Annual Report State Fiscal Year 2000/2001

LOUISIANA MEDICAID PROGRAM

Louisiana Department of Health and Hospitals
Bureau of Health Services Financing

LOUISIANA
Department of HEALTH and HOSPITALS

David W. Hood
Secretary, Department of Health and Hospitals

Charles F. Castille
Undersecretary, Office of Management and Finance

Ben A. Bearden
Director, Bureau of Health Services Financing

Message from the Director

Dear Readers,

I am extremely proud that the Medicaid program has continue to address the health needs of Louisiana citizens. In SFY 2000/01 (State Fiscal Year 2000-2001), Medicaid was highlighted as the cornerstone of the Department of Health and Hospitals' Seven Point Plan to improve health care in Louisiana by enhancing primary and preventive care, improving access to care and focusing on community-based services.

We continued our commitment to reducing the number of uninsured children in the state by expanding the Louisiana Children's Health Insurance Program (LaCHIP) to cover children in families whose income level was up to 200 percent of the Federal Poverty Level. This allows them to receive the full array of health care available to Medicaid recipients leading to healthier children with improved outcomes for the future.

The agency began to implement the requirements of the Health Insurance Portability and Accountability Act (HIPAA) which will affect the billing, payment and record-keeping activities of all health insurance programs, in the public as well as the private sectors. All Medicaid agencies will be required to change local billing codes to national codes, to meet new standards regarding electronic transactions and to meet requirements related to privacy and security, and national identification numbers. Bringing the state into compliance with the initial phases of the project is a massive undertaking requiring a significant commitment of staff hours and other resources.

The Children's Choice Waiver program was implemented in January 2001 to provide more community -based services to children with disabilities. Participants are eligible for all medically necessary Medicaid services, including Early and Periodic Screening, Diagnosis and Testing. Waiver services include case management, respite services, physical adaptations to the home or vehicle within certain limitations and family support. The goal is to allow children with developmental disabilities to remain in community-based settings rather than reside in an institution.

Funding for the Medicaid program was again an issue in SFY2000/01. Numerous cost containment measures were initiated or continued while alternative funding sources such as the Intergovernmental Transfers program were pursued. We were able to increase rates for some services such as dental services under the EPSDT program, certain physician services, and certain emergency transportation services.

The 2001 Legislative Session authorized and/or directed the Department to begin several new initiatives or activities. Most significant was authorization to establish a prior authorization process to constrain the cost of prescription drugs. As a result of two other pieces of legislation, the Department will review and revise the way in which reimbursements to facilities providing long-term care and hospital services are paid, including disproportionate share payments, leading to a more efficient and cost-effective program.

My staff and I await the many challenges facing Medicaid and health care services in the coming year. We are committed to the continued improvement and evolution of the Medicaid program, the enhancement of preventive and primary care services and to improving health outcomes for our recipients.

Sincerely,

Ben A. Bearden

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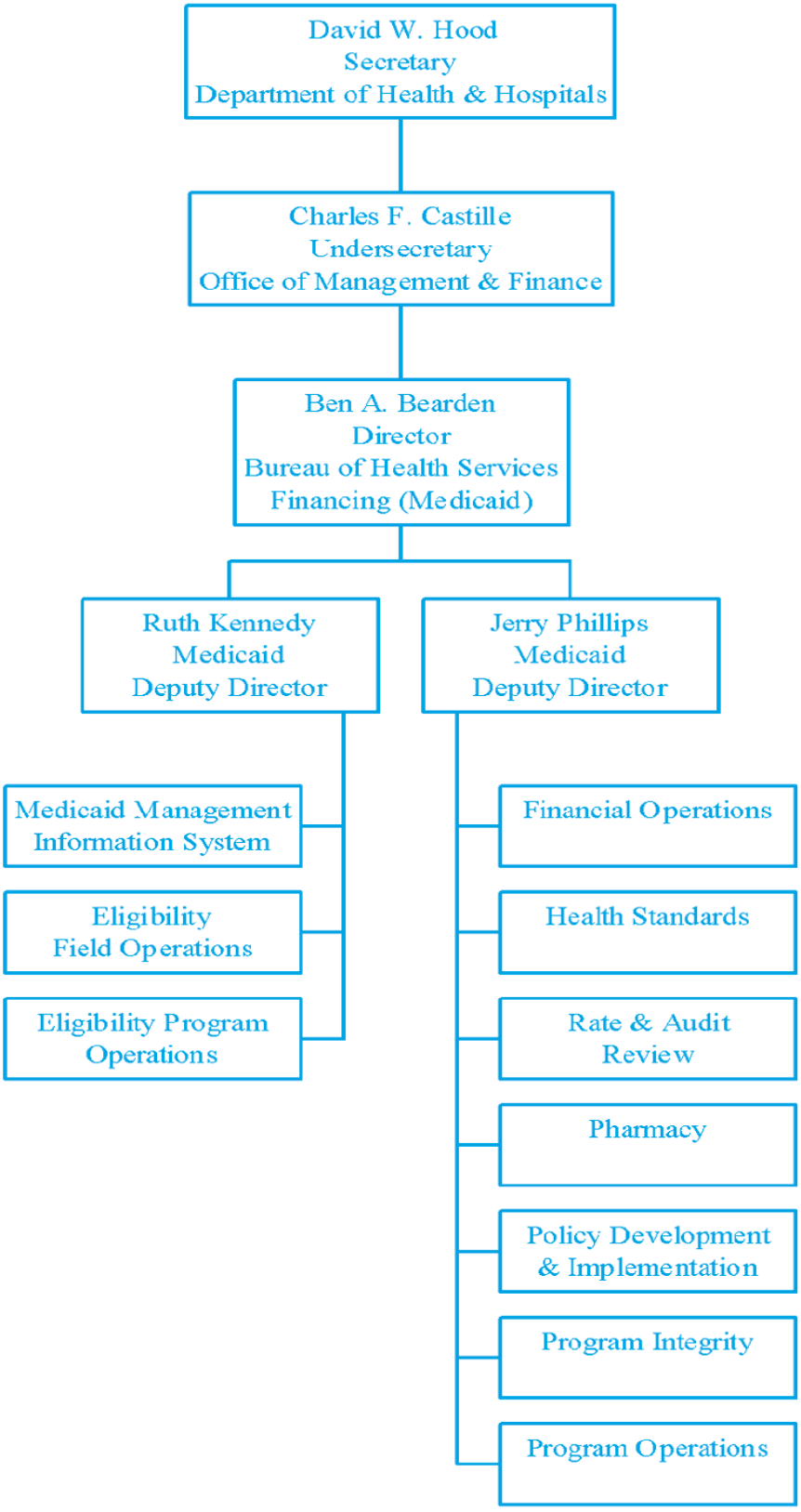
FIGURES

Acronyms:

CM	Case Management
DSH	Disproportionate Share
FFP	Federal Financial Participation
FPL	Federal Poverty Level
LaCHIP	Louisiana Children's Health Insurance Program
PCP	Primary Care Physician
PCS	Personal Care Services
OBRA	Omnibus Budget Reconciliation Act
SNF	Skilled Nursing Facility
TEFRA	Tax Equity Fiscal Responsibility Act

TABLES

MEDICAID ORGANIZATIONAL CHART



INTRODUCTION

With Title XIX of the Social Security Act, Congress enacted the Medicaid Program in 1965. Medicaid is a jointly funded cooperative venture between the federal and state governments. Medicaid helps states provide adequate medical care to eligible needy persons who are uninsured or under-insured. The federal government set national guidelines but each state determined the following:

- eligibility standards
- type, amount, duration and scope of services
- rate of payment for services
- administrative structure for their respective programs

Nearly one out of every five Louisiana residents is enrolled and eligible to receive Medicaid services (18.5 percent). The uninsured rated is estimated to be 19.1 percent and those with either private or other insurance is estimated to 62.4 percent. The ratios are based on the U.S. Census Bureau 2001 reports.

At some point in your life you and your family members will need to visit a physician, dentist, nursing home, optometrist or some other health care provider. Your chief concern will, of course, be the quality of the care that you receive. It is the business of the Louisiana Department and Hospitals to ensure that your concerns are short-lived because you will know from casual conversations or empirical studies that the health care you receive in Louisiana is the best in the world.

This report has been developed to give you a concise yet complete understanding of the importance of providing quality health care for the citizens of Louisiana. Providing quality health care —while improving services and watching the "bottom line" of the budget—is a daunting task that we are committed to providing for the citizens of Louisiana.

We recognize possible Medicaid flashpoints in regards to improving health care. As a result, we are aligning our resources to meet these challenges. Louisiana has a large but shrinking uninsured population, due in part to our outreach efforts. Louisiana citizens ages 65+, which historically have been a high-cost Medicaid group, are growing at a faster rate than the overall population growth in the state. The costs of medical prescriptions are growing rapidly both nationally and in Louisiana. Our citizens are requesting services in their respective communities. Several parishes have been identified that may need additional providers to help serve people in their communities.

To address these issues some programs and strategies have been implemented:

- Implementing the Louisiana's Children's Health Insurance Program
- Improving access to primary and preventive care
- Implementing more community-based programs
- Implementing Intergovernmental Transfer Program(s)
- Implementing plans to care for the elderly and/or disabled
- Implementing measures to control drug costs

As you proceed through this report your confidence should grow. You will know that Louisiana is preparing for the future today.

BRIEF HISTORICAL LOOK AT MEDICAID IN LOUISIANA

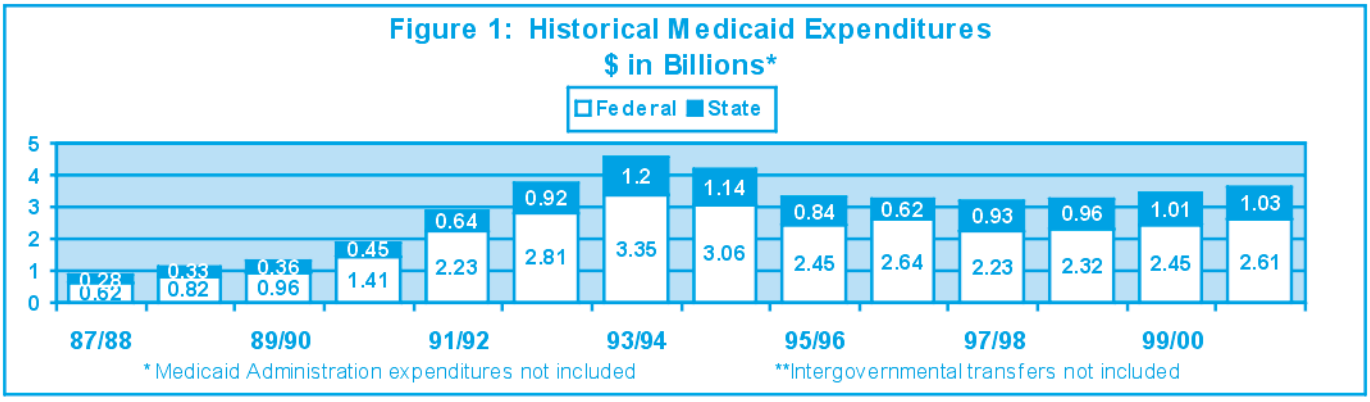
Medicaid: Looking to the Future

As Louisiana moves into the 21st century, the Department of Health and Hospitals is committed to making fundamental changes in the Medicaid program to make it more responsive to the needs of Louisiana citizens. The foremost concern is to make the changes necessary to find more effective, more efficient ways to keep people healthy, and to treat them once they become ill. This includes those needing basic medical services and prescription drugs as well as citizens with special medical needs.

The proper funding of the Medicaid budget continues to present challenges for DHH, legislators, health care providers and citizens. As an entitlement program, necessary health care services cannot be denied to qualified recipients. In Louisiana, almost one in five people—more than 825,000 citizens—were eligible for Medicaid in SFY 2000/01.

Financial pressures outside the control of government contribute to the uncertainty of Medicaid spending. These factors include the continued, rising cost of health care, general price inflation, new and better (and more expensive) medications, changes in federal health care policy, changing medical practices and the behavior of recipients.

For example, recent growth in the Medicaid budget can be attributed primarily to continued and unabated price increases for prescription drugs and to changes in the federal Medicare program. Ironically, the cost to the Medicaid program due to the rise in drug prices is amplified as best health care practices call for more reliance on drugs as a way to reduce hospital costs. It is for this reason that DHH has initiated several programs designed to curb the escalating cost of prescription medications. These are highlighted elsewhere in this Annual Report.



Historical Spending

Figure 1 shows Louisiana Medicaid expenditures for SFY 1987/88 through SFY 2000/01. The rapid rise in spending from SFY 1987/88 to SFY 1993/94 can be attributed to several factors. Eligibility for participation in Medicaid was extended to greater numbers of people. Medicaid expanded coverage to allow people access to a broader array of services.

The single greatest contributor to increased spending from SFY 1988/89 to SFY 1993/94 was the Disproportionate Share Hospital (DSH) program. The federal reimbursement policy that provides higher levels of funding to cover the costs of uncompensated hospital care to the indigent population is referred to as DSH. Louisiana enacted this program July 1, 1988, to comply with Section 4112 of the Omnibus Budget Reconciliation Act of 1987 (OBRA). This federal regulation required states to make payments to hospitals that provide inpatient and outpatient services to a disproportionate number of indigent/uninsured patients.

The state used the DSH program to maximize payments to state-operated charity hospitals. Revenues from these payments were used to finance nearly all the growth in the Medicaid program from SFY1988/99 through SFY 1994/95. Averaging more than 30 percent per year, this growth outstripped the program's ability to provide effective oversight. In 1995, rule changes mandated by Congress caused a crisis when $800 million in state matching funds were no longer available. Extensive budget cuts followed. Since 1996, DHH has focused on providing more effective program oversight and cost containment. Growth has been promoted only for certain targeted areas such as services for children and persons with disabilities.

Rapidly increasing DSH payments were not limited to Louisiana; DSH payments were increasing rapidly nationally as well. Consequently, Congress enacted OBRA 1993 to limit DSH payments made to public hospitals in 1994 and to private hospitals in 1995. The total amount of federal funds available to a state was eventually capped and that cap was lowered from year to year.

Beginning in July of 1994 the Louisiana Medicaid Program undertook new initiatives in fiscal accountability. It also implemented program changes intended to more cost effectively pursue the goals of increased access and improved quality of care for Medicaid recipients. Lower levels of spending since 1993/94 reflect the program's ability to adjust to the requirements of cost conscious management in the delivery of health care services.

In April 1995, Louisiana Medicaid implemented a number of measures to assure accountability. During SFY 1994/95, pre-admission screening and length-of-stay assignments for hospitals were implemented. Also, the Non-Emergency Medical Transportation (NEMT) program was reformed to eliminate inappropriate use of the service. This program was originally established to ensure necessary transportation for people to and from health care providers. The rationale for providing this service is based on the belief that if a person is declared eligible for Medicaid, that eligibility would be diminished if the eligible person were unable to visit providers due to a lack of transportation. Other changes that resulted from the reform included the following:

- Enrolling families and friends as transportation providers
- Implementing screening procedures of enrollees
- Retooling the rate structure
- Establishing that service is provided only to those recipients who have no other source of transportation to medical appointments

At the beginning of SFY 1995/96, DHH was forced to impose more than $300 million in budget cuts due to the loss of state matching funds that had been generated by the DSH program prior to federal reforms. These cuts impacted every area of Medicaid and included rate reductions and program eliminations.

