients as collected by the number of individuals who are recipients of Medicare Part B Buy-In. On the 190 report, it is identified as "Code 11," "Code 41," "Code 43," and "Code 45."

8. **Scope**: This indicator's scope is aggregate. It is the statewide total for recipients of Medicare Part B Buy-In for all Medicare Savings Programs.

9. **Caveats**: Counts will never totally match counts produced independently as CMS controls processing of the data. There may be problems or inconsistencies in an individual's data. There is a difference in Medicaid deadlines of when an individual's Buy-In starts and ends. The Social Security Administration is responsible for Supplemental Security Income (SSI) eligibility, so any problems they have would affect new or terminated Part B Buy-In SSI eligibles. Unmeasurable variables that impact totals may cause uneven and fluctuating counts.

10. **Responsible Persons**: Jessica Wright, Premium Assistance Coordinator 2, (225) 342-9098, Jessica.Wright5@la.gov; Octavius Youngblood, Medicaid Program Manager 3, (225) 342-8404, Octavius.Youngblood@LA.GOV; and Rhett Decoteau, Medicaid Program Manager 4, (225) 342-9044, Rhett.Decoteau@LA.GOV

PERFORMANCE INDICATOR DOCUMENTATION

Program: Buy-Ins & Supplements (Program C)

Activity: Medicare Savings Programs for Low-Income Seniors & Persons with Disabilities

Objective: The Medicare Savings Program for Low-Income Seniors & Persons with Disabilities Activity will avoid more expensive costs that would otherwise be funded by Medicaid by ensuring that eligible low-income senior citizens do not forego health coverage due to increasing Medicare premiums that make maintaining coverage increasingly difficult.

Indicator Name: Total number of Buy-In eligibles (Part A & B)

Indicator LaPAS PI Code: 2263

1. **Type and Level**: Output and General (G)

2. **Rationale:** This indicator provides the number of Medicare Part A and Part B recipients eligible for Buy-In and supports the expenditures for Medicare premium payments through the Buy-In Program. The number of recipients is important to estimate future expenditures.

3. **Use**: This indicator determines the current cost and estimated future cost and participation for program budget development and monitoring. It is used for internal management purposes and performance- based budgeting purposes.

4. **Clarity**: The indicator name clearly identifies what is being measured. Part A is Medicare hospital insurance. Medicare Part B pays for doctors, outpatient hospital care, and some other medical services not covered by Part A. The Buy-In program pays Medicare premiums for individuals eligible for Medicaid. Payment of Part A premiums is required for all individuals or their spouse who did not work the required number of quarters under the Social Security Program to qualify for no cost premiums for Part A. A premium for Part B is billed to all individuals who participate in the Medicare program.

5. **Accuracy, Maintenance, and Support**: The Office of the Legislative Auditor does not audit the indicator, but all other Medicare Savings Programs indicators are audited, annually.

6. **Data Source, Collection, and Reporting**: The data source is the CMS monthly buy-in reports, "S19" and "190." CMS sends these with the monthly billing statement for premiums. Data is also stored and collected from the LaMEDS system. Business Analytics provides the number of cases. The report is provided monthly. The timing of collection and reporting varies, but are usually received in the beginning of each month.

7. **Calculation Methodology**: CMS reports the number of recipients and cost as collected by the number of individuals who are recipients of Medicare Part A and Part B Buy-In. On the S19 report, it is identified as "Code 11" and "Code 41." On the 190 report, it is identified as "Code 11," "Code 41," "Code 43," and "Code 45."

8. **Scope**: This indicator's scope is aggregate. It is the statewide total for recipients of Medicare Part A and Part B Buy-In for all Medicare Savings Programs.

9. **Caveats**: Counts may not match those produced independently as CMS controls processing of the data. There may be problems or inconsistencies in an individual's data and there is a difference in Medicaid deadlines of when an individual's Buy-In starts and ends. The Social Security Administration controls eligibility for some of the Buy-In eligibles. Unmeasurable variables that impact totals may cause uneven and fluctuating counts.

