# State Fiscal Year 1996/97

# Annual Report

# LOUISIANA'S MEDICAID PROGRAM

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*Dear Reader:*

*We are pleased to submit our first annual report on the Louisiana Medicaid Program. We have followed the lead of many other states in constructing this informational document for policy makers, consumers, and health care providers.*

*Our program provides vital medical care to the elderly, disabled, and impoverished citizens of our state. Recently the Foster Administration and Legislature have enabled us to achieve financial stability and end the reliance on disproportionate share payments that led to both an inflated program and a funding crisis.*

*We are continuing our efforts to improve service delivery, reduce fraud and abuse, and become more prudent purchasers of health care for our citizens. There is still much to be done. In the upcoming year we will confront issues related to Welfare Reform, the new Children's Health Care Program, Managed Care and the aging of our population.*

*We hope that this document will be useful as an information source for the general public and those that engage in the policy making decisions that affect medical service delivery for our clients.*

*Sincerely,*
*Thomas Collins*
*Director,*
*Bureau of Health Services Financing*

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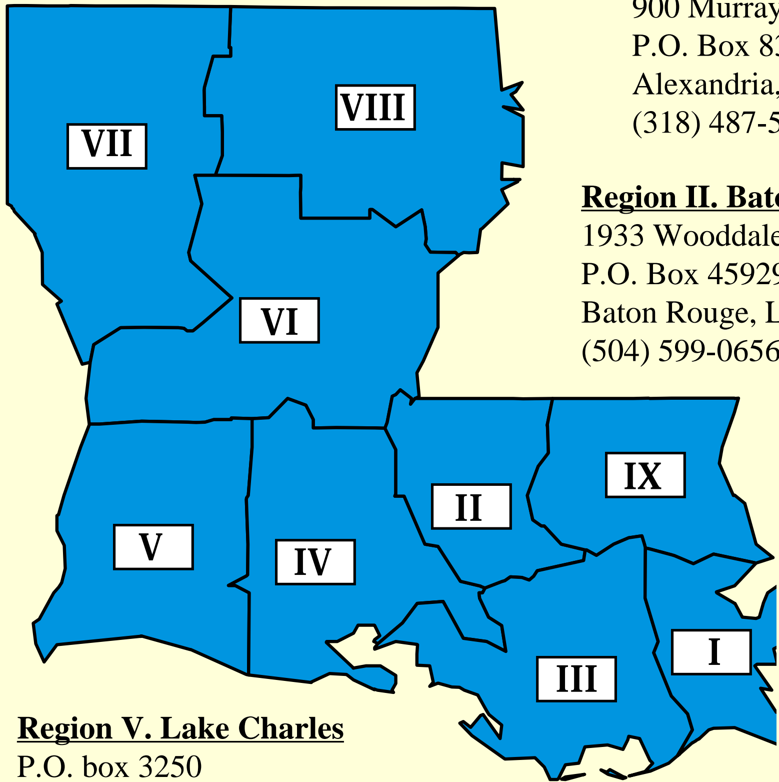


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# INTRODUCTION

### Medicaid Defined

Medicaid is the Federally sponsored public insurance system for health care services and products for low income and disabled persons. Each State administers its own program within Federal guidelines. The cost of each State's Medicaid Program is divided between the State and the Federal government based on the State's per capita income relative to the rest of the nation. Health care benefits include mandatory medical services such as physician and hospital services, laboratory and x-ray services and many optional services including pharmacy benefits. The uncompensated care program provides payment for indigent care in hospitals and mental health facilities. Medicaid also serves as the State's primary source of funding for nursing home care.

The Medicaid program was created in 1965 with the passage of the Title XIX of the Social Security Act by the United States Congress. Louisiana adopted the Medicaid program in 1966. Over the years the program has grown very fast, both nationally and within the State. The growth has been evident not only in the costs of providing basic medical services, but also in terms of the number of eligibility categories and number and types of services offered. However, lately the program has been significantly reduced and Louisiana is no longer among the highest growth states. In fact, in a recent GAO report, Louisiana had the 8th best expenditure stability index in the country and the largest single year reduction of any state for the most recent year reported (1995/96).

### Medicaid Regulation Shared

Eligibility to receive Medicaid benefits or receive payment for providing services to a Medicaid eligible person is defined by Federal and State legislation and regulations. Some of these regulations are national, and others reflect the unique circumstances of each State. Many of these policies are currently the subject of broad debate both within the State and nationally.

### Purpose of the Report

The purpose of this report is to provide relevant information about Louisiana's Medicaid Program, to outline some of the most pressing current issues, and provide a glimpse of what the future entails. The report emphasizes 1996/97, however data from prior years are often utilized to provide a historical picture, which helps to illustrate the changes that have occurred.

Medicaid is the largest single expenditure program in the State budget. It is hoped that the information contained in the report will prove helpful to all of those who have a stake in gaining an understanding of the program and the issues that will be important in the future....in other words, all of us.

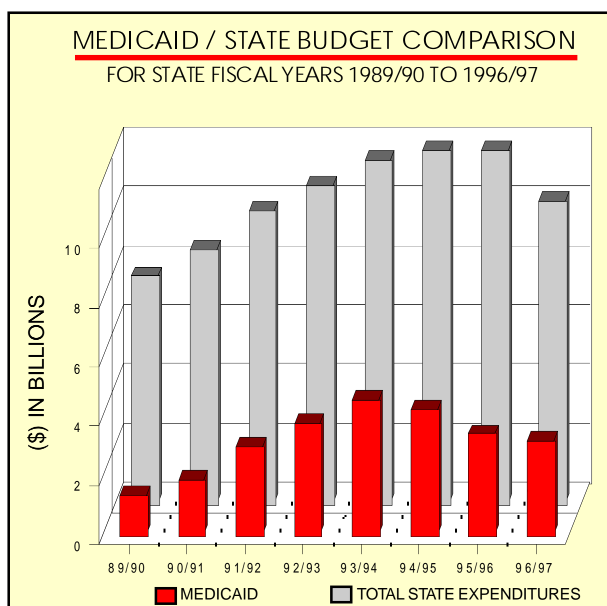



Figure 1

## A BRIEF HISTORICAL LOOK AT MEDICAID IN LOUISIANA

In SFY 1987/88 Louisiana served 542,600 recipients and had expenditures of about $935 million. The program has faced many changes since then, including Federal regulations, Federal supplements, eligibility requirements, and increases in health care costs. Expenditures peaked in 1993/94 and have fallen sharply since then. Figure 2 shows the growth and the recent decline of Louisiana's Medicaid program expenditures.

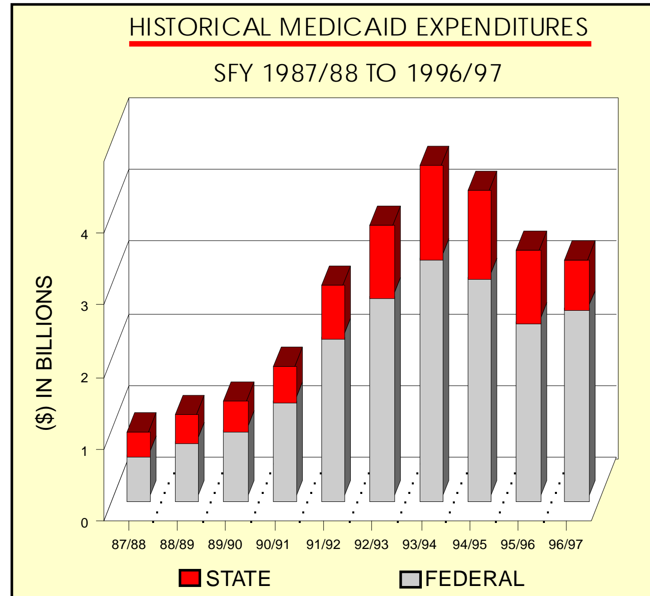



Figure 2

*Louisiana was among the nation's leaders in the use of Uncompensated Care payments and took particular advantage of the provision which reimbursed indigent inpatient care up to 300% of costs. The State recovered this excess reimbursement from the charity hospitals and State mental health facilities and used it as match for the program. When the Federal government withdrew this windfall in 1993/94 , it precipitated a crisis in Medicaid financing that was not rectified until the 1997/98 budget. It is a welcome development that the Louisiana Medicaid program is now on solid financial ground, and no longer needs special Federal funding allowances to operate.*

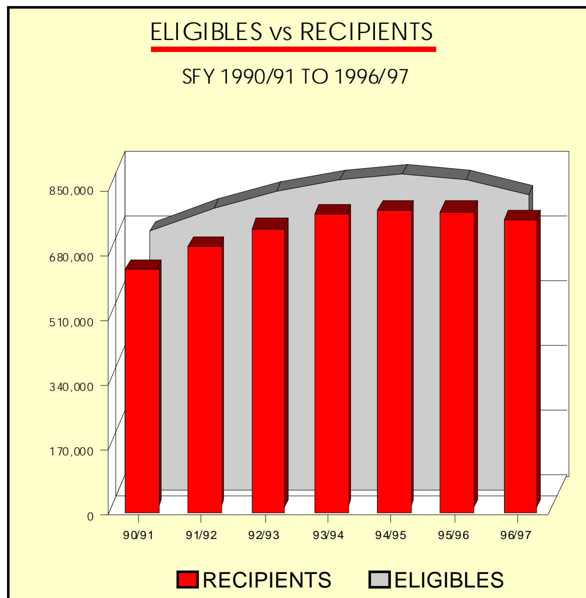



Figure 3

The number of Medicaid recipients reached a peak in 1994/95 and has gradually decreased each year since. However, large increases were experienced between the early 1980's and 1990's. The main reason for that growth was a number of expansions in Federal mandates which define the eligibility criteria for Medicaid. As of 1996/97, 775,416 people were eligible for medicaid services, and 762,095 received services.

Throughout this report an **eligible** is a person who qualifies to receive Medicaid services. A **recipient** is a person who is eligible and has received one or more Medicaid services.

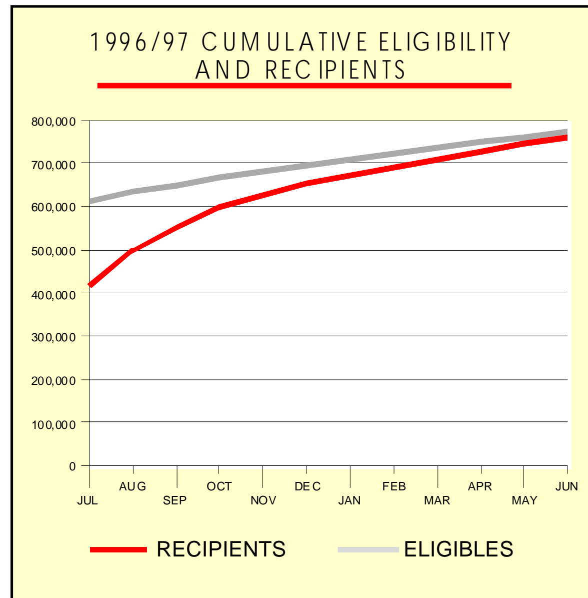
## HIGHLIGHTS FROM STATE FISCAL YEAR 1996/97

### Utilization

During 1996/97, of the 775,416 people that were eligible, 762,095 people actually received some form of Medicaid service.

### Participation

The annual participation rate is rising and is approaching 99%. Figure 4 shows the accumulation of new eligibles and recipients monthly for the year. For SFY 1996/97 eligibles fell by about 4.8% from the prior year, while the number of recipients only fell by 2.8%. This illustrates that the average participation rate has increased, while the costs per Medicaid recipient have been reduced.




| | *1996/97* | *1995/96* | *%CHANGE* |
|---|---|---|---|
| *ELIGIBLES* | *775,416* | *814,589* | *-4.81* |
| *RECIPIENTS* | *762,095* | *783,830* | *-2.77* |
| *PARTICIPATION RATE* | *98.3* | *96.2* | *2.18* |
| *COST PER RECIPIENT* | *$3,127* | *$3,204* | *-2.40* |

The adjacent table shows the changes in these key indicators since 1995/96.

### Medicaid Cost per Recipient

It has been a goal of the Bureau to bring the cost per medicaid recipient down to the average of the 16 States in the Southern Legislative Conference (SLC). The latest data shows this measure going from 21% above the average in FFY 1993/94 to about 11% above in FFY 1995/96. Figure 5 illustrates that Louisiana has successfully reduced the average payment per recipient, while the SLC and the U.S. averages have continued to grow. Average expenditure per recipient was calculated using HCFA 2082 data, which are based on the Federal fiscal year and exclude disproportionate share payments.

