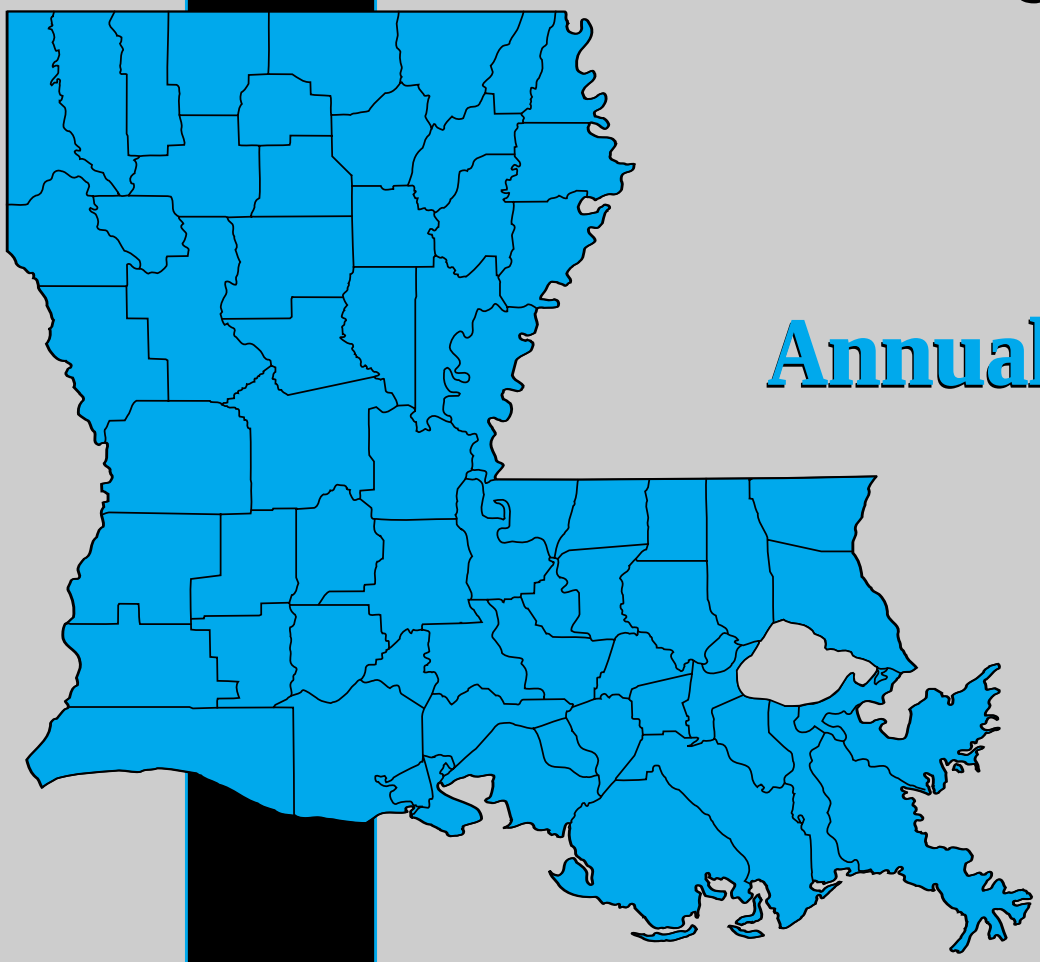
State Fiscal Year
1998/99



Annual Report

LOUISIANA'S MEDICAID PROGRAM

Louisiana Department of Health and Hospitals
Bureau of Health Services Financing

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MESSAGE FROM THE DIRECTOR

Dear Reader:

During the past year, the Medicaid program in Louisiana dealt with several issues.

For the first time since SFY 1996, the program was confronted by a projected deficit caused primarily by dramatic and unexpected costs in the outpatient drug program. This particular problem was experienced by virtually all State Medicaid programs and health insurance organizations. In cooperation with the LSU-MC Health Care Services Division, the Division of Administration and the Joint Legislative Committee on the Budget, the Department of Health and Hospitals identified and budgeted additional revenues to prevent the occurrence of a deficit or the wholesale shut-down of medical services reimbursement prior to the end of SFY 1999.

A successful outreach program was initiated on November 1, 1998, for Louisiana's version of the Children's Health Insurance Program (LaCHIP), and is on target to meet first-year goals of enrolling 58,000 children as either Title XIX (Medicaid) or Title XXI (LaCHIP) eligibles.

Governor Mike Foster issued an Executive Order related to year 2000 Compliance efforts and Medicaid successfully responded for all mission critical systems. In addition, a 30-year old eligibility system was replaced and a PC-based fraud control system (PC-SURS) was implemented and attained first year performance goals.

In accordance with Executive and Legislative initiatives, there was continued expansion of home and community-based alternatives to institutionalization for the disabled and elderly. A separate organizational unit was established in Medicaid for focused management of Home and Community-Based Waivers. The unit was successful in streamlining the admission process for clients' entry into waiver programs. Additionally, the unit responded immediately and successfully to concerns raised by the Health Care Financing Administration (HCFA) based upon a review of the waiver for the developmentally disabled.

Medicaid continued to work cooperatively with rural hospitals to enhance revenues in accordance with the Rural Hospital Preservation Act.

In SFY 1999-2000 issues confronting the program will concern allocation of the Tobacco Settlement, the continued need to reduce waiting lists for waiver services, demands by providers for increased levels of reimbursement, development of newer more sophisticated reimbursement methodologies, and various issues surrounding services for the disabled and elderly.

In addition, Medicaid began implementation of Phase II (expansion to 150% of the Federal Poverty Level) of the LaCHIP Program on October 1, 1999 and plans implementation of the "TEFRA-Section 134" (Katie Becket) Eligibility Option to provide services to disabled children in January of 2000.