10. **Responsible Persons**: Jessica Wright, Premium Assistance Coordinator 2, (225) 342-9098, Jessica.Wright5@la.gov; Octavius Youngblood, Medicaid Program Manager 3, (225) 342-8404,

Octavius.Youngblood@LA.GOV; and Rhett Decoteau, Medicaid Program Manager 4, (225) 342-9044, Rhett.Decoteau@LA.GOV

PERFORMANCE INDICATOR DOCUMENTATION

Program: Buy-Ins & Supplements (Program C)

Activity: Medicare Savings Programs for Low-Income Seniors & Persons with Disabilities

Objective: The Medicare Savings Program for Low-Income Seniors & Persons with Disabilities Activity will avoid more expensive costs that would otherwise be funded by Medicaid by ensuring that eligible low-income senior citizens do not forego health coverage due to increasing Medicare premiums that make maintaining coverage increasingly difficult.

Indicator Name: Buy-In Expenditures (Part A)

Indicator LaPAS PI Code: 2264

1. **Type and Level**: Output and General (G)

2. **Rationale:** This indicator is the total cost for Medicare Part A monthly premiums. Records of cost are important to estimate future expenditures.

3. **Use**: This indicator determines the current cost and estimated future cost and participation for program budget development and monitoring. Internal management uses this indicator for performance-based budgeting purposes.

4. **Clarity**: The indicator name clearly identifies what is being measured. Part A is Medicare hospital insurance. The Buy-In program pays Medicare premiums for individuals eligible for Medicaid. Payment of Part A premiums is required for all individuals or their spouse who did not work the required number of quarters under the Social Security Program to qualify for no cost premiums for Part A.

5. **Accuracy, Maintenance, and Support**: The Office of the Legislative Auditor will audit this indicator annually.

6. **Data Source, Collection, and Reporting**: The data source is the CMS monthly billing statement for premiums, "S19." Data is also stored and collected via LaMEDS Buy-in Summary. The total cost of premiums will be handled through LaMEDS Pentaho reporting system "Part A Monthly CMS Billing Report," once this report is corrected and put into production. In the interim, LDH's Eligibility Systems team produces this report on a monthly basis. The timing of collection and reporting varies.

7. **Calculation Methodology**: CMS reports the cost as collected by the number of individuals who are recipients of Medicare Part A: Buy-In, including retroactive eligibility. The net cost is adjusted for credits due to retroactive closures or mistaken entitlement.

8. **Scope**: This indicator's scope is aggregate. It is the statewide total for recipients of Medicare Part A: Buy-In for all Medicare Savings Programs.

9. **Caveats**: A limitation may result when billing problems occur at CMS; however, when this occurs, LDH is given a new deadline for the payment of premiums. Unmeasurable variables that impact totals may cause uneven and fluctuating amounts.

10. **Responsible Persons**: Jessica Wright, Premium Assistance Coordinator 2, (225) 342-9098, Jessica.Wright5@la.gov; Octavius Youngblood, Medicaid Program Manager 3, (225) 342-8404, Octavius.Youngblood@LA.GOV; and Rhett Decoteau, Medicaid Program Manager 4, (225) 342-9044, Rhett.Decoteau@LA.GOV

PERFORMANCE INDICATOR DOCUMENTATION

Program: Buy-Ins & Supplements (Program C)

Activity: Medicare Savings Programs for Low-Income Seniors & Persons with Disabilities

Objective: The Medicare Savings Program for Low-Income Seniors & Persons with Disabilities Activity will avoid more expensive costs that would otherwise be funded by Medicaid by ensuring that eligible low-income senior citizens do not forego health coverage due to increasing Medicare premiums that make maintaining coverage increasingly difficult.

Indicator Name: Buy-In Expenditures (Part B)

Indicator LaPAS PI Code: 2265

1. **Type and Level**: Output and General (G)

2. **Rationale:** This indicator is the total cost for Medicare Part B monthly premiums. Records of cost are important to estimate future expenditures.

