State Fiscal Year
1997/98

Annual Report

LOUISIANA'S MEDICAID PROGRAM

Louisiana Department of Health and Hospitals
Bureau of Health Services Financing

David W. Hood	Charles F. Castille	Thomas D. Collins
Secretary	Undersecretary	Director
Department of Health and Hospitals	Office of Management and Finance	Bureau of Health Services Financing

MESSAGE FROM THE DIRECTOR

Dear Reader:

Last year we submitted the first annual report on the Louisiana's Medicaid Program. We thank those readers whose suggestions resulted in an improved second annual report.

Under the leadership of Secretary David Hood and Undersecretary Charles Castille, we ended the 1997/98 SFY with our third consecutive budget surplus. We were, with the policy guidance of the Legislature and Administration, able to expand services to the developmentally disabled and re-instate a joint Federal-State funded Medically Needy Program. Other initiatives on the Child Health Insurance (LaCHIP), hospice, and assisted living programs were also undertaken.

The advent of plastic eligibility cards, state-of-the-art management information, and claims processing/review system fulfilled a departmental goal to rely on improved technology.

The Medicaid Program continued to direct 97% of its resources to services and 3% to administrative functions.

Next year issues will revolve around an elderly population that is rapidly growing, the waiting list for community-based waiver services, expansion of the LaCHIP Program, dramatic cost increases in the pharmacy program and compliance with Year 2000 information systems deadlines.

We hope that you find this report both interesting and useful.

Sincerely,

Thomas D. Collins
Director

This report was prepared by Curtis Boyd, Planning Analyst, and Bill Perkins, Senior Planning Analyst, under the direction of Shawn Barry, Director, Financial Research and Planning Division. Please address questions and comments to any one of the above at P.O. Box 629, Baton Rouge, LA 70821-0629.

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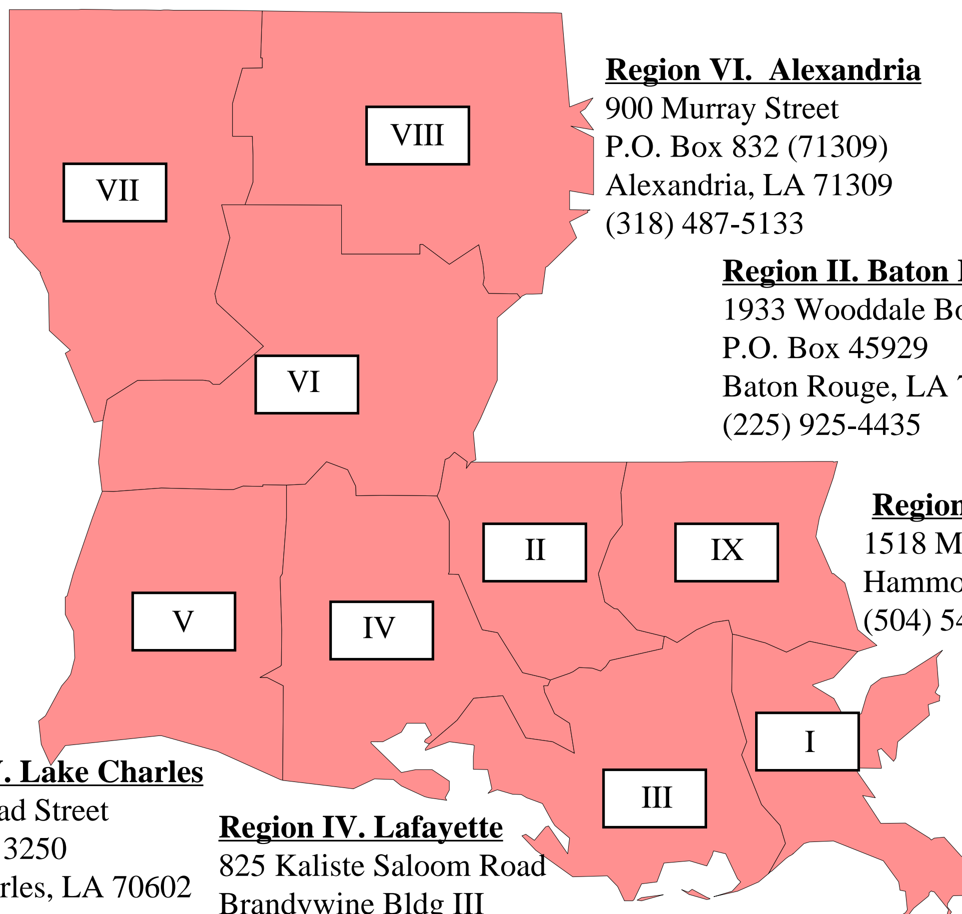
REGIONAL MEDICAID OFFICES

Region VII. Shreveport
3020 Knight Street
Suite 260-B
Shreveport, LA 71105
(318) 862-9808

Region VIII. Monroe
122 St. John Street
State Office Building, Rm. 412
Monroe, LA 71201
(318) 362-3452



Region VI. Alexandria
900 Murray Street
P.O. Box 832 (71309)
Alexandria, LA 71309
(318) 487-5133

Region II. Baton Rouge
1933 Wooddale Boulevard
P.O. Box 45929
Baton Rouge, LA 70895
(225) 925-4435

Region IX. Mandeville
1518 Martens Drive
Hammond, LA 70401
(504) 543-4218

Region V. Lake Charles
2300 Broad Street
P.O. Box 3250
Lake Charles, LA 70602
(318) 491-2782

Region IV. Lafayette
825 Kaliste Saloom Road
Brandywine Bldg III
Suite 210 (70508)
P.O. Box 80708
Lafayette, LA 70598
(318) 262-1430

Region III. Thibodaux
1000 E. Plantation Road
P.O. Box 1038
Thibodaux, LA 70302
(504) 449-5051

Region I. New Orleans
1001 Howard Avenue
Suite 900 (70113)
P.O. Box 60840
New Orleans, LA 70160
(504) 599-0656

INTRODUCTION

What is Medicaid?

Medicaid is a 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 state Medicaid programs are divided between the state and the federal governments and the proportions are based on the state's per capita income relative to the rest of the nation. The federal government mandates that certain health care services be covered by states who participate in the Medicaid program. Mandatory medical services include the following:

- inpatient and outpatient hospital services
- physician services
- laboratory and x-ray services
- long-term care facilities (nursing homes)
- family planning
- services for early periodic screening, diagnosis and treatment (EPSDT) of those under age 21

State Optional Services *include adult dentures, prescription drugs, hemodialysis, ICF-MR, chiropractic care, psychiatric rehabilitation, community services, case management, appliances and medical devices, and substance abuse services.*

State Plan

Each state is required to submit a plan to the federal government for its approval. The State Plan sets the guidelines for the Medicaid program to provide health care services to both the Medicaid eligibles and the indigent population. The Health Care Financing Administration (HCFA), under the United States Department of Health and Human Services, provides federal oversight. Each state administers its Medicaid program following federal rules, regulations and laws. The State Plan establishes eligibility criteria and payment methodologies and identifies which optional services the state will provide for the Medicaid program.

Medicaid History

The Medicaid program was created in 1965 with the passage of 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. Lately, however the program has been significantly reduced and Louisiana is no longer among the highest growth states. The Historical Medicaid Expenditures chart on the next page indicates a stable budget from SFY 1995/96 through 1997/98.

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 which includes federal regulations, federal supplements, eligibility requirements, and increases in health care costs. Expenditures peaked in 1993/94 with expenditures of $4.6 billion serving 775,561 recipients. Since then, expenditures have fallen sharply. Expenditures for SFY 1997/98 were $3.26 billion. Figure 1 shows the growth, recent decline and stabilization of Louisiana's Medicaid expenditures.

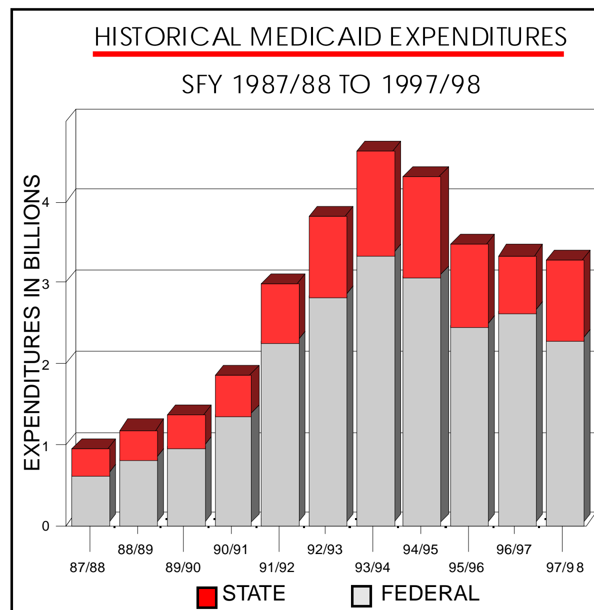


Figure 1

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 the growth was a number of expansions in federal mandates which define the eligibility criteria for Medicaid. During the SFY 1997/98, 752,747 people were eligible for Medicaid services, and 730,898 received one or more services.

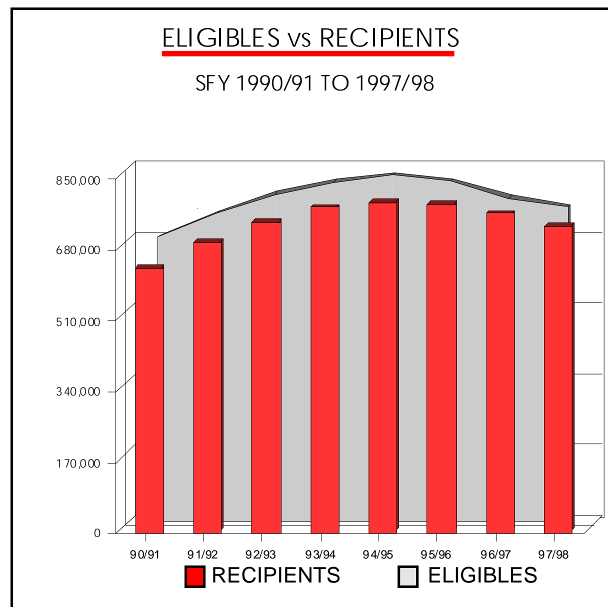


Figure 2

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

History of Charity Hospitals in Louisiana

In 1812, Louisiana became one of the first states in the nation to assume responsibility for providing health care to the needy when the state took over management of the New Orleans Charity Hospital. The name came from the Sisters of Charity who built and operated the first health care facility. Since that time, Louisiana has built "charity" hospitals and clinics throughout the state. Louisiana operates differently from other states. For example, Louisiana State University operates the charity hospital system in Louisiana. In other states, safety net public hospitals are usually city or county facilities which are supported by special taxing districts and administered by public or quasi-public entities. Louisiana is unique in that the safety net health care for the uninsured is a mandate assumed by the state rather than local governments. The state pays for the majority of the cost of the charity hospitals with federal funds from the uncompensated care program.