We welcome your input on this, our third annual report, and hope that it is useful to you.

Sincerely,

Thomas D. Collins

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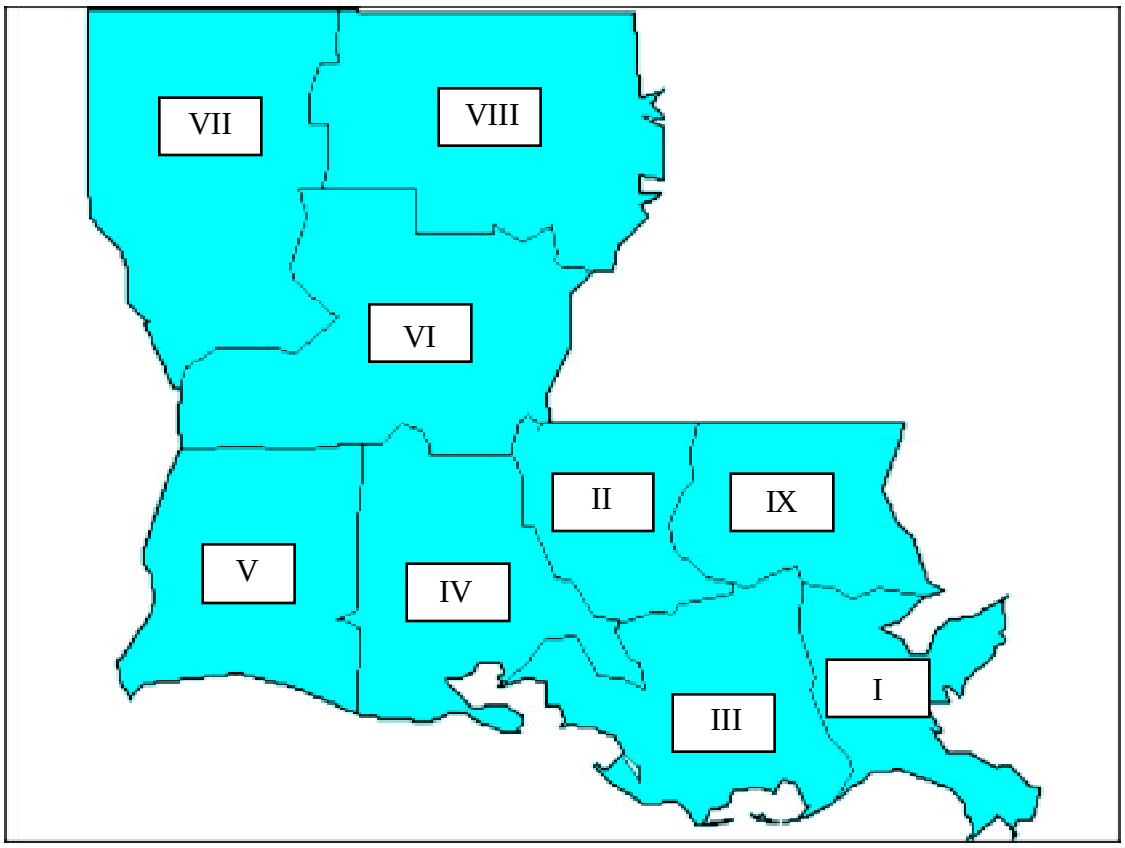
REGIONAL MEDICAID OFFICES



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INTRODUCTION

WHAT IS MEDICAID?

Medicaid is a federally sponsored public insurance system of health care services and products for low-income and disabled persons. Each state administers its own program within federal guidelines. The cost of state Medicaid programs are divided between the state and the federal governments and the proportions are based on the state's per capita income relative to the rest of the nation. The federal government mandates that certain health care services be covered by states who participate in the Medicaid program. Mandatory medical services include the following:

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

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

STATE PLAN

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

Medicaid History

The Medicaid program was created in 1965 with the passage of Title XIX of the Social Security Act by the United States Congress. Louisiana adopted the Medicaid program in 1966. Over the years the program has grown very fast, both nationally and within the state. The growth has been evident not only in the costs of providing basic medical services, but also in terms of the number of eligibility categories and number and types of services offered. Lately, however the program has been significantly reduced and Louisiana is no longer among the highest growth states. The Historical Medicaid Expenditures chart on the next page indicates a stable budget from SFY 1995/96 through 1998/99.

BRIEF HISTORICAL LOOK AT MEDICAID IN LOUISIANA

In SFY 1987/88 Louisiana served 542,600 recipients and had expenditures of about $935 million. The program has faced many changes which include federal regulations, federal supplements, eligibility requirements, and increases in health care costs. Expenditures peaked in 1993/94 with expenditures of $4.6 billion serving 775,561 recipients. Since then, expenditures have fallen sharply. Expenditures for SFY 1998/99 were $3.28 billion (excluding administrative cost). Figure 1 shows the growth, decline and stabilization of Louisiana's Medicaid expenditures.

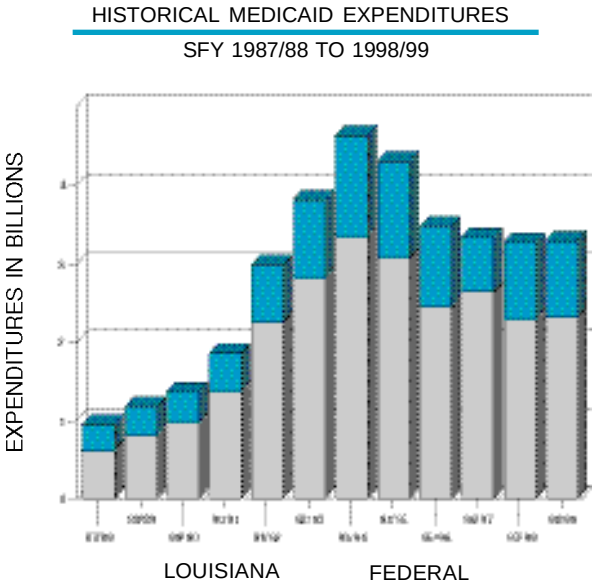


Figure 1

The number of Medicaid recipients reached a peak in 1994/95 and has gradually decreased each year since. However, large increases were experienced between the early 1980's and 1990's. The main reason for the growth was a number of expansions in federal mandates which define the eligibility criteria for Medicaid. During the SFY 1998/99, 726,500 people were eligible for Medicaid services, and 717,813 received one or more services.