3. **Use**: This indicator determines the current cost and estimated future cost and participation for program budget development and monitoring. Internal management uses this indicator for performance-based budgeting purposes.

4. **Clarity**: The indicator name clearly identifies what is being measured. Medicare Part B pays for doctors, outpatient hospital care, and some other medical services not covered by Part A. The Buy-In program pays Medicare premiums for individuals eligible for Medicaid. A premium for Part B is billed to all individuals who participate in the Medicare program.

5. **Accuracy, Maintenance, and Support**: The Office of the Legislative Auditor will audit the indicator annually.

6. **Data Source, Collection, and Reporting**: The data source is the CMS monthly billing statement for premiums, "190." Data is also stored and collected from LDH's LaMEDS Buy-in Summary. The total cost of premiums will be handled through LaMEDS Pentaho reporting system "Part A Monthly CMS Billing Report," once this report is corrected and put into production. In the interim, LDH's Eligibility Systems team produces this report on a monthly basis. The timing of collection and reporting varies.

7. **Calculation Methodology**: CMS reports the cost as collected by the number of individuals who are recipients of Medicare Part B Buy-In, including retroactive eligibility. The net cost is adjusted for credits due to retroactive closures or mistaken entitlement.

8. **Scope**: This indicator's scope is aggregate. It is the statewide total for recipients of Medicare Part B Buy-In for all Medicare Savings Programs.

9. **Caveats**: A limitation may result when billing problems occur at CMS; however, when this occurs, LDH is given a new deadline for the payment of premiums. Unmeasurable variables that impact totals may cause uneven and fluctuating amounts.

10. **Responsible Persons**: Jessica Wright, Premium Assistance Coordinator 2, (225) 342-9098, Jessica.Wright5@la.gov; Octavius Youngblood, Medicaid Program Manager 3, (225) 342-8404, Octavius.Youngblood@LA.GOV; and Rhett Decoteau, Medicaid Program Manager 4, (225) 342-9044, Rhett.Decoteau@LA.GOV

PERFORMANCE INDICATOR DOCUMENTATION

Program: Buy-Ins & Supplements (Program C)

Activity: Medicare Savings Programs for Low-Income Seniors & Persons with Disabilities

Objective: The Medicare Savings Program for Low-Income Seniors & Persons with Disabilities Activity will avoid more expensive costs that would otherwise be funded by Medicaid by ensuring that eligible low-income senior citizens do not forego health coverage due to increasing Medicare premiums that make maintaining coverage increasingly difficult.

Indicator Name: Total savings (cost of care less premium cost) for Medicare benefits

Indicator LaPAS PI Code: 2266

1. **Type and Level**: Output and Key (K)

2. **Rationale:** This indicator provides the amount of the Medicare savings minus the amount of Medicare Part A and Part B premiums paid out through the Buy-In Program.

3. **Use**: Accumulation of this data produces a record of the current Medicare savings after considering the cost of the premiums and provides a basis for future estimates.

4. **Clarity**: Total savings (cost of care less premium costs for Medicare benefits)

5. **Accuracy, Maintenance, and Support:** The Office of the Legislative Auditor audits the indicator annually.

6. **Data Source, Collection, and Reporting**: Savings figures are obtained from the MR-O-68 quarterly reports, and the Medicare Premium costs are obtained from the monthly buy-in bills produced by Eligibility staff.

7. **Calculation Methodology**: The savings from claims crossing from Medicare for Payment of coinsurances. The cost of the premiums paid through the Buy-In Program is deducted from the cost avoidance for Part A and B.

8. **Scope**: This indicator's scope is statewide.

9. **Caveats**: The MR-O-68 is dependent upon claims processed through the DXC/Medicaid system. Any breakdown or variation in the system could directly affect the claim count and the total savings. In addition, mailing loss or problems processing a claims tape from Medicare could also affect the count. Unmeasurable variables that impact totals may cause uneven and fluctuating amounts.