During 1996/97, the Low Income Families and Children (LIFC) program was implemented. The Personal Responsibility and Work Opportunity Act of 1996 severed the ties between Medicaid eligibility and eligibility for cash assistance, more commonly known as welfare. This law eliminated the Aid to Families with Dependent Children (AFDC) cash assistance program, replacing it with the Temporary Aid to Needy Families (TANF) block grant program, and established a mandatory Medicaid-only eligibility group for low income families.

Effective October 1, 1996, Louisiana began providing Medicaid coverage under the LIFC program to families:

- with a dependent child in the home,
- whose income and resources do not exceed the applicable AFDC income and resource standards in effect on July 16, 1996, and
- who meet AFDC deprivation requirements (such as absence of a parent, incapacity of parent, or unemployment/underemployment of parent) in effect on July 16, 1996.

In July 1996, the optional federally funded Medically Needy Program (MNP) was discontinued. MNP provides Medicaid coverage for catastrophic medical bills when income and resources exceed eligibility limits but large medical bills remain. During SFY 1997/98, federally funded MNP was re-implemented although some limits were placed on services. This program is intended primarily for families who incur catastrophic medical bills which they would otherwise be unable to pay.

The option to have a "medically needy" program allows States to extend Medicaid eligibility to additional qualified persons who may have too much income to qualify under the mandatory or optional categorically needy groups. This option allows them to "spend down" to Medicaid eligibility by incurring medical and/or remedial care expenses to offset their excess income, thereby reducing it to a level below the maximum allowed by that state's Medicaid plan.

During SFY 1998/99, LaCHIP was implemented for uninsured children. In August 1997 Title XXI of the Social Security Act created the State Children's Health Insurance Program (SCHIP) which enabled states to receive federal funds to expand health care coverage for uninsured children (birth through age 19) in families not eligible for

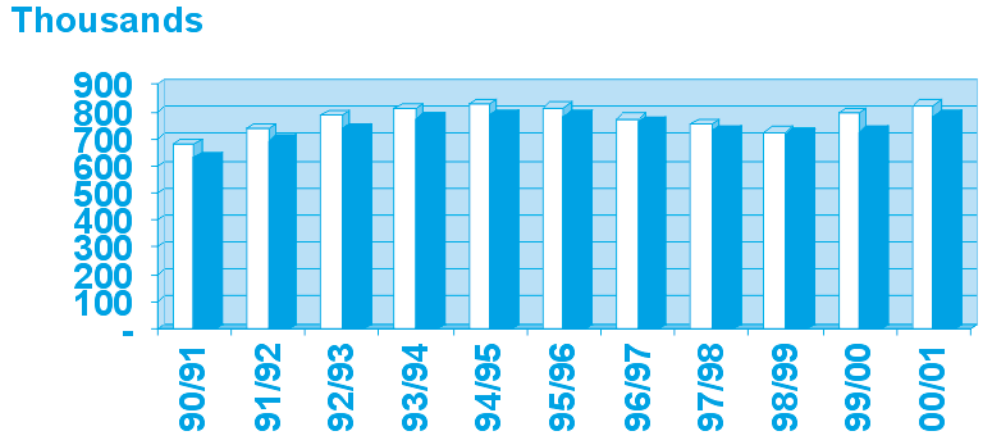
Medicaid. Louisiana elected to implement LaCHIP in three phases as a Medicaid expansion. Phase I was implemented effective November 1, 1998, with the household income threshold set at 133 percent of the Federal Poverty Level (FPL).

During SFY 1999/00, LaCHIP Phase II was implemented effective October 1, 1999. Under this expansion, the eligibility standard for household income was set at 150 percent of the FPL.

During SFY 2000/01, LaCHIP Phase III was implemented on January 1, 2001. Under this expansion, the eligibility standard for household income was increased to 200 percent of the FPL.

The data in Figure 2 should not be used for trend analysis because the data shown for SFY 1990/91 through SFY 1998/99 is based on a different criteria than SFY 1999/00 and SFY 2000/01. See Technical Notes on page 30.

Figure 2: Medicaid Eligibles and Recipients



An "eligible" is a person who has qualified for Medicaid and who may or may not have received any type of Medicaid service. The data for this report is based on the claim Date of Payment (DOP) and not on the Date of Service (DOS). Therefore, a person is counted as a "recipient" if any financial/claims related transaction(s) occurred on that person's behalf during SFY 2000/01.

HIGHLIGHTS FOR STATE FISCAL YEAR (SFY) 2000/01

Louisiana Children's Health Insurance Program (LaCHIP)

Louisiana is a national leader in enrolling children in its Children's Health Insurance Program. The state is attacking the problem of uninsured children with vigor. – Vernon Smith, National Alliance for Health Reform.

One of the biggest problems in Louisiana today is the high number of people who do not have insurance or are under-insured. The problem is magnified when it comes to children. In 1998, the Children's Defense Fund ranked Louisiana third in the nation for the percentage of children without health care coverage – 22.2 percent. But, through its Children's Health Insurance Program, Louisiana has aggressively tackled this problem.

Title XXI of the Social Security Act (1997) created the State Children's Health Insurance Program (SCHIP) which enabled states to receive federal funds to expand health care coverage for uninsured children (birth to age 19) in families not eligible for Medicaid. Louisiana's SCHIP program is known locally as LaCHIP and has been implemented in three phases. The three phases of implementation and the household income threshold eligibility criteria are listed below in Table 1.

Since implementing LaCHIP in November 1998, almost 135,000 more children have been enrolled into Medicaid. In most instances, these are the children of the hard-working parents whose jobs do not provide health insurance or they do not earn enough money to purchase this coverage. LaCHIP pays for doctor visits for primary care as well as preventive and emergency care, immunizations, prescription medications, hospitalization, home health care and many other health services.

LaCHIP success has been cited by several national organizations as one of the best children's health insurance programs in the nation. This includes the Alliance for Health Reform, Families USA and the Children's Defense Fund.

Table 1: LaCHIP Eligibility Thresholds

Phase	Income Threshold	Household Income *	Implementation Date
Phase I	133% of Federal Poverty Level (FPL)	$1,890	November 1, 1998
Phase II	150% of the FPL	2,132	October 1, 1999
Phase III	200% of the FPL	2,842	January 1, 2001

* Monthly Federal Poverty Income guidelines effective April 1, 2000, for a family of four.

There were 62,301 LaCHIP eligibles during SFY 2000/01 and 50,828 LaCHIP recipients who received at least one service. This equates to a utilization rate of 82 percent. As Table 2 reflects, the LaCHIP payments for SFY 2000/01 were $46,857,070. The average annual cost per LaCHIP recipient was $922. All recipients are not eligible the entire year.

Table 2: LaCHIP (Title XXI) Children

Age	Eligibles		% Change	Recipients		%	Payments ($)		% Change
	1999/00	2000/01		1999/00	2000/01	Change	1999/00	2000/01	
Under 1	462	1,116	141.56	240	733	205.42	$397,530	$1,443,729	263.17
1-5	3,083	8,062	161.50	2,816	8,007	184.34	2,457,688	7,436,350	202.58
6-14	18,548	31,628	70.52	13,712	24,969	82.10	10,056,976	19,241,468	91.32
15-18	18,286	21,495	17.55	13,930	17,119	22.89	16,255,993	18,735,522	15.25
Total	**40,379**	**62,301**	**54.29**	**30,698**	**50,828**	**65.57**	**29,168,187**	**46,857,070**	**60.64**

Recipient Payments for all Medicaid Children Under the Age of Twenty-One

The following table details the average annual cost for Medicaid recipients from birth to age 21. The payments shown below also include LaCHIP recipients and payments. The average annual cost for all Medicaid recipients ages 0 to 19 was $1,606.

Table 3: All Medicaid (Title XIX and XXI) Children

Age	Eligibles		% Change	Recipients		% Change	Payments ($)		% Change
	1999/00	2000/01		1999/00	2000/01		1999/00	2000/01	
Under 1	58,785	58,538	-.042	51,411	54,929	6.84	181,052,932	211,341,819	16.73
1-5	144,465	154,161	6.71	157,603*	171,513	8.83	172,862,937	196,282,672	13.55
6-14	203,228	222,461	9.46	168,377	192,538	14.35	196,883,904	227,146,328	15.37
15-18	66,569	76,012	14.19	52,682	61,843	17.39	123,090,298	137,356,164	11.59
Total Birth thru Age 18	**473,047**	**511,172**	**8.06**	**430,073**	**480,823**	**11.80**	**673,890,071**	**772,126,983**	**14.58**
19-20	23,317	24,282	4.14	20,196	21,227	5.10	68,384,925	74,558,474	9.03
Total	**496,364**	**535,454**	**7.88**	**450,269**	**502,050**	**11.50**	**742,274,996**	**846,685,457**	**14.07**

**See Technical Notes (page 30) for an explanation of how the number of recipients can be greater than the number of eligibles.*

Improving Access to Primary and Preventive Care

Because of the cost of health care, when families lack insurance, they oftentimes put off preventive care. Those who are uninsured or under-insured are also less likely to visit doctors for minor problems. Instead, it is only when the problem becomes severe that medical attention is sought. And because they do not have family doctors, they seek care at one of the state's charity hospitals or in the emergency rooms of private hospitals. These are two of the most expensive health care options, with their costs paid for by tax dollars and higher insurance rates.

DHH's challenge is to put more resources into early childhood health care and other preventive health measures. Done successfully, the result will be to slow the growth in health care spending. The Louisiana Children's Health Insurance Program (LaCHIP) and the CommunityCARE program (primary care for most Medicaid patients) are two key examples of how DHH is addressing the issues of health care coverage and access to care. This can be summed up in the equation: **Coverage + Access = CARE**

More Community-Based Care through Children's Choice

In January 2001, DHH began its Children's Choice program that funds special services for children with disabilities. This is an expansion of the state's efforts to provide more home and community-based services to children with disabilities up to age 19.

The program was especially designed for the families of children living at home who have medical and other expenses associated with caring for their children who have developmental disabilities and low to moderate needs. Children's Choice is intended to supplement the natural family and community supports already available. The array of services was developed with these considerations in mind, and in conjunction with parents and advocates.

In order to maximize funding and assure community-based services to as many children as possible, services provided by Children's Choice are capped at $7,500 yearly. Examples of these services include case management, center-based respite, family training, family support, diaper services and modifications to homes to make them accessible to children with disabilities. There is no limit to the medical services that Children's Choice will cover.

Nursing Home Intergovernmental Transfer Program

Act 143 of the First Extraordinary Session of the Louisiana Legislature established the Nursing Facility Intergovernmental Program and the Medicaid Trust Fund for the Elderly. The Department of Health and Hospitals was successful in having a State Plan approved to implement Act 143 before the Health Care Financing Administration {now named Centers for Medicare and Medicaid Services (CMS)} terminated the program that allowed large payments. The State Plan was approved with an effective date of October 13, 2000.

The funds generated from this program are deposited in the Medicaid Trust Fund for the Elderly and can only be disbursed in accordance with the original Act 143 conditions, unless CMS approves new terms. The Department has committed that no more than two-thirds of the net income from the Trust Fund interest will be used to enhance the quality of care in nursing homes and a minimum of one-third for development of additional community-based services and for increasing access to care for the medically underserved.

During SFY 2000-2001, approximately $306.6 million was deposited in the Medicaid Trust Fund for the Elderly. Approximately $17 million was disbursed from the fund, generating $53 million total funds for rebasing nursing home rates. Before the payments are reduced on October 1, 2002, to comply with new federal rules, approximately $900 million should be on deposit in the Trust Fund. After October 1, 2002, the program will generate approximately $2.5 million for deposit in the fund each quarter.

Caring for Persons with Disabilities and Persons Age 65 and Older

Louisiana must continue to seek alternatives to costly institutional care for persons with disabilities, and for persons age 65 and older. In addition to more community living options and alternatives to nursing homes, people are demanding better and easy-to-read information about quality of care standards.

Currently, Medicaid spending on individuals in nursing homes consumes almost a quarter of DHH's budget. Another significant amount of money is spent on providing care in group homes and large institutions for people with developmental disabilities. The cost to provide this care can better be controlled by seeking and implementing lower-cost options. This is achievable since citizens and advocates have indicated they would prefer alternatives to institutional care.

According to Gov. Mike Foster, "Our citizens want to grow old with grace and dignity. If they choose to spend their twilight years in a nursing home, they should be assured of receiving excellent care. However, a nursing home should not be their only option. Louisiana is now moving forward by offering our oldest and frailest citizens more living and health care options in a way that best manages limited resources."

> *During the summer of 2001, Department of Health and Hospitals Secretary David W. Hood testified before the United States Senate Special Committee on Aging. Hood made recommendations to reform the Medicaid and Medicare programs to better meet the needs of aging Louisiana citizens. Hood outlined problems associated with how long-term care is financed and how the aging baby boomers will place greater demands on states that seek to meet the needs of an aging population.*
>
> *"There is a wide disparity between rich and poor states when it comes to providing a continuum of care for those needing long-term care," Hood said. "When we see socially progressive states such as Vermont having difficulties, we can understand the extreme difficulties that poor, southern states like Louisiana are facing."*
>
> *Hood said that providing long-term care for Louisiana's seniors has traditionally revolved around nursing home care.*
>
> *"When it comes to long-term care in Louisiana, we spend over $800 million caring for people living in nursing homes. This includes direct payments to nursing homes as well as other services that the state pays to care for these older citizens. This compares to less than $8 million for community-based care for the elderly."*

Settlement Reached on Olmstead-like Lawsuit

More alternatives to nursing home care to be provided

In 2001, DHH reached an agreement that will result in persons age 65 and older having more choices about their long-term care. The settlement in *Barthelemy v. Louisiana Department of Health and Hospitals* draws upon the Americans with Disabilities Act and the Supreme Court decision, *Olmstead v. L.C.*, that increases state obligations to provide services in the most integrated setting.

The plaintiffs in *Barthelemy* argued that they were forced to live in nursing homes to receive care, even though they could successfully live outside an institution with minimal state-funded services. The settlement acknowledges DHH's policy to expand the Medicaid program by offering more community-based services to people residing in

nursing homes or who are at imminent risk of requiring the nursing facility level of care. This includes seeking necessary funding from all available sources, receiving federal approval for these expanded services and working to increase the number of private providers who offer these services.

The settlement plan submitted by DHH and approved by the plaintiffs, addresses four broad areas, each of which is outlined below:

Waiting Time Reduction – DHH will seek to eliminate the waiting time for those seeking community-based services who are residents of nursing homes or who are at imminent risk of nursing home placement by expanding the number of opportunities (slots) for community-based services.

- Elderly and Disabled Adult Waiver – DHH will add 600 slots in 2002 and 2003, 200 slots in 2004 and 100 slots in 2005.
- Personal Care Attendant Waiver – 25 slots a year to be added from 2002 through 2005.
- Adult Day Health Care Waiver – 25 slots a year to be added from 2002 through 2005.

Informed Choice – Information will be developed and provided about the nature and availability of community services to persons already in nursing facilities or at imminent risk of placement.

Personal Care Services Option — DHH will submit a Medicaid State Plan Amendment to provide personal assistant services as a fully-funded Medicaid service. Doing so will mean that waivers will not be required, and residents of nursing homes and those at imminent risk of such placement would be able to access up to 56 hours per week of these services.