HIGHLIGHTS FOR STATE FISCAL YEAR 1997/98

Louisiana Children's Health Insurance Program (LaCHIP)

The Federal Balanced Budget Act of 1997 amended the Social Security Act to create a new program targeted towards children. This program, the State Children's Health Insurance Program, was established to assist state efforts to initiate and expand child health care access to uninsured, low-income children. Under this program, states will receive an annual grant over the next five years to expand health care insurance for low-income children. During the first three years, states receive an annual allotment based on the number of low-income, uninsured children in the state. The Louisiana Children's Health Insurance Program (LaCHIP) is scheduled for implementation November 1, 1998. The first phase of the program will entail an expansion of Medicaid services to all children under the age of 19, whose family income is 133% of the Federal Poverty Level (FPL). Phase II will begin in 1999/00, subject to approval by the legislature, with another Medicaid expansion up to 150% of the FPL. Phase III, subject to approval by the legislature, will offer coverage using a private insurance model to eligible children between 150-200% of the FPL the following year.

Recipient, Eligible and Expenditure Data for Children Under the Age of Twenty-one

	UNDER 1	1 - 5	6 - 14	15 - 20
ELIGIBLES	46,619	153,419	177,201	70,156
RECIPIENTS	46,648	153,459	164,056	66,244
EXPENDITURES	141,944,734	161,660,274	164,126,405	153,967,742
AVERAGE COST PER ELIGIBLE	3,045	1,054	926	2,195
AVERAGE COST PER RECIPIENT	3,043	1,053	1,000	2,324

See technical note on inside back cover for explanation of how the number of recipients can be greater than the number of eligibles.

Children Receiving Quality Care

The KIDMED health screening program has continued to improve services from last year, increasing the number of children being served by 2 percent. Today, of the 447,395 Louisiana children eligible for Medicaid, more than 94 percent of them have received some form of preventive care, including physical and dental exams, vision and hearing checkups, immunizations, blood and urine tests, eyeglasses, hearing aids, and other services.

Vaccines for Children Program Administered by the Louisiana Medicaid Program

Childhood vaccines prevent several infectious diseases: polio, measles, diptheria, mumps, pertussis (whooping cough), rubella (German measles), tetanus, hepatitis-B, influenza, varicella (chicken pox) and Hemophilus Influenza B (HiB) (the most common cause of spinal meningitis).

The Vaccines For Children program (VFC) is a federally funded and state operated program which was developed to improve the immunization levels among children, especially infants and young children. The VFC program provides vaccines at no cost to private and public health care providers who participate in the program. Medicaid providers are also reimbursed by Medicaid for administering the vaccines to Medicaid eligible children.

The program has four major approaches to improve children immunization levels: (1) service and delivery; (2) information and education; (3) assessment; and (4) coordination and oversight.

The VFC Program has improved access to immunization, decreased cost to families, improved public awareness of the need to immunize and educates health care providers about proper immunization practices.

Hospice Care Feasibility Study

Louisiana's Medicaid program completed its feasibility study on hospice care services as an optional service under the Medicaid State Plan. Hospice is a form of care that provides home care for persons who are terminally ill. The goal of hospice care is to help terminally ill persons continue their expected life span with minimal disruptions of normal activities, and with as little physical and emotional discomfort as possible.

It is anticipated that hospice care may generate some savings if the service delivery and payment system reinforce incentives to managed care, because in-home care generally costs less than hospitalization. Hospice care services will be implemented when funds become available.

Disproportionate Share Cap

In 1981, Congress required states to make additional Medicaid payments to hospitals that provide treatment for a "disproportionate share" (DSH) of low-income patients. A study by the Urban Institute showed that significant amounts of Medicaid DSH payments were being used without benefit to Medicaid recipients or indigent patients. The finding of the study prompted HFCA to set a DSH cap on states for spending accountability. The new accountability for Medicaid spending guarantees federal matching funds for eligible individuals to be used for health related purposes.

DSH payments made to hospitals are divided into two components, general acute-care hospitals and mental health hospitals. Under the above-mentioned DSH cap, there is an additional cap placed directly on institutions for mental disease (IMD's).

Federal law and HCFA policy freezes DSH spending for FFY 1998 at FFY 1995 levels, with a gradual decline to $8 billion in DSH spending by FFY 2002. DSH reductions will be achieved by taking equal percentages of states' FFY 1995 DSH spending. If a state's DSH spending in 1995 was greater than 12 percent of its Medicaid expenditures, the reduction will be applied to this 12 percent rather than the full DSH spending amount.

DSH Payments for 1995/96 to 1997/98 in Louisiana

YEAR	DSH PAYMENTS	NON-DSH PAYMENTS	TOTAL MEDICAID	DSH AS A % OF TOTAL
		($) in millions		
1995/96	685.8	2,685.2	3,371.0	20.34
1996/97	672.8	2,672.5	3,345.1	20.11
1997/98	757.4	2,500.3	3,257.7	23.25

Assisted Living Pilot Project

The Louisiana Legislature passed Act 1185 during the 1997 regular session to provide an alternative to nursing home care. The Act mandates that the Department of Health and Hospitals develop a pilot project to provide assisted living to the elderly as a home community-based waiver to be funded through the Medicaid program. This project will be developed in conjunction with the Department of Social Services and the Governor's Office of Elderly Affairs. The legislation also mandated the establishment of the Louisiana Advisory Committee on Assisted Living to assist in the development of the project. The committee is composed of representatives from elderly advocacy groups, the business community, and government agencies.

In order to participate in a home and community-based service waiver, an individual must meet the same financial eligibility and medical certification criteria used for nursing home admission as shown below:

Admission Criteria

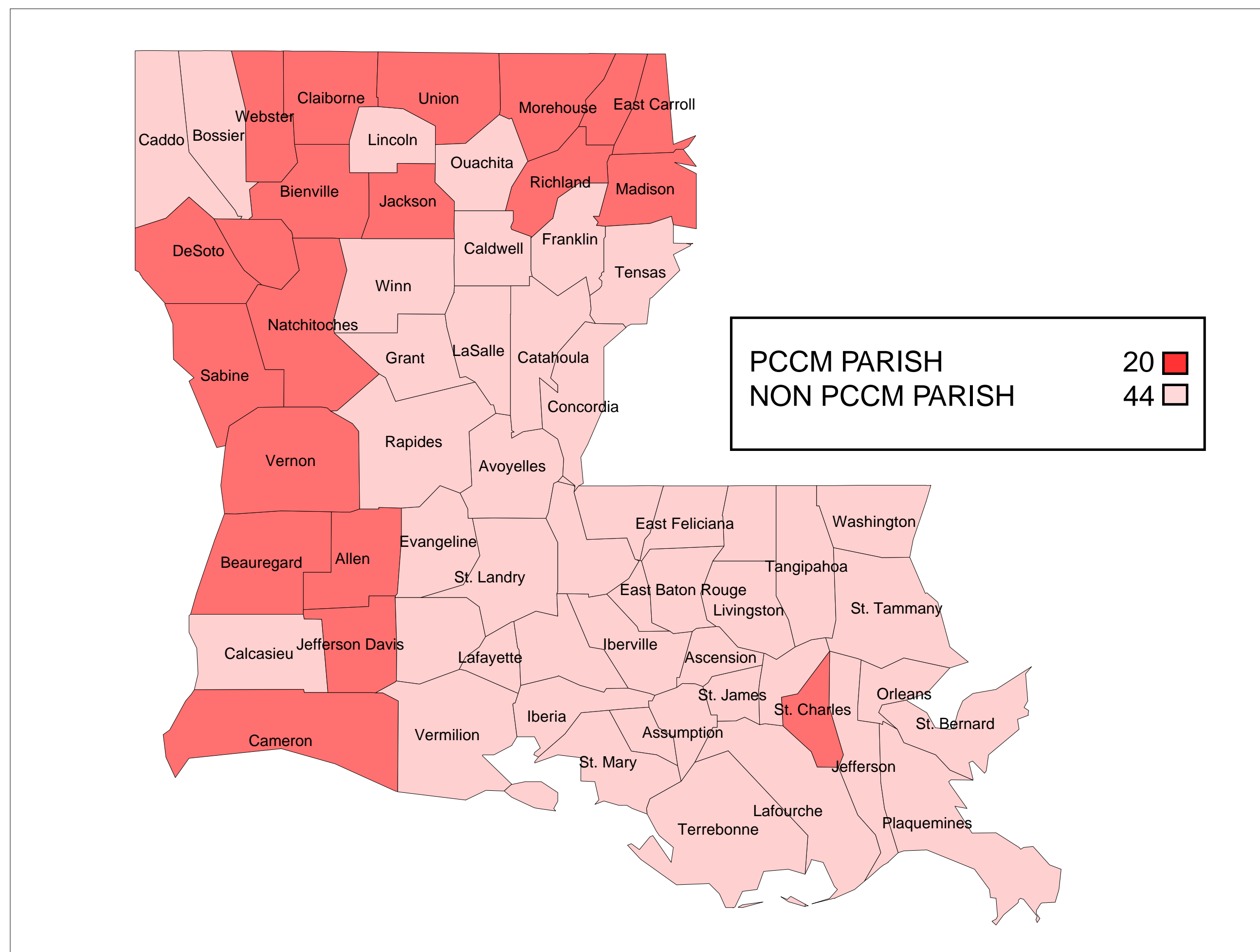
- Residence in Louisiana
- U. S. citizen or status as a qualified alien
- Possession of a Social Security number
- Monthly income not to exceed three times the SSI rate of $494 or ($1,482)
- Countable resources less than $2,000 for an individual or $3,000 for a couple
- Must be aged, blind or disabled in accordance with Social Security criteria

Primary Care Case Management (PCCM)

Louisiana has implemented a PCCM program in 20 parishes, covering approximately 47,000 people. The program, referred to as "CommunityCARE" provides a Medicaid recipient with a physician, FQHC, or rural health clinic as the recipient's primary care physician. A recipient is required to contact his/her CommunityCARE provider before visiting another physician, clinic or hospital. Most services require a referral except for family planning, dental, eye (eye glasses, ophthalmology, optometry) and psychiatric services. All services are fee-for-service and primary care providers are recruited and paid on a per-person basis for case management.

Enhanced Primary Care Case Management

The Department is planning to initiate an enhanced primary care case management program that will encompass Region III (Assumption, Lafourche, St. Charles, St. James, St. John the Baptist, St. Mary and Terrebonne parishes) and Region V (Allen, Beauregard, Calcasieu, Cameron and Jefferson Davis parishes). Under the enhanced PCCM program, the providers will have the benefit of the new magnetic strip card, physician point of sale system and a new quality outcome measures program. The program in Region V is slated to go on-line in early calendar year 1999. The Region III pilot will require legislative authorization.



Group Health Insurance Premium Payment Program (GHIPP)

In accordance with federal regulations, a recipient or person acting on the recipient's behalf must cooperate to establish the availability of group health insurance as a condition of Medicaid eligibility. The Louisiana Department of Health and Hospitals has implemented a GHIPP program that pays for the cost of health insurance premiums, co-insurances and deductibles when it is "cost-effective". Medicaid recipients are eligible to apply for participation in GHIPP when enrolled in a group health insurance plan or when such health plans are available through an employer.

FINANCING

Medicaid is funded by both state and federal funds. Each state has a predetermined match rate based on relative per capita income in the state. Louisiana received a special match rate for 1995/96 and 1996/97 which ended in June of 1997.