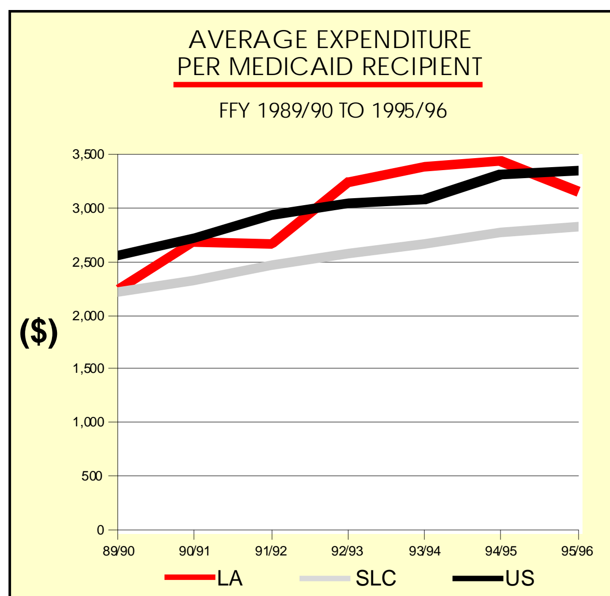



Figure 5

**Where the Money Comes From**
Of the $3,345,068,520, in total Medicaid expenditures, the Federal share was $2,693,662,879, which amounts to 80.51% of the total program. The State was under a special financing arrangement for this year and received a favorable Federal match rate in return for a fixed cap on Federal expenditures.

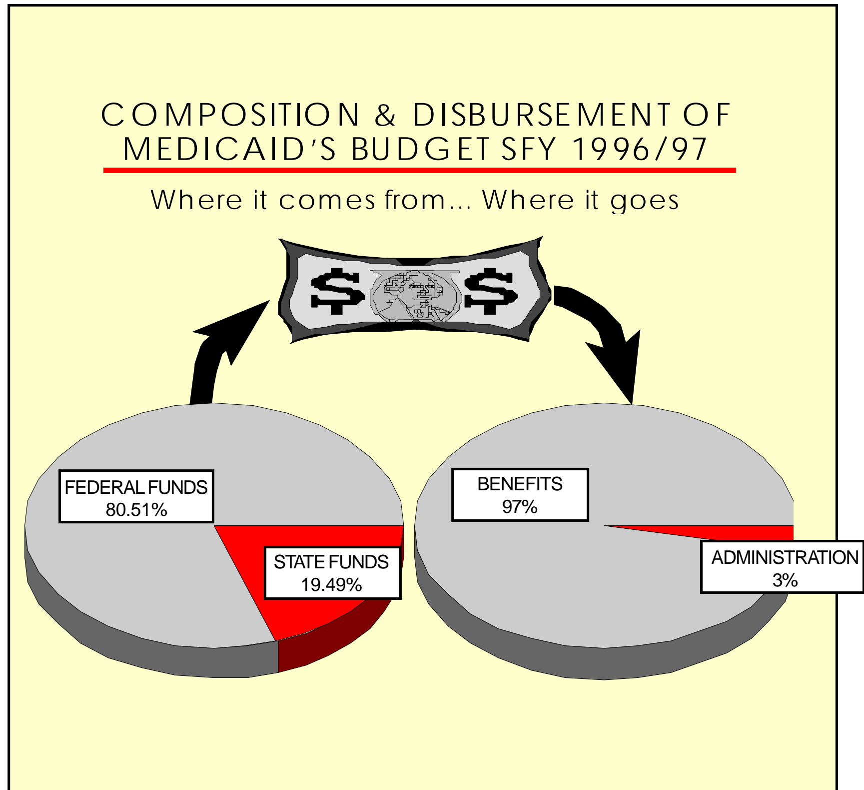



Figure 6

**Where the Money Goes**

The program expended $25 million less in 1996/97 than in 1995/96. The amount spent included someone-time expenditures such as cost reports (see glossary).

Of this amount, 97% went to benefits and about 3% went toward administrative costs. The chart below provides expenditure totals by budget program.

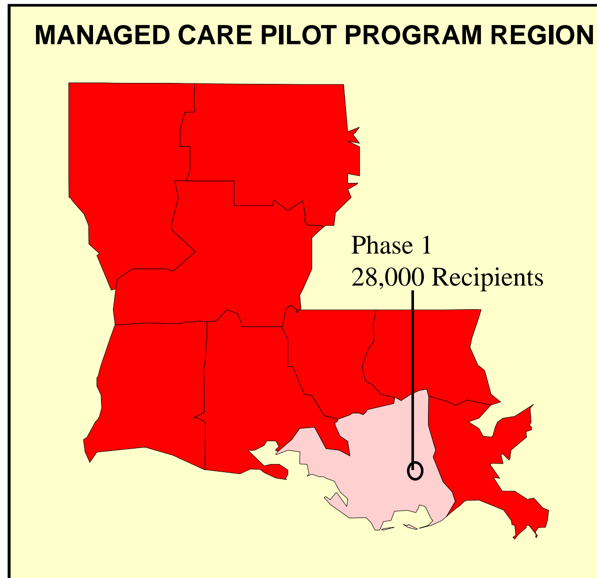
| | |
|---|---|
| *PRIVATE PROVIDERS* | *$2,016,113,794* |
| *PUBLIC PROVIDERS* | *$489,603,447* |
| *UNCOMPENSATED CARE* | *$672,751,765* |
| *MEDICARE PREMIUMS* | *$82,743,087* |
| *ADMINISTRATION* | *$83,856,427* |
| ***TOTAL FOR 1996/97*** | **$3,345,068,520** |

**Clearing the Books**
The program had accumulated about $150 million in past due bills. Those owed were dozens of private hospitals and the Federal government. The Bureau has paid a majority of the $110 million debt owed to the private hospitals and will pay the remaining balance this year. The Bureau has also sent $44 million to the Federal government to repay overpayments made to Louisiana's nine charity hospitals.

CURRENT ISSUES

**Improving Medicaid Services via Managed Care**

In the 1997 legislative session, legislation was passed clearing the way for the Department to embark on a number of pilot projects to improve the way services are delivered and compensated. One program is the Managed Care pilot project which will establish an HMO style delivery system for AFDC members in the Houma / Thibodaux region. This project is being undertaken as a 1915 (b) Waiver under Federal law and is subject to approval from Federal authorities. It is discussed in detail later in the report.



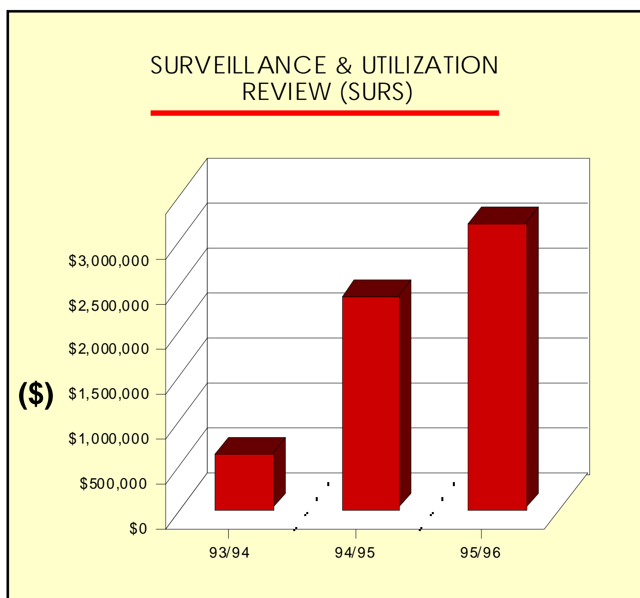




Figure 7

**Combating Fraud and Abuse**

The Medical Assistance Program Integrity Surveillance Utilization Review Section (SURS) is ranked among the nation's best. SURS has collected about $3 million from a host of medical providers and has excluded several providers from the Medicaid program. At the time of this report, the latest data available for the SURS program was SFY 1995/96.

An anti-fraud Act was passed, strengthening the Bureau's efforts to combat fraud and abuse. The Act authorizes triple damages in fraud cases, prohibits kickback or bed-hold fees, imposes liens on property of providers during fraud investigations, and authorizes sanctions and suspends payment to providers found guilty of fraud. It also allows the inclusion of debt when a Medicaid provider's business is sold.

DHH's no-nonsense, zero-tolerance policy against waste, abuse and fraud has led to the collection of $23 million. There are 15 inpatient psychiatric providers who until January 1996 had only repaid Louisiana $1,000 of the $26 million they owed the State. Since then the State has collected $20 million from those providers and has identified another $15 million for collection.

### Medicaid Payer of Last Resort

In 1996/97, third party liability collections were strengthened. The Department of Health and Hospitals was given first-claim privilege for any medical assistance payments made by the Department on behalf of a Medicaid recipient, in a case where money is recovered, by judgement, by settlement or compromise, from another person providing for indemnity or compensation to the injured person.

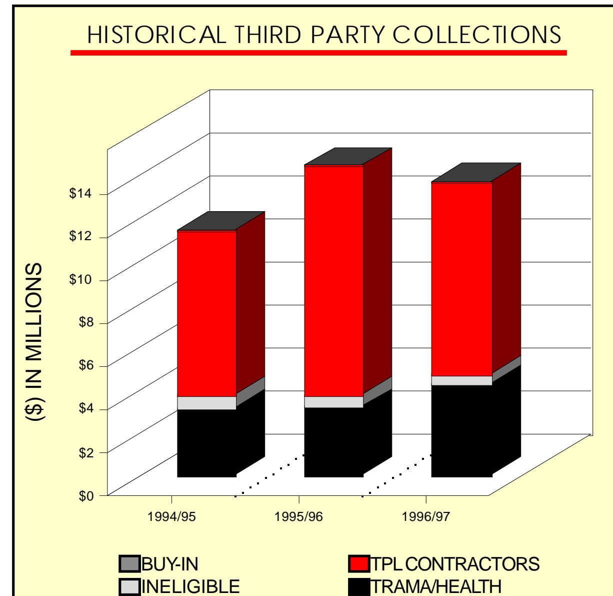


Figure 8

### Moratoriums Used to Keep Expenditures Down

The existing moratorium on home health agencies was extended for four additional years and for nursing homes the current moratorium was extended for two years. New moratoriums were put in place for long-term hospitals and mental health clinics for four years.

### Tightening up on Institutional Care

The Department has recently been given extensive authority to revoke the license of providers of mental retardation and developmental disabilities services or residential living options who fail to timely report or pay any fee or become delinquent in payment of any fee owed to the Department.

### Expanding the Medically Needy Program by Receiving Federal Funds

Legislation abolishing the State Medically Needy Program was enacted as the Bureau was able to reinstate the Federally cost-shared Medically Needy Program.

### FQHCs Receive Additional Assistance

The Rural Hospital Preservation Act and the Federally Qualified Health Centers Preservation Act were passed providing these providers with additional financial and regulatory assistance.

### Technology Saves

Computer technology resulted in at least $13 million in savings in 1996/97. Two pharmacy programs have instituted the new technology to ensure that there are no duplicate, inappropriate or unnecessary prescriptions being dispensed.

An internet home page has been established. This will allow citizens to report Medicaid fraud and abuse 24 hours a day 7 days a week. The website address is HTTP://www.dhh.state.la.us/MEDICAID/fraud.htm.

**Children Receiving Quality Care**

The KIDMED health screening program has jumped from 37th to 3rd place in the U.S. and is among the more successful child-screening programs. Today, of the 447,000 Louisiana children on Medicaid, more than 411,000 (or 92 percent) of them have been provided some preventative care, including physical and dental exams, vision and hearing checkups, immunizations, blood and urine tests, eyeglasses, hearing aids and other services.

More children than ever before are getting necessary immunizations and health screenings to prevent more serious, costly illnesses. Today, 79 percent of Louisiana's two-year-olds were current on their vaccinations, compared with 1992 figures where 55 percent were current. Also, 70 percent of Louisiana's 67,000 newborns receive some immunization care through DHH's 119 parish health units. DHH has received a $5 million Federal grant to provide immediate immunization information via computer to health units, hospitals, clinics, and doctors.

| | UNDER 1 | 1 - 5 | 6 - 14 | 15 - 20 |
|---|---|---|---|---|
| ELIGIBLES | 49,563 | 164,033 | 179,405 | 72,600 |
| RECIPIENTS | 47,963 | 165,759 | 166,430 | 69,799 |
| EXPENDITURES | $134,492,256 | $183,111,616 | $174,888,637 | $166,498,052 |
| AVERAGE COST PER ELIGIBLE | $2,714 | $1,116 | $975 | $2,293 |
| AVERAGE COST PER RECIPIENT | $2,804 | $1,104 | $1,051 | $2,385 |

# ELIGIBILITY

**States Given Flexibility in Managing Their Programs**

Medicaid gives individual States the flexibility to tailor their programs within a Federal legal framework establishing the minimum and maximum eligibility. Federal law mandates entitlements to certain categories of individuals for medical assistance. The State has the option of entitling other categories of individuals for coverage. There are 27 separate categories of "mandatory categorically needy individuals" specified by Federal law which also offers over two dozen optional coverage categories.