Needs Assessment and Single Point of Entry – DHH will develop and utilize assessment protocols and processes to identify the long-term care needs of seniors. All persons requesting nursing home care or community-based care will be assessed as to their needs and preferences.

State's Effort to Control Drug Costs Withstands Challenge

Over the past 12 years, Louisiana's Medicaid drug spending has grown from $75 million a year to nearly $550 in gross payments to pharmacies in SFY 2000/01. The actual cost to Louisiana's Medicaid Program was $417 million, after rebates from pharmaceutical manufacturers (which are federally negotiated by HCFA/CMS) of $124 million. At the current rate of growth, the cost is projected to double to $1.1 billion a year by 2006.

In response, DHH developed a two-tiered pharmacy rate structure (based on a study by Myers & Stauffer) to determine how much pharmacies pay to purchase drugs from the manufacturers. The study showed that large, chain pharmacies have greater purchasing power and can get better prices from manufacturers than can smaller, independent drug stores.

The DHH reimbursement methodology, which received Legislative approval, provides for a two-tiered reimbursement system for chain and independent pharmacies. DHH reimbursement rates for SFY 2000/01 were as follows:

- Chain Pharmacies - Average wholesale price of drug less 16.5 percent.
- Independent Drug Stores - Average wholesale price less 15 percent.

DHH's methodology was challenged by several large chain pharmacies. The Walgreen Company attempted to end DHH's reimbursement methodology in August of 2000 and the Department prevailed in District Court in February of 2001. The District Court ruling was appealed to the U.S. Fifth Circuit Court of Appeals and DHH expects to prevail.

The rate structure is one of several of DHH's recent initiatives to control pharmacy spending. During the 2001 Regular Legislative Session, a bill was passed to allow the state to establish a formulary for prescription drugs that will be covered by the Medicaid program. Plans are in place for this program to be implemented before the end of SFY 2001/02 fiscal year.

Medicaid to Provide Behavior Management Services (including Autism)

Medicaid will soon provide specialized services to people with pervasive developmental disorders, including autism, following the settlement of the *Chisholm vs. Hood* lawsuit. The settlement calls for DHH to make appropriate psychological and behavioral services available to Medicaid-eligible children under age 21 with pervasive developmental disorders.

The plan establishes 15 professional teams throughout the state that will consist of at least one psychologist who will act as team leader, one person with a master's level degree or higher in psychology, one licensed clinical social worker and three behavioral specialists. Teams will be established throughout the state according to population.

DHH termed the agreement "an innovative and creative approach" to serving children with pervasive developmental disorders including autism. The plan will result in a state-of-the-art system of care that will serve as a model for other states, agencies and health care professionals who care for these children.

In addition to the settlement, DHH is also developing a Center of Excellence for these services. The Center will provide training and assistance for children with pervasive developmental disorders, including autism, and plans are to eventually provide clinical services.

FINANCING AND EXPENDITURES

Medicaid is funded by both state and federal funds. Each state has a pre-determined match rate based on relative per capita income in the state. The total expenditures for SFY 2000/01 excluding administrative costs were $3,648,079,415. Louisiana expended $1,033,671,883 in state financing and $2,614,407,532 in federal funds.

Table 4: Medicaid Means of Financing SFY 2000/01

	Medicaid Program ($)	Medicaid Administration ($)	Total ($)
State	1,033,671,883	42,058,557	1,075,730,440
Federal	2,614,407,532	59,989,798	2,674,397,330
Total	3,648,079,415	102,048,355	3,750,127,770

The table below shows this distribution by budget program for SFY 1999/00 and for SFY 2000/01.

Table 5: Medicaid Program and Administrative Expenditures

Program	SFY 1999/00	SFY 2000/01	% Change
Private Providers	$ 2,163,744,718	$ 2,354,374,934	8.81
Public Providers	389,197,445	383,247,904	-1.53
Uncompensated Care	821,424,802	826,902,940	0.67
Medicare Buy-In	85,827,705	83,553,637	-2.65
Program Total	**$ 3,460,194,670**	**3,648,079,415**	**5.43**
Administration	103,327,178	102,048,355	-1.24
Total Medicaid	**$ 3,563,521,848**	**3,750,127,770**	**5.24**

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 five years.

Federal Medical Assistance Percentages (FMAP)

Table 6: Historical FMAP

	1998/99	1999/00	2000/01
State	29.71	29.67	29.52
Federal	70.29	70.33	70.48

Federal Medical Assistance Percentages (LaCHIP)

Table7: Historical FMAP (LaCHIP)

	1998/99	1999/00	2000/01
State	20.92	20.75	20.67
Federal	79.08	79.25	79.33

Disproportionate Share Hospital (DSH) Payments

In 1981, Congress required states to make additional Medicaid payments to hospitals that provide certain health services for a "disproportionate share" of indigent patients. By 1991, the unceasing expansion of the states' DSH payments prompted Congress to start placing limits on the amount of federal match that could be appropriated for the program. With the Balanced Budget Act (BBA) of 1997, DSH spending for FFY 1997/98 was limited to FFY 1994/95 levels. Federal policy intended that federal spending on DSH would decline to $8.5 billion by FFY 2001/02. By federal rule, DSH reductions were to be achieved by gradually reducing the federal DSH match for 30 of the 50 states. Except for Arizona ($81 million), the rule slated for reductions any state whose federal match in 1998 exceeded $40 million. Although the reductions will not be fully implemented for FFY 2000/01 and FFY 2001/02, the federal government expects that the original FFY 2001/02 levels will be reached by FFY 2002/03. For **FFY 2000/01**, the federal government capped its DSH match to Louisiana at $713 million**.**

Table 8: Historical DSH/Non-DSH Expenditures ($ in Millions)

SFY	DSH	Non-DSH	Total Medicaid (administration not included)	DSH as a % of Total
1996/97	672.8	2,588.4	3,261.2	20.63
1997/98	757.4	2,406.7	3,164.1	23.94
1998/99	784.3	2,500.3	3,284.6	23.88
1999/00	821.4	2,638.8	3,460.2	23.74
2000/01	826.9	2,821.2	3,648.1	22.67

Cost avoidance is defined as measures taken to prevent the incurring of allowable medical costs for a particular service or group of services or for a recipient or group of recipients. Implementation of the Medicare Buy-In Program is an example of a cost avoidance measure. The Medicare Buy-in Program pays for Medicare Parts A and B for recipients.

Table 9: Collections/Cost Avoidance SFY 00/01

COLLECTIONS/COST AVOIDANCE SFY 2000/01	$
PHARMACY PROGRAM	
Drug Rebate Program	123,877,196
Pro-DUR	24,030,694
Co-payments	11,520,341
Medicare Cost Avoidance of Crossovers	5,064,603
Recoupments (started 1/01)	1,169,794
PROVIDER FEES	
Nursing Facilities	62,021,590
ICF/MR	21,250,028
Prescriptions	5,737,585
RECOUPMENTS	43,327,820
THIRD-PARTY LIABILITY COLLECTIONS	
Insurance	4,493,291
Trauma Recovery	5,551,384
Other Collections	499,895
INELIGIBLE RECOVERIES / ESTATE RECOVERY	683,636
MEASURABLE COST AVOIDANCE	
Medicare Cost Avoidance	287,857,934
Dispensing Fee Adjustment	16,181,514
TOTAL COLLECTIONS/COST AVOIDANCE	613,267,305

ELIGIBILITY

Eligibility Determination

Eligibility determination is a federally approved process which is operated in the same manner throughout the state. All eligibility decisions are made objectively in accordance with standardized, written policy. Decisions must be made within 45 days (90 days if a disability determination by the agency is required) from the date of application.

Individuals who meet all requirements receive full Medicaid coverage plus vendor payment to the facility or waiver services providers. Individuals with income may be required to contribute a portion of that income to pay for the services they receive. Federal laws establish the standards for determining family income, which take into account certain individual and family expenses. Federal law also determines enrollment and eligibility determination rules, including out-stationed enrollment for pregnant women and children at Federally Qualified Health Centers.

Eligibility Process

The eligibility process begins with completion of a Medicaid application form and a face-to-face interview at a Medicaid Application Center or a local Medicaid eligibility office. More than 600 Medicaid Application Centers are certified statewide, and locations include community health and social service organizations, medical providers, and faith-based centers. A simplified one-page LaCHIP application is used for children under age 19 and an interview is not required. Most applications for children are submitted by mail.

All applications are processed by Medicaid Analysts who determine eligibility by establishing that the applicant meets the eligibility criteria for one of the more than 200 category/type combinations for Louisiana Medicaid. Examples of eligibility factors are Louisiana residence, age, disability, income, assets, alien status, and pregnancy. The process for establishing eligibility includes obtaining documentary evidence from the applicant and third parties (employers, insurance companies, financial institutions), as well as by accessing electronic records (wage records, Food Stamp and FITAP records). Average application processing time varies by program, but the overall average is less than 30 days. Federal regulations require most applications to be processed within 45 days.

- If applicants are determined eligible, they are added to the Medicaid file effective the month the application was received, **which is usually a prior month**, and they receive a notice of decision and plastic Medicaid identification card.

- If the applicant had medical bills and is otherwise eligible **prior** to the month the application is received, the effective date of Medicaid coverage can be as early as three calendar months prior to the application date.

These two factors combine to create a significant lag between the service date and payment date. Example: Application received September 28; certified November 3 with eligibility effective date June 1. The earliest date the provider could receive payment for June services is November.

Certification periods vary, but the most common is 12 months. At that point renewal is necessary in order for Medicaid benefits to continue. Children under age 19 are eligible for 12 months continuous coverage regardless of changes in circumstances. For adults, changes in circumstances trigger a renewal and eligibility can terminate at any time eligibility factors are no longer met.

Eligibility Criteria

The table on the following pages includes a listing of the programs that make up the five major eligibility groupings: Families and Children, Poverty Level Women and Children, Blind and Disabled, Old Age Assistance and Other. For additional information on these eligibility groupings, please refer to pages 17-19**.**

Table 10: Eligibility Criteria as of June 30, 2001

PROGRAM	DESCRIPTION	INCOME LIMIT	ELIGIBILITY GROUPINGS
LIFC—Section 1931	Children & families	16% of poverty; no assets test	Families and Children
LIFC—Section 1931 "PAP"	Children & families	16% of poverty with income of sibling, step-parent, and grandparent of minor child disregarded (anyone not legally responsible for child); No assets test	Families and Children
AFDC-Related Medically Needy	Children & families	20% of poverty; no assets test	Families and Children
AFDC-Related Spend down Medically Needy	Children & families	All income over 20% of poverty considered available to meet medical expenses for quarter; no assets test	Families and Children
TANF (FITAP) Recipients	Recipients of FITAP have LIFC eligibility determined by DSS Office of Family Support	16% of poverty; *assets below $2,000*	Families and Children
Transitional Medicaid	Former LIFC recipients with earnings now exceeding 16% of poverty; former TANF recipients with earnings now exceeding 19% of poverty	185% of poverty for coverage in seventh through twelfth month of transitional eligibility period; people cannot gain eligibility for this program unless they have previously been eligible under another program with income limits below 16% of poverty	Families and Children
CHAMP—Pregnant Woman	Verified pregnancy-2 month post-partum period	133% of poverty; *no assets test*	Poverty Level Women and Children
Deemed Eligible Child	Child under age 1 born to Medicaid eligible mother	No income limit; *no assets test*	Poverty Level Women and Children
Presumptive Eligible Pregnant Woman	Provides ambulatory pre-natal services to pregnant women as determined eligible by a qualified provider	133% of poverty; *no assets test*	Poverty Level Women and Children
CHAMP—Low Income Children	Ages 0-5	133% of poverty; *no assets test*	Poverty Level Women and Children
	Ages 6 and up but born no earlier than 10/1/83	100% of poverty; *no assets test*	
MCHIP—Title 21 children not eligible for Title XIX Medicaid (LaCHIP)	Ages 0-5	>133% poverty to 200% of poverty; *no assets test*	Poverty Level Women and Children
	Ages 6 and up but born no earlier than 10/1/83	>100% poverty to 200% of poverty; *no assets test*	
	Born before 10/1/83 to age 19	200% of poverty; *no assets test*	

PROGRAM	DESCRIPTION	INCOME LIMIT	ELIGIBILITY GROUPINGS
Breast and/or Cervical Cancer Program	Women screened under the CDC National Breast & Cervical Cancer Early Detection Program and need treatment for breast and/or cervical cancer	No income limit; *no assets test*	Other
Section 4913 Child	Individuals under age 18 denied SSI cash because of an SSI provision which is prohibited in Medicaid	74% of poverty (+ $20); *assets limit $2000 for individual*	Blind/Disabled
Early Widows/ Widowers	Individuals who lost SSI because of receipt of Social Security widow/widowers benefits	74% of poverty (+ $20); *assets limit $2000 individual, $3000 couple*	Blind/Disabled
Personal Care Attendant	Aged and disabled recipients who meet medical criteria for institutional level of care	222% of poverty; *assets limit $2,000 individual, $3,000 couple*	Blind/Disabled
Qualified Disabled Working Individual	Provides Medicare Part A Buy-In for non-aged individuals who lost SS disability benefits and premium-free Part A Medicare coverage because they went to work	Equal to or below 200% of poverty; *asset limit: $4,000 for individual, $6,000 couple*	Blind/Disabled
SSI Recipients	Aged and disabled recipients of federal SSI cash payments as determined by Social Security Administration	74% of poverty (+ $20); *assets limit $2000 individual, $3000 couple*	Aged/Blind/Disabled
SSI-Related Spend down Medically Needy	Aged and disabled recipients with income above 74% of poverty (+ $20)	All income over 14% of poverty (+ $20) is considered available to meet medical expenses for quarter; *assets limit $2000 individual, $3000 couple*	Aged/Blind/Disabled
Disabled Adult Child	Individuals over age 18 who become blind or disabled before age 22 and lost SSI eligibility on or before 7/1/87 as a result of entitlement to or increase in Social Security benefits.	Social Security benefits are disregarded in determining countable income with limit 74% of poverty (+ $20); *assets limit $2000 individual, $3000 couple*	Aged/Blind/Disabled
Disabled Widows/ Widowers	Restores Medicaid eligibility to disabled widows/widowers who would be eligible for SSI had there been no elimination of the reduction factor and no subsequent cost-of-living increases	74% of poverty (+ $20); *assets limit $2000 individual, $3000 couple*	Aged/Blind/Disabled
Long-Term Care	Aged and disabled recipients who meet medical criteria for institutional level of care	222% of poverty; *assets limit $2000 individual, $3000 couple*	Aged/Blind/Disabled

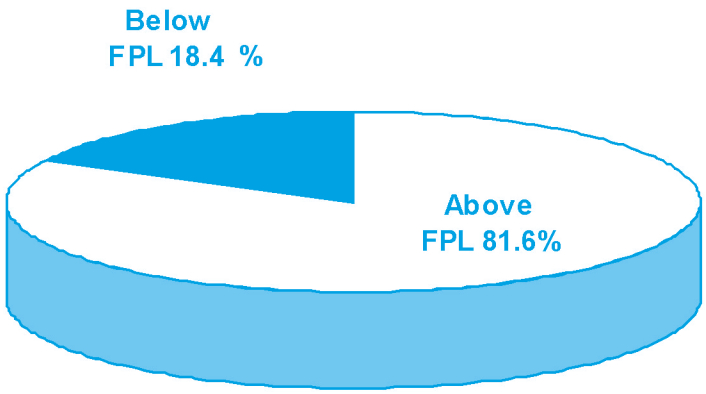
PROGRAM	DESCRIPTION	INCOME LIMIT	ELIGIBILITY GROUPINGS
Home & Community-Based Waivers: Adult Day Health, Elderly & Disabled, MR/DD	Aged and disabled recipients who meet medical criteria for institutional level of care	222% of poverty; *assets limit $2000 individual, $3000 couple*	Aged/Blind/Disabled
Extended Medicaid (Pickle)	Former SSI recipients who lost eligibility due to annual SSA cost-of-living increase	All cost-of-living raises are disregarded in calculating countable income with limit 74% of poverty (+$20); *assets limit $2000 individual, $3000 couple*	Aged/Blind/Disabled
Qualified Medicare Beneficiary	Pays Medicare premiums, deductibles and co-insurance for Medicare covered services	Below 100% of poverty; *asset limit $4,000 individual, $6,000 couple*	Other
Specified Low Income Medicare Beneficiary	Pays Part B Medicare premium only	100% and less than 120% of poverty; asset limit $4,000 individual, $6,000 couple	Aged/Blind/Disabled
Qualified Individual—Category 1	Pays Part B Medicare premium only	120% and less than 135% of poverty; *asset limit $4,000 individual, $6,000 couple*	Aged/Blind/Disabled
Qualified Individual—Category 2	Pays a portion of Part B premium	135% and less than 175% of poverty; *asset limit $4,000 for individual, $6,000 for couple*	Aged/Blind/Disabled
Tuberculosis Infected Individual	Persons who have been diagnosed as, or are suspected of, being infected with tuberculosis	74% of poverty (+$20); *assets limit $2000 individual*	Other

LOUISIANA MEDICAID PROFILE

A snapshot of the state's population shows the importance of the Louisiana Medicaid program. Medicaid is a health coverage program for certain low income citizens. It is jointly funded by the state and federal governments. Administered by DHH, Medicaid provides health care coverage to low income families, children, the aged, blind, and people with disabilities.