SFY 1997/98	ADMINISTRATION ($)	%	MEDICAL VENDOR ($)	%	TOTAL ($)	%
STATE	36,345,690	38.9	936,518,146	29.6	972,863,836	29.9
FEDERAL	57,066,543	61.1	2,227,730,877	70.4	2,284,797,420	70.1
TOTAL	93,412,233	100	3,164,249,023	100	3,257,661,256	100

The total expenditure for SFY 1997/98 was $3,257,661,256. Louisiana expended $972,863,836 in state financing for Medicaid expenditures and a total of $2,284,797,420 was federal funds.

Where the Money Goes

For 1997/98, the program expended $3,257,661,256 which was 2.6 percent less than 1996/97. The table below shows this distribution by budget program.

Budget Program	Expenditures
PRIVATE PROVIDERS	1,951,546,239
PUBLIC PROVIDERS	372,029,540
UNCOMPENSATED CARE	757,447,832
MEDICARE BUY-IN	83,225,412
ADMINISTRATION	93,412,233
TOTAL FOR 1997/98	3,257,661,256

Federal Funds

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 percent and no lower than 17 percent. For administration and some other areas of expenditure (i.e., information technology), the federal contribution may be anywhere between 50 percent and 100 percent. The following table 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 1997/98

	1988/89	1989/90	1990/91	1991/92	1992/93	1993/94	1994/95	1995/96*	1996/97*	1997/98
STATE	29.64	27.39	25.86	24.80	25.86	26.45	27.14	27.92	28.51	29.64
FEDERAL	70.36	72.61	74.14	75.20	74.14	73.55	72.86	72.08	71.49	70.36
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 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. The alternative payment plan ended June 1997.

Act 1465 - Performance Indicators
The state implemented significant legislation in 1997 with the passage of Act 1465. This Act formally links the Department's appropriation and the Strategic Plan which establishes performance indicators to ensure program effectiveness. DHH has responded positively to this change. The Department has established a Performance Based Budgeting Committee, and has formalized the collection and reporting of information and the use of the performance measure concept in making plans, setting goals and establishing objectives.

In compliance with Act 1465, DHH, in conjunction with legislative staff, established the performance indicators for the Department and which are separated into two major budget components: (1) Medical Vendor Payments, (2) Medicaid Administration. See the tables below for the performance indicators for each component.

Medical Vendor Payments Performance Indicator Categories

Institutional Alternatives
Quality of Care
Cost Effectiveness
Cost Avoidance
Cost Savings

Medicaid Administration Performance Indicator Categories

Efficiency
Access
Program Integrity
Quality Assurance

COLLECTIONS AND MEASURABLE COST AVOIDANCE

COLLECTIONS 1997/98	($)
PHARMACY PROGRAM	
Drug Rebate Program	59,796,604
Prospective Drug Utilization Review	13,684,438
Dispensing Fee Adjustment	13,468,216
Co-payments	8,867,372
Pharmacy Provider Fees	6,116,417
Medicare Cost Avoidance of Crossovers	2,046,748
Audit Program	1,264,329
PROVIDER FEES	
Nursing Facilities	48,028,176
MR/DD	20,001,797
RECOUPMENTS	58,905,164
THIRD-PARTY LIABILITY CONTRACTORS	
Insurance	4,288,675
Trauma/TOA Recovery	4,961,702
INELIGIBLE RECOVERIES	631,160
MEASURABLE COST AVOIDANCE	
Medicare Buy-In Cost Avoidance	265,271,752
TOTAL COLLECTED 1997/98	**$507,332,550**

MEASURABLE COST AVOIDANCE (WAIVERS) 1996/97	
WAIVER SERVICES COST AVOIDANCE - ELDERLY AND DISABLED	778,371
WAIVER SERVICES COST AVOIDANCE - PCA*	(25,752)
WAIVER SERVICES COST AVOIDANCE - ADULT DAY HEALTH	2,509,336
WAIVER SERVICES COST AVOIDANCE - MR/DD	65,140,736
TOTAL MEASURABLE COST AVOIDANCE 1996/97	**$68,483,691**

*This Waiver is cost effective when acute care services are considered.

Medicare Premiums (Buy-In Program)

There are a number of individuals who qualify for both Medicaid and Medicare; these individuals are known as dual eligibles. Dual eligibles include both 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.

ELIGIBILITY

States Given Flexibility in Managing Their Programs

Medicaid gives individual states the flexibility to tailor their programs within federal guidelines 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.

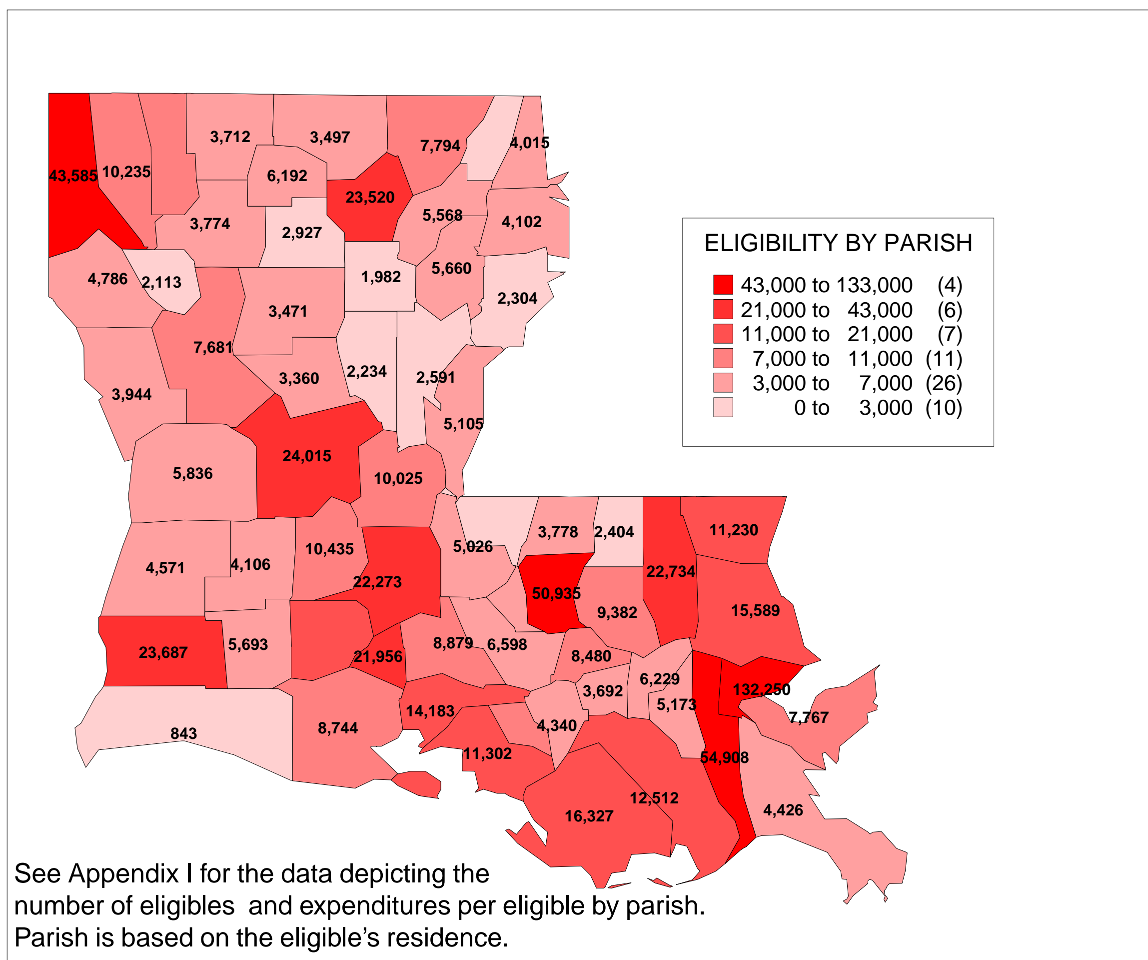
Eligibility Determination

Eligibility is determined by a federally approved process which is operated in the same manner throughout each of the regions.

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 out-stationed enrollment for pregnant women and children at federally qualified, health centers are also determined by federal law.

Eligibility by Parish

The map below illustrates concentrated areas of Medicaid eligibility by parishes. (The larger number of eligibles are represented by the darker colors.)



See Appendix I for the data depicting the number of eligibles and expenditures per eligible by parish. Parish is based on the eligible's residence.

ELIGIBILITY PROCESS

Initial Contact
The application process begins with a telephone conversation or a face-to-face meeting with a representative from the parish office. Various agencies also make referrals. Medicaid applicants may directly contact a certified Medicaid Application Center to schedule an interview.

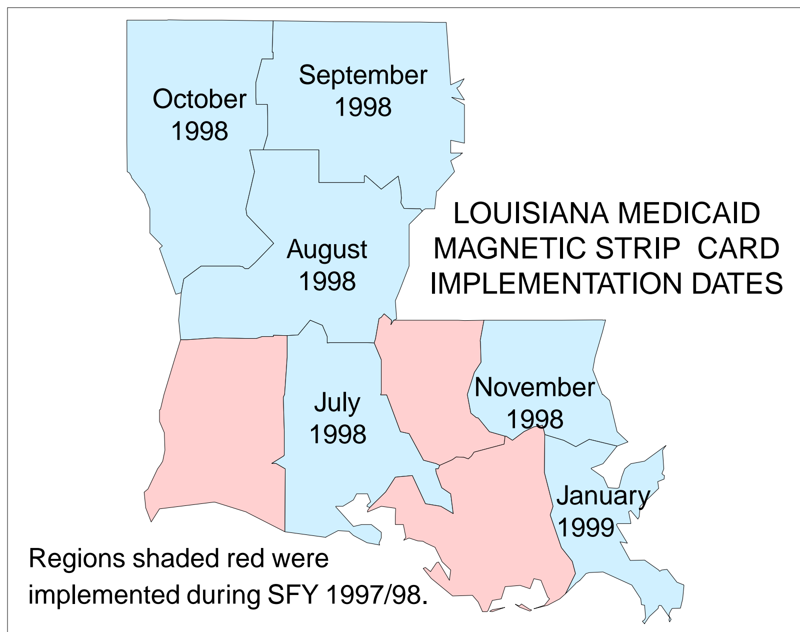
Application Interview
Methods of application interviews:
The parish office may conduct a face- to- face or telephone interview. Certified application center requires a face-to-face interview. The application center representative completes the application form and related forms.

Application Processing
Applications are processed by the parish offices within 45 days of the application date or 90 days if a disability determination is needed. Application centers DO NOT determine Medicaid eligibility. An application center's main function is to complete the interview process and forward the completed application to a parish office.

Verification for Documentation
Documentation must be submitted by the applicant to verify stated circumstances. For example, the Department checks to see if the individual has any other source of health insurance coverage.

Completion of Additional Forms
Additional forms may be required for the determination of eligibility.

Issuance of Medicaid Eligibility Card
The Department is taking advantage of technology by issuing a magnetic strip card to replace the paper Medicaid Eligibility Card that is currently being used. The Medicaid program began issuing the magnetic strip card in March of 1998; the Department plans to complete the distribution by January of 1999. (See page 29 for more information.)



The adjacent map indicates the regions that have or are scheduled to receive the Health Network for Louisiana (Medicaid magnetic strip card) Card.

Questions regarding the magnetic strip card should be directed to 1-800-843-3333.

IMPACT OF WELFARE REFORM ON LOUISIANA'S MEDICAID PROGRAM

As a result of Welfare Reform, the Medicaid program has implemented new eligibility requirements. From March 1, 1991 through June 30, 1996, BHSF provided Medicaid-only coverage for individuals who met all eligibility requirements for cash assistance under the Aid to Families with Dependent Children (AFDC) program. HCFA allowed the state the option of covering this group of individuals without first having a cash determination made by the Department of Social Services, Office of Family Support.