10. **Responsible Persons**: Jessica Wright, Premium Assistance Coordinator 2, (225) 342-9098, Jessica.Wright5@la.gov; Octavius Youngblood, Medicaid Program Manager 3, (225) 342-8404, Octavius.Youngblood@LA.GOV; and Rhett Decoteau, Medicaid Program Manager 4, (225) 342-9044, Rhett.Decoteau@LA.GOV

PERFORMANCE INDICATOR DOCUMENTATION

Program: Buy-Ins & Supplements (Program C)

Activity: Louisiana Health Insurance Premium Payment (LaHIPP) Program

Objective: Each year, the LaHIPP program will assist eligible Medicaid enrollees and their families in purchasing private health insurance through an employer or the individual market while maintaining Medicaid/LaCHIP coverage as a secondary payer of medical expenses for Medicaid enrollees, resulting in reduced cost to the state.

Indicator Name: Number of cases added in LaHIPP

Indicator LaPAS PI Code: 22327

1. **Type and Level**: Output and Key (K)

2. **Rationale:** This indicator gives the number of LaHIPP cases added each year.

3. **Use**: Accumulation of this data illustrates how well staff is doing with regard to adding cases into the program.

4. **Clarity**: LaHIPP - Louisiana Health Insurance Premium Payment program

5. **Accuracy, Maintenance, and Support**: This Performance Indicator is subject to audit by the Office of the Legislative Auditor.

6. **Data Source, Collection, and Reporting**: The data is derived from our LaHIPP system, the caseload activity report on a monthly basis and can be bundled by SFY or FFY depending on the need of the report.

7. **Calculation Methodology**: The caseload activity report within the LaHIPP system provides a monthly snap shot of the number of cases added. This number is use to report the quarterly findings. This is a standard method of calculating; the program does not affect any other agency.

8. **Scope**: Statewide

9. **Caveats**: This indicator does not have any limitations or weaknesses.

10. **Responsible Person**: Octavius Youngblood, Medicaid Program Manager 3, (225) 342-8404, Octavius.Youngblood@LA.GOV; and Rhett Decoteau, Medicaid Program Manager 4, (225) 342-9044, Rhett.Decoteau@LA.GOV

PERFORMANCE INDICATOR DOCUMENTATION

Program: Buy-Ins & Supplements (Program C)

Activity: Louisiana Health Insurance Premium Payment (LaHIPP) Program

Objective: Each year, the LaHIPP program will assist eligible Medicaid enrollees and their families in purchasing private health insurance through an employer or the individual market while maintaining Medicaid/LaCHIP coverage as a secondary payer of medical expenses for Medicaid enrollees, resulting in reduced cost to the state.

Indicator Name: LaHIPP Total Savings

Indicator LaPAS PI Code: 24099

1. **Type and Level**: Output and Key (K)

2. **Rationale:** This indicator gives the amount of Medicaid savings minus the amount of LaHIPP premiums reimbursement and wrap around costs.

3. **Use**: Accumulation of this data produces a record of the current Medicaid savings after considering the cost of premiums paid out through the LaHIPP program.

4. **Clarity**: Total savings (cost of care less the premium and wrap around costs)

5. **Accuracy, Maintenance, and Support**: This Performance Indicator is subject to audit by the Office of the Legislative Auditor.

6. **Data Source, Collection, and Reporting**: Savings figures are derived from the LaHIPP Cost Savings quarterly reports, which are created from the fiscal intermediary and the LaHIPP system.

7. **Calculation Methodology**: The savings are generated by taking the LaHIPP Cost Avoidance less the prior quarter premium payments from the LaHIPP system.

8. **Scope**: Statewide

9. **Caveats**: The LaHIPP Cost Avoidance is dependent on claims processed through the MOLINA/ Medicaid system. Any breakdown or variation in the system could directly affect the claim count and the total savings.