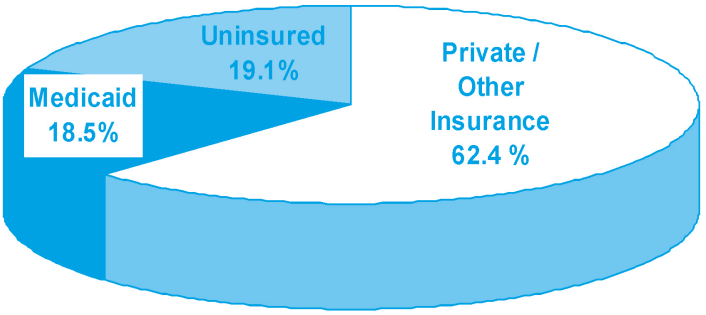
Census bureau data indicates that Louisiana has a higher percentage of people living below the poverty line than any other state. The population for Louisiana in 2001 was 4,465,430.[1] It is estimated that 18.4 percent of Louisiana citizens lived in families with incomes at or below the 2000 FPL.[2]

Figure 3: Poverty in Louisiana 2001



Using Medicaid and Census data, an estimate of Louisiana health insurance coverage rates for 2000 can be made. During this SFY, the Louisiana Medicaid program covered 19.1 percent of the state's population. The U.S. Census Bureau estimates that the rate of uninsured persons in Louisiana was approximately 19.1 percent. Estimating the 2001 uninsured rate at 19.1 percent puts the rate of persons with some other kind of coverage (e.g. private, Medicare, Veterans) at 62.4 percent. Figure 4 shows the estimated distribution of the uninsured population in Louisiana for SFY 2000/01.

Figure 4: Louisiana Health Insurance Coverage SFY 2000/01



Medicaid is a means-tested program, and the programs have different income limits, depending on the category and type of Medicaid assistance. Income limits for most Medicaid programs are based on the Federal Poverty Guidelines (FPG), and increase annually. There are two slightly different versions of the federal poverty measure:

- The poverty thresholds, and
- The poverty guidelines

The **poverty thresholds,** originally developed in the early 1960s by Molly Orshansky of the Social Security Administration, are the original version of the federal poverty measure. Updated each year by the **Census Bureau**, the thresholds are used mainly for **statistical** purposes – for instance, preparing estimates of the number of Americans in poverty each year. All official poverty population figures are calculated using the poverty thresholds.

The **poverty guidelines** are the other version of the federal poverty measure. They are issued each year in the *Federal Register of* the **Department of Health and Human Services** (HHS). The guidelines are a simplification of the poverty thresholds for **administrative** purposes – for instance, determining financial eligibility for certain federal programs, including Medicaid. Poverty guideline are adjusted effective April of each year.

Monthly Poverty Income Guidelines
Effective April 1, 2001

Family Size	100%	133%	150%	200%
1	716	953	1074	1432
2	968	1,287	1452	1935
3	1220	1622	1829	2439
4	1471	1957	2207	2942
5	1723	2291	2584	3445
6	1975	2626	2962	3949
7	2226	2961	3339	4452
8	2478	3296	3717	4955

MEDICAID ELIGIBLES, RECIPIENTS AND PAYMENTS BY CATEGORIES OF AGE AND GENDER

In SFY 2000/01 a total of 825,678 persons in Louisiana were eligible for Medicaid. Of those, 341,683 were males and 483,946 were females*. In the age range birth to age 14, eligible males outnumbered females. However, females outnumber males overall with a much greater enrollment among persons ages 15 and over. Females between 21 and 44 years of age represented the highest gender/age group of persons eligible.

Figure 5 shows the distribution of unduplicated **eligibles** by age and gender. In the younger age groups the number of males exceeds female. However, among the higher age categories, females far exceed males. This is primarily due to Medicaid eligibility criteria for adults.

Figure 6 refers to unduplicated **recipients**. In the younger age groups the number of males slightly exceeds females. However, among the higher age categories, the number of females exceeds males.

Figure 7 shows the distribution of Medicaid **payments** by age and gender. In the younger age groups payments on behalf of males exceeds females. Among the higher age categories, payments for females exceed payments for males.

*In the eligibility records there were 49 cases in which gender was not specified.

Figure 5: Unduplicated Eligibles by Age and Gender

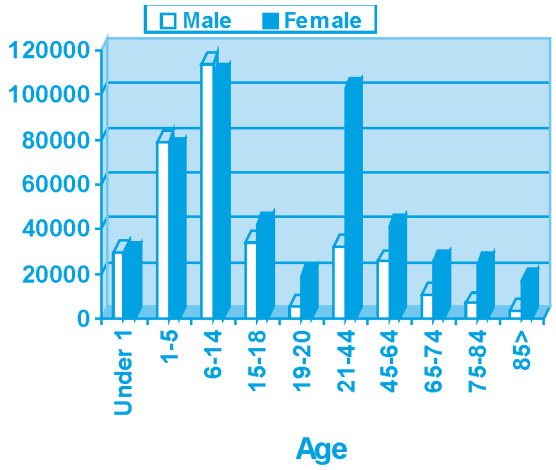
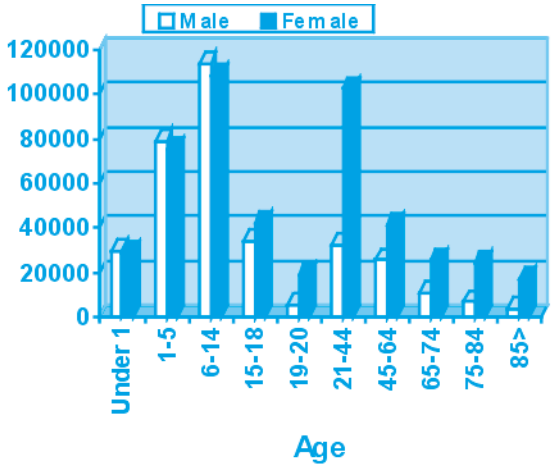


Figure 6: Unduplicated Recipients by Age and Gender



SFY 2000/01 Medicaid Eligibles by Parish

Figure 7: Payments by Age and Gender

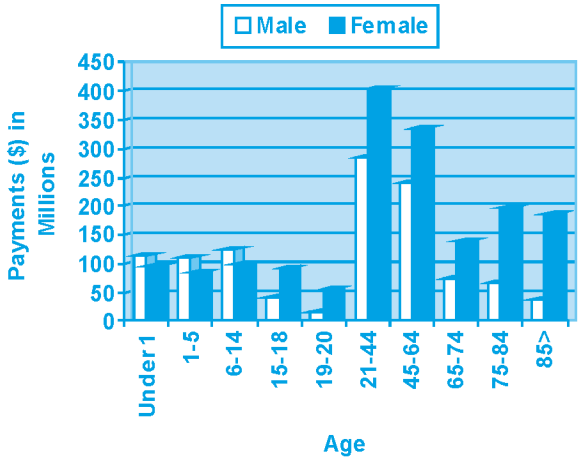


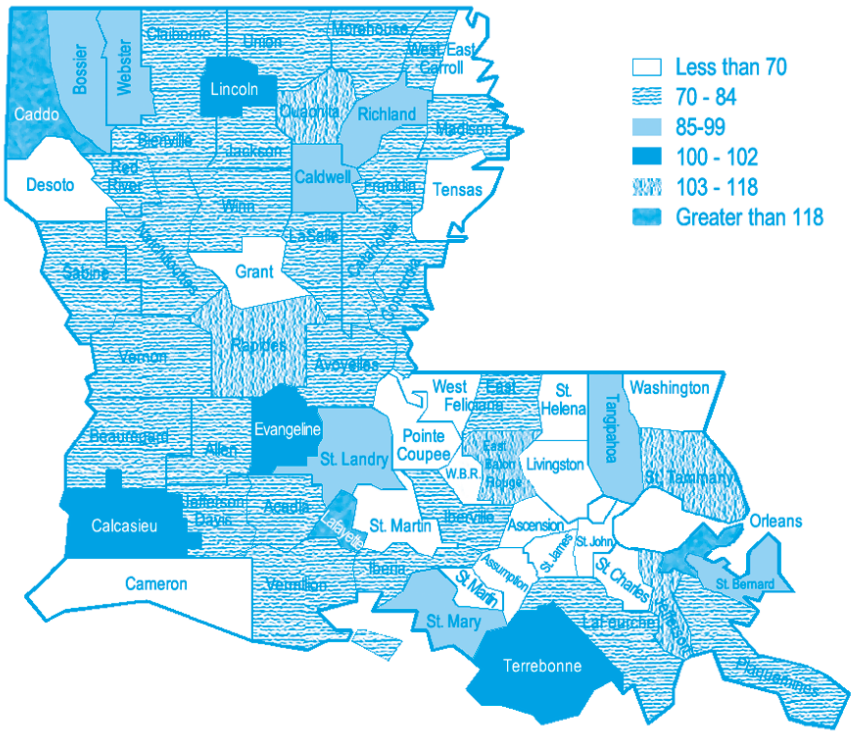
Table 11: Eligibles by Age and Gender

	Males 2000	Males 2001	% Change	Females 2000	Females 2001	% Change	Total 2000	Total 2001	% Change
Children under 19	237,366	256,760	8.17	235,658	254,372	7.94	473,024	511,132	8.06
Ages 19-20	4,427	5,306	19.86	18,889	18,976	.46	23,316	24,282	4.14
Total	241,793	262,066	8.38	254,547	273,348	7.39	496,340	535,414	7.87

	Males 2000	Males 2001	% Change	Females 2000	Females 2001	% Change	Total 2000	Total 2001	% Change
Children under 21	241,793	262,066	8.38	254,547	273,348	7.39	496,340	535,414	7.87
Adults	81,947	79,617	-2.84	214,962	210,598	-2.03	296,909	290,215	-2.25
Total	323,740	341,683	5.54	469,509	483,946	3.07	793,249	825,629	4.08

LOUISIANA PROVIDER PARTICIPATION RATIOS

The map below reports Medicaid payments made to participating providers in each parish. It also reports payments made on behalf of Medicaid recipients residing in each parish regardless of where they received services. The "Provider Payments/Recipient Payments Ratio" intervals shows the ratio of provider payments to recipient payments times 100. A ratio of 100 indicates that provider payments and recipient payments in a parish or region are the same. A ratio less than 100 means that recipient payments are greater than provider payments in the parish and indicates a net loss of recipient payments to other parishes. A ratio greater than 100 implies that providers realize a net gain of Medicaid payments from services provided to recipients from other parishes. The ratios are not provided to imply a shortage or oversupply of providers in a parish. Provider shortages or oversupplies can only be determined through detailed analysis. However, the ratios may be used to help identify parishes that may need to consider if there are measures that could be taken to meet the health care needs of the patients (recipients) in their respective communities.



The map translates into a visual representation of ratios. It shows geographically in which parishes Medicaid payments to providers exceed payments for recipients. It also shows those parishes where provider payments fall below total reimbursement for the parish's Medicaid recipients.

MEDICAID ELIGIBLES, RECIPIENTS AND PAYMENTS BY CATEGORIES OF ASSISTANCE

In Louisiana, the federally defined eligible / recipient **categories** (or groupings) are: Families and Children, Poverty-Level Women and Children, Blind /Disabled, Old Age Assistance and Other because the eligibility criteria are similar for eligibles within the eligibility groupings.

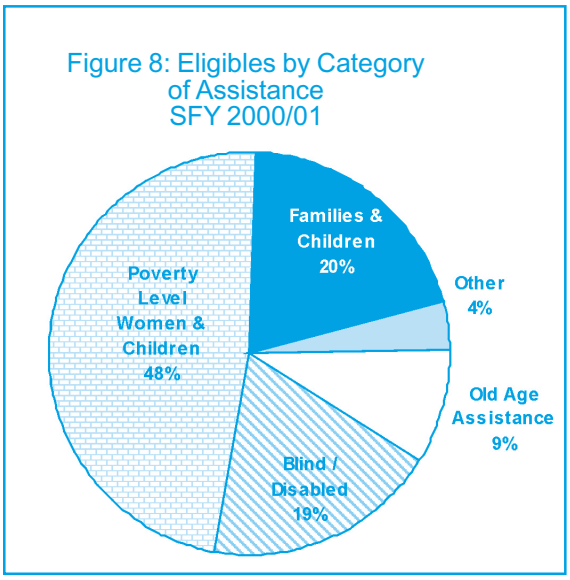
Families and Children – Includes individuals with low income and limited resources whose household income level is equal to or less than 16 percent of the FPL.

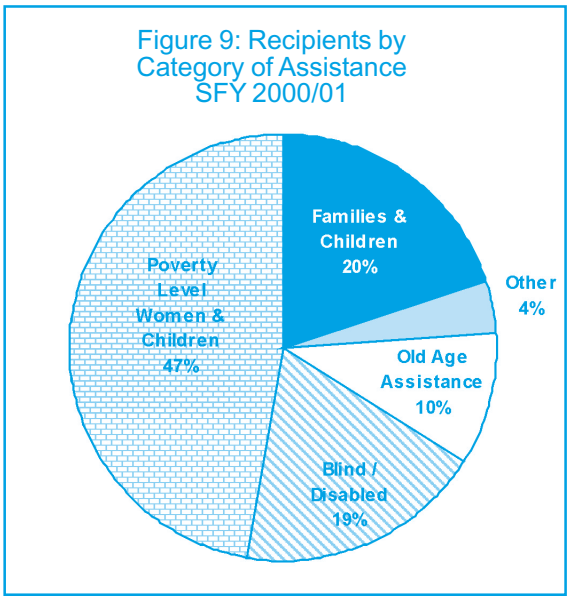
Poverty Level Women and Children - Includes individuals whose household income level may be from 17 percent up to 200 percent of the FPL.