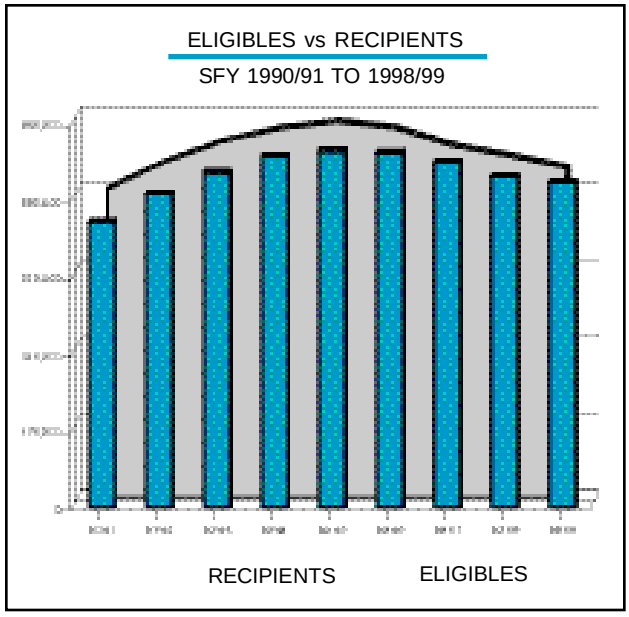


Figure 2

Throughout this report an eligible is a person who is enrolled in the Medicaid program. A recipient is a person who is eligible and received Medicaid services.

IMPACT OF WELFARE REFORM ON LOUISIANA'S MEDICAID PROGRAM

As a result of Welfare Reform, the Medicaid program has implemented new eligibility requirements. From March 1, 1991 through June 30, 1996, Bureau of Health Services Financing provided Medicaid-only coverage for individuals who met all eligibility requirements for cash assistance under the Aid to Families with Dependent Children (AFDC) program.

The Personal Responsibility and Work Opportunity Act of 1996 eliminated the AFDC cash assistance program and replaced it with a block grant program for Temporary Assistance for Needy Families (TANF).

HIGHLIGHTS FOR STATE FISCAL YEAR 1998/99

LOUISIANA CHILDREN'S HEALTH INSURANCE PROGRAM (LACHIP)

Phase I of the LaCHIP program began November 1, 1998. The department has received national recognition for the outreach efforts for the LaCHIP program. The department is on schedule to reach the target enrollment for Phase I. This phase expanded Medicaid services to all children under the age of 19, whose family income was at or below 133% of the Federal Poverty Level (FPL).

Under this program, states will receive an annual grant over the next five years to expand health care insurance for children of low-income families. The state will implement LaCHIP in three phases. Phase II began October 1,1999, with another Medicaid expansion up to 150% of the FPL. Phase III, subject to approval by the Legislature, will offer coverage to eligible children between 150-200% of the FPL the following year.

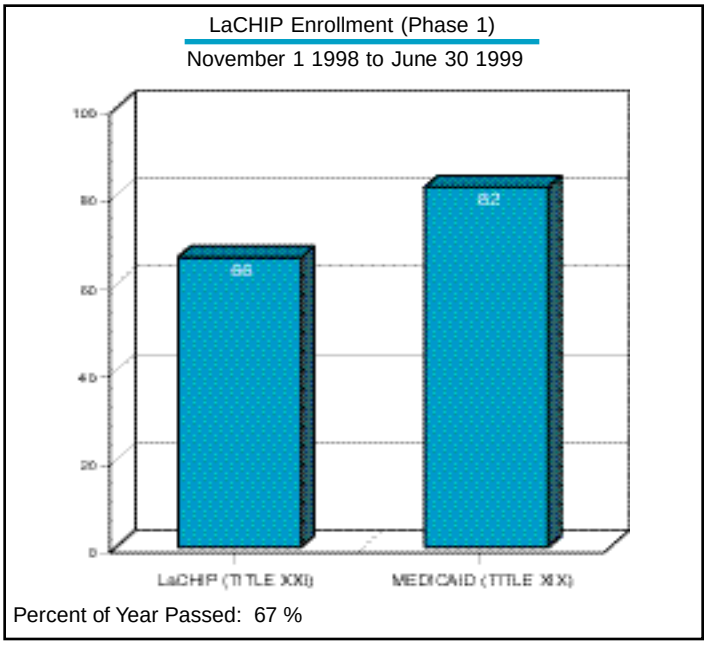


Figure 3

LACHIP ENROLLMENT

Total enrollment for LaCHIP reached 47,554 or 82% of the target while only 67% of the program year had passed. The program year is from November 1 through October 31.

The Louisiana Medicaid program established a target number of 28,350 LaCHIP children for Phase I. The adjacent graph shows that 18,598 were enrolled. Medicaid reached 66% of the target in 67% of the year.

The target for new enrollees through LaCHIP outreach was 29,412. However, LaCHIP outreach efforts contributed to 28,956 of enrollees which represent 98% of the target amount as of June 30, 1999.