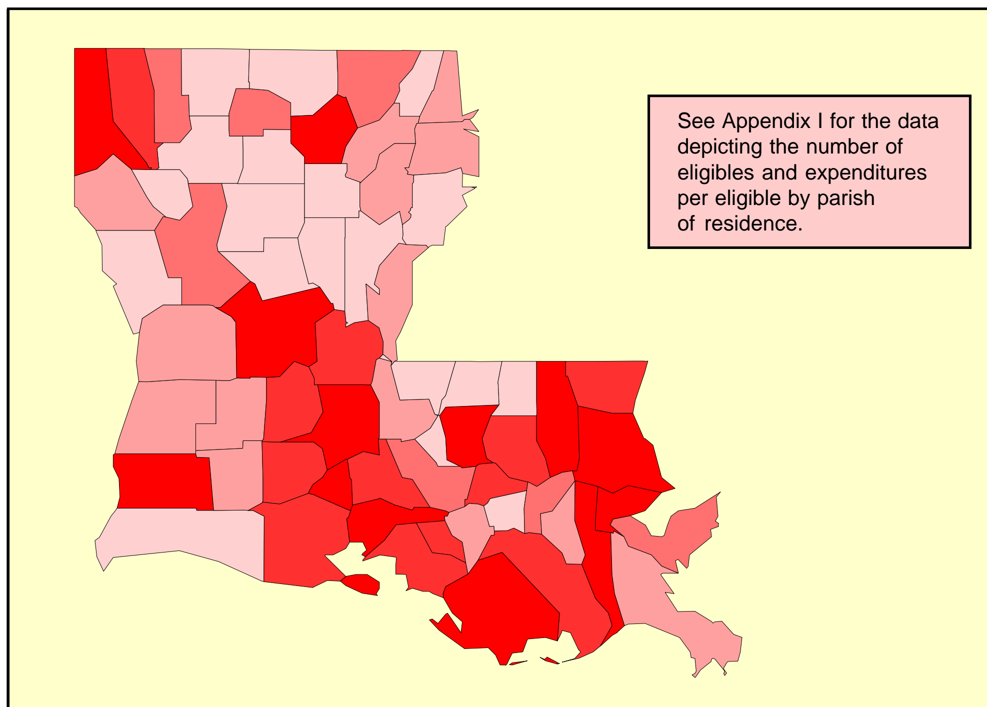
Eligibility Determination

Eligibility is determined by a Federally approved process which is operated in the same manner throughout each of the regions. There is no longer a direct link between eligibility for Social Services cash assistance and Medicaid eligibility. Welfare reform at the national level has broken this link and there will have to be a separate eligibility determination process in place by January 1998.

Federal laws establish the standards for determining family income, which take into account certain individual and family living expenses. Enrollment and eligibility determination rules including outstanding enrollment for pregnant women and children at Federally qualified health centers are also determined by Federal law.

**Eligibility by Parish**

The graph below shows the concentration of Medicaid eligibles by parish. (The larger number of eligibles are represented by the darker colors.)



## ELIGIBILITY PROCESS

### Initial Contact
The process begins with a telephone conversation or a face-to-face meeting with a representative. An applicant is then referred to an application clearance facility.

### Application Clearance Facility
The applicant is given the necessary paperwork to be completed in order to determine eligibility status. Once the paperwork is complete, an eligibility worker reviews the information in order to prepare for an interview with the applicant.

### Interview with Eligibility Counselor
The interviewer and interviewee together go through the written application and additional information is gathered where necessary. Once the interview is complete, the interviewer compares the data collected with the Federal and State regulations concerning eligibility criteria.

### Verification for Documentation
Once an individual meets the qualifications for eligibility, the worker must verify all documents submitted by the applicant. For example, the Department checks to see if the individual has any other source of health insurance coverage.

### Completion of Additional Forms
Once the information has been verified and documented for an individual that has met the eligibility qualifications, the individual must then fill out application forms to be submitted to the Department.

### Receipt of Card
Once DHH has processed the information and eligibility guidelines satisfied, the individual will receive a recipient card in the mail.

# MEDICAID DEMOGRAPHICS

## Gender

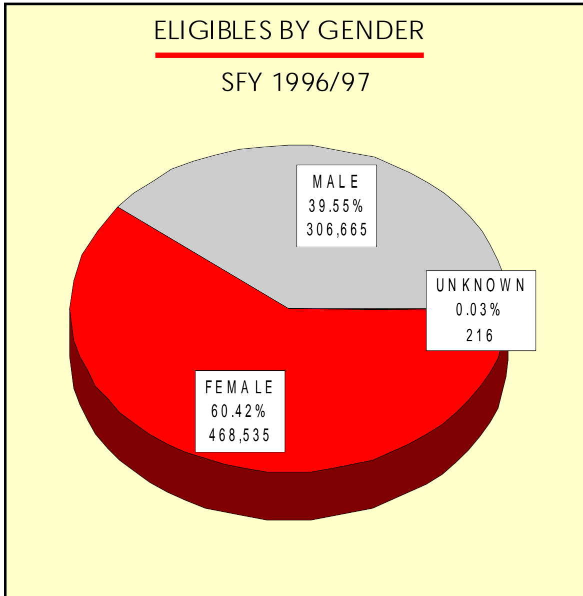



Figure9

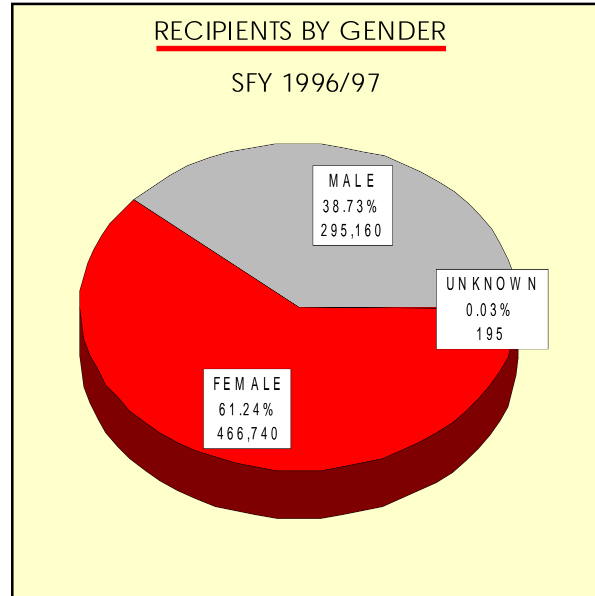



Figure 10

**Average Expenditure by Gender**

The average expenditure per recipient by gender was: male $3,155 and female $3,109. The overall average for a Medicaid recipient for SFY 1996/97 was $3,127 per recipient. The average expenditure per eligible by gender: male $3,037 and female $3,097. The overall average expenditure for a Medicaid eligible was $3,073.

**Louisiana Population Comparison to Medicaid Eligibility**

| | Total | Male | Female |
|---|---|---|---|
| Population | 4,350,579 | 2,097,558 | 2,253,021 |
| Eligibles | 775,416 | 306,665 | 468,535 |

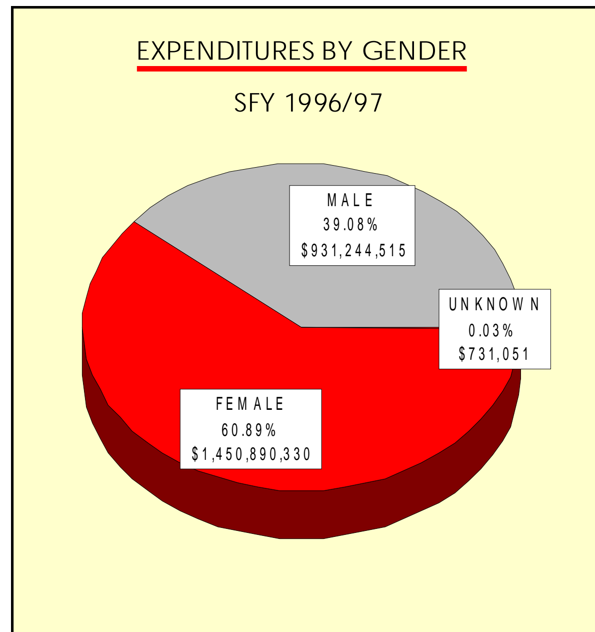



Figure 11

Race

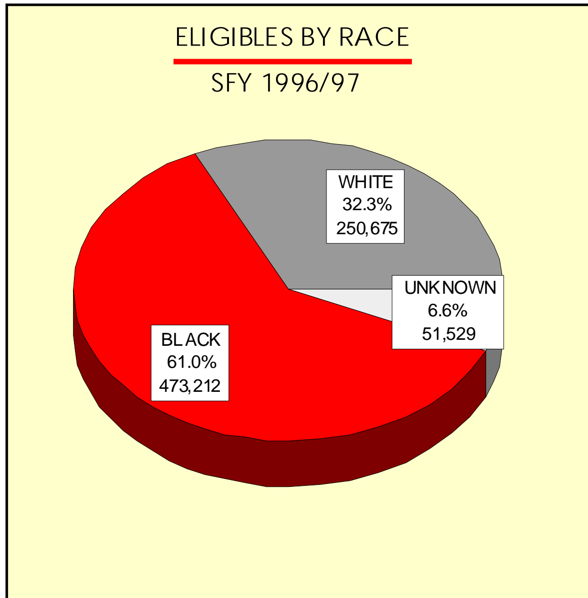



Figure 12

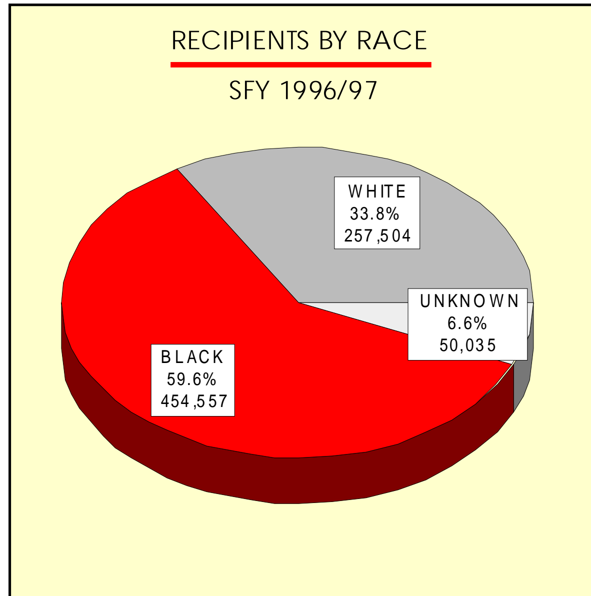



Figure 13

**Average Expenditure by Race**

The average expenditure per Medicaid recipient by race: white $4,301 (white male $4,389, white female $4,247), black $2,352 (black male $2,384, black female $2,332). The average expenditure per Medicaid eligible by race: white $4,418 (white male $4,420, white female $4,417), black $2,260 (black male $2,244, black female $2,270). One reason that the average cost per white recipient is greater than the average cost per black recipient is that proportionately, there are a higher number of disabled and aged white recipients, who tend to require more costly services.