The Personal Responsibility and Work Opportunity Act of 1996 eliminated the AFDC cash assistance program and replaced it with a block grant program for Temporary Assistance for Needy Families (TANF). The law eliminated automatic Medicaid eligibility for persons eligible for TANF cash assistance and established a new mandatory Medicaid eligibility group for Low Income Families with Children (LIFC) effective the date of a state's TANF implementation. (See Glossary for Aid Category definitions)

Aid for Families with Dependent Children (AFDC) changed to **Temporary Assistance for Needy Families (TANF).** Under the Louisiana Medicaid program, **Low Income Families with Children (LIFC)** is used. LIFC includes families with children who were deprived of parental support based on absent parent(s), unemployment, and underemployment.

Sixth Omnibus Budget Reconciliation Act (SOBRA). Under the Louisiana Medicaid program, **Child Health And Maternity Program (CHAMP)** is used. CHAMP provides benefits to pregnant women and children born after 10/1/83.

Old Age Assistance (OAA) - includes persons age 65 or older.
Blind/Disabled - blind includes persons with corrected vision not better than 20/200 or limited visual field of 20 degrees or less. Disabled are persons who receive disability-based SSI or who meet SSA defined disability requirements.

Qualified Medicare Beneficiaries (QMBs) - Medicaid pays the Medicare premiums, the deductibles and Medicare co-insurance for Medicare covered services for certain Medicare recipients.

Other- include Foster Care/AFDC, Regular Foster Care, Voluntary, Foster Care/Non-FFP, and Vietnam/Cambodian Refugee.

LOUISIANA MEDICAID PROFILE

The estimated population for Louisiana at July 1997 was 4,351,769. Of these, 1,020,182 (23.4%) persons had income at or below the 1997 Federal Poverty Level (FPL).

Of the total population for 1996, those persons with private insurance represented the highest proportion with 47.9 percent. This was followed by persons with no health insurance at 20.5 percent, those with Medicaid coverage at 18.1 percent and Medicare with 13.5 percent.

Figure 4 below shows the distribution of the uninsured and the insured persons in Louisiana.

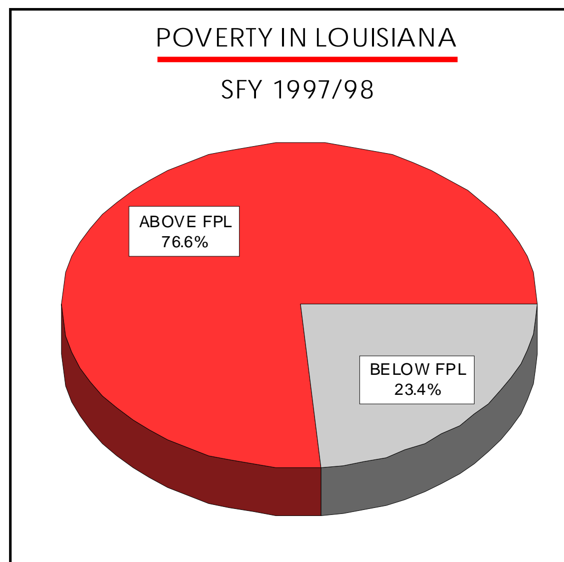


Figure 3

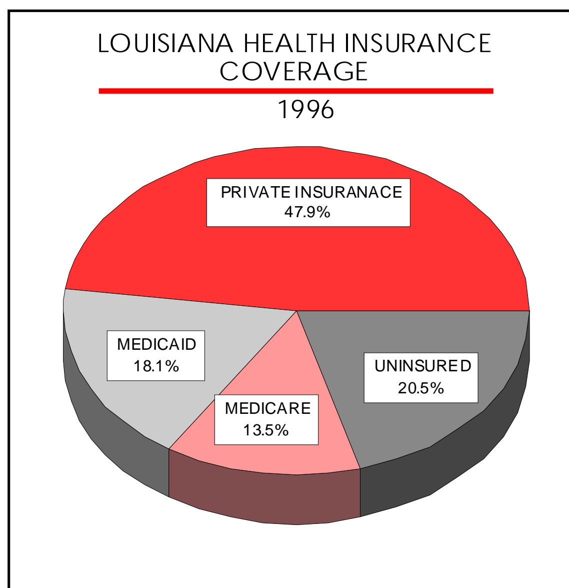


Figure 4

As mentioned above, Louisiana had a total poverty population of 1,020,182. As indicated below, of those, 73.8 percent were eligible for Medicaid. Others representing the remaining 26.2 percent of the poverty population either had not applied for Medicaid benefits or did not meet the requirements for Medicaid.

Federal Poverty Level 1997

Family Size	Level Income
1	8,050
2	10,850
3	13,650
4	16,450
5	19,250

For each additional person add $2,800.

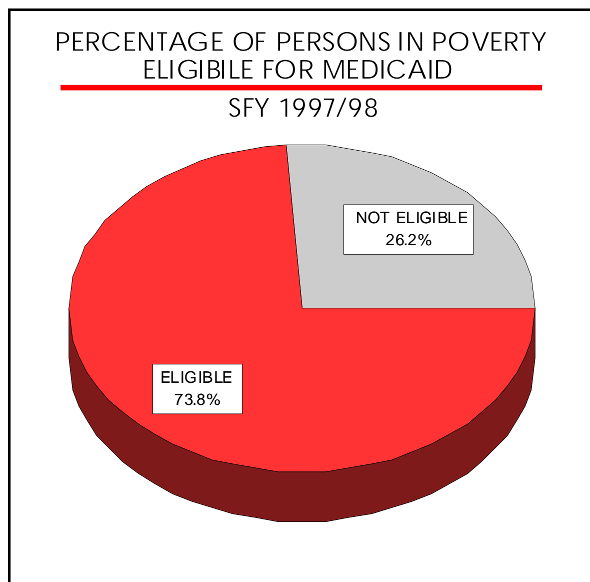


Figure 5

MEDICAID ELIGIBLES AND RECIPIENTS BY AGE AND GENDER

There were a total of 752,747 persons in Louisiana eligible for Medicaid. Of those, 298,701 were males and 453,953 were females. There were more eligible males than females from birth to age 14. However, females outnumber males overall with a much greater enrollment among persons ages 15 and over. Females aged 21-44 represented the highest gender/age group of persons eligible.

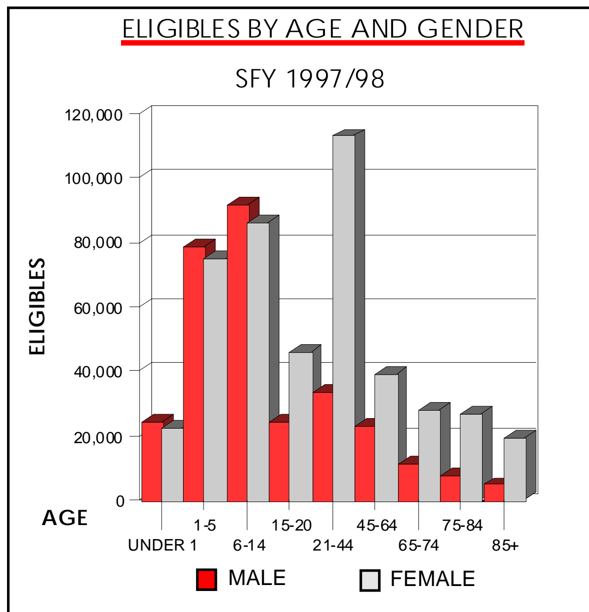


Figure 6

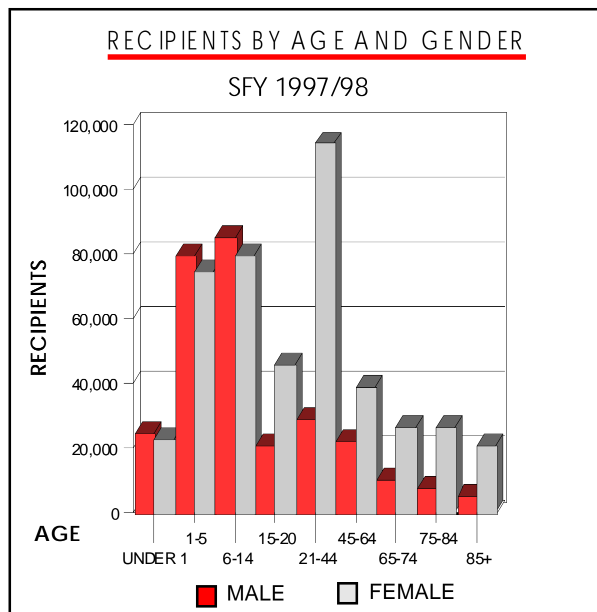


Figure 7

Louisiana's Medicaid program had a total of 730,898 recipients for SFY 1997/98. The gender and age distribution of eligibles and recipients are closely related. The graph on the left shows a greater number of service recipients among age groups 1-14 and 21-44. The number of persons receiving services declines at the ages 45 and above.

Even though there are relatively few infants under 1 and seniors over 74 years old, the expenditure distribution shows these groups receive a high proportion of the total Medicaid benefits. This is consistent with other health care plans which typically show high health care cost at the start and end of life. In addition, women in childbearing years receive a high proportion of benefits.

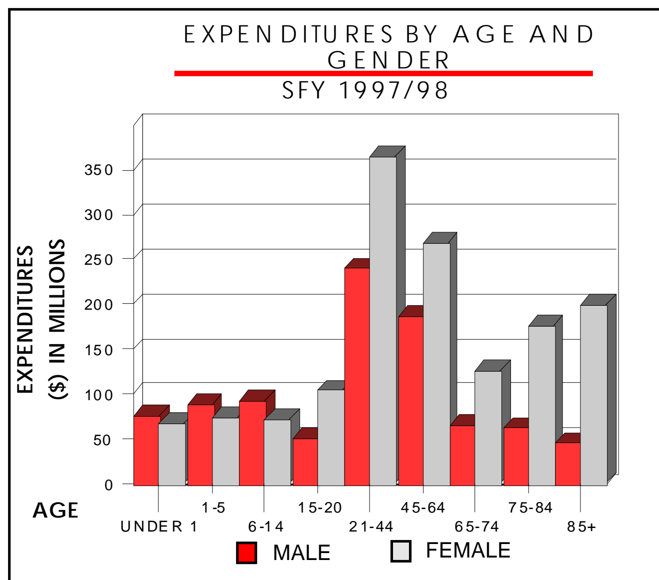


Figure 8

MEDICAID ELIGIBLES, RECIPIENTS AND EXPENDITURES BY AID CATEGORY

There were 752,747 Medicaid eligible persons. Of the total, persons eligible as TANF represented the highest proportion, with 353,361 or 47.0 percent. This was followed by persons enrolled as Blind and Disabled which had 159,376 or 21.2 percent participation followed by SOBRA with 100,371 or 13.3 percent. A smaller number of persons were eligible in various other categories as mentioned in the box on page 15.