RECIPIENT, ELIGIBLE AND EXPENDITURE DATA FOR CHILDREN UNDER THE AGE OF TWENTY-ONE

	UNDER 1	1 - 5	6 - 14	15 - 20
ELIGIBLES	42,190	136,235	180,338	75,565
RECIPIENTS	27,214	154,079	167,468	67,200
EXPENDITURES ($)	93,715,179	206,112,048	168,969,555	149,700,437
AVERAGE COST PER ELIGIBLE ($)	2,221	1,513	937	1,981
AVERAGE COST PER RECIPIENT ($)	3,444	1,338	1,009	2,228

See technical note on page 40 for explanation of how the number of recipients can be greater than the number of eligibles.

Children Receiving Quality Care

The KIDMED screening program continues to provide quality care to Medicaid children. For FFY 1998, 90 percent of the Medicaid children that should have received a preventative screening service did, in fact, receive at least one screening service. Some 293,000 children benefitted from KIDMED screenings. The KIDMED program includes medical, vision, hearing, and dental screenings.

Medicaid Eligibility Data System

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

Magnetic Strip Card

The magnetic strip card referred to as "Health Network for Louisiana" has replaced the monthly paper card. The swipe card is issued with a unique card control number, recipient name, issue date and bank identification number. This card is replaced only when it is lost, stolen, damaged or the recipient's name changes. Each replacement card deactivates the previous card issued and the previous card becomes obsolete. The card is designed with security features to deter abuse and fraud.

The magnetic strip cards are used by the providers to verify eligibility via the Medicaid Electronic Verification System (MEVS). The MEVS system is programmed to give basic eligibility, service limits, third-party liability, Medicare and program restriction information.

Waiver Unit

The Department of Health and Hospitals established a Waiver Unit, August 1998 to administer four Medicaid Home and Community-Based Waiver programs. These programs allow Medicaid recipients who would otherwise require care in an institutional setting (nursing facility or intermediate care facility for the mentally retarded) to stay in their own homes and receive services in the community. These community-based services are specialized and are available to Medicaid waiver recipients in addition to regular Medicaid services. To qualify, an individual must have an income level at or below three times the monthly SSI benefit rate and resources at or below the usual Medicaid limits. They must meet SSI disability standards and be determined eligible for institutional care. Individuals must apply for a waiver program in addition to applying for Medicaid coverage (for more information please see page 20).

Electronic Funds Transfer

The Department of Health and Hospitals implemented an electronic funds transfer system in October 1998. The electronic funds transfer allows direct deposit of funds received from providers. Six months after implementation, the Department reached its target of 95% of the total dollars being processed through electronic funds transfer. The 95% is also required by the Cash Management Improvement Act (CMIA).

PC-SURS

PC-SURS is a proprietary system developed by the U.P.I. Government Group for San Mateo, California. Louisiana was the founth state to implement this profiling system, after the states of Oklahoma, Maryland and Michigan. Subsequent to the acquisition by Louisiana, the states of Illinois and New York secured the system.

This PC-based Surveillance and Utilization Review (SURS) profiling system allows data from the mainframe to be manipulated quickly without the need for programmers to design "special reports" on each atypical situation being investigated. This ability to quickly identify potential fraudulent actions on the part of providers will have both direct cost savings, as fraud and abuse cases can be developed much quicker, and enhanced cost avoidance, as fraudulent and abusive actions are stopped much quicker.

TAX EQUITY AND FISCAL RESPONSIBILITY ACT (TEFRA)-KATIE BECKET

With the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, Congress defined a new optional group for Medicaid eligibility called the Disabled Children Home Care State Plan Options. In the Omnibus Budget Reconciliations Act (OBRA) of 1987, changes were made to the qualifying criteria to make eligibility more consistent with the requirements for persons who are eligible because they are receiving institutional care (living in a hospital, nursing home, or ICF/MR). The TEFRA optional eligibility category allows states the option to extend Medicaid coverage to children who meet the eligibility criteria listed below. Children determined eligible under TEFRA option will receive regular Medicaid State Plan services, including EPSDT services. They are not eligible for services available in a home community based services waiver. The Louisiana Legislature has mandated coverage of this optional eligibility group. DHH will implement TEFRA in January 2000.

CRITERIA FOR TEFRA ELIGIBILITY:

- *must be under the age of 19*
- *is disabled by severe medical condition or mental retardation*
- *lives at home with his/her family that has income higher than SSI limits*
- *does not receive SSI or cash assistance, or have an MR/DD waiver slot*
- *has personal income and resources low enough to meet financial criteria to qualify for Medicaid payment for institutional care*
- *is disabled according to SSI criteria*
- *meets level-of-care criteria for institutional placement in a hospital, nursing facility, or ICF/MR facility*
- *can be safely cared for at home, according to a physician's statement*
- *meets all other Medicaid non-financial criteria (citizenship, residency, social security number, etc.)*

Disproportionate Share Cap

In 1981, Congress required states to make additional Medicaid payments to hospitals that provide treatment for a "disproportionate share" (DSH) of low-income patients.

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

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

Payments for 1995/96 to 1998/99 in Louisiana (Excludes Medicaid Administration)

YEAR	DSH PAYMENTS	NON-DSH PAYMENTS	TOTAL MEDICAID	DSH AS A % OF TOTAL
		($) in millions		
1995/96	685.8	2,604.6	3,290.5	20.84
1996/97	672.8	2,588.4	3,261.2	20.63
1997/98	757.4	2,406.7	3,164.2	23.94
1998/99	784.3	2,500.3	3,284.6	23.88

Financing

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.