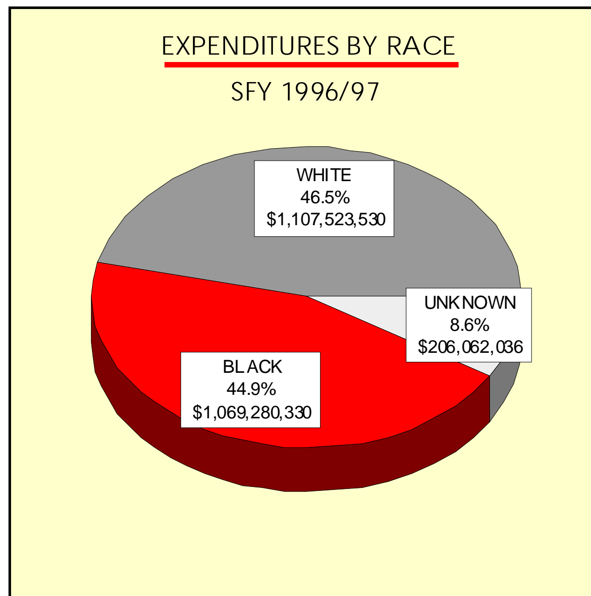



Figure 14

**Louisiana Population Comparison to Medicaid Eligibility**

| | Total | White | Black |
|---|---|---|---|
| Population | 4,350,579 | 2,906,136 | 1,444,443 |
| Eligibles | 775,416 | 250,675 | 473,212 |

Age

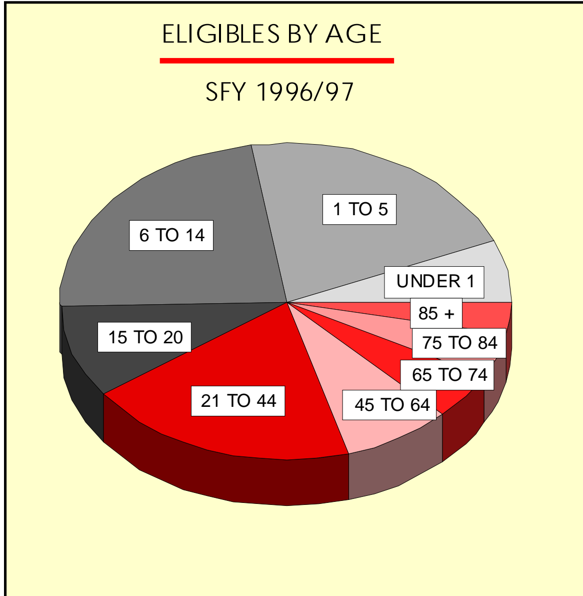



Figure 15

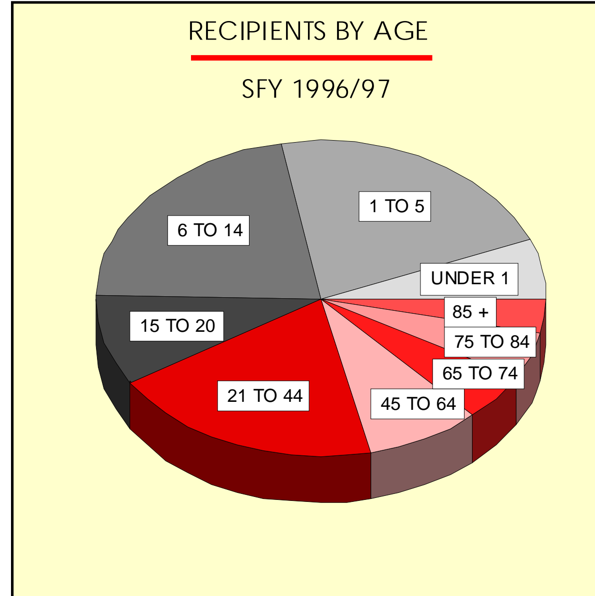



Figure 16

Children under 21 accounted for 59% of the recipients and only 27% of the total expenditures. For adults between the ages of 21 and 64, this segment represented 28% of the recipients and 45% of the expenditures. Senior adults from the age of 65 and over accounted for 13% of the recipients and 28% of the expenditures.

**Louisiana Medicaid Recipients by Age**

| Children (under 21) | Adults (21 to 64) | Senior Adults (65 and over) |
|---|---|---|
| 449,951 | 211,628 | 100,515 |
| 59% | 28% | 13% |

**Louisiana Population by Age**

| Children (under 20) | Adults (20 to 64) | Senior Adults (65 and over) |
|---|---|---|
| 1,375,780 | 2,478,193 | 496,606 |
| 32% | 57% | 11% |

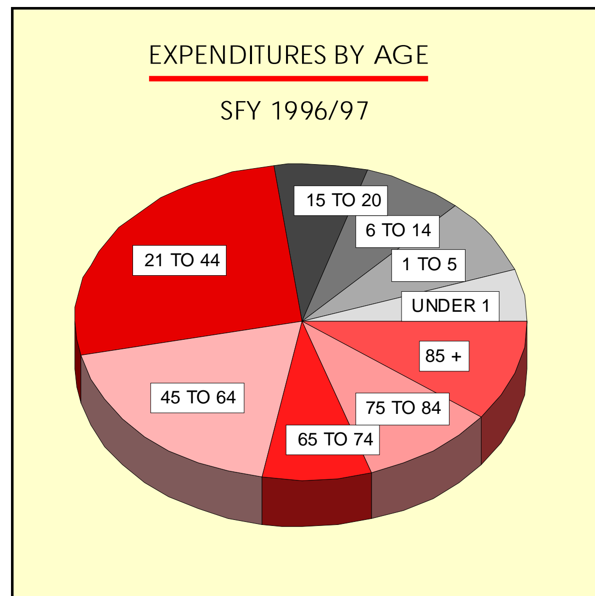



Figure 17

# SERVICES AND UTILIZATION

States participating in Federally-supported financial assistance must provide the following services:

- Inpatient Hospital Services
- Outpatient Hospital Services
- Rural Health Clinic (including Federally qualified health centers) Services
- Other Laboratory and X-ray Services
- Nurse Practitioners' Services
- Nursing Facilities (NF) Services and Home Health Services for individuals age 21 and older
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) for individuals under age 21
- Family Planning Services and Supplies
- Physicians' and Dental Services (Medical and Surgical Services)
- Nurse-Midwife Services

**Mandatory Services:**
Services that the Federal government deems essential services that must be provided to Medicaid recipients.

**Optional Services:**
Services that an individual State provides beyond the scope of the mandatory services.

## TOP TEN SERVICES BY EXPENDITURE

**Hospitals**

**Inpatient Services**
Services are provided to recipients during their stay in a licensed Medicaid participating hospital. Included are medical supplies, nursing care, therapeutic services, lab and x-ray, emergency room care, rehabilitation services and drugs. Prior authorization extends visits due to medical needs.

**Outpatient Services**
Services are provided to recipients in an outpatient setting of a licensed Medicaid participating hospital. Included are emergency care, ambulatory surgery and periodic prior authorized therapy. Total expenditures for the SFY 1996/97 for hospital care were $687,019,940. The number of hospital care services provided were 954,723 yielding an average cost per service of $719.60.

**Long Term Care Facilities**
Services include professional nursing and rehabilitation services provided on a 24-hour-a-day basis to recipients in State licensed Medicaid participating nursing facilities. Recipients require only limited medical supervision and custodial care.

Total expenditures for SFY 1996/97 for Long Term Care Facilities were $483,339,294. The number of long-term care services provided were 11,909,951 yielding an average cost per service of $40.58.

**Intermediate Care Facilities for the Mentally Retarded**
ICF/MRs are homes for long-term care of mentally retarded and/or developmentally disabled recipients. Preventative care is also provided within the facilities. Total expenditures for SFY 1996/97 for ICF/MRs were $323,992,394. The number of ICF/MR services provided were 2,778,203 yielding an average cost per service of $116.62.

**Pharmacy Services**
Services include the dispensing of FDA approved drugs by a State licensed participating pharmacy. Prescriptions must be prescribed by a licensed physician, dentist, podiatrist, or a certified optometrist. Co-payments of $.50 to $3.00 are paid by recipients between 22 and 64 years of age, unless the recipient meets one of the exempted criteria. Total expenditures after rebates for SFY 1996/97 for pharmacy were $254,438,836. The number of pharmacy services provided were 10,557,800 yielding an average cost per service of $24.10.

**Physician Services**
Services include the diagnosis and treatment of a recipient's illness in a doctor's office, the recipient's home, a hospital, a nursing home, emergency room, surgery, clinics including rural health clinics, Federally Qualified Health Centers (FQHC's) or other settings. Total expenditures for SFY 1996/97 for physicians were $240,771,041. The number of physician services provided were 14,719,196 yielding an average cost per service of $16.36.

**Durable Medical Equipment**
Durable medical equipment products include wheelchairs, oxygen concentrators, prostheses and other medical devices. Total expenditures for SFY 1996/97 for durable medical equipment were $31,059,557. The number of durable medical equipment services provided were 11,264,494 yielding an average cost per service of $2.76.

**Home Health Agencies**
Services include part-time nursing services and home health aide services. Services are provided in the recipient's home. Total expenditures for SFY 1996/97 for home health agencies were $26,292,500. The number of home health services provided were 484,595 yielding an average cost per service of $54.26.

**Distinct Part Psychiatric**

Services must be provided according to a mental health rehabilitation plan that is developed by a licensed professional who is a qualified mental health provider in conjunction with a physician and be pre-authorized by State staff. The attending physician must document that the recipient meets the definition of disability required to receive this type of service and must order the rehabilitation plan. Services may not be provided to inpatients of a mental institution or a psychiatric unit in an acute hospital. Total expenditures for SFY 1996/97 for distinct part units were $26,220,916. The number of distinct part unit psychiatric services provided were 76,344 yielding an average cost per service of $343.46.

**Dentists**

Dental services include both emergency and regularly scheduled check-ups for both general and surgical procedures. Total dental expenditures for SFY 1996/97 for dentist were $24,817,663. The number of dentist services provided were 958,348 yielding an average cost per service of $25.90.

**Personal Care Attendant**

Personal care attendants provide services within the recipients home. Services could include but are not limited to the following: sitting, bathing, preparing meals, administering medications. This type of service enables recipients to remain in their homes rather than being institutionalized in some cases. Total expenditures for SFY 1996/97 for personal care attendant were $24,430,267. The number of personal care attendant services provided were 2,348,126 yielding an average cost per service of $10.40.

**Optional Services**
(include, but are not limited to)

Adult Day Health
Certified RN Anesthetists (CRNA's)
Elderly & Disabled Adults Waiver
Adult Dentures
ICF-MR (MR/DD Community Homes)
Appliances & Medical Devices
Case Management
Hemodialysis Services
Psychiatric Rehabilitation
Rehabilitation Services
Alcohol/Substance Abuse
MR/DD Waiver (HCBS)
Chiropractic Service

## Other Programs

### Uncompensated Care

This is a program to provide inpatient care for individuals who do not qualify for Medicaid, but are not financially capable of paying for medical services received. Hospitals must qualify by providing a certain percentage of their total patient care to the indigent population. Besides inpatient acute care services, the uncompensated care program covers the following additional services: metal health rehabilitation, clinic services, medical transportation, optional targeted case management and durable medical equipment. Because Louisiana owns the charity inpatient institutions it makes a lot of sense financially for the State to fund this program. Total payments in 1996/97 were almost $673 million, of which only $127 million were State funds. States that do not own their own charity institutions do not have the same incentive to make use of this program.

### Medicare Premiums

There are a number of individuals who qualify for both Medicaid and Medicare; these individuals are known as dual eligibles. Dual eligibles include the disabled individuals and the elderly. The Department has determined in some cases, it is more cost effective to purchase Medicare premiums than to provide care directly.

### Waiver Services

Alternative to Institutional Living

(1) Adult Day Care — Currently 350 recipients enrolled.

(2) Personal Care Attendant — Currently 110 recipients enrolled.

(3) Elderly — Currently 335 recipients enrolled; the program grew from 235 recipients last year.

(4) MR/DD — Currently has 2,411 waiver slots approved by the Federal government. During the Legislative session this past year, the Legislature authorized 340 additional slots for a total of 2,751 slots. There are 2,053 recipients currently in the MR/DD Waiver. The average cost per recipient is $26,000. With more waivers allocated to the residents of Pinecrest Developmental Center and needy people, the average cost per recipient is estimated to increase next year.

# FINANCING

Medicaid is funded by both State and Federal funds. Each State has a determined match rate based on relative per capita income in the State. The lower the rate the more the Federal government pays. In SFY 1996/97 Louisiana received a special match rate allowing $651 million in State match to draw down $2,693 million Federal funds, reflecting a total program of $3,345 million and an effective match rate of 19.5%. Next year the State will not be receiving a special match rate. The State will be required to provide about 29.9%, or about $982 million, of $3,281 million.

Federal Funds

| SFY 1996/97 | Administration | Medical Vendor | Total |
|---|---|---|---|
| State | *$36,460,030* | $614,945,611 | *$651,405,641* |
| Federal | $47,396,397 | $2,646,266,482 | *$2,693,662,879* |
| Total | $83,856,427 | $3,261,212,093 | $3,345,068,520 |

The Federal government stipulates the rate at which the States must match Federal Financial Participation (FFP). The rate for the majority of services is based on the relative *per capita* income in each State and can be no higher than 50% and no lower than 17%. For administration and some other areas of expenditure (i.e., information technology), the Federal contribution may be anywhere between 50% and 100%. The table below shows the Medicaid match rates for Louisiana for the past ten years.