Blind and/or Disabled - Includes individuals determined to meet the Social Security Administration (SSA) eligibility criteria for blindness or disability eligibility criteria.

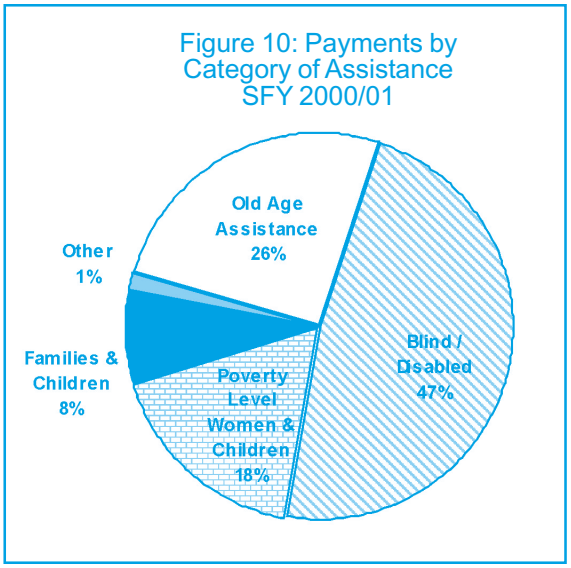
Old Age Assistance - Includes individuals who meet the SSA definition of aged, which is age 65 and older.

Other - Includes individuals in foster care receiving state funds only, etc.





Figures 9 and 10 show that "Blind and Disabled" and "Old Age Assistance" recipients account for about one-third of all Medicaid recipients, but account for *three-quarters* of all Medicaid claim payments for services. The women, children and families programs represent almost *two-thirds* of all recipients but account for only *one-fourth* of claims payments for services.



TOP TEN PAYMENTS BY PROVIDER TYPE

Top Ten Payments represents the ten provider types with the highest Medicaid levels of reimbursement. The Top Ten list that follows represents approximately 92 percent of all payments to public and private providers. In SFY 2000/01 Medicaid made $2,821,510,784 in claims payments to providers, of which $2,572,920,653 were to Louisiana-based providers.

1. Hospital (Inpatient and Outpatient)

Hospital services include both inpatient and outpatient services. Inpatient services are provided to recipients during their stays in licensed hospitals participating in the Medicaid Program. Services that are included are medical supplies, nursing care, therapeutic services, lab and x-ray, emergency room care, rehabilitation services and drugs. Prior authorization is required to extend visits due to medical needs. Outpatient services are provided to recipients in outpatient settings of licensed Medicaid participating hospitals. The total payments for SFY 2000/01 for both inpatient and outpatient hospital services were $690,292,810.

2. Pharmacy

Services include the dispensing of FDA approved drugs by state licensed participating pharmacies. Prescriptions must be prescribed by licensed physicians, dentists, podiatrists, or certified optometrists. 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. Payments for SFY 2000/01 were $543,536,749. This $543,536,749 represents gross payments to pharmacists. Gross payments to pharmacists less rebates from drug manufacturers ($123,877,196) results in payments net of rebates in the amount of $419,659,553.

3. Nursing Homes (LTC)

Services include professional nursing and rehabilitation services provided on a 24-hour-a-day basis to recipients in state licensed Medicaid nursing facilities. Recipients require only limited medical supervision and custodial care. Payments for SFY 2000/01 for nursing homes were $542,520,888.

4. Intermediate Care Facilities for the Mentally Retarded (ICF-MR)

Intermediate Care Facilities-Mentally Retarded (ICF-MR) services are rendered on a regular basis by state licensed Medicaid facilities structured to treat mentally retarded recipients who need daily supervision. Payments for SFY 2000/01 were $345,990,919. These payments include payments to both private and public, ICF-MR group homes and state developmental centers.

5. Physicians (MD)

Services include the diagnosis and treatment of a recipient's illness in a doctor's office, the recipient's home, hospital, nursing home, emergency room, ambulatory surgical center including rural health clinic, Federally Qualified Health Center (FQHC) or other setting. Payments for SFY 2000/01 were $272,324,662.

6. Personal Care Attendant (PCA)

A Personal Care Attendant is an individual who provides personal care to a person with a very severe disability by providing assistance with activities of daily living that the individual would typically perform if the individual did not have a disability. PCA services include, but are not limited to, assistance with the following activities of daily living: routine bodily functions, such as bowel or bladder care, dressing, preparation and consumption of food, house cleaning and laundry, moving in/out of bed, routine bathing, ambulation and any other similar activity of daily living. Payments for SFY 2000/01 were $57,503,754.

7. Independent Living

Independent Living services are those services that enable an individual with a significant disability to function independently in the family or the community. Independent Living services include, but are not limited to, counseling, mobility training, physical rehabilitation, interpreter and reader services, and individual and group social and recreational services. Payments for SFY 2000/01 were $37,444,209.

8. Durable Medical Equipment (DME)

Durable Medical Equipment products include wheelchairs, oxygen concentrators, prostheses and other medical devices. Payments for SFY 2000/01 for Durable Medical Equipment were $30,426,833.

9. Respite Care

Respite Care is a service which provides temporary relief to caregivers who provide care to individuals who are mentally retarded, developmentally disabled, physically disabled or medically fragile. The purpose of this service is to relieve the stress encountered by caregivers, or deliver care when the caregiver is faced with an emergency. Payments for SFY 1999/00 were $27,162,060.

10. Dental

Dental services include an annual dental screening which consists of an examination, radiographs (x-rays), prophylaxis, topical fluoride application and oral hygiene instruction. In addition to these diagnostic and preventive procedures, certain surgical and restorative dental services (extractions, fillings) and dental prosthetics (dentures) may also be covered. Payments for SFY 2000/01 were $25,717,769.

Table 12: SFY 2000/01 Top Ten Payments by Provider Type

PROVIDER TYPE	1999/00 Payments ($)	2000/01 Payments ($)	Percent Change (%)
Hospital (Inpatient and Outpatient)	681,999,961	$690,292,810	1.22%
Pharmacy (Gross Payments)	466,762,909	543,536,749	16.45%
Nursing (LTC)	503,992,717	542,520,888	7.64%
ICF(MR)	349,726,094	345,990,919	-1.07%
Physicians (MD)	262,322,549	272,324,662	3.81%
Personal Care Attendant (PCA)	44,301,750	57,503,754	29.80%
Independent Living	27,060,849	37,444,209	38.37%
Durable Medical Equipment (DME)	35,625,769	30,426,833	-14.59%
Respite Care	21,504,440	27,162,060	26.31%
Dental	22,847,086	25,717,769	12.56%
Top Ten Total – In State	**2,416,144,124**	**2,572,920,653**	6.49%
All Other Provider Payments (53 Types)	**208,859,163**	**248,590,131**	19.02%
Total All Payments	**2,625,003,287**	**$2,821,510,784**	7.49%

Table 12 shows payments to the top ten provider types during SFY 1999/00 **before** all financial adjustments were applied. Figures in Table 13 are taken from the **DHH Medicaid Year End Financial Report for SFY 1999/00**, and represent **net** expenditures, **after** all financial adjustments are taken into account (as reflected in the Division of Administration's ISIS system). Further, expenditures are shown according to the budget category of service under four broad groupings (refer to Table 13 for the budget categories of service):

- Private Providers
- Uncompensated Care
- Public Providers
- Medicare Buy-Ins and Supplements

Differences in terminology and groupings explain the variation in dollar amounts in Table 12 and Table 13. Underlying definitions of the categories being reported differ. For example, in Table 12, hospital payments reflect payments for **all** claims associated with the provider type "Hospital," including inpatient, outpatient, and laboratory and X-ray services. No distinction is made between private, public, and state hospitals. On the other hand, hospital related expenditures in the Table 13 are divided into Hospital-Inpatient, Hospital-Outpatient, as well as Laboratory and X-ray Services categories. Differentiation is also made between private (all non-state) and public (LSU-HCSD) hospitals.

Tables 12 and 13 reflect two specialized and different ways to view Medicaid reimbursements (payments/expenditures) for services received from providers. Therefore, caution should be exercised when making any inferences or reaching conclusions relative to overall Medicaid Program costs.

Table 13: SFY 2000/01 Expenditures by Budget Category of Service

Budget Category of Service	Expenditures ($)
Private Providers	
Adult Dentures	2,122,538
Case Management Services	10,958,602
Certified RN Anesthetists (CRNA's)	4,728,203
Durable Medical Equipment	29,788,764
EPSDT (Screening and Early Diagnosis)	56,713,618
Family Planning	5,937,315
Federally Qualified Health Centers	5,085,472
Hemodialysis Services	17,580,500
Home Health Services	23,617,291
Hospital – Inpatient	506,559,638
Hospital – Outpatient	116,052,441
ICF-MR (MR/DD Community Homes)	175,097,706
Laboratory and X-Ray Services	42,228,988
Mental Health – Inpatient Services	6,054,352
Mental Health Rehabilitation	24,482,610
Nursing Homes	526,719,492
Pharmaceutical Products and Services	417,322,672
Physicians Services	199,304,854
Rehabilitation Services	1,024,430
Rural Health Clinics	12,111,195
Transportation – Emergency	17,827,191
Transportation – Non-Emergency	12,109,813
Waiver – Adult Day Health	2,550,576
Waiver – Children	1,250
Waiver – Elderly & Disabled Adults	4,925,860
Waiver – MR/DD (Community Services)	124,978,164
Other Private Providers	8,491,399
Sub–Total Private Providers	**2,354,374,934**

Public Providers	Expenditures ($)
LSU – HCSD	97,193,298
LSUMC – Shreveport	59,992,219
DHH – State MR/DD Services	174,772,209
DHH – State Nursing Homes	16,226,952
DHH – Office of Public Health	12,578,425
DHH – Community Mental Health	7,976,625
DHH – Public Psych. Free Standing	1,365,400
DHH – Public Psych. Distinct Part	3,966,701
State Education	7,584,670
Other Public Providers	1,591,406
Sub–Total Public Providers	**383,247,904**
Uncompensated Care	
LSU – HCSD	569,748,926
LSUMC	123,591,899
Public Free Standing Unit	77,400,268
Villa Feliciana	931,914
Private Hospitals	55,229,933
Sub–Total Uncompensated Care	**826,902,940**
Medicare Buy-In & Supplements	
Medicare Buy-Ins and Supplements	83,553,637
Sub – Total Medicare Buy-Ins and Supplements	**83,553,637**
Total Medical Vendor Program	**3,648,079,415**

LOUISIANA HOME AND COMMUNITY-BASED WAIVER SERVICES

A Home and Community-Based Waiver is an agreement between the state(s) and the Centers for Medicare and Medicaid Services (CMS) that "waives" the usual requirements for Medicaid services. States have the flexibility to design each waiver program and select the mix of waiver services that best meets the needs of the population to be served by the waiver. Services may be provided statewide or may be limited to specific geographic areas. Services do not have to be offered to every Medicaid recipient. Aggregate program costs must be equal to or less than the costs of institutional care for a similar population. Cost effectiveness is reported each year to CMS. The goal of these programs is to provide a framework for home and community-based services for Louisiana citizens where the individuals who choose this option can be assured a safe and healthy environment, quality services, and are empowered with state and federal rules and regulations with the opportunity to direct their lives based on their desired personal outcomes. The waiver agreement contains some required assurances on the part of the state. Some of the assurances are:

- the health and welfare of all the participants will be safeguarded
- that only qualified providers of services will be enrolled into the program
- no services are provided that are not part of an approved care plan

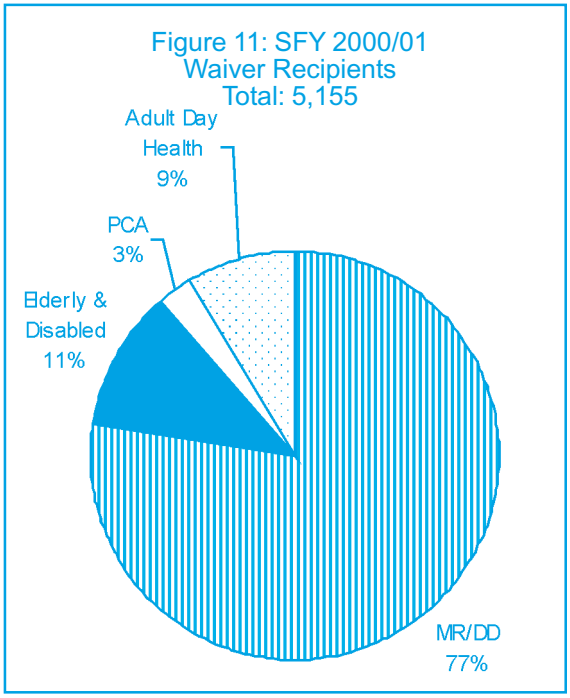
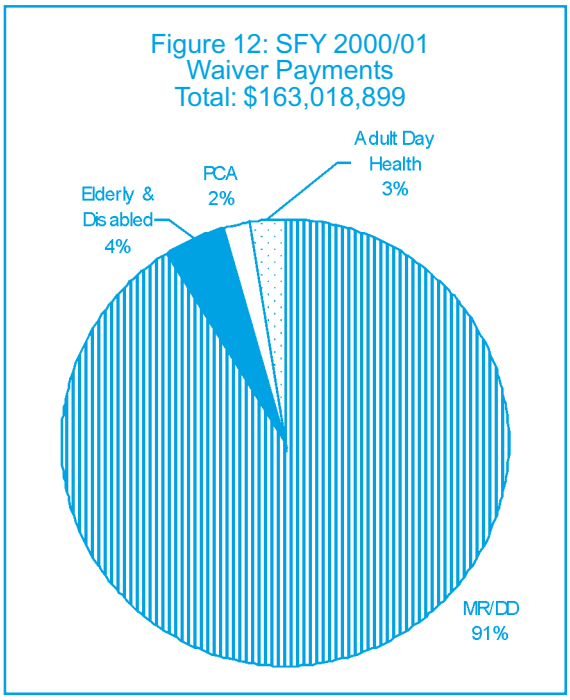


Figure 11 reports the number of unduplicated waiver recipients on whose behalf the Medicaid Program paid a claim during SFY 2000/01. Figure 12 reports claims payments for both the waiver services and other medical services provided to recipients. Currently, there are **five** Home and Community–Based Services Waivers: Adult Day Health Care, Mental Retardation and Developmental Disabilities, Personal Care Attendant, Elderly and Disabled, and Children's Choice.



Adult Day Health Care Waiver was implemented January 1, 1985 and is the first waiver established in Louisiana. The target population consists of elderly Medicaid recipients and disabled adults who meet Medicaid standards for disability and who choose waiver services as an alternative to nursing facility care. The waiver is 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 only service in this waiver is Adult Day Health Care services provided at a licensed health care facility on a daily basis. Since only one service is available, case management is provided as an integral part of that one service. There were 441 recipients in Adult Day Health Care Waiver Program SFY 2000/01.