SFY 1998/99	ADMINISTRATION ($)	%	MEDICAL VENDOR ($)	%	TOTAL ($)	%
STATE	43,903,105	44.0	963,370,389	29.3	1,007,273,494	29.8
FEDERAL	55,874,105	56.0	2,321,231,585	70.7	2,377,105,690	70.2
TOTAL	99,777,210	100	3,284,601,974	100	3,384,379,184	100

The total expenditure for SFY 1998/99 was $3,384,379,184. Louisiana expended $1,007,273,494 in state financing for Medicaid expenditures; a total of $2,377,105,690 were federal funds.

Where the Money Goes

For 1998/99, the program expended $3,384,379,184, which was slightly higher than 1997/98. The table below shows this distribution by budget program.

BUDGET PROGRAM	EXPENDITURES
PRIVATE PROVIDERS	2,045,720,399
PUBLIC PROVIDERS	371,124,958
UNCOMPENSATED CARE	784,254,399
MEDICARE BUY-IN	83,502,218
ADMINISTRATION	99,777,210
TOTAL FOR 1998/99	3,384,379,184

Federal Funds

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

Federal Medical Assistance Percentages (FMAP)

On a State Fiscal Year Basis, 1989/90 to 1998/99

	1989/90	1990/91	1991/92	1992/93	1993/94	1994/95	1995/96*	1996/97*	1997/98	1998/99
STATE	27.39	25.86	24.80	25.86	26.45	27.14	27.92	28.51	29.64	29.71
FEDERAL	72.61	74.14	75.20	74.14	73.55	72.86	72.08	71.49	70.36	70.29
STATE	Alternative Payment Method*						15.72	18.54		
FEDERAL	Alternative Payment Method*						84.28	81.46		

* Under the alternative payment method which Congress made available to Louisiana, (P.L. 104-134 Section 519), the state was able to obtain federal funds at a preferred match rate in return for a cap on federal funds. This helped Louisiana manage a serious financial problem. The alternative payment method was one tool which allowed time to scale the program down in an organized fashion without sustaining large budget deficits or disruption in providing essential services. The alternative payment plan ended June 1997.

COLLECTIONS AND MEASURABLE COST AVOIDANCE

COLLECTIONS/COST AVOIDANCE 1998/99	$
PHARMACY PROGRAM	
Drug Rebate Program	69,700,795
Prospective Drug Utilization Review	15,706,298
Dispensing Fee Adjustment	14,056,681
Co-payments	9,385,806
Pharmacy Provider Fees	4,433,583
Medicare Cost Avoidance of Crossover	2,903,870
Audit Program	897,947
PROVIDER FEES	
Nursing Facilities	55,104,825
ICF/MRs	19,746,934
RECOUPMENTS	49,641,909
THIRD-PARTY LIABILITY COLLECTIONS	
Insurance	4,754,005
Trauma/TOA Recovery	4,201,352
Other Collections	1,185,399
INELIGIBLE RECOVERIES	677,674
ESTATE RECOVERY	81,055
MEASURABLE COST AVOIDANCE	
Medicare Buy-In Cost Avoidance	264,134,287
TOTAL COLLECTIONS/COST AVOIDANCE	**$516,612,420**

MEDICARE PREMIUMS (BUY-IN PROGRAM)

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

ELIGIBILITY

States Given Flexibility in Managing Their Programs

Medicaid gives individual states the flexibility to tailor their programs within federal guidelines establishing the minimum and maximum eligibility. Federal law mandates entitlements to certain categories of individuals for medical assistance. States have the option of entitling other categories of individuals for coverage.

Eligibility Determination

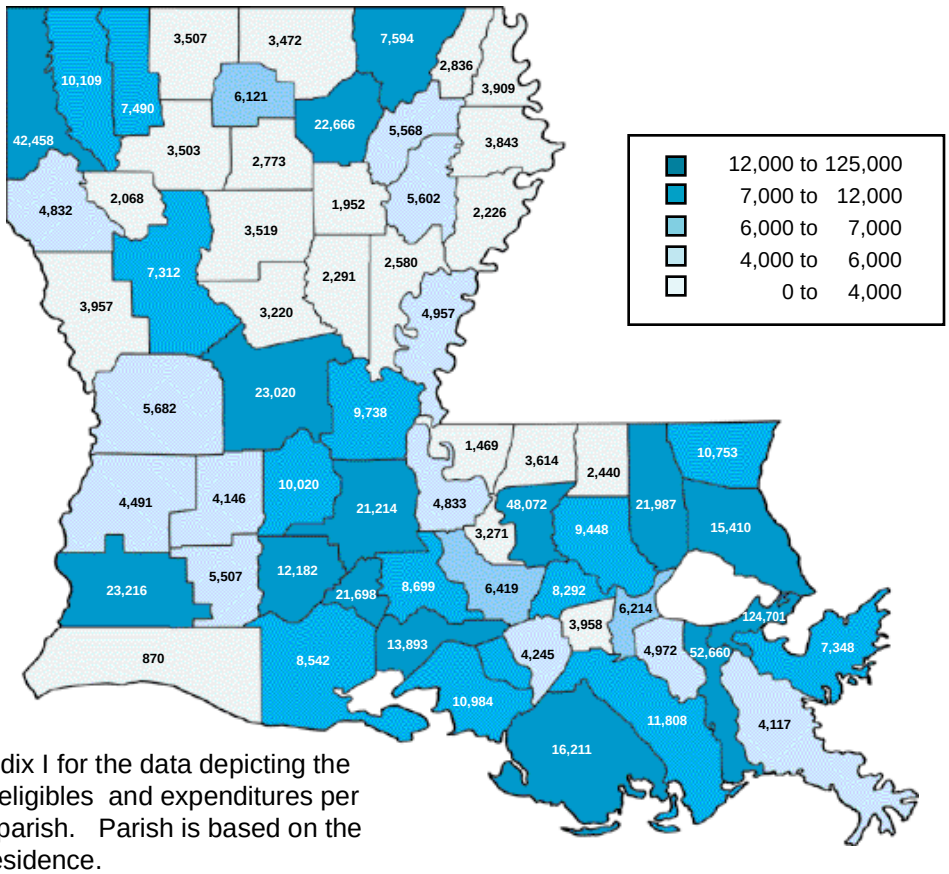
Eligibility is determined by a federally approved process which is operated in the same manner throughout each of the regions.