10. **Responsible Person**: Octavius Youngblood, Medicaid Program Manager 3, (225) 342-8404, Octavius.Youngblood@LA.GOV; and Rhett Decoteau, Medicaid Program Manager 4, (225) 342-9044, Rhett.Decoteau@LA.GOV

PERFORMANCE INDICATOR DOCUMENTATION

Program: Buy-Ins & Supplements (Program C)

Activity: Louisiana Health Insurance Premium Payment (LaHIPP) Program

Objective: Each year, the LaHIPP program will assist eligible Medicaid enrollees and their families in purchasing private health insurance through an employer or the individual market while maintaining Medicaid/LaCHIP coverage as a secondary payer of medical expenses for Medicaid enrollees, resulting in reduced cost to the state.

Indicator Name: Number of Medicaid enrollees with private coverage paid by LaHIPP

Indicator LaPAS PI Code: 26593

1. **Type and Level**: Output and Key (K)
2. **Rationale:** This indicator gives the number of Medicaid recipients with ESI paid by LaHIPP.
3. **Use**: Accumulation of this data illustrates how many Medicaid recipients are enrolled in the program.
4. **Clarity**: LaHIPP - Louisiana Health Insurance Premium Payment program
5. **Accuracy, Maintenance, and Support**: This Performance Indicator is subject to audit by the Office of the Legislative Auditor.
6. **Data Source, Collection, and Reporting**: The Department uses the statistical report provided by the contractor.
7. **Calculation Methodology**: No calculation is made as this is taken directly from the contractor's report.
8. **Scope**: Statewide
9. **Caveats**: The Department is depending on the contractor to provide this information on a monthly basis through its efforts of administering the LaHIPP program.
10. **Responsible Person**: Octavius Youngblood, Medicaid Program Manager 3, (225) 342-8404, Octavius.Youngblood@LA.GOV; and Rhett Decoteau, Medicaid Program Manager 4, (225) 342-9044, Rhett.Decoteau@LA.GOV

PERFORMANCE INDICATOR DOCUMENTATION

Program: Buy-Ins & Supplements (Program C)

Activity: Louisiana Health Insurance Premium Payment (LaHIPP) Program

Objective: Each year, the LaHIPP program will assist eligible Medicaid enrollees and their families in purchasing private health insurance through an employer or the individual market while maintaining Medicaid/LaCHIP coverage as a secondary payer of medical expenses for Medicaid enrollees, resulting in reduced cost to the state.

Indicator Name: Number of non-Medicaid family members with private coverage paid by LaHIPP

Indicator LaPAS PI Code: 26594

1. **Type and Level**: Output and Key (K)
2. **Rationale:** This indicator gives the number of non-Medicaid family members with ESI paid by LaHIPP.
3. **Use**: Accumulation of this data illustrates how many non-Medicaid family members have ESI paid by LaHIPP.
4. **Clarity**: LaHIPP - Louisiana Health Insurance Premium Payment program
5. **Accuracy, Maintenance, and Support**: This Performance Indicator is subject to audit by the Office of the Legislative Auditor.
6. **Data Source, Collection, and Reporting**: The Department uses the statistical report provided by the contractor.
7. **Calculation Methodology**: To determine the number of beneficiaries, we take the total number enrolled in LaHIPP minus the recipients.
8. **Scope**: Statewide
9. **Caveats**: The Department is depending on the contractor to provide this information on a monthly basis, through their efforts of enrolling and maintaining the LaHIPP program.
10. **Responsible Person**: Octavius Youngblood, Medicaid Program Manager 3, (225) 342-8404, Octavius.Youngblood@LA.GOV; and Rhett Decoteau, Medicaid Program Manager 4, (225) 342-9044, Rhett.Decoteau@LA.GOV

PERFORMANCE INDICATOR DOCUMENTATION

Program: Uncompensated Care Costs (UCC Program D)

Activity: Uncompensated Care Costs (UCC) Program

Objective: Through the Uncompensated Care Costs activity, to encourage hospitals and other providers to provide access to medical care for the uninsured.