**Federal Medical Assistance Percentages (FMAP)**
On a State Fiscal Year Basis, 1988/89 to 1996/97

| | 1988/89 | 1989/90 | 1990/91 | 1991/92 | 1992/93 | 1993/94 | 1994/95 | 1995/96* | 1996/97* |
|---|---|---|---|---|---|---|---|---|---|
| State | 29.64 | 27.39 | 25.86 | 24.80 | 25.86 | 26.45 | 27.14 | 27.92 | 28.51 |
| Federal | 70.36 | 72.61 | 74.14 | 75.20 | 74.14 | 73.55 | 72.86 | 72.08 | 71.49 |
| State | Alternative Payment Method* | | | | | | | 15.72 | 18.54 |
| Federal | Alternative Payment Method* | | | | | | | 84.28 | 81.46 |

* Under the alternative payment method which Congress made available to Louisiana, (P.L. 104-134 Section 519), the State was able to obtain Federal funds at a preferred match rate in return for a cap on Federal funds. This helped Louisiana manage a serious financial problem. The problem was the result of a heavy reliance on Uncompensated Care overpayments which were paid as an inducement for hospitals to provide care to the uninsured. Louisiana recovered these payments from the publicly owned charity hospitals and mental health facilities and used the windfall as State match. When the Federal government discontinued the overpayments, Louisiana was faced with very large budget shortfalls which required program reductions of an equivalent magnitude. The alternative payment method was one tool which allowed time to scale the program down in an organized fashion without sustaining large budget deficits or disruption in providing essential services.

## COST CONTAINMENT

### Third Party Liability

Third Party Liability (TPL) refers to the legal obligation of alternative heath care sources to pay the medical claims of Medicaid beneficiaries prior to Medicaid paying any amount of the claim. Medicaid is designated as the payer of last resort. Third parties include: private health insurance, Medicare, employment-related health insurance, medical support from non-custodial parents, court judgements or settlements from a liability insurer, State worker's compensation, first party probate-estate recoveries, long-term care insurance, and other Federal programs. In SFY 1996/97 about 7.5 percent of Medicaid recipients had other insurance coverage. The Department also investigated cases involving accidental injuries for which a third party was liable.

### Drug Rebate

In SFY 1996/97 received $58 million from the different pharmaceutical companies. The rebate is used to offset the expenditures for the prescription drug expenditures.

### Pre-certification

The pre-certification program is operated under a contractual arrangement with Unisys using Department assigned criteria, which screens eligibles to determine the need for services. This allows recipients to receive medically necessary services, and helps the Assurance Unit to alleviate some costs that may have been spent on recipients who do not meet the established criteria.

### Program Integrity

The Department is responsible for monitoring both provider and recipient utilization of Medicaid services. State and Federal laws require periodic checks of provider records in order to verify actual receipt of services for which payment has been made and to investigate any cases suggestive of program abuse misuse or fraud.

# ADMINISTRATION

The Medicaid program operates within the Louisiana Department of Health and Hospitals and is administered by the Bureau of Health Services Financing. The goals of the Bureau are as follows:

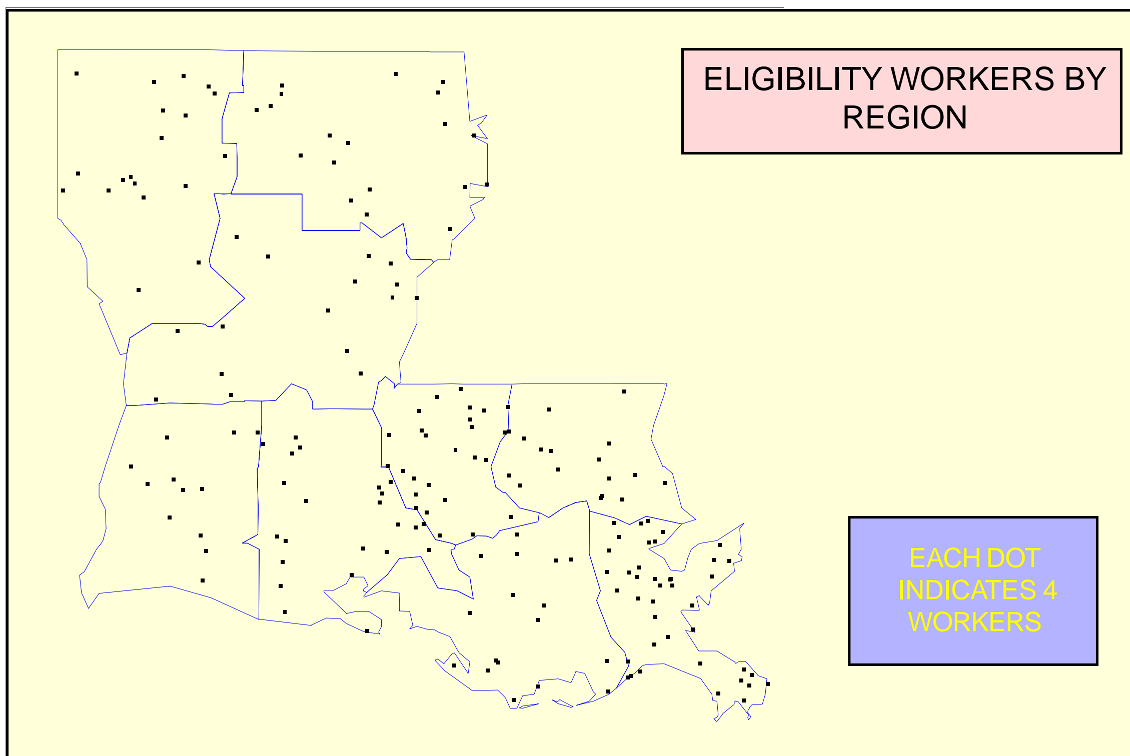
*To provide medical services under Title XIX of the Social Security Act to qualified residents of Louisiana and ensure access to quality health care services.*

*To protect the health and safety of residents of Louisiana; develop alternatives to institutional living and encourage preventative health care.*

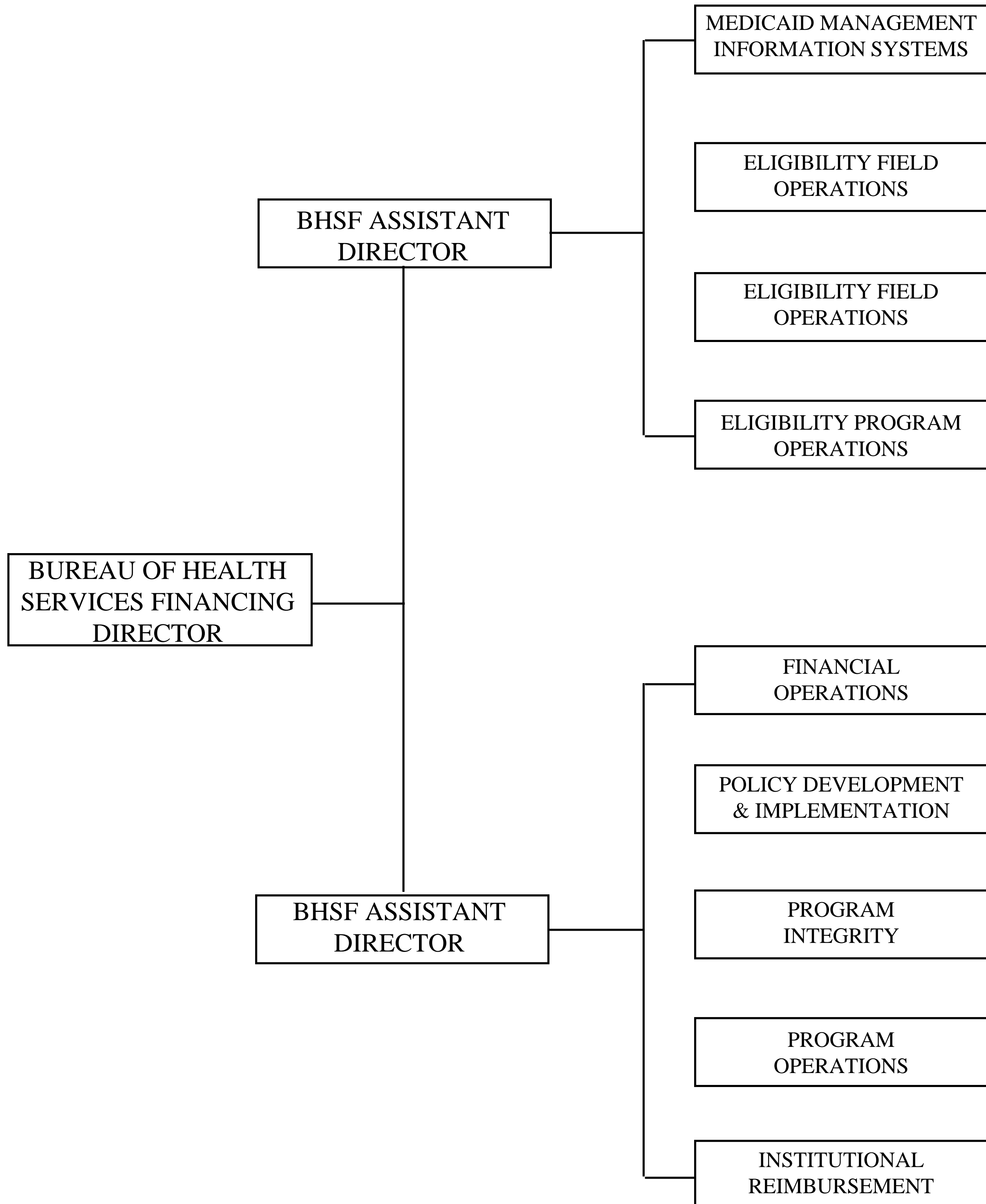
*To operate the Medicaid program in an efficient, effective manner in accordance with Federal and State statutes, rules and regulations.*

**Organizational Structure**

There are 1,143 authorized positions in the Bureau of Health Services Financing. Of those, 958 are in eligibility determination and licensing and certification functions throughout the State. The majority of the remaining 185 employees work in the main office located in Baton Rouge. The Bureau is organized according to the chart on the following page.



## DHH - BUREAU OF HEALTH SERVICES FINANCING



The following section provides information pertaining to the functions of the various sections within the Bureau of Health Services Finance, although many additional tasks are often performed as circumstances dictate.

## DIRECTOR

### Functions

- Responsible for the overall operation of the program. This includes ensuring all of the State and Federal regulations (known as the "State Plan") are followed, ensuring expenditures do not exceed the budget and generally supervising and prioritizing the various activities of each Section. Two Assistant Directors help manage this effort.

## MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS)

### Functions

- Oversee operations of the Louisiana Medicaid Management Information System (LMMIS). The LMMIS is owned by the State and is operated by Unisys, a fiscal intermediary.
- Maintain and update the Medicaid provider files for the 60 different types of providers.
- Responsible for the accurate, prompt and efficient payment of Medicaid claims.
- Responsible for administering the Recipient Reimbursement Program. The primary objective of the program is to process and authorize payments on behalf of recipients for reimbursement for those medical expenses paid prior to receiving their Medicaid cards.
- Responsible for the administration and managerial operation of the Statewide Medicaid Recipient subsystem of the MMIS and Claims Resolution.
- Responsible for the monthly Medicaid card production and the coordination of messages and inserts with the cards.
- Investigate rejected medical claims forwarded from the Unisys' provider relations unit, in accordance with recipient subsystem documentation on eligibility error code edits.
- Maintain an effective Third Party Liability (TPL) Recovery unit. The unit's purpose is to help reduce Medicaid expenditures by ensuring that Medicaid is the payer of last resort.
- Bring together all detailed information, captured by other subsystems concerning all vital program activity, and assemble the information in a summarized format.

### Highlights

- The number of Provider Enrollment transactions varies from 750 to 1,000 monthly.
- There were 39,831,772 claims processed during the year.
- The recipient subsystem processed claims for 762,095 medicaid recipients this year.
- Printed over 399,480 Medicaid cards monthly for over 546,872 eligible recipients.
- Processed over 600 rejected Medicaid claims monthly.
- Updated the Recipient Eligibility Verification System (REVS), which is used by providers to verify recipient eligibility by telephone.

**Future Concerns**

- ☐ Development of "swipe cards" for recipients Statewide.
- ☐ The development of the Executive Information System / Decision Support System slated for implementation in January 1999.
- ☐ Altering the computer programs that generate the HCFA reports to conform to the changes that HCFA has made in the reports.

## ELIGIBILITY OPERATIONS

**Functions**

- Determine categorical eligibility based on disability and/or incapacity.
- Administer the Title XIX eligibility programs in accordance with Federal and State regulations.
- Maintain Medicaid eligibility data base in compliance with State and Federal regulations.
- Monitor information gathered by the Department of Social Services to ensure data integrity prior to processing data to the Medicaid Management Information System (MMIS).
- Administer Medicaid Eligibility Quality Control program in accordance with Federal and State regulations for reducing erroneous expenditures.
- Oversee the 520 Medicaid Application Centers located throughout the State. The centers take 75% of the initial applications for eligibility. However, Federal regulations require that all applications must be reviewed and certified by an eligibility worker.