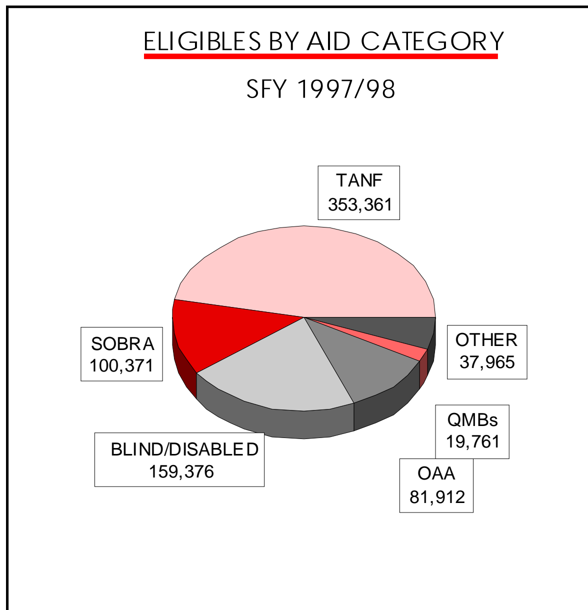


Figure 9

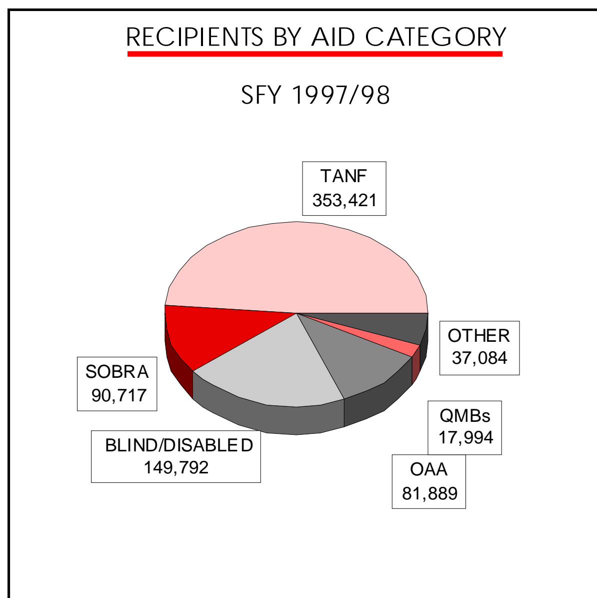


Figure 10

There were 730,898 service recipients. Of the total, persons enrolled as TANF represented the highest proportion with 48.3 percent. This was followed by persons enrolled as Blind and Disabled which had 20.3 percent participation followed by SOBRA with 13.3 percent. A smaller number of persons who received services were enrolled in various other categories.

Persons enrolled as Blind and Disabled received the highest share of expenditure at 45.1 percent followed by Old Age Assistance (OAA) with 27.5 percent. Persons enrolled as TANF had the highest number of recipients but ranked third in expenditures, at just under 18 percent. This finding is not surprising as the majority of TANF recipients received regular or non-intensive services, while the aged and disabled typically receive a much more expensive array of services.

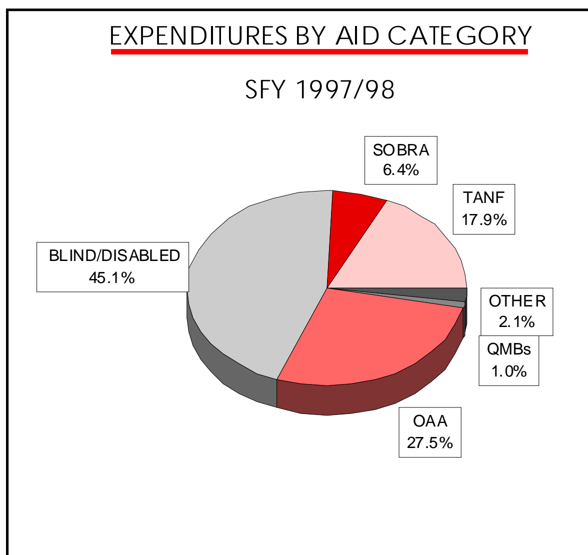


Figure 11

TOP TEN FEDERAL CATEGORIES OF SERVICE BY EXPENDITURE

Of the most common services, inpatient hospital ranked first in total expenditures with $512,509,284 or 21.8 percent of total (non-DSH) expenditures. This was followed by expenditures for nursing facilities and prescribed drugs. Although a larger number of persons received physicians and outpatient hospital services, those services are on average less expensive, and therefore rank lower on the top ten list.

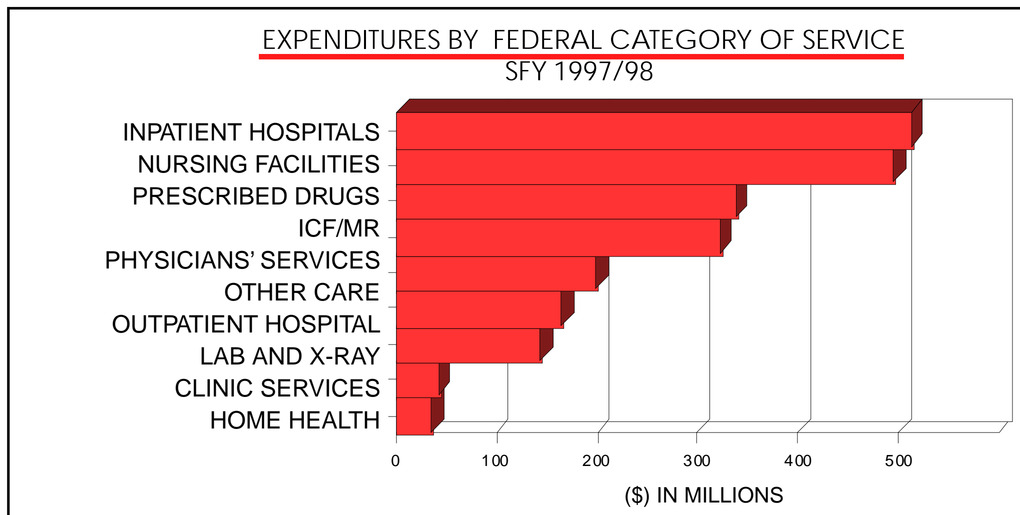


Figure 12

The table below is sorted in the same order as the expenditure table, but shows that it is not necessarily the most used services that are the most expensive ones. For example, there were very few ICF/MR recipients. However, ICF/MR recipients ranked fourth in overall expenditures.

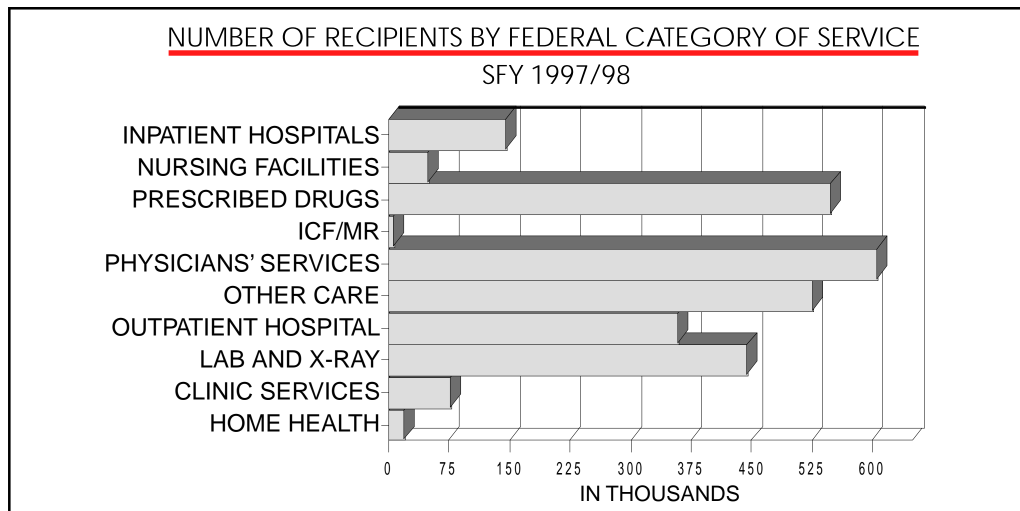


Figure 13

Note: *See Appendix 2 for all Categories of Service.*

LOUISIANA COMPARISON TO THE SOUTHERN LEGISLATIVE CONFERENCE AVERAGE EXPENDITURE PER RECIPIENT

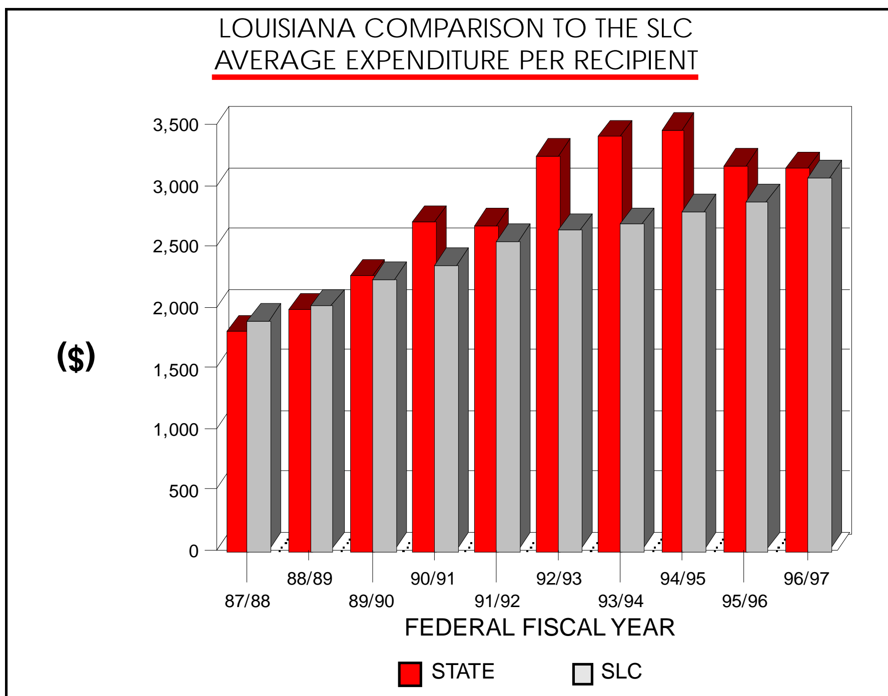


Figure 14

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 about 27 percent above the average in FFY 1993/94 to about 2.5 percent above in FFY 1996/97. Figure 14 illustrates that Louisiana has successfully reduced the average payment per recipient, while the SLC average has 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.

FEDERAL FISCAL YEAR	LOUISIANA	SOUTHERN LEGISLATIVE CONFERENCE	PERCENT DIFFERENCE
	($)	($)	(%)
1987/88	1,790	1,877	(4.64)
1988/89	1,967	1,999	(1.60)
1989/90	2,247	2,219	1.26
1990/91	2,690	2,335	15.20
1991/92	2,667	2,536	5.17
1992/93	3,239	2,623	23.48
1993/94	3,392	2,673	26.90
1994/95	3,449	2,783	23.93
1995/96	3,154	2,858	10.36
1996/97	3,129	3,055	2.42

WAIVER SERVICES

Home and Community-Based Service Waiver (HCBS)

Home and community-based service waivers were established under section 1915(c) of the Social Security Act to permit states to offer an array of services that are not otherwise available under the Medicaid program to individuals as an alternative to institutionalization. A 1915(c) waiver grants states the authority to "waive" certain statutory requirements such as statewideness (same application of Medicaid policy and procedures throughout the state) and comparability of services (same services available to all eligible persons). Under the auspices of the waiver, a state may target a certain population to serve and limit the number of people who may participate in the waiver. The Louisiana Medicaid program currently operates three home and community-based service waiver programs that provide services for both elderly and MR/DD recipients.