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

Eligibility by Parish

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

Medicaid Eligibles By Parish SFY 1998/99



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

ELIGIBILITY PROCESS

Initial Contact

The application process can begin with a telephone conversation or a face-to-face meeting with a representative from the parish office. Medicaid applicants may directly contact a Certified Medicaid Application Center to schedule an interview. The simplified "mail-in" LaCHIP application can be used for all children under age 19 and can be obtained from the LaCHIP Processing Center, parish/regional Medicaid offices, Certified Medicaid Application Centers, and many community organizations.

Application Interview

No interview is required for the simplified "mail-in" LaCHIP application for all children under age 19. The parish office may conduct a face-to-face or telephone interview. A face-to-face interview is required if conducted by a Certified Application Center. The Application Center representative completes the application form and related forms.

Application Processing

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

Verification for Documentation

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

Completion of Additional Forms

Additional forms may be required for the determination of eligibility.

Issurance of Medicaid Eligibility Card

After a case has been certified, a Health Network for Louisiana card (Medicaid swipe card) is issued to an eligible.

LOUISIANA MEDICAID PROFILE

The estimated population for Louisiana as of July 1998 was 4,368,967. Of these, 912,513 (20.9%) persons had income at or below the 1998 Federal Poverty Level (FPL).

Of the total population for 1997, those persons with private insurance represented the highest proportion, with 49.7 percent. This was followed by persons with no health insurance at 19.5 percent, those with Medicaid coverage at 17.3 percent and Medicare at 13.5 percent.

Figure 5 below shows the distribution of the uninsured and the insured persons in Louisiana.

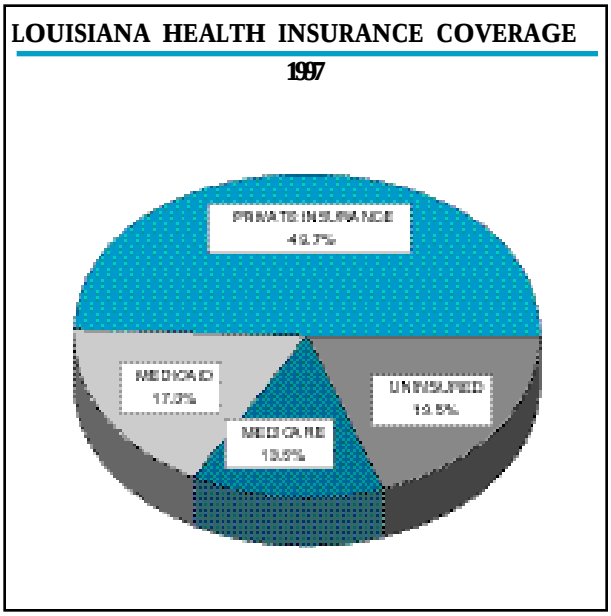


Figure 5

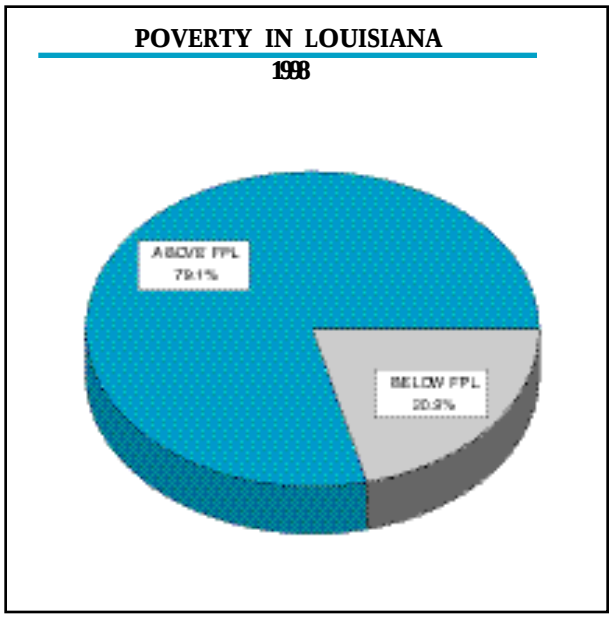


Figure 4

As mentioned above, Louisiana had a total poverty population of 912,513. As indicated below, of those, 79.6 percent were eligible for Medicaid. Others representing the remaining 20.4 percent of the poverty population either had not applied for Medicaid benefits or did not meet the requirements for Medicaid.