Indicator Name: Total DSH funds collected in millions

Indicator LaPAS PI Code: 17040

1. **Type and Level**: Input and Supporting (S)

2. **Rationale:** The indicator measures payments made during the state fiscal year to all hospitals (both public and private) that qualify for Medicaid disproportionate share payments and incurred uncompensated care costs. DSH funds hospital services for uninsured with federal funds.

3. **Use**: This performance indicator is use to track the payments for uninsured patients and Medicaid patients for whom regular Medicaid payments did not cover the costs of services provided in hospitals qualifying for Medicaid disproportionate share throughout the state.

4. **Clarity**: The indicator name refers to Medicaid Disproportionate Share Hospital (DSH) payments.

5. **Accuracy, Maintenance, and Support**: Medicaid's hospital audit contractor, LeBlanc, Robertson, Chisholm & Associates, LLC, Meyers and Stauffer, LLC and the Legislative Auditors have reviewed DSH payments.

6. **Data Source, Collection, and Reporting**: The data collection sources are budget projections and actual payment records from BHSF – Rate Setting and Audit Section. The actual amounts paid and the number of hospitals paid is taken from the Weekly Check-write Report.

7. **Calculation Methodology**: For public state-owned, small rural and large non-state public and rural hospitals - Total payments for all hospitals receiving disproportionate share payments during the state fiscal year for uncompensated care costs incurred. For private non-rural hospitals - a pool amount divided between qualifying hospitals based on their number of paid Medicaid days. For community hospitals – uninsured patient charges multiplied by hospital specific cost to charge ratios. For private hospitals with qualifying mental health, emergency room extensions (MHEREs), actual uncompensated costs less payments for uninsured, and Medicaid patients treated.

8. **Scope**: The indicator is a statewide aggregate amount, which is broken done into separate indicators for public (state-owned) hospitals and, if desired, can segregated by small rural hospital DSH payments and private hospital DSH payments.

9. **Caveats**: DSH payments each year are limited to the statewide cap established in federal regulation, as well as funding appropriated by the Legislature. Each hospital's DSH payments are also limited in accordance with federal regulation to its uncompensated care costs for services provided during the year.

10. **Responsible Person**: Sonya Webb-Forbes, Medicaid Program Manager 3 , Rate Setting & Audit, (225) 342-0325, Sonya.Webb-Forbes@la.gov

PERFORMANCE INDICATOR DOCUMENTATION

Program: Uncompensated Care Costs (UCC Program D)

Activity: Uncompensated Care Costs (UCC) Program

Objective: Through the Uncompensated Care Costs activity, to encourage hospitals and other providers to provide access to medical care for the uninsured.

Indicator Name: Total federal funds collected in millions

Indicator LaPAS PI Code: 17041

1. **Type and Level**: Input and Key (K)

2. **Rationale:** The indicator measures payments made utilizing federal financial participation funds during the state fiscal year to all hospitals (both public and private) that qualify for Medicaid disproportionate share payments and incurred uncompensated care costs. DSH funds hospital services for uninsured with federal funds.

3. **Use**: This performance indicator is to track the federal financial participation expended for payments for uninsured patients and Medicaid patients for whom regular Medicaid payments did not cover the costs of services provided in hospitals qualifying for Medicaid disproportionate share throughout the state.

4. **Clarity**: The indicator name refers to Medicaid Disproportionate Share Hospital (DSH) payments.

5. **Accuracy, Maintenance, and Support**: Medicaid's hospital audit contractor, LeBlanc, Robertson, Chisholm & Associates, LLC, Meyers and Stauffer, LLC and the Legislative Auditors have reviewed DSH payments.

6. **Data Source, Collection, and Reporting**: The data collection sources are budget projections and actual payment records from BHSF – Rate Setting and Audit Section. The actual amounts paid and the number of hospitals paid comes from the Weekly Check-write Report.