Mental Retardation and Developmental Disability Waiver (MR/DD)

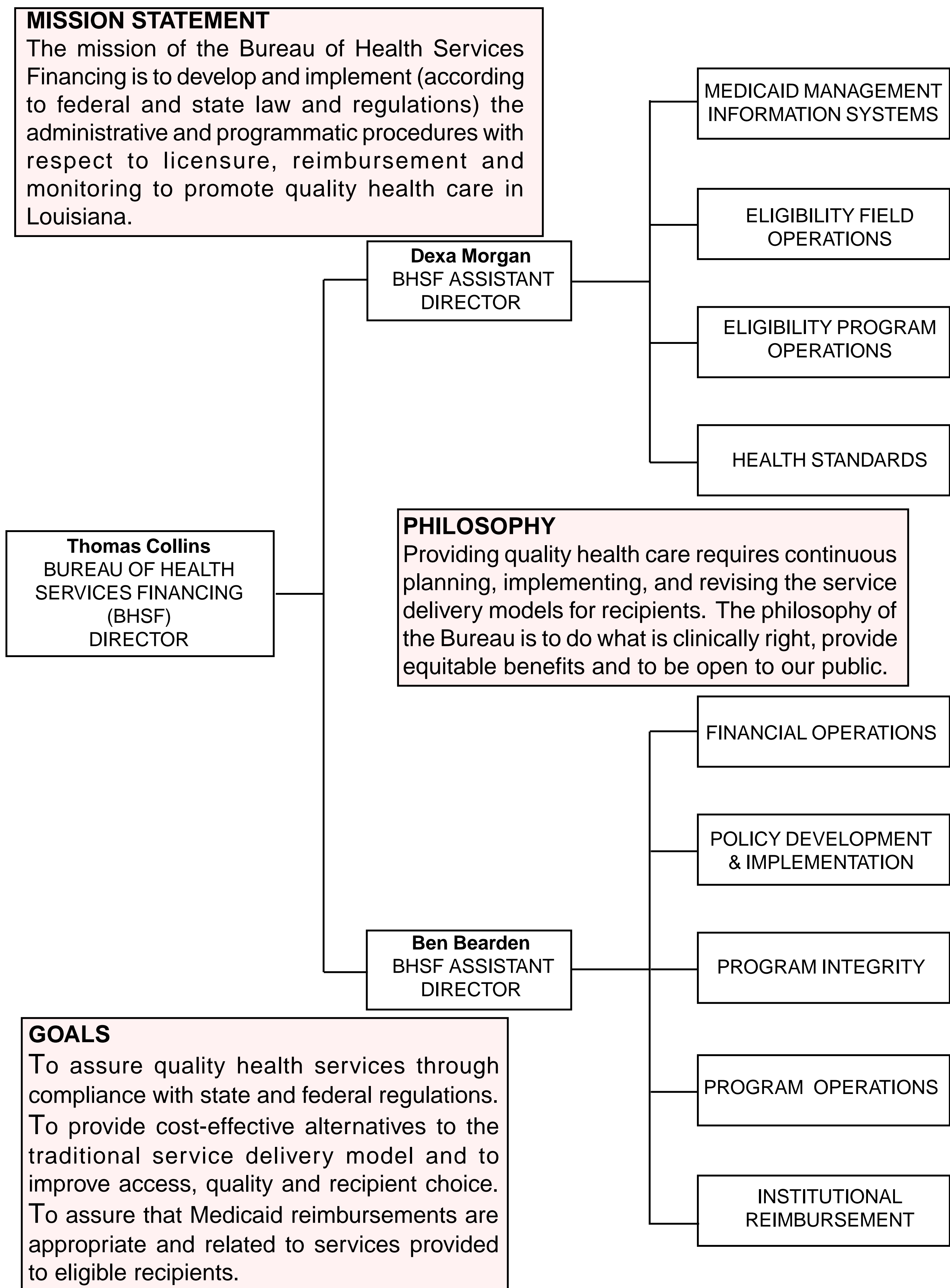
The MR/DD waiver is an alternative to institutional care for persons with mental retardation or other developmental disabilities. During the 1997/98 SFY, the federal government approved a total of 2,411 waiver slots. An additional 700 slots have been appropriated by the Legislature for SFY 1998/99 which would increase the total number of slots to 3,111.

The Adult Day Health Waiver

The adult day health waiver was approved effective January 1, 1985. This waiver was designed to provide direct care in a day-care setting during weekdays to individuals who meet medical certification criteria for nursing home services and require direct professional medical supervision or personal care supervision. The adult day health waiver program serves 300 waiver recipients. There are 20 licensed adult day health care facilities operating in the state and 15 of these facilities participate in the Medicaid program.

Elderly and Disabled Adult Waiver

Elderly and disabled adult waiver (formerly Home Care for the Elderly Waiver) was approved effective 1993. This waiver was designed to provide support services to the elderly in their home as an alternative to nursing home placement. On April 1, 1997 the home care for the elderly waiver was amended to incorporate the following changes: the waiver was renamed the elderly and disabled adult waiver, the target population was expanded to include disabled adults age 22 through 64, and a daily cost cap of $35 per day was established for waiver services to ensure continued cost effectiveness. The elderly and disabled adult waiver serves 429 waiver recipients.



MISSION STATEMENT
The mission of the Bureau of Health Services Financing is to develop and implement (according to federal and state law and regulations) the administrative and programmatic procedures with respect to licensure, reimbursement and monitoring to promote quality health care in Louisiana.
MEDICAID MANAGEMENT INFORMATION SYSTEMS
ELIGIBILITY FIELD OPERATIONS
Dexa Morgan
BHSF ASSISTANT DIRECTOR
ELIGIBILITY PROGRAM OPERATIONS
HEALTH STANDARDS
PHILOSOPHY
Providing quality health care requires continuous planning, implementing, and revising the service delivery models for recipients. The philosophy of the Bureau is to do what is clinically right, provide equitable benefits and to be open to our public.
Thomas Collins
BUREAU OF HEALTH SERVICES FINANCING (BHSF) DIRECTOR
FINANCIAL OPERATIONS
POLICY DEVELOPMENT & IMPLEMENTATION
Ben Bearden
BHSF ASSISTANT DIRECTOR
PROGRAM INTEGRITY
GOALS
To assure quality health services through compliance with state and federal regulations.
To provide cost-effective alternatives to the traditional service delivery model and to improve access, quality and recipient choice.
To assure that Medicaid reimbursements are appropriate and related to services provided to eligible recipients.
PROGRAM OPERATIONS
INSTITUTIONAL REIMBURSEMENT

LOUISIANA'S MEDICAID PROGRAM

The Medicaid program operates within the Louisiana Department of Health and Hospitals and is administered by the Bureau of Health Services Financing.

ORGANIZATIONAL STRUCTURE

The Bureau of Health Services Financing has 1,180 authorized positions. Of those, 989 are in eligibility determination, licensing and certification functions throughout the state. The majority of the remaining 191 employees work in Baton Rouge.

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

DIRECTOR

Functions

The Director is responsible for the overall operation of the program which includes that state and federal regulations (known as the "State Plan") are followed and effective management of budgetary matters. The Director is also responsible for general supervision and prioritizing various activities of each section. Two Assistant Directors help manage this effort.

MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS)

(Susan Taskin, Section Chief)

Key Functions

- Oversee operations of the Louisiana Medicaid Management Information System. The Louisiana Medicaid Management Information System is owned by the state and is operated by Unisys through a fiscal intermediary contract.
- Execute accurate, prompt and efficient payment of Medicaid claims.

1997/98 Highlights

- There were 37,705,094 claims processed during the year.
- Implemented the issuance of the Medicaid magnetic strip cards to eligible recipients.

Future Issues

- Year 2000 Compliance work.
- The implementation of the Executive Information System/Decision Support System and the interface of the state Medicaid Eligibility Data System (MEDS) with the current Welfare Information System (WIS) scheduled for January 1999.

ELIGIBILITY FIELD OPERATIONS
(Ruth Kennedy, Section Chief)
Functions
State Office Responsibilities:

■ Supervise Regional and Parish Medicaid Offices and Medical Assistance Program Units.
■ Monitor field activities by developing administrative and operational plans and procedures to ensure implementation and operation of all program activities.

Field Office Responsibilities

■ Process Medicaid eligibility applications, redeterminations and notify applicants of decisions.
■ Deliver services through direct contact with applicants and recipients of Medicaid.
■ Provide assistance to the Medicaid Application Centers.

Highlights

☐ Development and implementation of an Appeals Tracking program to ensure that timely action is taken by Eligibility Field Operation staff (state/regional/parish) on a continual basis.
☐ Development and implementation of General Orientation (November 1997) which focuses on Customer Service and provides general information.

Future Issues

¨ Timely processing of Medicaid applications, timely Appeals and retroactive reimbursement will continue to be pressing issues to assure compliance.
¨ Changing from the Welfare Information System (WIS) to the new Medical Eligibility Data System (MEDS) with Year 2000 compliance.

ELIGIBILITY OPERATIONS
(Donna Dedon, Section Chief)
Functions

■ Develop and implement eligibility policies and procedures for statewide utilization.
■ Provide statewide direction and guidance in the application of new and established eligibility policies and procedures.
■ Develop system programming to identify and classify Medicaid eligibles for federally funded programs matching and the determination of categorical eligibility based on disability and/or incapacity.

1997/98 Highlights

☐ Assisted the Bureau of Appeals by adjudicating 1,119 appeal hearings.
☐ Conducted a federally approved Quality Control Pilot Project targeting selected elements of newly certified long term care cases.
☐ Provided support to the task force for initial development of the Louisiana Children's Health Insurance Program.

Future Issues
- Complying with IRS confidentiality rules and regulations regarding client information. To ensure security measures for each parish office to protect client information.
- Development of policies for LaCHIP.
- Development of the Medical Eligibility Data System (MEDS) for the Year 2000 compliance. This new system will replace Welfare Information System (WIS), the currently used system.

HEALTH STANDARDS

(Lily McAlister, Section Chief)

Key Functions
- Enforce licensing standards and certification through licensing, survey and certification of health care providers, and also review complaints made in connection with health care facilities.
- Certify individuals for long term care admission and manage emergency medical transportation and non-emergency medical transportation services, controlled dangerous substances, and resident assessment instruments.

1997/98 Highlights
- Implemented a moratorium for nursing homes, long-term care hospitals and home health agencies until the year 2001.
- Developed the Minimum Data Set (MDS) which automates the assessment of nursing homes.

Future Issues
- Quality assurance program to conduct trend analysis for staff improvement.
- Maintain the licensing of the growing number of hospitals, institutions and providers throughout the state.

FINANCIAL OPERATIONS

(Darryl Johnson, Section Chief)

Key Functions
- Oversee Medicaid financial transactions including federal transfers, interface with fiscal intermediary and budget analysis.
- Manage administrative expenditures.
- Organize and report federally required Medicaid expenditure forecast, budget and policy changes.