**Highlights**

- ■ Reduced the number of applications pending Out-of-Conformity from 4,657 in SFY 1995/96 to 1,343 in 1996/97, a 71 percent decrease.
- ■ Developed a formal case review system to ensure that case errors are at a minimum in eligibility determinations, in order to avoid Federal sanctions.
- ■ Developed and implemented Medicaid Application System (MAS) software to be used by eligibility staff to assist with eligibility decisions which are more accurate and efficient than the previous system.
- ■ HCFA mandated that all Medicaid outreach facilities be capable of registering voters. Approximately 1,200 personnel received training to accomplish this task.

**Future Concerns**

- ☐ With the anticipated increase in Medicaid applications due to the Medically Needy Program and Welfare Reform, the major challenge is how to maintain or improve quality and quantity.
- ☐ Timely processing of Medicaid applications, timely Appeals and Retroactive Reimbursement will continue to be pressing issues to assure compliance.

## HEALTH STANDARDS

### Functions

- Enforce licensing standards and certification through licensing, survey and certification of health care providers.
- Certify individuals for admission and continued stay review based on necessity of medical care.
- Certify Nurse Aide Competency Evaluation Programs and maintenance of a Nurse Aide Registry.
- Update and maintaining the Clinical Laboratory Improvement Amendments (CLIA).
- Manage Emergency Medical Transportation (EMT) Services, Controlled Dangerous Substances (CDS) , and implement Resident Assessment Instrument (RAI).
- Impose sanctions upon a facility for not complying to standards.
- Review complaints made in connection with health care facilities.

### Highlights

- The licensure program established a standard fee of $600 per provider, and fees per bed for hospitals and long term care facilities.
- Health Standards has imposed sanctions on providers for not complying to established standards. The total dollar value is around $150,000 which includes sanctions imposed as far back as December of 1989.
- The number of facilities that are certified yearly by the Health Standards has risen from 1,109 facilities in 1989 to 2,024 at year-end 1996/97.

### Future Concerns

- To maintain the licensing of the growing number of hospitals, institutions and providers throughout the State.

## FINANCIAL OPERATIONS

### Functions

- Administer the Title XIX program's fiscal operations within Federal and State regulations.
- Maintain Federal funding for Title XIX services and administration expenditures.
- Responsible for reporting the Federally required Medicaid expenditure forecast, budget and policy changes.
- Submission of data to HCFA for Federally mandated reports.

### Highlights

- Successful completion of the Federal government (HCFA) financial audits without adjustments to the cost projections.
- Successful implementation of the Bureau's internal inventory system to meet State government's rules and regulations.

- Maintained the level of Federal disallowance sanctions at zero.
- Annual adjustment of the Bureau's cost allocation plan to draw down additional Federal funds.

**Future Concerns**

- ☐ Financial maintenance and stability for managed care and fee-for-service dual Medicaid system.
- ☐ Financing of the Managed Care pilot parishes and the resulting expansion of this pilot to other parishes.
- ☐ Data collection for a dual Medicaid system and the Federal reporting of these statistics.
- ☐ Continued efforts to automate Medicaid administrative functions and programmatic MMIS subsystems.

## POLICY DEVELOPMENT AND IMPLEMENTATION

**Functions**

- Maintain the *State Plan* (see glossary) as required by the Social Security Act.
- Execute the facility need review process as statutorily mandated.
- Develop waiver programs as an alternative to costly Medicaid services.
- Publish the rules governing the Medicaid program in Louisiana.
- Develop new and expanded programs under the State plan to provide appropriate, medically necessary services to Medicaid recipients.
- Monitor and implement State legislation actions which affect the Bureau.
- Monitor and implement Federal law and regulations which affect the Bureau.

**Highlights**

- There were a total of 39 new transmittals of the State Plan submitted, 8 pending that were resubmitted, 49 approved and 1 withdrawn.
- All transmittals of the State Plan were approved except for the one withdrawn and 3 that cannot be approved until pending hospital transmittals are resolved.
- A simplified file of all agency rule making was implemented to expedite research.
- Significant progress was made on development of the three major provider manuals - Case Management, ICF/MR Standards, and EPSDT.
- Other material developed and circulated: 7 manual changes, 4 memorandums of understanding, and 47 other circulations.

**Future Concerns**

- ☐ Continue efforts toward the resolution of the State Plan transmittals in *clock-stopped status* (see glossary). Complete the database of the State Plan transmittals.
- ☐ Complete Case Management, ICF/MR Standards, and EPSDT Provider manuals.
- ☐ Complete revisions to the Nursing Home Blue Book and Lock-In Handbook.
- ☐ Complete the database on Rulemaking activities.

## PROGRAM INTEGRITY

### Functions

- Assure that expenditures for Medicaid services are made within all of the regulatory structure and to identify any fraud or abuse in the system.
- Provide information to assist management of fiscal planning and control.
- Assure that doctors prescribe appropriate pharmaceuticals, while permitting sufficient professional prerogatives to allow for individualized drug therapy.

### Highlights

- Increased the amount of Surveillance and Utilization Review (SURS).
- Increased the number of recipients that are locked in to one provider or pharmacist—from 500 recipients a year ago to 3,000 recipients. The lock-in program saved the State nearly $9 million in SFY 1996/97.
- Senate Bill 1559 provided effective civil and anti-fraud and abuse "tools" including triple damages and fines of up to $10,000 per violation, non-dischargability of debt through bankruptcy, forfeiture of property to satisfy debts, and a State Qui Tam provision. The Qui Tam statute allows private citizens to sue on behalf of the government in cases of fraud and share in the recovery.
- Senate Bill 1325 is a provider enrollment and bonding law that provides for the posting of bonds of up to $50,000 to enroll and set out conditions that providers must adhere to, for participation in the program.
- Conducted 300 Pharmacy Audits (full scope and limited scope combined) this program recouped nearly $1.2 million.

### Future Concerns

- Increase the review of SURS from 2.5% to 5%.
- Activation of the new PC SURS system online.

## PROGRAM OPERATIONS

### Functions

- Oversee the operations of the Medicaid Program in relation to reimbursement and coverage of services.
- Assure that the program guidelines are in accordance with Federal and State statues, rules and regulations.
- Assure the integrity of the files maintenance subsystem of the Medicaid Management Information System.
- Develop and implement initiatives to assure efficient and effective provision of medical services of adequate quality to recipients.
- Ensure that contractors are in compliance with Federal and State regulations and the appropriateness of health care provided through review and monitoring.

**Highlights**

- A new EPSDT Health Services/PCS manual has been written and is in circulation.
- The Personal Care Services reimbursement rate was raised to reflect the minimum wage increase.
- Implemented Louisiana Medicaid Pharmacy Benefits Management System.
- Pharmacy point-of-sale and prospective drug utilization review program was begun and rendered a cost savings of nearly $7,624,000.
- Pharmacy disease management was implemented. Educational brochures were submitted to recipients and providers. The disease states include the following: asthma, diabetes, and anti-ulcer therapy.
- Pharmacy dispensing fee has been maintained at the level that was established in fiscal year 1994.
- Re-implementation of the Chiropractic Program effective January 20, 1997.
- Assignment of global surgery periods to surgical procedure codes.
- Implementation of pediatric anesthesia/analgesia policy for recipients up to age 13.
- Decrease in the number of services paid and a decrease in cost per service, which resulted in a surplus in the Physicians Program.
- Flat rates were implemented for non-emergency transportation which have continued to control the cost of providing these services.
- The CommunityCARE program had a cost savings of 14.3% over the non-Community Care Parishes.

**Future Concerns**

- Dispensing Cost Survey to determine the cost of dispensing a prescription in the State and other reimbursement issues.
- Continue to develop educational brochures on specific disease states.
- Implementation of duration of therapy with the certain drugs such as H2 receptor antagonists, proton pump inhibitors and sucralfate.
- Transition of a portion of current KIDMED functions to Unisys.
- Because of increases in minimum wage, gasoline prices and insurance premiums, there has been a decrease in the number of transportation providers in rural areas.

**INSTITUTIONAL REIMBURSEMENT**

**Functions**

- Administer Title XIX reimbursements to institutional providers (i.e., hospitals, ICF/MRs, and nursing homes) in compliance with Federal and State regulations.
- Administer accountability of provider expenditures in compliance with Federal and State regulations.
- Administer recoupment of overpayments in compliance with Federal and State regulations.

**Highlights**

- Developed and formalized a "findings" process pursuant to requirements of the "Boren Amendment" (see glossary).

- ■ Performed desk reviews and cost settlements of home health cost reports in-house without additional staffing (in the past contracted an audit intermediary).
- ■ Commenced initial stages of development of an audit unit (to pursue possible irregularities in reimbursements to providers).

**Future Concerns**

- ☐ Eradicating backlog of home health cost reports.
- ☐ Clarifying and refining reimbursement methodologies for various providers.
- ☐ Development of new reimbursement methodologies to meet changing services and Federal mandates.
- ☐ Completion of the audit unit development and having the unit fully operational.
- ☐ Hiring staff for preparation of State operated mental health, substance abuse and nursing facilities cost reports.

## FEDERAL INITIATIVES

**The President's Medicaid Reform Plan**
Cuts $22 billion from the national Medicaid program over the next five years. About two-thirds of the cuts are to come from the DSH program.

**President Clinton's Children's Health Care Initiative**
Will extend coverage to approximately 5 million of the estimated 10 million children who lack health insurance, at a total cost of about $24 billion.

**State Partnership Grants**
A small grant that would cover children whose families' incomes are too high to be eligible for Medicaid but can't afford private coverage.

**Medicaid 12-month Continuous Eligibility**
This provision will allow for a child who signs up for Medicaid to remain eligible for a year regardless of changes in the family's income.

**Medicaid Outreach**
This initiative is aimed to enroll the nearly 3 million children who are eligible for Medicaid but are not receiving any assistance.

### MANAGED CARE IN MEDICAID

The three Medicaid managed care models that have been most often implemented in attempting to control Medicaid costs are as follows:

**Full-Risk Capitation Programs**
Similar to most private sector plans. States contract with HMOs to provide care to Medicaid recipients. Some States also contract on a full-risk basis with Federally funded community health centers that have traditionally served Medicaid and other low income recipients.

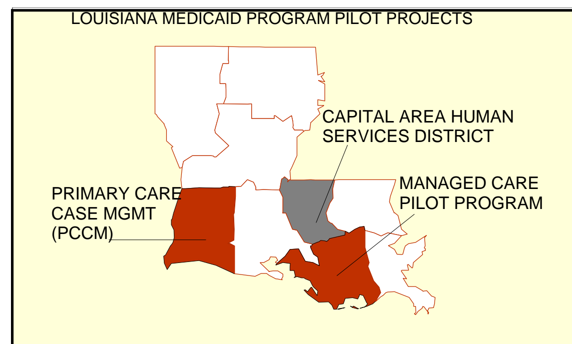
**Partial Capitation Programs**
States contract directly with providers on a capitation basis for a sub-set of services but continue to pay non-capitated services on a fee-for-service basis.

**Primary Care Case Management (PCCM)**
All services are fee-for-service and primary care providers are recruited and paid on a per-person basis for case management. Louisiana has implemented a PCCM program in 20 parishes, covering approximately 47,000 people generally referred to as "Community Care."

## PREPARING FOR THE FUTURE IN LOUISIANA

Since January 1996, the Bureau has proposed, and the Legislature has approved, three new ways to deliver Medicaid services.

Already up and running is the Capital Area Human Services District, approved by the Legislature last year. The Baton Rouge area pilot project moves the management of various outpatient services under local management and closer to the people. The district is managed by a volunteer board and an executive director and serves people in Ascension, East and West Baton Rouge, East and West Feliciana, Iberville and Pointe Coupee parishes. The District gets about $26 million annually from DHH to provide outpatient services for mental health, substance abuse and developmental disabilities. DHH and the Legislature have oversight of the District, but the board will be responsible for the quality of care, purchasing, leasing, contracting, accounting, and personnel.




Two additional programs are slated to be online around the third quarter of State fiscal year 1997/98. The Managed Care pilot program in Region III will encompass 28,000 women and children. The program is expected to improve health education, reduce high-risk behavior, reduce the number of cesarean deliveries, enhance preventive care, increase the immunization rate, and provide more early prenatal care (which is expected to decrease the low-birth weight rate, neonatal mortality rate and increase health outcomes while decreasing overall costs). Several States have already implemented a managed care program. It is hoped the managed care program will reduce the rate of growth in Medicaid costs, while improving appropriate preventive services to the Medicaid population. The long-term result anticipated will be a healthier outlook for the Medicaid population.