Elderly and Disabled Adult Waiver was implemented in 1993. This waiver is designed to provide up to seven support services to the elderly in their homes (case management, personal care attendant, household supports, day supervision, night supervision, personal emergency response systems, and environmental modifications) as an alternative to nursing home placement. On April 1, 1997 the waiver was amended to include disabled adults ages 21 through 64 in addition to elderly and disabled ages 65 and over. Participants in the program must meet admission requirements for a nursing facility. In order to remain in the program participants must be able to be served safely with the array of services available within this waiver. The daily cost cap of $35 per

day was established for these waiver services to ensure continued cost effectiveness. There were 566 recipients in the Elderly and Disabled Adult Waiver Program in SFY 2000/01.

Mental Retardation and Developmental Disability (MR/DD) Waiver is Louisiana's largest home and community-based program. This program was implemented in June of 1990 and serves citizens above the age of 3 who are mentally retarded or developmentally disabled. Onset of the disability must have occurred prior to the age of 22. The target population consists of Medicaid people who are eligible to enter an ICF-MR facility but choose community-based services instead. The MR/DD Waiver combines a variety of Medicaid services. These services include personal care attendant services, respite care, substitute family care, residential habilitation, habilitation/supported employment, pre-vocational habilitation, day habilitation, environmental modifications, personal emergency response systems, and assistive devices. Case management to this population is available as a separate service outside of the waiver service package. There were 3,996 recipients in the MR/DD Waiver Program in SFY 2000/01.

Personal Care Attendant (PCA) Waiver was implemented in July of 1989. The Personal Care Attendant Waiver serves citizens ages 18 through 55 who only require Personal Care Attendant services to avoid institutionalization. Services may continue after the age of 55 or until eligibility is lost. The target population consists of disabled adult Medicaid recipients with lost sensory or motor function (quadriplegic) who are eligible to enter a nursing facility, and are being served by an Independent Living Center which receives funds under Title VI of the Rehabilitation Act. There are currently three such designated centers in Louisiana: New Orleans, Lake Charles, and Shreveport. Each of these centers has satellite offices giving coverage across the state. Since this is a single waiver, the case management services are included in the fee to the provider. There were 152 recipients in the PCA Waiver Program in SFY 2000/01.

Children's Choice was implemented February 21, 2001, to offer supplemental support to children with developmental disabilities who currently live at home with their families, or who will leave an institution to return home. Families choose to either apply for Children's Choice or remain on the MR/DD Request for Services Registry. Children's Choice was implemented to serve people from birth through age 18 who meet the federal definition for mental retardation or a developmental disability.

HOME AND COMMUNITY-BASED WAIVER SERVICES
Visions for the Future

- Provide a seamless access to delivering a long-term care system to persons with a wide range of conditions and service needs.
- Invest in quality assurance and quality improvement.
- Continue to develop new partnerships with key stakeholders.
- Continue to increase the number of providers who deliver quality services.

HOW MEDICAID WORKS

Administrative Organizational Structure

The Medicaid Program operates within the Louisiana Department of Health and Hospitals (DHH) and is administered by the Bureau of Health Services Financing (BHSF). BHSF has **1,206** authorized positions as of **6/30/01**. The following information provides insight pertaining to the functions of the ten administrative sections within the BHSF.

ELIGIBILITY FIELD OPERATIONS - JOHN FRALICK

Key Functions

State Office Responsibilities:

- Supervise Regional and Parish Medicaid Offices, Medical Assistance Program Units, and the LaCHIP Processing Center.

Field Office Responsibilities:

- Monitor field activities by developing administrative and operational plans and procedures to ensure implementation and operation of all program activities.
- Process Medicaid eligibility applications and re-determinations and notify applicants of decisions regarding their applications.
- Deliver services through direct contact with applicants and recipients of Medicaid.
- Provide assistance to the Medicaid Application Centers.

ELIGIBILITY PROGRAM OPERATIONS - DONNA DEDON

Key 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 for matching and the determination of categorical eligibility based on disability and/or incapacity.

FINANCIAL OPERATIONS - DARRYL JOHNSON

Key Functions

- Administer the Title XVIII, Title XIX and Title XXI fiscal operations within federal and state regulations.
- Maintain federal funding for program services and administrative expenditures.
- Develop and implement fiscal policy and audit procedures for the Bureau.
- Develop and implement corrective action plans where necessary.
- Develop and implement the Bureau's strategic plan, operational plan and performance indicator reporting function.

HEALTH STANDARDS - LISA DEATON

Key Functions

- Enforce state licensing standards and federal certification regulations through licensing and certification surveys of health care providers. Review and investigate complaints made in connection with health care facilities.
- Certify individuals for long-term admission; certify controlled dangerous substance providers; and certify resident assessment instruments.

INSTITUTIONAL REIMBURSEMENT - JOHN MARCHAND

Key Functions

- Administer Medicaid reimbursements to institutional providers (i.e., hospitals 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.

MEDICAID MANAGEMENT INFORMATION SYSTEM - SUSAN WAGNER

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 Unysis through a fiscal intermediary contract.
- Execute accurate, prompt and efficient payment of Medicaid claims.
- Third-party liability functions.

PHARMACY - M.J. TERREBONNE

Key Functions

- Development, implementation and administration of the Medicaid pharmacy outpatient program.
- Issue quality pharmacy services while developing efficiencies in operation, service and cost.

The Pharmacy Section consists of the following components:

- network development
- formulary incentives
- claims management
- clinical interventions
- drug utilization review
- pharmaceutical manufacturer rebates, policy development
- pharmacy provider audits
- disease management
- outcomes management reporting
- recipient lock-in program
- a provider help desk

POLICY DEVELOPMENT AND IMPLEMENTATION - SANDRA VICTOR

Key Functions

- Promulgate all rules governing the operations of the Medicaid Program in compliance with the Administrative Procedure Act.
- Maintain the Medicaid State Plan including amendments as required by the Social Security Act.
- Execute the facility need review process as statutorily mandated.
- Develop new and expanded programs under the Medicaid State Plan to provide appropriate, medically necessary services to Medicaid recipients.

PROGRAM INTEGRITY - DON GREGORY

Key Function

- Assure that expenditures for Medicaid services are appropriate.
- Identify fraud or abuse in the system.

PROGRAM OPERATIONS – KAY GAUDET

Key Functions

- Oversee the operation 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.

GLOSSARY

CHAMP Child
Child Health and Maternity Program (CHAMP) is for children born on or after October 1, 1983, who 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 primary care physicians, 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.

Department of Health and Human Services (DHHS)
DHHS administers many of the "social" programs at the federal level dealing with the health and welfare of citizens of the United States. It is the "parent" of the Center for Medicare and Medicaid Services.

Disproportionate Share (DSH) - Uncompensated Care
Compensation for the 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 DSH payments for administering indigent medical care.

Deemed Newborn
A child born to a woman that is determined eligible for Medicaid benefits is deemed Medicaid eligible from the date of birth through the child's first birthday, regardless of income.

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.

Eligible
For this report, an eligible is a person who has qualified for Medicaid, who may or may not have received any type of measurable Medicaid service. (See technical notes on page 30.)

Expenditure
In this report, refers to fiscal information derived from the financial system of the Integrated State Information System (ISIS). ISIS reports the program expenditures after all claims and financial adjustments have been taken into account.

Federal Fiscal Year (FFY)
The FFY starts October 1 and ends September 30 of the calendar year.

FITAP
In Louisiana, Temporary Assistance for Needy Families (TANF) is provided under a program known as the Family Independence Temporary Assistance Program (FITAP). This program provides temporary assistance for needy

pregnant women and families with minor children under Title IV-A of the Social Security Act. The program provides eligible individuals with cash assistance and supportive services if those families meet eligibility requirements and are otherwise complying with FITAP requirements.

HCFA (Health Care Financing Administration)
The federal agency charged with overseeing and approving states' implementation and administration of the Medicaid and Medicare programs.

Inflation
Inflation has been defined as a process of continuously rising prices or, equivalently, of a continuously falling value of money.

Long-Term Care (LTC)
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 for the mentally retarded and meets all eligibility requirements.

Louisiana Children's Health Insurance Program (LaCHIP)
This is 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 is named LaCHIP.

Low Income Families with Children (LIFC) - formerly known as AFDC-M
Provides Medicaid only coverage to individuals and families who would have been eligible for cash assistance under rules of the state's AFDC Program on August 12, 1996 (Section 1931 Eligibility Group).

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.

Medicare Buy-Ins and Supplementals (Buy-In Program)
The mission of Medicare Buy-Ins and Supplementals is to allow states to enroll certain groups of needy people (disabled individuals and the elderly) in the supplemental medical insurance program and pay their premiums. As part of its total assistance plan, a state may provide medical insurance protection to designated categories of needy individuals who are eligible for Medicaid and also meet the eligibility requirements. It has the effect of transferring some medical costs for this population from the Title XIX Medicaid Program, which is partially state financed, to the Title XVIII program, which is financed by the federal government. Federal matching money is available through the Medicaid Program to assist the states with the premium payments for certain buy-in enrollees. Premiums may be for either Part A or Part B. (See definitions below.)

Outcome
The result of performance (or non-performance) of a function or process.

Part A
Part A is the hospital insurance portion of Medicare. Part A covers inpatient hospital care, skilled nursing facility care, some home health agency services, and hospice care.

Part B
Part B is the supplementary or "physicians" insurance portion of Medicare. Part B covers services of physicians/other suppliers, outpatient care, medical equipment and supplies, and other medical services not covered by the hospital insurance part of Medicare.

Payment
In this report, payment refers to information derived from the claims-based data sets produced by the Medicaid Program's fiscal intermediary, Unisys. The Unisys data set was drawn from the claims reporting system, which reports paid claims to providers before the application of certain financial adjustments.

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 Medicare Beneficiary (QMB-Dual)
Individuals who are entitled to Medicare Part A have income of 100% of the FPL or less and resources that do not exceed twice the limit for SSI eligibility, and are eligible for full Medicaid benefits. Medicaid pays their Medicare Part A premiums, if any, Medicare Part premiums and, to the extent consistent with the Medicaid State Plan, Medicare deductibles and coinsurance, and provides full Medicaid benefits. Federal financial participation (FFP) equals the federal medical assistance percentage (FMAP).

Qualified Medicare Beneficiary (QMB-Pure)
Individuals who are entitled to Medicare Part A have income of 100% of the FPL or less and resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for full Medicaid. Medicaid pays their Medicare Part A premiums, if any, Medicare Part B premiums and, to the extent consistent with the Medicaid State plan, Medicare deductibles and coinsurance for Medicare services provided by Medicare providers. FFP equals FMAP.

Qualifying Individuals (1)
The Qualifying Individuals (QI-1) Program went into effect January 1, 1998, and 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, have income of 120% to 135% of federal poverty level, resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for Medicaid.

Qualifying Individuals (2)
The Qualifying Individuals (QI-2) Programwent into effect January 1, 1998 and 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, have income of 135% to 175% of the FPL, resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for Medicaid.

Quality
Quality, as defined by the Institute of Medicine, is the degree to which health services for individuals and populations increase the likelihood of desired outcomes and are consistent with current professional knowledge.

Recipient
The data for this report is based on a claim's date of payment (DOP) and not on its date of service. Therefore, a person is counted as a 'recipient' if any financial/claims related transaction(s) occurred on that person's behalf during SFY 1999/00. This means that a Medicaid eligible person who received a service during the fiscal year, but for whom no financial/claims related transaction occurred, is not counted. Similarly, every recipient included in this count did not necessarily receive a service during the fiscal year.

Social Security Income
A federal cash assistance program for low-income aged, blind and disabled individuals established by Title XVI of the Social Security Act. States may use SSI income limits to establish Medicaid eligibility.

Specified Low-Income Medicare Beneficiary (SLMB)
Provides for Medicare Part B Premium, only. The eligibility requirements are the same as for the Qualified Medicare Beneficiary (QMB) except that income exceeds the QMB income limit of 100 percent of the FPL.

State Fiscal Year (SFY)
The SFY is a 12-month calendar period which begins July 1 and ends June 30 of the following year.

State Plan
The State Plan is the formal agreement between Louisiana and the Health Care Financing Administration (HCFA) regarding the policies governing the administration of the state's Medicaid Program. Amendments to the State Plan must be submitted to HCFA for review and approval no later than the end of the quarter in which the amendment becomes effective. Federal financial participation (FFP) is not available to the state until the amendment is approved.

Temporary Assistance for Needy Families (TANF)
Temporary Assistance for Needy Families (TANF), commonly known as welfare, is the monthly cash assistance program for poor families with children under age 18. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) (Pub. L. 104-193), as amended, is the welfare reform law that established the Temporary Assistance for Needy Families (TANF) program.

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.

Waiver
A Medicaid waiver is when the federal government allows or grants states permission to waive certain federal requirements in order to operate a specific kind of program. Federal law allows states to enact two types of Medicaid waivers: 1) Program Waivers [1915 (b), 1915(c)] and 2) Research and Demonstration Waivers [1115].

TECHNICAL NOTES
This Annual Report presents a summary view of the organization and activities of the Louisiana Medicaid Program for State Fiscal Year (SFY) 2000/01.

Data Sources
In the past, the Louisiana Medicaid Program Annual Report used a combination of data sources to provide the most accurate information possible. A lead source has been the MARS (Management Administrative Reporting System) Report MR-0-07S which is an annual report that reports information based on the SFY. The definitions of categories (e.g. eligibles, recipients) reported by the MR-0-07S are consistent with the federal Statistical Report on Medical Care (HCFA-2082). The HCFA-2082 has been the main federal document for standardized state Medicaid statistical reporting. Since the publication of the SFY 1998/99 Louisiana Medicaid Program Annual Report, however, HCFA has undertaken a fundamental revision of the report logic and data processing methods. Categorizing Medicaid eligibility and spending in the state has significantly changed as well (e.g. SOBRA, TANF). These developments require that the current annual report implement revised methods of extracting and categorizing state data. In the process, state specific rules and methods of program organization are taken into account (e.g. reporting categories).

For the current report, information is drawn from two primary sources. Budget and overall Medicaid Program expenditures are drawn from the financial system of the Integrated State Information System (ISIS). ISIS reports the program expenditures after all claims and financial adjustments have been taken into account. Payments for recipients and for specific provider groups are drawn from data sets produced by the Medicaid Program's fiscal intermediary, Unisys. The data sets were specially derived for the annual report according to the criteria specified in this technical note. The Unisys data set was drawn from the claims reporting system, which reports paid claims to providers before the application of certain financial adjustments. The provider payments reported in this data set will therefore differ from expenditure reports based on ISIS. In this report, the term "expenditures" refers to fiscal information derived from ISIS. "Payments" refers to information derived from the claims-based data.

Reporting Categories

In organizing claims and other data, we have chosen to be guided by the HCFA-2082 principles when possible but have developed eligibility, provider, and expenditure categorizations to more closely reflect the way the Medicaid Program is conducted in Louisiana. The current specification of eligible and recipient categories has undergone the greatest modification since the last report. Using eligibility processing information, eligibles were assigned uniquely to one of over 200 administrative categories of eligibility. Using claims data, recipients were similarly assigned. For summary reporting, these categories were then combined to form the five major categories of eligibility (defined on p. 19):

1) **Families and Children below 16% of the Federal Poverty Level**
2) **Poverty Level Pregnant Women and Children**
3) **Blind and Disabled**
4) **Old Age Assistance**
5) **Other**

These five categories more closely conform to the way HCFA categorizes eligibility groups. This technique makes reporting on subgroups such as LaCHIP eligibles more convenient. In addition to eligibility group designation, eligibles and recipients were uniquely assigned an age group and parish of residence. Gender was also included for reporting purposes.