1997/98 Highlights
- Completion of the federal government (HCFA) financial audits without adjustments to the cost projections and maintained the level of federal disallowance sanctions at zero.
- Successful implementation of the Bureau's state match allocations by the incorporation of additional federal funding sources.

Future Issues

- Financial maintenance and stability for managed care and fee-for-service dual Medicaid system.
- Continue efforts to automate Medicaid administrative functions and programmatic MMIS subsystems.

POLICY DEVELOPMENT AND IMPLEMENTATION

(Sandra Victor, Section Chief)

Key Functions

- Maintain the Medicaid State Plan including changes as required by the Social Security Act.
- Execute the facility need review process as statutorily mandated.
- Develop new and expanded programs under the State Plan to provide appropriate, medically necessary services to Medicaid recipients.

1997/98 Highlights

- Completed the major revisions and rewrites of four manuals - Case Management, ICF/MR Standards for Payment, Transportation, and EPSDT.
- Finished the revisions of lock-in and nursing home procedure manuals.

Future Issues

- Complete revision/rewrite to the following providers, standards for payment or licensing standards manuals: mental health rehabilitation, durable medical equipment, dental services, psychiatric hospitals, substance abuse minimum standards, and basic care facilities.
- Implement the assisted living pilot project.

PROGRAM INTEGRITY

(Don Gregory, Section Chief)

Key Functions

- Assure that expenditures for Medicaid services are appropriate and identify fraud or abuse in the system.
- Certify that doctors prescribe appropriate pharmaceuticals, while permitting sufficient professional prerogatives to allow for individualized drug therapy.

1997/98 Highlights

- Louisiana Act 1373 of 1997, established effective civil and anti-fraud and abuse "tools" including triple damages and fines up to $10,000 per violation, non-dischargability of debt through bankruptcy, forfeiture of property to satisfy debts, and a State Qui Tam provision.
- Louisiana Act 1142 of 1997, implemented an enrollment and bonding law that provides for the posting of bonds up to $50,000 to enroll and set conditions for providers to participate in the program.

Future Issues

- Increasing the number of Surveillance Utilization Review (SURS) from 200 cases to 900 per year.
- Development and implementation of a new on-line PC SURS system.

PROGRAM OPERATIONS

(Bruce Gomez, Section Chief)

Key Functions

- Oversee the operations of the Medicaid program in relation to reimbursement and coverage of services.
- Develop and implement initiatives to assure efficient and effective provision of medical services of adequate quality to recipients.

1997/98 Highlights

- Ensured elderly waiver cost effectiveness at a rate of $35 per day and added 200 slots to elderly waiver program.
- Increased disease management to cover Attention Deficit Disorder (ADD), arthritis and hyperlipidemia.
- Reduction in home health participants due to the crackdown on homeboundness.
- Increased codes payable to certified nurse midwives.
- Mental health rehabilitation program has implemented a Hospital Admissions Review Process program (HARP) to divert hospital admissions for mental health to the community. Also, implemented an enrollment criteria and certification for the mental health rehabilitation program.

Future Issues

- Implementing a dispensing and ingredient cost survey to determine the cost of dispensing a prescription in the state and other reimbursement issues.
- Developing educational brochures on specific disease states.
- Transportation coverage with a decrease in the provider community.

INSTITUTIONAL REIMBURSEMENT

(John Marchand, Section Chief)

Key Functions

- Administer Medicaid reimbursements to institutional providers (i.e., hospital, ICF/MRs, and nursing homes) in compliance with federal and state regulations.
- Manage accountability of provider expenditures in compliance with federal and state regulations.
- Perform desk reviews and cost settlements of home health cost reports in-house without additional staffing.

Highlights

- Developed rules and regulations to comply with mandates with Louisiana Rural Hospitals Preservation Act.
- Participated in the development of new admission and length of stay criteria for LTC hospitals.

Future Issues

- Development of reimbursement methodology in association with the adoption of the Inventory for Client and Agency Planning (ICAP) for ICF/MR.
- The segregation of the LTC audit contract into two separate contracts to create a better response.
- Request For Proposals (RFP) for rebasing hospital rates that will address deficiencies in the current rebase methodology for teaching hospitals.
- Clarifying and refining reimbursement methodologies for various providers and meeting changes in services and Federal mandates.

PREPARING LOUISIANA FOR THE FUTURE

Rural Hospital Preservation

Under the Rural Hospital Preservation Act, the Department of Health and Hospitals will allow rural hospitals to certify, as a contributing public agency, public funds as representing expenditures eligible for federal financial participation in the Medicaid program to the extent authorized by federal law. It will also maximize existing disproportionate share funding to the extent allowed by federal law and in the amounts appropriated by the Legislature.

Federal requirements for the State Plan permit the Department to impose further restrictions on payments for medical services provided to Louisiana Medicaid recipients that are rendered by out-of-state providers. The Department would promulgate regulations restricting payment.

MR/DD Parent Committee

The Department of Health and Hospitals implemented the MR/DD Parent Committee to discuss issues relative to MR/DD waivers. The purpose of the committee is to develop an environment which would allow parents of children participating in the MR/DD waiver program to have a voice in the decision-making process. The Department meets on a monthly basis with committee members to address the parent's concerns regarding policy changes to the program and the eligibility process. Parents who serve on the committee also serve as liaisons between the Department and their respective communities.

Year 2000 Compliance

HCFA's definition of being Year 2000 compliant means that the information system will accurately process date/time data from the nineteenth through the twenty-first century and beyond including leap year calculations. Furthermore, Year 2000 compliant information technology will accurately process date/time with the other information technologies as long as the ability to interface the date/time data.

Governor Mike J. Foster has issued an Executive Order to ensure that the State of Louisiana complies with the Year 2000 requirements. The Executive Order stipulates that any contract for the purchase or acquisition of computer hardware, software products, data processing service, information system and/or custom computer items in excess of $5,000 will be Year 2000 compliant on or before July 1, 1999.

Medicaid Eligibility Data System

Medicaid Eligibility Data System (MEDS) will replace the current system Welfare Information System (WIS). The MEDS project involves rewriting the current Medicaid eligibility main frame data base simultaneously bringing the system into year 2000 compliancy. The primary function of MEDS is to capture Medicaid eligibility data. While the actual determination of Medicaid eligibility is a function done by the worker, the new system will both record the results of the determination and provide assistance in making the determination. One key area of assistance provided by the system is the budget worksheet which records both income and deduction amounts for the assistance unit. Another key feature is an expanded data base for capturing and retaining information on applicants in history files. Testing of the new system is scheduled for May 1999.

Magnetic Strip Card

The monthly paper Medicaid eligibility cards are being replaced with a magnetic strip identification card referred to as "Health Network for Louisiana." The magnetic strip card will contain a unique 16 digit card control number, recipient name, issue date and bank identification number. The magnetic strip card was designed with a card control number to allow recipients to maintain a single ID number even if their WIS number changes.

The magnetic strip card can be utilized by providers to retrieve verification from the Medicaid Eligibility Verification System or the Recipient Eligibility Verification System. The Medicaid Eligibility Verification System will allow the provider to receive printed information on a magnetic strip card device or computer and the Recipient Eligibility Verification System will allow a Medicaid provider to receive information over the telephone.

PC SURS

The Department will be implementing a PC SURS system next year. PC SURS is a proprietary system owned by UPI Government Group. The intended results of the system include more efficient use of staff, higher rates of problem case identification, increased recoupment rate, higher provider sanction rate, and more timely provider notification when problems arise.

The PC-based profiling system is designed for efficiency. The system's expected flexibility would be a great improvement to the current mainframe system. The profiling on the current mainframe system will be discontinued once the PC SURS system is fully functional.

Basically, the system moves the process of profiling data off the mainframe and onto a PC system.

- Focused runs on issues as they arise
- Run reports on an ad hoc basis
- Rapidly incorporate policy changes into reporting
- Expanded reporting features
- Simplify the creation and updating of reporting specifications
- User control of production schedules
- View the output of reports on-line
- Selectively print reports needed
- Expand the number of users able to request and analyze profiles

Physician Point of Service (MD-POS)
The Department is planning to implement a MD-POS system in the near future. The purpose of the MD-POS is to process a Medicaid eligibility inquiry via a magnetic strip card and to process the claim while the recipient is in the physician's office. In return, the physician immediately receives a response verifying the claim has cleared a few simple edits. The claim is then held for payment to the physician in the following weekly payment cycle.

The MD-POS system is operated in conjunction with the Louisiana Medicaid Management Information System (LMMIS), which provides all information necessary to adjudicate a claim. This system also reports to the physician information which will assist in the correction of claims errors.

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 providers, statewideness 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.

1915(c) Waiver
1915(c) of the Social Security Act, also known as a "home and community-based waiver," allows states to serve people who would otherwise be in an institution by providing them with services in a home or community setting. The waiver addresses statewideness, comparability of services, community income and resource rules and rules that require states to provide services to all persons in the state who are eligible on an equal basis.

Capitation
A capitation is 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.

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.

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 statewideness {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.

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 reports. If the interim payment has not covered all the approved costs, Medicaid owes the provider for the difference, and vice versa.

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.

Disproportionate Share (DSH) - Uncompensated Care
Compensation for care of individuals in hospitals 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.

Eligible
For this report, an eligible is a person who has qualified for Medicaid, who may or may not have received any type of Medicaid service.

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

Extended Medicaid
Medicaid coverage is protected for the following applicants/recipients who lose SSI/MSS eligibility and who continue to 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 Retirement and Survivors Disability Insurance (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 increases in RSDI benefits or any other reason.

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

HCFA - Health Care Financing Administration
A federal agency charged with overseeing and approving states' implementation and administration of the Medicaid program.

Home & Community-Based Waiver Services (MR/DD, ADHC, PCA, Home Care for the Elderly)
Provides reimbursement for services to individuals living in the community who would otherwise require services in an institution.

Long Term-Care
An applicant/recipient may be eligible for Medicaid services in the LTC program if he/she is a resident of a Medicaid certified nursing facility, a certified Medicare skilled nursing facility/ Medicaid nursing facility, including a swing-bed facility or a Medicaid certified intermediate care facility/mentally retarded facility and meet all eligibility requirements.

Louisiana Children's Health Insurance Program (LaCHIP)
A federal and state initiative to address the growing number of uninsured children in the country. As a result of the Federal Balanced Budget Act of 1997 and the Social Security Act, the federal government has provided states with funding for a state children's health insurance program. In Louisiana this program will be called LaCHIP.

Low Income Families with Children (LIFC) -- formerly known as AFDC
Provides Medicaid coverage to individuals and families receiving cash assistance under the State's Title IV-A program administered by the Department of Social Services, Office of Family Support.

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 duplication, unnecessary or dangerous combinations of care.

Medically Needy Program (MNP)
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 women whose eligibility is determined by a qualified provider prior to an agency determination of Medicaid eligibility.

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 outcomes.

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

Provider
A person, group or agency who provides a covered Medicaid service to a Medicaid recipient.

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.

Qualifying Individuals (1)

Qualifying Individuals (QI-1) went in effect January 1, 1998 will be effective until December 31, 2002. There is an annual cap on the amount of money available , which may limit the number of individuals in the group. These individuals are entitled to Medicare Part A, having income of 120 percent -135 percent FPL, resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for Medicaid.

Qualifying Individuals (2)

Qualifying Individuals (QI-2) went in effect January 1, 1998 will be effective until December 31, 2002. There is an annual cap on the amount of money available, which may limit the number of individuals in the group. These individuals are entitled to Medicare Part A, having income of 135 percent -175 percent FPL, resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for Medicaid.