The program in Region IV is an enhanced primary care case management (PCCM) program. All services are paid fee-for-service and primary care providers are recruited and paid on a per-person basis for case management.

The pilot programs collectively will 1) make Medicaid more like private insurance, 2) use better clinical outcome measures and new electronic benefits cards to enhance cost monitoring, 3) reduce fraud, 4) eliminate costly paperwork, and 5) prevent processing delays.

## GLOSSARY OF TERMS

**1115 Waiver "Research and Demonstration"**
This type of waiver authorizes "experimental, pilot, or demonstration" projects that will promote program objectives and may be granted for a period of up to five years. These waivers are usually used to expand Medicaid coverage to indigent populations not normally covered under existing Medicaid programs and have been utilized as part of a larger "health care reform" effort.

**1915(b) Waiver "Programmatic Waiver"**
This type of waiver allows States to waive certain provisions such as freedom of choice of provider, State wideness of program, and service comparability. To implement managed care plans within Medicaid, the 1915 (b) waiver does not require as extensive an evaluation methodology as section a 1115 waiver (which is Statewide, 100% comprehensive) and is ideal for small pilot programs.

**Boren Amendment**
An amendment to the Federal Medicaid law that allowed State Medicaid programs to depart from Medicare's cost reimbursement system for nursing homes (in 1980) and hospitals (in 1981). It requires State payments to hospitals and nursing homes to be sufficient to meet the cost of "efficient and economically operated" facilities. The amendment was repealed by Congress in the 1997 Balanced Budget Act.

**Capitation**
A method of health care payment which pays a predetermined amount per person per time period, usually a month, for all of the required health care services. By paying a flat rate, it creates an incentive to economize on care rather than maximize the amount of care provided. It also contains incentives to keep long-term clients healthy.

**Clocked-Stopped Status**
Under normal circumstances, HCFA has 90 days to approve or disapprove a State plan amendment. If HCFA requires additional information to make a determination, the "clock is stopped" on the 90-day time frame, effectively extending the review period.

**CommunityCARE Program**
This is a primary care case management program for Medicaid recipients which operates under a waiver of Freedom of Choice under the authority of Section 1915(b) (1) of the Social Security Act and under a waiver of State-wideness {Section 1902(a)(1) of the Social Security Act}. This program, which links Medicaid recipients to a primary care physician, operates in 20 rural parishes across the State.

**Medicaid Hotline Number**
A toll free hotline was established to allow citizens to report Medicaid fraud and abuse; the number is 1-800-488-2917.

**Cost Reports**
For any institutional provider where payment is made on a retrospective basis, there is an initial payment for the services provided, and then a process to determine the actual (audited) cost report. If the interim payment has not covered all the approved costs, Medicaid owes the provider for the difference, and vice versa.

**Eligible**
For this report, an eligible is a person who has qualified for Medicaid, but did not receive any type of Medicaid service.

**Federal Fiscal Year (FFY)**
The Federal fiscal year starts October 1 and ends September 30 each year.

**Findings Process**
An audit process that assures that reimbursements are "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, quality and safety standards."

**Managed Care**
In the insurance context, managed care is an arrangement where care is provided through a single insurer contracting with a wide range of providers. It builds in incentives to economize on the amount and type of care delivered. Providers are usually paid at a flat rate (capitation rate). In a clinical sense, managed care is the coordination of health care for maximum benefit and to avoid either duplication, unnecessary or dangerous combinations of care.

**Moratorium**
A suspension of activity, this allows the Department to freeze the number of agencies providing a service.

**Prior Authorization**
A management tool to verify that the treatment being proposed is appropriate for the patient. It may also be used to determine if the care that is proposed has a more economical alternative with the same (or better) expected clinical outcome.

**Recipient**
An individual that received a Medicaid service.

**State Fiscal Year (SFY)**
The State fiscal year starts July 1 and ends June 30 each year.

**State Plan**
The plan that sets the policies for the Bureau to follow in accordance with the Health Care Financing Administration (HCFA). Any State Plan amendments must be submitted to and approved by HCFA quarterly.

**TPL Contractor**
An entity hired by DHH to pursue health insurance coverage for claims paid without regard to third party. "Paid without regard" due to HCFA mandated pay and chase services or State approved P & C (pharmacy) or the TPL was unknown at the time the claim was paid.

**Trauma/Health**
Pursuit of recoveries from liable third parties who were responsible for injuries sustained by a recipient and the treatment was paid by Medicaid.

**Uncompensated Care (disproportionate share)**
Care that is administered to individuals who do not qualify for Medicaid, but are not financially capable of paying for medical services received. Hospitals must qualify in order to receive payments for administering indigent medical care.

# TECHNICAL NOTE

Throughout this report a combination of data sources were used to provide the most accurate information possible. There was no single data source that could provide the information needed. A HCFA 2082 "State Hybrid Report" was developed by UNISYS for purposes of populating this report. The HCFA 2082 report was readily available based on the Federal fiscal year however, some adaptations (i.e., source directly off claims history; addition of special "state only total" for Foster Care Children and Refugees; and based on state fiscal year )were made to create the State Hybrid Report. In addition, regular MMIS reports and budget documents were used.

The total number of eligibles and recipients are calculated on a statewide basis and by various subsections. When measured on a statewide basis, the unduplicated number of eligibles exceeds the number of recipients. However, when any type of subsection is measured (i.e., parish, aid category, etc.) recipient numbers may exceed eligible numbers. There are three reasons why this may occur:

(1) retroactive eligibility -- a person applies for Medicaid, then uses services prior to receiving eligibility status. For example, this could apply to SSI recipients or recipients who have appealed their Medicaid eligibility.

(2) provider billing habits -- some providers hold on to claims for several months and submit them all at once. For example a recipient receives a service in June 1997 and the provider doesn't submit the claim until May 1998 (providers have a one year timely filing limit), the recipient will not be counted during SFY 1996/97, but will be counted as a recipient in SFY 1997/98. However, the recipient might not be eligible in 1997/98 which would create one more recipient than eligible.

(3) reconciliation with recipient original identification number -- a recipient number is made up of 13 digits of which a 2 digit parish code, a 2 digit aid category, a 1 digit multiple grant indicator , a 6 digit case number, and a 2 digit recipient number are embedded in the identification number. So, if an individual moves to a different parish or changes aid categories a new number will be created. In order not to count a recipient more than once we have to establish a point-in-time with in a given year to determine the count of recipients and eligibles and reconcile with the original identification number.

APPENDIX 1

| PARISH | POPULATION | RANK | ELIGIBLES | RANK | RECIPIENTS | POP. COVERED BY MEDICAID (%) |
|---|---|---|---|---|---|---|
| ACADIA | 57,590 | 19 | 12,832 | 15 | 12,986 | 22.28 |
| ALLEN | 23,892 | 37 | 4,151 | 44 | 4,539 | 17.37 |
| ASCENSION | 67,958 | 17 | 8,864 | 23 | 8,851 | 13.04 |
| ASSUMPTION | 22,681 | 41 | 4,607 | 42 | 4,554 | 20.31 |
| AVOYELLES | 40,433 | 29 | 10,177 | 19 | 10,280 | 25.17 |
| BEAUREGARD | 31,771 | 33 | 4,794 | 40 | 5,000 | 15.09 |
| BIENVILLE | 16,676 | 52 | 3,874 | 49 | 3,972 | 23.23 |
| BOSSIER | 91,811 | 12 | 10,091 | 20 | 9,691 | 10.99 |
| CADDO | 245,095 | 4 | 43,931 | 4 | 40,960 | 17.92 |
| CALCASIEU | 178,881 | 6 | 24,775 | 5 | 24,546 | 13.85 |
| CALDWELL | 10,189 | 59 | 2,014 | 62 | 2,027 | 19.76 |
| CAMERON | 8,733 | 63 | 874 | 64 | 958 | 10.01 |
| CATAHOULA | 11,155 | 58 | 2,643 | 57 | 2,591 | 23.70 |
| CLAIBORNE | 17,185 | 50 | 3,752 | 50 | 3,917 | 21.83 |
| CONCORDIA | 20,854 | 46 | 5,148 | 37 | 4,999 | 24.69 |
| DESOTO | 23,428 | 39 | 5,042 | 39 | 5,278 | 21.52 |
| EAST BATON ROUGE | 395,914 | 3 | 53,134 | 3 | 50,385 | 13.42 |
| EAST CARROLL | 9,154 | 62 | 4,068 | 46 | 4,233 | 44.43 |
| EAST FELICIANA | 20,833 | 47 | 3,974 | 47 | 3,923 | 19.07 |
| EVANGELINE | 34,281 | 31 | 10,610 | 18 | 10,872 | 30.95 |
| FRANKLIN | 22,078 | 42 | 5,921 | 32 | 5,909 | 26.82 |
| GRANT | 18,591 | 49 | 3,450 | 54 | 3,517 | 18.56 |
| IBERIA | 71,685 | 16 | 13,593 | 13 | 13,632 | 18.96 |
| IBERVILLE | 30,929 | 35 | 6,710 | 29 | 6,614 | 21.69 |
| JACKSON | 15,492 | 53 | 2,984 | 55 | 3,134 | 19.26 |
| JEFFERSON | 455,043 | 2 | 57,868 | 2 | 56,427 | 12.72 |
| JEFFERSON DAVIS | 31,753 | 34 | 5,877 | 34 | 6,306 | 18.51 |
| LAFAYETTE | 181,851 | 5 | 22,184 | 10 | 22,320 | 12.20 |
| LAFOURCHE | 87,772 | 13 | 13,323 | 14 | 13,309 | 15.18 |
| LASALLE | 13,840 | 54 | 2,169 | 60 | 2,235 | 15.67 |
| LINCOLN | 43,302 | 27 | 6,255 | 31 | 6,088 | 14.79 |
| LIVINGSTON | 82,900 | 15 | 9,289 | 21 | 9,338 | 11.21 |

See Technical Note on page 37.

| EXPENDITURES | RANK | PER CAPITA ($) | RANK | PER ELIGIBLE ($) | RANK | PER RECIPIENT ($) | RANK |
|---|---|---|---|---|---|---|---|
| 46,348,868 | 12 | 805 | 15 | 3,612 | 13 | 3,569 | 13 |
| 14,193,307 | 40 | 594 | 31 | 3,419 | 19 | 3,127 | 22 |
| 25,868,467 | 27 | 381 | 55 | 2,918 | 35 | 2,923 | 37 |
| 11,848,610 | 48 | 522 | 41 | 2,572 | 54 | 26,002 | 51 |
| 35,596,186 | 18 | 880 | 12 | 3,498 | 15 | 3,463 | 15 |
| 13,942,816 | 41 | 439 | 50 | 2,909 | 37 | 2,789 | 46 |
| 11,933,887 | 47 | 716 | 20 | 3,080 | 30 | 3,005 | 30 |
| 42,737,470 | 14 | 465 | 47 | 4,235 | 5 | 4,410 | 5 |
| 118,509,948 | 5 | 484 | 44 | 2,698 | 48 | 2,893 | 39 |
| 84,011,757 | 7 | 470 | 46 | 3,391 | 20 | 3,423 | 16 |
| 10,219,211 | 54 | 1,003 | 7 | 5,075 | 3 | 5,042 | 3 |
| 2,276,998 | 64 | 261 | 64 | 2,604 | 53 | 2,376 | 62 |
| 7,902,035 | 59 | 708 | 21 | 2,990 | 32 | 3,050 | 27 |
| 11,727,203 | 49 | 682 | 24 | 3,125 | 27 | 2,994 | 31 |
| 13,678,330 | 43 | 656 | 27 | 2,657 | 50 | 2,736 | 49 |
| 12,785,470 | 45 | 546 | 37 | 2,536 | 56 | 2,422 | 59 |
| 147,821,919 | 4 | 373 | 56 | 2,782 | 46 | 2,934 | 35 |
| 10,632,661 | 52 | 1,162 | 3 | 2,614 | 52 | 2,512 | 55 |
| 19,769,420 | 33 | 949 | 8 | 4,975 | 4 | 5,039 | 4 |
| 36,998,744 | 16 | 1,089 | 5 | 3,487 | 16 | 3,403 | 17 |
| 20,868,320 | 32 | 945 | 9 | 3,524 | 14 | 3,532 | 14 |
| 10,741,196 | 51 | 578 | 33 | 3,113 | 29 | 3,054 | 26 |
| 38,052,767 | 15 | 531 | 40 | 2,800 | 43 | 2,791 | 45 |
| 16,807,027 | 35 | 543 | 38 | 2,505 | 57 | 2,541 | 54 |
| 10,296,669 | 53 | 665 | 25 | 3,451 | 17 | 3,286 | 20 |
| 161,504,370 | 3 | 355 | 58 | 2,791 | 44 | 2,862 | 41 |
| 18,332,484 | 34 | 577 | 34 | 3,120 | 28 | 2,907 | 38 |
| 63,885,989 | 10 | 351 | 59 | 2,880 | 38 | 2,862 | 40 |
| 35,004,700 | 20 | 399 | 52 | 2,627 | 51 | 2,630 | 50 |
| 8,652,484 | 58 | 625 | 29 | 3,990 | 9 | 3,872 | 9 |
| 24,140,947 | 29 | 571 | 35 | 3,859 | 11 | 3,965 | 7 |
| 27,381,511 | 23 | 330 | 60 | 2,948 | 34 | 2,932 | 36 |


See Technical Note on page 37.