An eligible was identified as anyone with an active case during SFY 2000/01. An eligible person's parish of residence was determined to be the parish of record as of the last day of the SFY. The eligible person's eligibility category was taken from the most current active case for the SFY. A LaCHIP eligible was identified as an active case with a LaCHIP designation (Type Case 7) at any time during the SFY. Counts of the total number of unique eligibles in the report refer to individuals who were ever enrolled during the SFY. This number will be larger than a "snapshot" count of individuals currently enrolled at one point during the year (e.g. as of the last day of a month).

Since people leave the program during the period, they will not be counted in subsequent "snapshots," but will be counted in a summary of persons eligible during the year. A recipient was identified as anyone with an original paid claim during the specified SFY. A recipient's parish of residence designation uses the parish from the last date of payment for the SFY. Similarly, a recipient's category of assistance was assigned using the last date of payment for the SFY. A LaCHIP recipient was identified as anyone who had at least one original paid claim with a LaCHIP designation (Type Cases 7, 15, or 55) during the SFY. A person's age was calculated as of January 1, 2001. Provider types were categorized according to the "Provider Type" code that is assigned when a provider becomes Medicaid certified and which then appears on the claim for reimbursement. For instance, Provider Type "60" on a claim designates a hospital provider. The claim payment could be one of many services a hospital provides in either inpatient or outpatient settings. The net payment for the claim in question, therefore, would be assigned to the category "Hospital." The SFY 2000/01 Annual Report utilized information sources similar to those used in prior Louisiana Medicaid Program Annual Reports and the reporting of the information used equivalent organizing criteria.

The current report uses category definitions that are different from those used prior to the SFY 1999/00 Annual Report. The reader should not expect that all the financial information and counts of eligibles and recipients within the reported categories are directly comparable to reports before SFY 1999/00. The information presented in this report and in the SFY 1999/00 report is comparable. Using data from the current report and/or from the SFY 1999/00 report for "trending" analysis with data from prior years is not recommended.

Recipient Counts Compared to Eligible Counts

In some categories (e.g. within a parish), the number of recipients reported may exceed the number of eligibles. There are two main reasons why this may occur:

(1) Closing a case near the end of a SFY - claims from a case closed at the end of SFY 1999/00 can still be paid in SFY 2000/01. Thus, when a claim is paid for a person who received a service in SFY 1999/00, she/he will be counted as a recipient in SFY 2000/01 although she/he is no longer eligible for Medicaid.

(2) Provider billing habits - some providers delay the submission of claims for many months. Medicaid's timely filing rule gives providers up to two years to submit a claim. Thus, it is possible for a claim paid in SFY 2000/01 to be for a service rendered in SFY 1998/99. The payment could, therefore, occur long after the person identified as the recipient on the claim has left the program.

APPENDIX I-A RECIPIENT INFORMATION

PARISH	Region	PARISH POPULATION 2000	RANK	ELIGIBLES 2001	RANK	RECIPIENTS 2001	% POP. COVERED BY MEDICAID
ACADIA	4	58,861	19	13,266	15	12,763	22.54%
ALLEN	5	25,440	38	4,744	41	4,820	18.65%
ASCENSION	2	76,627	16	9,633	23	9,101	12.57%
ASSUMPTION	3	23,388	40	4,629	42	4,324	19.79%
AVOYELLES	6	41,481	29	10,980	20	10,657	26.47%
BEAUREGARD	5	32,986	33	5,329	37	5,340	16.16%
BIENVILLE	7	15,752	52	3,596	52	3,694	22.83%
BOSSIER	7	98,310	12	12,223	17	11,387	12.43%
CADDO	7	252,161	4	47,161	4	43,048	18.70%
CALCASIEU	5	183,577	7	28,613	5	26,985	15.59%
CALDWELL	8	10,560	59	2,162	61	2,080	20.47%
CAMERON	5	9,991	61	975	64	1,015	9.76%
CATAHOULA	6	10,920	58	2,656	57	2,518	24.32%
CLAIBORNE	7	16,851	51	3,711	50	3,757	22.02%
CONCORDIA	6	20,247	48	5,326	38	5,058	26.31%
DESOTO	7	25,494	37	5,095	39	5,108	19.99%
EAST BATON ROUGE	2	412,852	3	58,706	3	52,807	14.22%
EAST CARROLL	8	9,421	63	3,868	48	3,951	41.06%
EAST FELICIANA	2	21,360	44	3,863	49	3,715	18.09%
EVANGELINE	4	35,434	31	10,447	21	10,425	29.48%
FRANKLIN	8	21,263	45	6,198	34	5,934	29.15%
GRANT	6	18,698	49	3,587	53	3,382	19.18%
IBERIA	4	73,266	17	15,930	13	15,297	21.74%
IBERVILLE	2	33,320	32	7,070	30	6,727	21.22%
JACKSON	8	15,397	53	2,925	56	2,974	19.00%
JEFFERSON	1	455,466	2	64,601	2	58,909	14.18%
JEFFERSON DAVIS	5	31,435	34	6,199	33	6,391	19.72%
LAFAYETTE	4	190,503	6	26,804	6	25,007	14.07%
LAFOURCHE	3	89,974	14	14,090	14	13,382	15.66%
LASALLE	6	14,282	55	2,555	58	2,484	17.89%
LINCOLN	8	42,509	27	6,804	32	6,406	16.01%
LIVINGSTON	9	91,814	13	11,479	19	10,905	12.50%
MADISON	8	13,728	56	4,228	45	4,299	30.80%
MOREHOUSE	8	31,021	35	8,387	26	8,509	27.04%
NATCHITOCHES	7	39,080	30	8,049	28	8,215	20.60%
ORLEANS	1	484,674	1	132,440	1	119,657	27.33%
OUACHITA	8	147,250	8	26,407	8	24,323	17.93%
PLAQUEMINES	1	26,757	36	4,498	43	4,138	16.81%
POINTE COUPEE	2	22,763	42	4,866	40	4,671	21.38%
RAPIDES	6	126,337	9	26,702	7	25,176	21.14%
RED RIVER	7	9,622	62	2,281	60	2,274	23.71%
RICHLAND	8	20,981	47	5,760	36	5,943	27.45%
SABINE	7	23,459	39	4,343	44	4,470	18.51%
ST. BERNARD	1	67,229	18	8,915	25	8,433	13.26%
ST. CHARLES	3	48,072	24	5,801	35	5,702	12.07%
ST. HELENA	9	10,525	60	2,495	59	2,389	23.71%
ST. JAMES	3	21,216	46	3,984	47	3,835	18.78%
ST. JOHN	3	43,044	26	7,747	29	6,969	18.00%
ST. LANDRY	4	87,700	15	23,313	10	22,324	26.58%
ST. MARTIN	4	48,583	23	9,898	22	9,543	20.37%
ST. MARY	3	53,500	21	12,671	16	12,194	23.68%
ST. TAMMANY	9	191,268	5	19,663	11	18,151	10.28%
TANGIPAHOA	9	100,588	11	24,983	9	23,642	24.84%
TENSAS	8	6,618	64	2,162	61	2,083	32.67%
TERREBONNE	3	104,503	10	18,529	12	17,214	17.73%
UNION	8	22,803	41	4,063	46	4,146	17.82%
VERMILION	4	53,807	20	9,434	24	9,062	17.53%
VERNON	6	52,531	22	6,941	31	6,903	13.21%
WASHINGTON	9	43,926	25	12,000	18	11,389	27.32%
WEBSTER	7	41,831	28	8,155	27	8,275	19.50%
WEST BATON ROUGE	2	21,601	43	3,375	54	3,203	15.62%
WEST CARROLL	8	12,314	57	3,112	55	3,118	25.27%
WEST FELICIANA	2	15,111	54	1,589	63	1,542	10.52%
WINN	6	16,894	50	3,662	51	3,423	21.68%
Unknown/Out of State						5,507	
TOTAL		4,468,976		825,678		781,073	
	(* Averages are based on provider payments by parish.)						

APPENDIXI-B

	PAYMENTS FOR PARISH RECIPIENTS	PAYMENTS TO PROVIDERS BY PARISH	RANK	PER CAPITA* ($)	RANK	PER ELIGIBLE* ($)	RANK	PER RECIPIENT* ($)	RANK
$	55,125,623	$42,909,583	14	$729.00	15	$3,234.55	21	$3,362.03	20
$	16,770,570	$13,053,951	37	$513.13	33	$2,751.68	29	$2,708.29	31
$	31,111,972	$20,398,686	29	$266.21	55	$2,117.58	47	$2,241.37	44
$	12,212,190	$5,728,354	56	$244.93	58	$1,237.49	59	$1,324.78	59
$	40,798,640	$29,274,440	20	$705.73	16	$2,666.16	31	$2,746.97	30
$	15,640,209	$12,698,957	38	$384.98	49	$2,382.99	39	$2,378.08	40
$	12,730,004	$9,161,062	47	$581.58	26	$2,547.57	35	$2,479.98	37
$	52,650,518	$47,322,542	13	$481.36	39	$3,871.60	11	$4,155.84	13
$	145,263,019	$190,513,356	5	$755.52	11	$4,039.64	9	$4,425.60	7
$	101,996,339	$103,044,205	7	$561.31	28	$3,601.31	15	$3,818.57	15
$	11,574,789	$10,315,074	42	$976.81	6	$4,771.08	4	$4,959.17	4
$	2,168,574	$632,648	64	$63.32	64	$648.87	64	$623.30	64
$	7,766,618	$5,489,695	57	$502.72	36	$2,066.90	48	$2,180.18	47
$	11,441,960	$8,036,223	52	$476.90	41	$2,165.51	45	$2,139.00	48
$	14,208,042	$10,576,957	41	$522.40	32	$1,985.91	50	$2,091.13	50
$	13,981,441	$6,982,245	54	$273.88	54	$1,370.41	58	$1,366.92	58
$	192,122,197	$222,195,503	3	$538.20	31	$3,784.89	14	$4,207.69	11
$	10,417,573	$7,077,660	53	$751.26	12	$1,829.80	52	$1,791.36	53
$	22,841,329	$17,840,424	32	$835.23	8	$4,618.28	5	$4,802.27	5
$	39,918,897	$40,316,239	16	$1,137.78	3	$3,859.12	12	$3,867.27	14
$	24,856,277	$17,638,310	33	$829.53	9	$2,845.81	27	$2,972.41	27
$	11,609,200	$4,333,767	59	$231.78	60	$1,208.19	61	$1,281.42	60
$	44,964,404	$37,332,822	17	$509.55	34	$2,343.55	41	$2,440.53	39
$	23,674,057	$18,757,890	31	$562.96	27	$2,653.17	32	$2,788.45	28
$	11,570,206	$9,125,147	48	$592.66	24	$3,119.71	22	$3,068.31	23
$	209,270,870	$224,446,274	2	$492.78	37	$3,474.35	16	$3,810.05	16
$	22,049,802	$15,878,022	35	$505.11	35	$2,561.38	34	$2,484.43	36
$	88,933,198	$139,410,923	6	$731.80	14	$5,201.12	3	$5,574.88	3
$	48,764,950	$40,792,841	15	$453.38	42	$2,895.16	25	$3,048.34	24
$	11,475,902	$8,521,318	51	$596.65	23	$3,335.15	18	$3,430.48	19
$	29,441,485	$29,732,062	19	$699.43	18	$4,369.79	7	$4,641.28	6
$	33,253,587	$22,846,184	26	$248.83	57	$1,990.26	49	$2,095.02	49
$	13,008,697	$9,587,289	45	$698.37	19	$2,267.57	42	$2,230.12	46
$	28,390,486	$23,037,314	25	$742.64	13	$2,746.79	30	$2,707.41	32
$	25,263,745	$18,908,014	30	$483.83	38	$2,349.11	40	$2,301.65	42
$	348,104,811	$431,867,860	1	$891.05	7	$3,260.86	20	$3,609.22	17
$	90,191,670	$101,555,136	9	$689.68	21	$3,845.77	13	$4,175.27	12
$	33,858,673	$27,058,504	21	$1,011.27	5	$6,015.67	2	$6,539.03	2
$	15,278,472	$9,376,757	46	$411.93	47	$1,926.99	51	$2,007.44	51
$	198,103,932	$221,240,042	4	$1,751.19	1	$8,285.52	1	$8,787.74	1
$	8,060,171	$6,765,748	55	$703.15	17	$2,966.13	24	$2,975.26	25
$	27,140,143	$25,766,221	23	$1,228.07	2	$4,473.30	6	$4,335.56	10
$	15,189,777	$11,250,077	39	$479.56	40	$2,590.39	33	$2,516.80	34
$	32,616,978	$30,201,099	18	$449.23	43	$3,387.67	17	$3,581.30	18
$	15,751,168	$10,146,055	44	$211.06	62	$1,749.02	54	$1,779.39	54
$	6,443,460	$3,035,523	62	$288.41	53	$1,216.64	60	$1,270.63	61
$	8,749,762	$4,149,327	60	$195.58	63	$1,041.50	63	$1,081.96	63
$	17,774,713	$10,721,426	40	$249.08	56	$1,383.95	57	$1,538.45	56
$	77,586,318	$66,366,616	11	$756.75	10	$2,846.76	26	$2,972.88	26
$	29,579,897	$16,812,266	34	$346.05	51	$1,698.55	55	$1,761.74	55
$	30,951,282	$22,249,531	28	$415.88	46	$1,755.94	53	$1,824.63	52
$	66,743,678	$78,707,261	10	$411.50	48	$4,002.81	10	$4,336.25	9
$	108,919,687	$102,709,626	8	$1,021.09	4	$4,111.18	8	$4,344.37	8
$	5,338,670	$2,498,368	63	$377.51	50	$1,155.58	62	$1,199.41	62
$	56,481,860	$56,262,061	12	$538.38	30	$3,036.43	23	$3,268.39	21
$	14,320,267	$10,233,082	43	$448.76	44	$2,518.60	36	$2,468.18	38
$	31,324,209	$22,782,238	27	$423.41	45	$2,414.91	38	$2,514.04	35
$	21,403,803	$15,418,568	36	$293.51	52	$2,221.38	44	$2,233.60	45
$	39,234,480	$25,592,399	24	$582.63	25	$2,132.70	46	$2,247.12	43
$	31,076,045	$26,780,425	22	$640.21	22	$3,283.93	19	$3,236.31	22
$	10,929,100	$4,748,543	58	$219.83	61	$1,406.98	56	$1,482.53	57
$	12,033,320	$8,565,550	50	$695.59	20	$2,752.43	28	$2,747.13	29
$	6,197,809	$3,596,070	61	$237.98	59	$2,263.10	43	$2,332.08	41
$	12,073,457	$9,116,151	49	$539.61	29	$2,489.39	37	$2,663.20	33
$	12,785,803	$32,022,276							
$	2,821,510,784	$2,821,510,784							