Recipient

A person who received a Medicaid service while eligible for the Medicaid program. A person may be Medicaid eligible without being a Medicaid recipient.

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).

State Fiscal Year (SFY)

The state fiscal year starts July 1 and ends June 30 each year.

State Plan

A plan which sets the policies for the Bureau to follow in accordance with the HCFA requirements. The State Plan must be submitted to and approved by HCFA quarterly.

Transitional Assistance

Medicaid coverage is continued for recipients who lose Family Independence Temporary Assistance Program (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.

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

Utilization
The extent to which members of a covered group use a program or obtain a particular service, or category of procedures, over a given period of time. Usually expressed as the number of services used per year or per number of persons eligible for the services.

READER NOTES

APPENDIX 1

PARISH	POPULATION	RANK	ELIGIBLES	RANK	RECIPIENTS	POP. COVERED BY MEDICAID (%)
ACADIA	57,703	19	12,665	14	12,564	21.95
ALLEN	24,079	38	4,106	43	4,261	17.05
ASCENSION	70,328	17	8,480	24	8,229	12.06
ASSUMPTION	22,866	41	4,340	42	4,106	18.98
AVOYELLES	41,102	29	10,025	20	9,978	24.39
BEAUREGARD	31,440	34	4,571	40	4,655	14.54
BIENVILLE	15,707	52	3,774	48	3,814	24.03
BOSSIER	93,752	12	10,235	19	9,669	10.92
CADDO	244,943	4	43,585	4	40,462	17.79
CALCASIEU	178,654	7	23,687	6	23,035	13.26
CALDWELL	10,162	59	1,982	62	1,966	19.51
CAMERON	9,171	63	843	64	916	9.19
CATAHOULA	10,775	58	2,591	57	2,538	24.05
CLAIBORNE	17,132	51	3,712	49	3,822	21.67
CONCORDIA	20,748	46	5,105	37	4,852	24.60
DESOTO	25,406	37	4,786	39	4,937	18.84
EAST BATON ROUGE	396,331	3	50,935	3	47,687	12.85
EAST CARROLL	9,239	62	4,015	45	4,088	43.45
EAST FELICIANA	20,828	45	3,778	47	3,709	18.14
EVANGELINE	34,392	31	10,434	18	10,393	30.34
FRANKLIN	22,324	42	5,660	34	5,539	25.36
GRANT	18,801	49	3,360	54	3,279	17.87
IBERIA	71,546	16	14,183	13	13,656	19.82
IBERVILLE	31,149	35	6,598	29	6,465	21.18
JACKSON	15,536	53	2,927	55	2,952	18.84
JEFFERSON	453,043	2	54,908	2	53,281	12.12
JEFFERSON DAVIS	31,149	33	5,693	33	5,874	18.06
LAFAYETTE	181,363	5	21,956	10	21,226	12.11
LAFOURCHE	88,060	13	12,512	15	12,159	14.21
LASALLE	14,081	54	2,234	60	2,157	15.87
LINCOLN	42,376	27	6,192	31	5,867	14.61
LIVINGSTON	83,487	14	9,382	21	9,109	11.24

EXPENDITURES	RANK	PER CAPITA ($)	RANK	PER ELIGIBLE ($)	RANK	PER RECIPIENT ($)	RANK
47,223,271	12	818	14	3,729	14	3,759	12
13,637,967	39	566	32	3,321	23	3,201	27
22,819,275	30	324	61	2,691	52	2,773	50
11,586,790	49	507	41	2,670	54	2,822	48
35,841,773	17	872	12	3,575	15	3,592	15
13,407,270	42	426	50	2,933	38	2,880	45
12,501,970	46	796	17	3,313	24	3,278	24
42,321,432	14	451	47	4,135	8	4,377	5
119,908,671	5	490	43	2,751	48	2,963	42
81,703,891	7	457	46	3,449	16	3,547	16
9,973,056	54	981	7	5,032	3	5,073	3
2,738,265	64	299	62	3,248	27	2,989	38
8,109,477	59	753	18	3,130	32	3,195	28
12,125,159	47	708	20	3,266	26	3,172	31
13,495,642	41	648	28	2,632	56	2,769	51
12,865,001	44	506	42	2,688	53	2,606	56
142,495,642	4	360	56	2,798	44	2,988	39
11,065,657	50	1,198	3	2,756	47	2,707	53
18,530,976	33	890	11	4,905	4	4,996	4
35,802,413	18	1,041	5	3,431	18	3,445	18
21,674,972	31	971	8	3,830	11	3,913	11
10,454,058	52	556	33	3,111	34	3,188	29
37,742,332	15	528	39	2,661	55	2,764	52
16,063,343	35	516	40	2,435	60	2,485	59
10,063,504	53	648	27	3,438	17	3,409	19
153,358,431	3	338	58	2,793	45	2,878	46
18,483,965	34	586	31	3,247	28	3,147	33
67,660,021	9	373	54	3,082	35	3,188	30
35,918,730	16	408	51	2,871	41	2,954	43
8,866,592	57	630	29	3,969	9	4,111	7
23,528,784	28	555	34	3,802	12	4,010	10
27,128,133	23	325	60	2,892	40	2,978	40

APPENDIX 1

PARISH	POPULATION	RANK	ELIGIBLES	RANK	RECIPIENTS	POP. COVERED BY MEDICAID (%)
MADISON	13,372	56	4,102	44	4,277	30.68
MOREHOUSE	31,722	32	7,794	25	8,089	24.57
NATCHITOCHES	37,896	30	7,681	27	7,813	20.27
ORLEANS	472,948	1	132,250	1	127,609	27.96
OUACHITA	147,177	8	23,520	7	22,270	15.98
PLAQUEMINES	25,965	36	4,426	41	4,228	17.05
POINTE COUPEE	23,769	40	5,026	38	4,827	21.36
RAPIDES	127,855	9	24,015	5	22,977	18.78
RED RIVER	9,873	60	2,113	61	2,118	21.40
RICHLAND	20,421	48	5,568	35	5,808	27.26
SABINE	23,769	39	3,944	46	4,194	16.59
ST. BERNARD	66,927	18	7,767	26	7,834	11.61
ST. CHARLES	47,308	22	5,172	36	5,364	10.93
ST. HELENA	9,715	61	2,404	58	2,381	24.75
ST. JAMES	21,569	44	3,692	50	3,593	17.12
ST. JOHN	42,035	28	6,229	30	5,901	14.82
ST. LANDRY	82,705	15	22,273	9	21,605	26.93
ST. MARTIN	46,555	24	8,879	22	8,534	19.07
ST. MARY	57,363	20	11,302	16	10,863	19.70
ST. TAMMANY	180,692	6	15,589	12	15,326	8.63
TANGIPAHOA	95,283	11	22,734	8	21,983	23.86
TENSAS	6,733	64	2,304	59	2,261	34.22
TERREBONNE	102,197	10	16,327	11	15,448	15.98
UNION	21,727	43	3,497	52	3,618	16.10
VERMILION	51,318	21	8,744	23	8,423	17.04
VERNON	47,229	23	5,836	32	5,973	12.36
WASHINGTON	43,736	25	11,230	17	11,163	25.68
WEBSTER	42,607	26	7,558	28	7,775	17.74
WEST BATON ROUGE	20,472	47	3,577	51	3,520	17.47
WEST CARROLL	12,199	57	2,922	56	2,966	23.95
WEST FELICIANA	13,505	55	1,545	63	1,508	11.44
WINN	17,195	50	3,471	53	3,404	20.19
TOTAL	4,351,769		752,747		730,898	17.30

EXPENDITURES	RANK	PER CAPITA ($)	RANK	PER ELIGIBLE ($)	RANK	PER RECIPIENT ($)	RANK
9,159,933	55	685	25	2,233	64	2,142	64
25,995,921	25	819	13	3,335	20	3,214	26
20,950,490	32	553	35	2,728	50	2,681	54
325,066,686	1	687	24	2,458	59	2,547	57
68,049,102	8	462	45	2,893	39	3,056	35
34,058,685	20	1,312	1	7,695	1	8,056	1
15,266,210	37	649	26	3,037	36	3,163	32
166,326,320	2	1,301	2	6,926	2	7,239	2
6,981,898	60	707	21	3,304	25	3,296	23
23,416,469	29	1,147	4	4,206	5	4,032	9
12,589,461	45	530	38	3,192	29	3,002	37
25,825,266	26	386	53	3,325	22	3,297	22
13,326,954	43	282	64	2,576	57	2,485	60
6,72856759	61	692	22	2,798	43	2,825	47
8,545,495	58	396	52	2,315	63	2,378	63
14,549,289	38	346	57	2,336	62	2,466	62
65,848,615	10	796	16	2,956	37	3,048	36
25,314,101	27	544	36	2,851	42	2,966	41
26,895,902	24	469	44	2,380	61	2,476	61
51,975,343	11	288	63	3,334	21	3,391	20
94,498,071	6	992	6	4,157	7	4,299	6
6,302,675	62	936	9	2,736	49	2,788	49
45,304,198	13	443	48	2,775	46	2,933	44
13,518,598	40	622	30	3,866	10	3,736	13
27,835,437	22	542	37	3,183	31	3,305	21
15,891,974	36	336	59	2,723	51	2,661	55
34,999,501	19	800	15	3,117	33	3,135	34
31,778,123	21	746	19	4,205	6	4,087	8
8,893,192	56	434	49	2,486	58	2,526	58
11,021,021	51	903	10	3,772	13	3,716	14
4,919,355	63	364	55	3,184	30	3,262	25
11,845,981	48	689	23	3,413	19	6,480	17
2,352,712,015		541		3,126		3,219	

APPENDIX 2

FEDERAL CATEGORY OF SERVICE	RECIPIENTS	EXPENDITURES	AVERAGE COST PER RECIPIENT
		($)	($)
INPATIENT HOSPITAL SERVICES	145,089	512,509,284	3,532
MENTAL HEALTH HOSPITAL SERVICES FOR THE AGED	301	423,881	1,410
INPATIENT PSYCHIATRIC FACILITY SERVICES FOR INDIVIDUALS AGE 21 & UNDER	2,519	6,984,137	2,772
ICF SERVICES FOR THE MENTALLY RETARDED	6,016	321,919,804	53,507
NURSING FACILITIES SERVICES	47,823	494,867,787	10,348
PHYSICIANS' SERVICES	604,427	198,410,376	328
DENTAL SERVICES	132,354	19,793,841	150
OTHER PRACTITIONERS' SERVICES	115,997	10,784,271	93
OUTPATIENT HOSPITAL SERVICES	358,677	143,024,901	399
CLINIC SERVICES	76,946	34,841,047	453
HOME HEALTH SERVICES	18,752	31,886,314	1,700
FAMILY PLANNING SERVICES	46,838	9,627,695	206
LAB & X-RAY SERVICES	443,585	41,402,149	93
PRESCRIBED DRUGS	548,171	338,436,088	617
EARLY & PERIODIC SCREENING	228,723	18,808,169	82
RURAL HEALTH CLINIC SERVICES	34,402	6,159,689	179
OTHER CARE	524,916	164,133,886	313

TECHNICAL NOTES

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 the purpose 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, in 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 within a given year to determine the count of recipients and eligibles and reconcile with the original identification number.

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