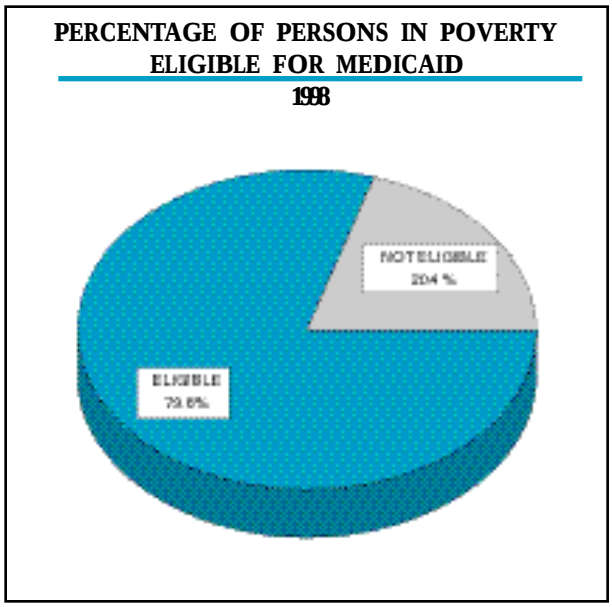


Figure 6

FEDERAL POVERTY LEVEL 1998

Family Size	Level Income at 133% FPL
1	10,707
2	14,431
3	18,155
4	21,879

For each additional person add $3,720.
FPL excludes Alaska and Hawaii

MEDICAID ELIGIBLES, RECIPIENTS AND EXPENDITURES BY AGE AND GENDER

There were a total of 726,500 persons in Louisiana enrolled in Medicaid in 1998/99. Of those, 290,705 were males and 435,754 were females. There were more eligible males than females from birth to age 14. However, females out-number males overall with a much greater enrollment among persons ages 15 and over. Females aged 21-44 represented the highest gender/age group of persons eligible.

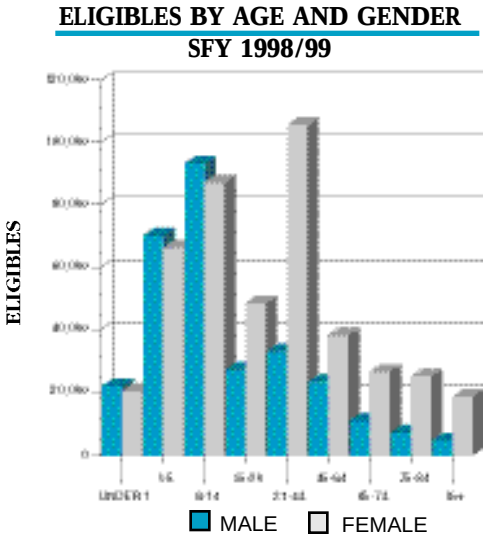


Figure 7

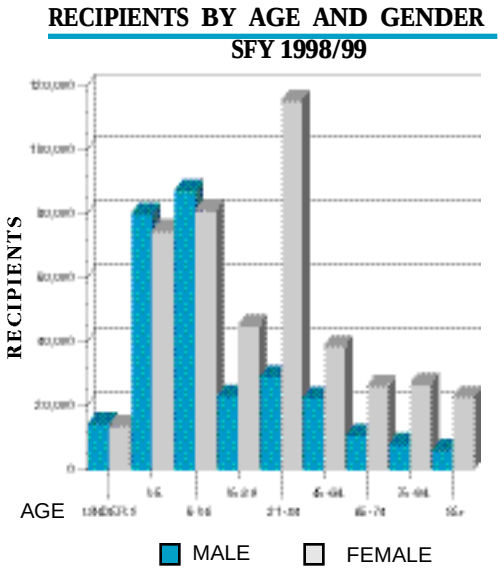


Figure 8

Louisiana's Medicaid program had a total of 717,813 recipients for SFY 1998/99. The gender and age distribution of eligibles and recipients are closely related. The graph on the left shows a greater number of recipients among age groups 1-14 and 21-44. The graph to the left shows the number of persons receiving services declines after ages 45.

Even though there are relatively few seniors over 74 years old, the expenditure distribution shows this group receives a high proportion of the total Medicaid benefits. This is consistent with other health care plans which typically show high health care costs in latter years of life. In addition, women in childbearing years receive a high proportion of benefits.

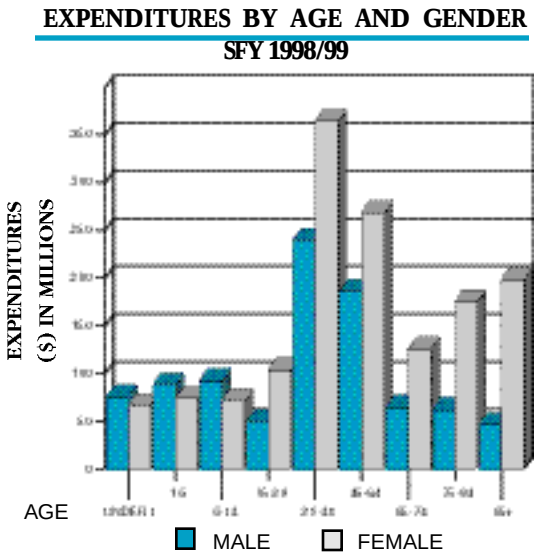


Figure 9

MEDICAID ELIGIBLES, RECIPIENTS AND EXPENDITURES BY AID CATEGORY

There were 726,500 Medicaid eligibles in 1998/99. Of the total, TANF eligibles represented the highest proportion with 347,247 recipients or 47.8 percent. Blind and Disabled had the second highest with 153,326 or 21.1 percent followed by SOBRA (Sixth Omnibus Budget Reconciliation Act) with 93,430 or 12.9 percent. A smaller number of persons were eligible in various other categories (foster care, voluntary, foster care/non-FFP and Vietnam/ Cambodian refugees).