APPENDIX II-A PROVIDER PAYMENTS INFORMATION

Parish Name	Dental Services	DME	Hospitals	ICF(MR)	Nursing Homes
Acadia Parish	$432,475	$20,706	$5,564,632	$8,178,948	$11,284,172
Allen Parish	$81,301	$5,439	$1,903,510		$4,293,223
Ascension Parish	$155,177	$26,659	$1,831,670	$254,415	$5,836,579
Assumption Parish	$13,439			$690,209	$2,233,694
Avoyelles Parish	$344,343	$32,799	$1,908,520	$258,144	$14,195,532
Beauregard Parish	$86,233		$2,887,788	$671,068	$4,225,687
Bienville Parish	$11,285		$1,018,247		$4,623,531
Bossier Parish	$117,604	$37,343	$3,044,659	$22,547,083	$9,997,657
Caddo Parish	$1,871,886	$5,313,742	$63,791,861	$8,308,098	$37,126,816
Calcasieu Parish	$1,366,896	$1,077,932	$27,706,181	$12,059,075	$19,011,455
Caldwell Parish		$9,059	$1,397,262	$3,148,412	$1,812,947
Cameron Parish			$129,606		$72,310
Catahoula Parish	$9,448				$2,241,280
Claiborne Parish	$53,224	$2,353	$1,360,811		$3,491,274
Concordia Parish	$295,168		$2,136,144		$3,155,521
DeSoto Parish	$152,723		$1,062,433	$550,281	$1,706,691
East Baton Rouge Parish	$2,299,359	$1,523,936	$79,341,829	$12,802,853	$34,715,482
East Carroll Parish	$279,931		$562,146		$3,009,920
East Feliciana Parish	$48,761	$29,258	$88,255	$1,298,570	$12,940,777
Evangeline Parish	$340,895	$192,483	$8,676,809	$2,757,560	$8,524,443
Franklin Parish	$150,362		$1,098,821	$1,888,869	$8,347,159
Grant Parish	$16,796			$281,360	$3,067,543
Iberia Parish	$360,595	$68,131	$6,097,019	$2,190,179	$9,404,667
Iberville Parish	$143,340	$378,049	$3,321,232		$4,828,688
Jackson Parish	$8,415	$1,132	$474,882		$4,523,547
Jefferson Parish	$1,579,431	$7,383,899	$44,141,730	$24,641,834	$28,063,269
Jefferson Davis Parish	$114,929		$1,930,256	$281,006	$5,822,135
Lafayette Parish	$1,309,425	$2,307,347	$42,116,984	$5,236,014	$18,540,911
Lafourche Parish	$307,237	$2,623,891	$5,737,402	$7,117,814	$8,028,639
LaSalle Parish	$850	$21,193	$1,713,882		$3,609,813
Lincoln Parish	$415,403	$147,934	$5,283,831	$10,614,377	$5,531,549
Livingston Parish	$342,095	$182,161	$168,207	$1,243,644	$12,419,404
Madison Parish	$49,105	$6,302	$908,324	$1,854,250	$2,801,481
Morehouse Parish	$34,883	$21,486	$2,382,981	$539,324	$9,471,988
Natchitoches Parish	$126,847	$316	$3,260,755		$3,712,203
Orleans Parish	$4,251,197	$1,444,837	$203,220,956	$11,605,062	$43,066,938
Ouachita Parish	$2,070,158	$1,012,003	$31,161,800	$7,516,736	$16,566,435
Plaquemines Parish	$39,765	($34)		$22,920,197	$1,409,743
Pointe Coupee Parish	$1,780	$87,828	$928,876		$3,811,301
Rapides Parish	$950,312	$1,175,624	$26,500,891	$105,431,448	$24,583,566
Red River Parish	$12,655	$12,870	$1,000,592	($949)	$3,125,600
Richland Parish	$199,165	$55,691	$1,595,225	$7,220,886	$6,921,378
Sabine Parish	$57,211	$126,075	$625,654	$1,674,657	$4,790,616
St. Bernard Parish	$336,097	$116,652	$4,313,938	$1,549,229	$6,183,219
St. Charles Parish	$115,052	$23,196	$1,124,177	$203,779	$1,367,280
St. Helena Parish	$86,916		$242,461	$286,409	$1,144,659
St. James Parish	$5,502		$297,503		$1,591,895
St. John the Baptist Parish	$465,165	($137)	$1,722,654	$841,252	$1,729,827
St. Landry Parish	$350,754	$861,135	$13,717,872	$2,302,097	$15,715,364
St. Martin Parish	$21,309	$6,061	$688,962	$1,132,464	$5,647,774
St. Mary Parish	$391,518	$245,072	$3,086,121	$578,285	$5,439,217
St. Tammany Parish	$1,148,884	$2,421,965	$19,070,858	$2,366,868	$21,805,337
Tangipahoa Parish	$1,094,777	$1,115,131	$18,319,597	$36,855,161	$10,516,003
Tensas Parish					$1,471,459
Terrebonne Parish	$183,329	$132,806	$21,694,857	$1,674,155	$7,278,093
Union Parish	$13,546	$9,445	$607,073	$294,598	$4,973,441
Vermilion Parish	$392,968	$11,699	$3,177,809	$553,550	$10,188,134
Vernon Parish	$706	$22,152	$2,350,421	$4,057,804	$3,951,699
Washington Parish	$313,922	$30,447	$4,291,834		$6,812,566
Webster Parish	$70,533	$39,424	$5,053,018	$5,140,261	$8,498,227
West Baton Rouge Parish	$125,807			$618,724	$2,080,036
West Carroll Parish		$9,048	$894,552	$285,180	$3,887,779
West Feliciana Parish	$77,964	$18,992	$272,397	$294,614	$2,124,930
Winn Parish	$20,916	$35,299	$1,284,048	$1,175,064	$3,166,385
Total In-State	**$25,717,769**	**$30,426,833**	**$690,292,810**	**$345,990,919**	**$542,520,888**
Texas		$250,080	$2,005,870		$152,101
Mississippi	$2,522	$16,001	$4,213,806		
Arkansas		$38,911	$816,459		
Other		$1,815,918	$2,467,212	$3,495,063	
Total In & Out of State Payments	**$25,720,291**	**$32,547,743**	**$699,796,157**	**$349,485,982**	**$542,672,989**
Total All Other Provider Types (53)					
Total of All Provider Types					

APPENDIX II-B

Personal Care Attendant	Pharmacy	Physicians (MD)	Respite Care	Independent Living	Total
$5,068	$11,033,263	$3,154,249			$39,673,512
$41,841	$4,217,198	$1,327,692			$11,870,204
$722,774	$6,878,232	$2,051,328	$126,139	$883,712	$18,766,685
$142,724	$1,889,333	$336,227	$71,315	$189,007	$5,565,949
	$9,001,911	$1,241,001			$26,982,251
	$2,754,163	$1,567,327			$12,192,267
$27,980	$2,252,749	$411,037			$8,344,830
$296,227	$5,702,078	$1,807,342	$24,461	$628,718	$44,203,172
$3,558,889	$31,274,140	$22,210,495	$1,154,791	$1,739,332	$176,350,050
$2,314,863	$17,802,148	$10,877,685	$698,789	$1,046,364	$93,961,388
	$2,967,883	$678,342			$10,013,904
	$259,559	$81,233			$542,708
	$2,679,364	$342,839			$5,272,930
$28,596	$2,170,063	$639,936			$7,746,257
$38,195	$3,048,296	$970,510	$55,187		$9,699,021
$26,220	$2,217,804	$600,870			$6,317,022
$6,835,745	$31,744,003	$24,928,315	$3,457,422	$2,910,670	$200,559,615
$24,124	$1,917,901	$921,428			$6,715,449
	$2,486,646	$287,742			$17,180,008
$242,407	$12,294,128	$3,384,059	$118,092		$36,530,876
$51,937	$4,721,593	$406,487			$16,665,228
	$571,812	$273,578			$4,211,090
$595,112	$9,529,725	$4,640,891	$429,434	$719,968	$34,035,721
$210,925	$5,414,429	$2,557,884	$30,016	$403,261	$17,287,823
$22,256	$2,332,182	$404,191			$7,766,605
$7,987,117	$54,737,350	$30,096,642	$3,561,294	$6,176,215	$208,368,780
$58,784	$4,993,300	$1,556,916		$144,963	$14,902,289
$6,645,030	$17,359,164	$15,308,458	$3,849,471	$4,634,726	$117,307,531
$1,891,657	$7,262,621	$3,024,489	$1,318,104	$1,403,960	$38,715,814
	$2,511,204	$310,771			$8,167,713
$231,458	$4,150,823	$1,902,091	$86,583	$251,547	$28,615,597
$781,436	$5,502,946	$577,545	$454,153	$516,070	$22,187,661
	$2,505,700	$610,946			$8,736,108
$202,926	$6,270,146	$2,562,625	$25,739	$512,317	$22,024,414
$282,099	$7,248,716	$2,329,973	$116,489	$523,038	$17,600,436
$5,301,220	$62,129,942	$52,308,391	$2,353,932	$2,517,006	$388,199,482
$4,142,628	$15,464,702	$9,693,145	$2,074,244	$2,968,835	$92,670,686
	$977,308	$374,593			$25,721,573
	$2,797,928	$710,806			$8,338,519
$1,527,122	$34,722,653	$8,803,151	$532,130	$5,150,050	$209,376,947
$41,049	$1,805,755	$356,716			$6,354,287
$679,523	$5,434,217	$1,621,977	$458,222	$326,760	$24,513,043
$58,296	$3,243,808	$571,710			$11,148,026
$2,861,227	$9,144,165	$2,107,472	$1,076,677	$1,110,368	$28,799,044
$115,739	$2,836,640	$1,210,896	$36,598	$110,298	$7,143,655
	$999,076	$221,628			$2,981,148
$2,580	$1,300,751	$756,117			$3,954,347
$432,296	$2,837,609	$1,728,702	$198,742	$18,877	$9,974,985
$464,202	$22,040,897	$8,132,348	$257,074		$63,841,742
$1,550,005	$5,422,609	$423,363	$1,252,414	$254,130	$16,399,089
$278,216	$6,619,073	$2,906,383	$162,788	$84,943	$19,791,615
$962,056	$16,228,851	$9,781,687	$534,288	$124,978	$74,445,772
$3,838,334	$15,396,298	$8,464,269	$1,626,732	$1,329,508	$98,555,810
	$880,874	$58,759			$2,411,092
$1,072,157	$11,494,386	$8,300,818	$831,107	$307,488	$52,969,195
$58,653	$3,239,478	$491,533			$9,687,769
$62,206	$5,646,380	$1,758,231			$21,790,977
	$3,142,454	$1,568,732			$15,093,967
$433,321	$9,128,686	$2,301,598	$64,368	$330,586	$23,707,328
$260,933	$3,672,332	$2,268,603	$102,854	$111,375	$25,217,560
$46,288	$1,499,590	$131,687	$22,412	$15,141	$4,539,684
	$2,536,998	$256,789			$7,870,346
	$605,365	$143,139			$3,537,400
$49,316	$2,585,354	$488,276			$8,804,657
$57,503,754	**$543,536,749**	**$272,324,662**	**$27,162,060**	**$37,444,209**	**$2,572,920,654**
	$5,595,244	$72,772			$8,076,068
	$697,127	$1,741,723			$6,671,179
	$97,973	$30,875			$984,218
	$4,759,998	$159,231			$12,697,421
$57,503,754	**$554,687,092**	**$274,329,263**	**$27,162,060**	**$37,444,209**	**$2,601,349,540**
					$220,161,244
					$2,821,510,784

NOTES

Report prepared by Clenton Goff, Planning Analyst
Division of Financial Research & Planning
Ronald Young, Director

Editorial direction by Bob Johannessen

Layout and design by W. Jerome Boyd

Please address questions and comments to:
Division of Financial Research & Planning
P.O. Box 629
Baton Rouge, Louisiana 70821-0629

Special Thanks
Donna Dedon
Tim Williams
Fred Mouton
Judy Cain
Darryl Johnson
Charles Ayles
Kyle Viator
Barbara Gulotta
Legal Services
Unisys Programmers

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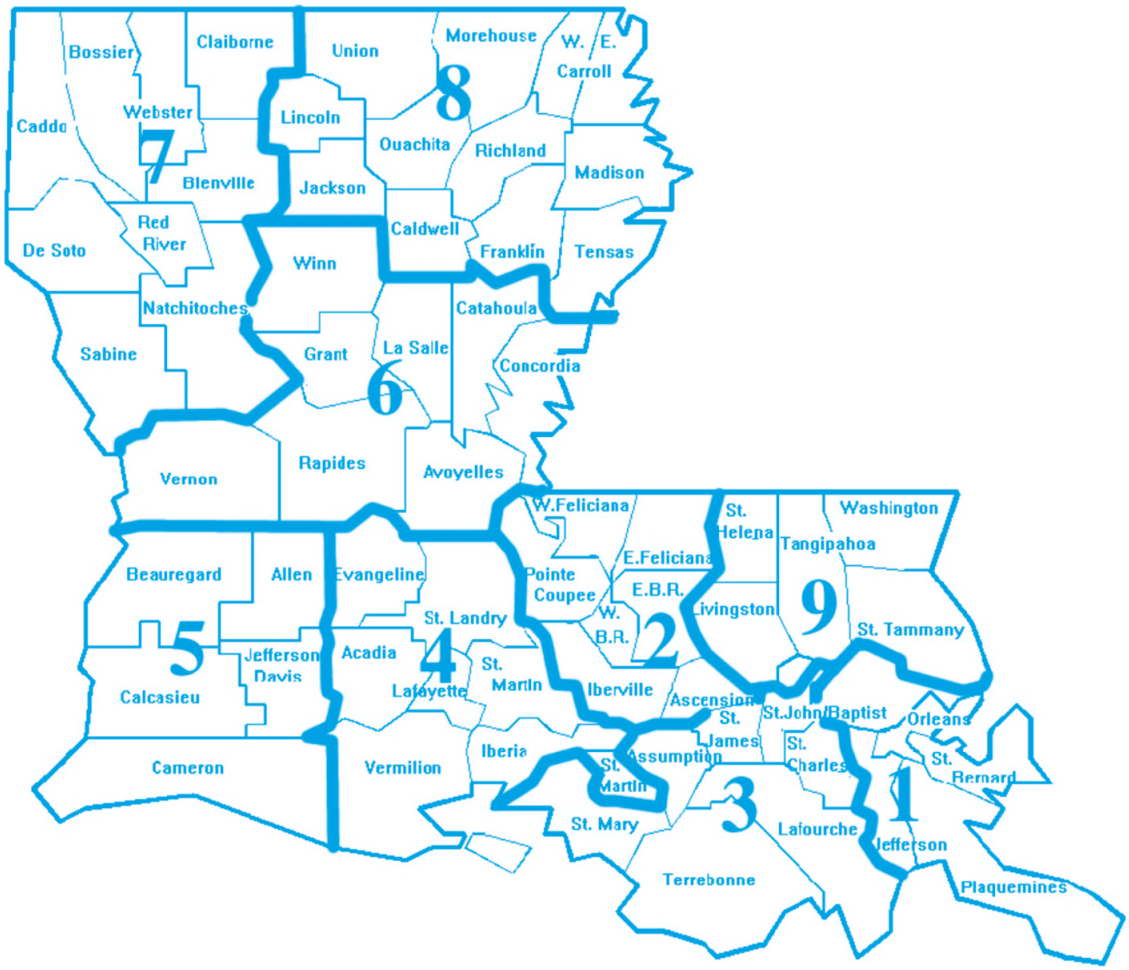

REGIONAL MEDICAID ELIGIBILITY OFFICES

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P.O. Box 60840
New Orleans, LA 70160
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