7. **Calculation Methodology**: For public state-owned small rural and large non-state public and rural hospitals - Total federal financial participation payments for all hospitals receiving disproportionate share payments during the state fiscal year for uncompensated care costs incurred. For private non-rural hospitals – the federal financial participation portion of the pool amount divided between qualifying hospitals based on their number of paid Medicaid days. For community hospitals – the federal financial participation portion of the amount of their uninsured costs paid. For private hospitals with qualifying mental health emergency room extensions (MHEREs), the federal participation portion of their actual uncompensated costs less payments for uninsured and Medicaid patients treated.

8. **Scope**: The indicator is the federal financial participation portion of the statewide aggregate amount which is broken done into separate indicators for public (state-owned) hospitals and, if desired, can also be segregated by small rural hospital DSH payments and private hospital DSH payments.

9. **Caveats**: DSH payments each year are limited to the statewide cap established in federal regulation, as well as funding appropriated by the Legislature. Each hospital's DSH payments are also limited in accordance with federal regulation to its uncompensated care costs for services provided during the year.

10. **Responsible Person**: Sonya Webb-Forbes, Medicaid Program Manager 3 , Rate Setting & Audit, (225) 342-0325, Sonya.Webb-Forbes@la.gov

PERFORMANCE INDICATOR DOCUMENTATION

Program: Uncompensated Care Costs (UCC Program D)

Activity: Uncompensated Care Costs (UCC) Program

Objective: Through the Uncompensated Care Costs activity, to encourage hospitals and other providers to provide access to medical care for the uninsured.

Indicator Name: Total state match in millions

Indicator LaPAS PI Code: 17042

1. **Type and Level**: Input and Supporting (S)

2. **Rationale:** The indicator measures payments made utilizing state general matching funds during the state fiscal year to all hospitals (both public and private) that qualify for Medicaid disproportionate share payments and incurred uncompensated care costs.

3. **Use**: This performance indicator is to track the state general matching funds expended for payments for uninsured patients and Medicaid patients for whom regular Medicaid payments did not cover the costs of services provided in hospitals qualifying for Medicaid disproportionate share throughout the state.

4. **Clarity**: The indicator name refers to Medicaid Disproportionate Share Hospital (DSH) payments.

5. **Accuracy, Maintenance, and Support**: Medicaid's hospital audit contractor, LeBlanc, Robertson, Chisholm & Associates, LLC, Meyers and Stauffer, LLC and the Legislative Auditors have reviewed DSH payments.

6. **Data Source, Collection, and Reporting**: The data collection sources are budget projections and actual payment records from BHSF – Rate Setting and Audit Section. The actual amounts paid and the number of hospitals paid is taken from the Weekly Check-write Report.

7. **Calculation Methodology**: For public state-owned small rural and large non-state public and rural hospitals - Total state general matching fund payments for all hospitals receiving disproportionate share payments during the state fiscal year for uncompensated care costs incurred. For private non-rural hospitals – the state general matching fund portion of the pool amount divided between qualifying hospitals based on their number of paid Medicaid days. For community hospitals – the state general fund-matching portion of the amount of their uninsured cost paid. For private hospitals with qualifying mental health emergency room extensions (MHEREs), the state general matching fund portion of their actual uncompensated costs less payments for uninsured and Medicaid patients treated.

8. **Scope**: The indicator is the state general matching fund portion of the statewide aggregate amount which is broken done into separate indicators for public (state-owned) hospitals and, if desired, can also be segregated by small rural hospital DSH payments and private hospital DSH payments.

9. **Caveats**: DSH payments each year are limited to the statewide cap established in federal regulation, as well as funding appropriated by the Legislature. Each hospital's DSH payments are also limited in accordance with federal regulation to its uncompensated care costs for services provided during the year.

10. **Responsible Person**: Sonya Webb-Forbes, Medicaid Program Manager 3 , Rate Setting & Audit, (225) 342-0325, Sonya.Webb-Forbes@la.gov