APPENDIX 1

| PARISH | POPULATION | RANK | ELIGIBLES | RANK | RECIPIENTS | POP. COVERED BY MEDICAID (%) |
|---|---|---|---|---|---|---|
| MADISON | 12,977 | 55 | 4,199 | 43 | 4,445 | 32.31 |
| MOREHOUSE | 31,969 | 32 | 8,126 | 26 | 8,578 | 25.42 |
| NATCHITOCHES | 38,173 | 30 | 7,778 | 27 | 7,993 | 20.38 |
| ORLEANS | 476,625 | 1 | 138,114 | 1 | 130,453 | 28.98 |
| OUACHITA | 147,302 | 8 | 24,406 | 6 | 23,318 | 16.57 |
| PLAQUEMINES | 25,848 | 36 | 4,782 | 41 | 4,737 | 18.50 |
| POINT COUPEE | 23,200 | 40 | 5,136 | 38 | 5,063 | 22.14 |
| RAPIDES | 126,290 | 9 | 24,242 | 7 | 23,820 | 19.20 |
| RED RIVER | 9,746 | 61 | 2,099 | 61 | 2,232 | 21.54 |
| RICHLAND | 20,892 | 45 | 5,666 | 35 | 6,015 | 27.12 |
| SABINE | 23,741 | 38 | 4,141 | 45 | 4,367 | 17.44 |
| ST. BERNARD | 66,641 | 18 | 8,255 | 25 | 8,387 | 12.39 |
| ST. CHARLES | 47,031 | 23 | 5,464 | 36 | 5,718 | 11.62 |
| ST. HELENA | 9,748 | 60 | 2,426 | 58 | 2,414 | 24.88 |
| ST. JAMES | 20,959 | 44 | 3,968 | 48 | 3,978 | 18.93 |
| ST. JOHN | 42,260 | 28 | 6,521 | 30 | 6,433 | 15.43 |
| ST. LANDRY | 82,955 | 14 | 22,865 | 9 | 22,618 | 27.56 |
| ST. MARTIN | 46,239 | 24 | 8,825 | 24 | 8,741 | 19.09 |
| ST. MARY | 57,425 | 20 | 12,111 | 16 | 11,763 | 21.09 |
| ST. TAMMANY | 178,483 | 7 | 15,722 | 12 | 15,789 | 8.81 |
| TANGIPAHOA | 94,273 | 11 | 22,881 | 8 | 22,541 | 24.27 |
| TENSAS | 6,883 | 64 | 2,390 | 59 | 2,332 | 34.73 |
| TERREBONNE | 102,097 | 10 | 16,850 | 11 | 16,587 | 16.50 |
| UNION | 21,607 | 43 | 3,639 | 52 | 3,795 | 16.84 |
| VERMILLION | 51,299 | 22 | 8,963 | 22 | 8,916 | 17.47 |
| VERNON | 54,546 | 21 | 5,897 | 33 | 6,354 | 10.81 |
| WASHINGTON | 43,315 | 25 | 11,494 | 17 | 11,390 | 26.54 |
| WEBSTER | 42,690 | 26 | 7,640 | 28 | 7,926 | 17.90 |
| WEST BATON ROUGE | 20,616 | 48 | 3,630 | 53 | 3,628 | 17.61 |
| WEST CARROLL | 12,191 | 57 | 2,956 | 56 | 3,056 | 24.25 |
| WEST FELICIANA | 12,964 | 56 | 1,600 | 63 | 1,620 | 12.34 |
| WINN | 16,824 | 51 | 3,696 | 51 | 3,696 | 21.69 |
| TOTAL | 4,350,579 | | 775,416 | | 762,095 | 17.82 |

See Technical Note on page 37.

| EXPENDITURES | RANK | PER CAPITA ($) | RANK | PER ELIGIBLE ($) | RANK | PER RECIPIENT ($) | RANK |
|---|---|---|---|---|---|---|---|
| 10,139,444 | 55 | 780 | 16 | 2,414 | 61 | 2,281 | 64 |
| 26,116,655 | 25 | 817 | 13 | 3,214 | 23 | 3,045 | 28 |
| 22,378,806 | 31 | 586 | 32 | 2,877 | 39 | 2,800 | 44 |
| 334,952,035 | 1 | 703 | 23 | 2,425 | 60 | 2,568 | 53 |
| 69,667,402 | 8 | 473 | 45 | 2,854 | 40 | 2,988 | 33 |
| 35,721,949 | 17 | 1,382 | 1 | 7,471 | 1 | 7,541 | 1 |
| 14,967,379 | 38 | 645 | 28 | 2,914 | 36 | 2,956 | 34 |
| 162,802,958 | 2 | 1,289 | 2 | 6,716 | 2 | 6,853 | 2 |
| 6,886,176 | 60 | 707 | 22 | 3,280 | 22 | 3,085 | 25 |
| 23,076,786 | 30 | 1,105 | 4 | 4,073 | 8 | 3,836 | 10 |
| 13,072,487 | 44 | 551 | 36 | 3,157 | 25 | 2,993 | 32 |
| 26,042,181 | 26 | 391 | 54 | 3,155 | 26 | 3,105 | 23 |
| 13,915,165 | 42 | 296 | 62 | 2,547 | 55 | 2,434 | 58 |
| 6,052,732 | 62 | 621 | 30 | 2,495 | 59 | 2,508 | 56 |
| 9,116,998 | 56 | 435 | 51 | 2,298 | 64 | 2,292 | 63 |
| 15,334,103 | 37 | 363 | 57 | 2,351 | 62 | 2,384 | 61 |
| 64,160,143 | 9 | 773 | 17 | 2,806 | 42 | 2,837 | 43 |
| 24,932,402 | 28 | 540 | 39 | 2,829 | 41 | 2,856 | 42 |
| 28,263,911 | 22 | 492 | 43 | 2,334 | 63 | 2,403 | 60 |
| 52,155,166 | 11 | 292 | 63 | 3,317 | 21 | 3,303 | 19 |
| 94,819,971 | 6 | 1,006 | 6 | 4,144 | 6 | 4,207 | 6 |
| 63,83,582 | 61 | 927 | 10 | 2,671 | 49 | 2,737 | 48 |
| 45,468,288 | 13 | 445 | 48 | 2,698 | 47 | 2,741 | 47 |
| 14,251,619 | 39 | 660 | 26 | 3,916 | 10 | 3,756 | 11 |
| 26,790,921 | 24 | 522 | 42 | 2,989 | 33 | 3,005 | 29 |
| 16,434,878 | 36 | 301 | 61 | 2,787 | 45 | 2,586 | 52 |
| 35,279,531 | 19 | 814 | 14 | 3,069 | 31 | 3,097 | 24 |
| 31,274,349 | 21 | 733 | 19 | 4,093 | 7 | 3,946 | 8 |
| 9,085,361 | 57 | 441 | 49 | 2,503 | 58 | 2,504 | 57 |
| 11,124,157 | 50 | 912 | 11 | 3,763 | 12 | 3,641 | 12 |
| 5,118,856 | 63 | 395 | 53 | 3,200 | 24 | 3,159 | 21 |
| 12,577,734 | 46 | 748 | 18 | 3,446 | 18 | 3,403 | 18 |
| 2,382,865,896 | | 548 | | 3,073 | | 3,127 | |



See Technical Note on page 37.

## LOUISIANA MEDICAID ONLY PROGRAMS

**Champ Child**
Children born on or after October 1, 1983, are eligible for Medicaid if they meet all the requirements for the program.

**Champ Pregnant Woman**
Medicaid eligibility for a Champ Pregnant Woman may begin at any time during a medically verified pregnancy and as early as three months prior to the month of the application if all requirements of the program are met.

**Deemed Newborn**
A child born to a woman that is determined eligible for Medicaid benefits shall be deemed Medicaid eligible on the date the child is born until the child's first birthday.

**Emergency Medical Services for Illegal and Legal Aliens**
Legal and illegal aliens who do not meet Medicaid alien status requirements may be eligible for payment of life threatening emergency services only. Emergency services include labor and delivery of a newborn.

**Extended Medicaid**
Medicaid coverage is provided for the following applicants/recipients who lose SSI/MSS eligibility and who meet all eligibility requirements.

***Disabled Adult Child***
Covers individuals over the age of 18 who became blind or disabled before the age of 22 and have lost SSI eligibility on or after July 1, 1987, as the result of entitlement to or increase in RSDI.

***Disabled Widows/Widowers***
Covers disabled widows/widowers (between the ages of 50 and 59) who would be eligible for SSI had there been no elimination of the reduction factor in the Federal formula and no subsequent cost-of-living adjustments.

***Early Widows/Widowers***
Covers individuals who receive SSI prior to the age of 60 and lose SSI eligibility because of the recipient of RSDI early widow/widower's benefits.

***Disabled Widows/Widowers and Divorced Spouses Unable to Perform any Substantial Gainful Activity***
Covers individuals who lost SSI because of receipt of RSDI as a result of the change in the disability definition, if they were receiving SSI for the month prior to the month they began receiving RSDI, would continue to be eligible for SSI if the amount of the RSDI benefit were not counted as income, and they are not entitled to Part A Medicare.

***Pickle* (Amendment)**

Protects Medicaid coverage for two different groups of the aged, blind, or disabled persons who become ineligible for SSI or MSS as the result of a cost of living increase in RSDI benefits or any other reason.

**Home & Community Based Waiver Services (MR/DD, ADHC, PCA, Home Care for the Elderly)**

Provides coverage for individuals who would otherwise require services in an institution.

**LONG TERM CARE NURSING FACILITY**

An applicant/recipient may be eligible for Medicaid services in the LTC program if he/she is a resident of a Title XIX certified nursing facility, a certified Medicare Skilled Nursing Facility/ Medicaid Nursing Facility, including a swing-bed facility or a Title XIX certified Intermediate Care Facility/Mentally Retarded Facility and meet all eligibility requirements.

**Medically Needy Program**

Provides Medicaid coverage when income and resources of the individual or family are sufficient to meet basic needs in a categorical assistance program but are not sufficient to meet medical needs according to MNP standards.

**Presumptive Eligibility**

Provides limited and temporary coverage for pregnant woman whose eligibility is determined by a qualified provider prior to an agency determination of Medicaid eligibility.

**Prohibited AFDC Provisions**

Provides Medicaid to children and/or their parents denied LIFC because of an AFDC-related provision which is prohibited in Medicaid.

**Qualified Disabled Working Individuals**

Provides Medicare Part A Buy-in for certain non-aged individuals who lost Social Security disability benefits and premium-free Part A Medicare coverage because of Substantial Gainful Activity.

**Qualified Medicare Beneficiary**

The Medicare Catastrophic Coverage Act of 1988 required limited Medicaid coverage for certain Medicare individuals and expansion of Medicaid coverage for certain other Medicare beneficiaries.

***Pure QMB***

Provides Medicaid payment only for Medicare Part A and/or Part B premiums, Medicare covered services, and Medicare co-insurance for Medicare covered services.

***Dual QMB***

Provides the same benefits as the pure QMB plus the full range of Medicaid services as entitled by Medicaid in any other category of assistance.

**Specified Low-Income Medicare Beneficiary**

Provides for Medicare Part B Premium, only. The eligibility requirements are the same as the Qualified Medicare Beneficiary (QMB) except that income exceeds the QMB income limit of 100 percent of the Federal Poverty Level (FPL). Furthermore, there are new Federal requirements in relation to this eligibility group that must be implemented by January of 1998.

**Transitional Assistance**

Medicaid coverage is continued for recipients who lose FITAP cash benefits because of child support, earnings, loss of earned income exemptions, or an increase in the number of hours of employment. The assistance is provided for a limited period of time.