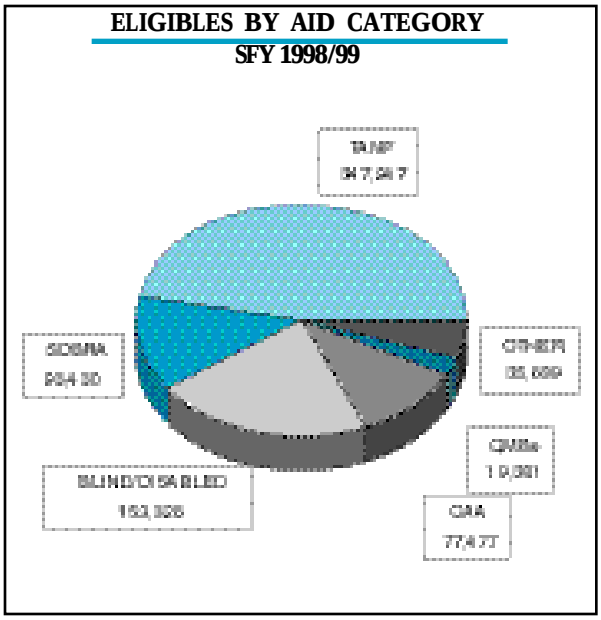


Figure 10

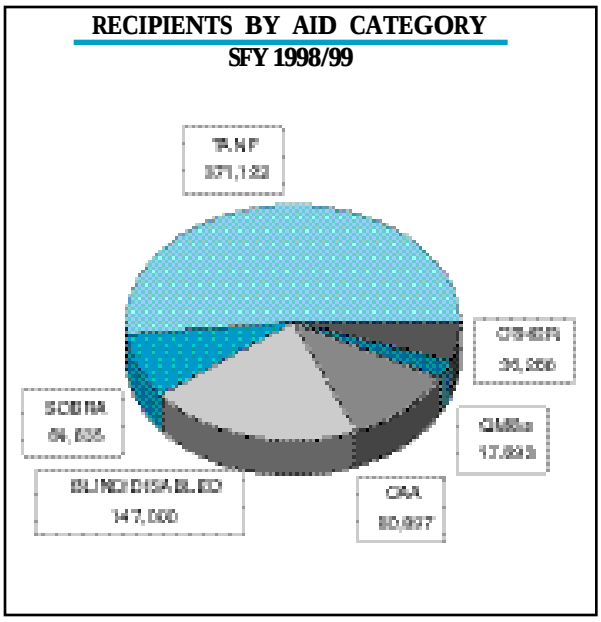


Figure 11

There were 717,813 recipients. Of the total, TANF recipients represented the highest proportion with 51.7 percent. This was followed by persons enrolled as blind and disabled which had 20.5 percent followed by OAA with 11.3 percent. A smaller number of persons who received services were enrolled in various other categories.

Persons enrolled as blind and disabled received the highest share of expenditures with 45.1 percent followed by Old Age Assistance (OAA) with 27.5 percent. Persons enrolled as TANF had the highest number of recipients but ranked third in expenditures, at 17.9 percent. The data are not surprising as the majority of TANF recipients receive regular or non-intensive services, while the aged and disabled typically receive a much more expensive array of services.

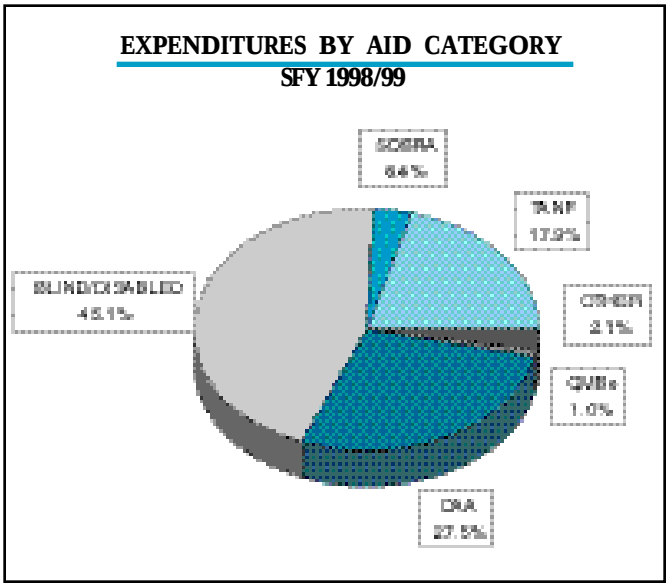


Figure 12

TOP TEN SERVICES BY EXPENDITURE

Hospital Services

Hospital services include both inpatient and outpatient services. Inpatient services are provided to recipients during their stay in a licensed Medicaid participating hospital. Included are medical supplies, nursing care, therapeutic services, lab and x-ray, emergency room care, rehabilitation services and drugs. Prior authorization is required to extend visits due to medical needs.

Outpatient services are provided to recipients in an outpatient setting of a licensed Medicaid participating hospital. Included are emergency care, ambulatory surgery and periodic prior authorized therapy. The total expenditures for the SFY 1998/99 for hospital services (inpatient and outpatient) were $672,868,350. The units of services were 870,879, yielding an average cost per service of $772.63.

Long-Term Care Facilities

Services include professional nursing and rehabilitation services provided on a 24-hour-a-day basis to recipients in state licensed Medicaid participating nursing facilities. Recipients require only limited medical supervision and custodial care. Total expenditures for SFY 1998/99 for Long-Term Care Facilities were $504,552,953. The total units of services provided were 12,345,783, yielding an average cost per service of $40.87.

Intermediate Care Facilities for the Mentally Retarded

ICF/MRs are homes for the long-term care of mentally retarded and/or developmentally disabled recipients. Preventative care is also provided within the facilities. Total expenditures for SFY 1998/99 for ICF/MRs were $336,893,650. The total units of services provided were 2,672,858, yielding an average cost per service of $126.04.

Pharmacy Services

Services include the dispensing of FDA approved drugs by a state licensed participating pharmacy. Prescriptions must be prescribed by a licensed physician, dentist, podiatrist, or a certified optometrist. Co-payments of $.50 to $3.00 are paid by recipients between 22 and 64 years of age, unless the recipient meets one of the exempted criteria. Total expenditures for SFY 1998/99 for pharmacy were $320,789,257. The total expenditures are net of pharmacy rebate. The total units of services provided were 10,730,290, yielding an average cost per service of $29.90.

Physician Services

Services include the diagnosis and treatment of a recipient's illness in a doctor's office, the recipient's home, a hospital, a nursing home, emergency room, ambulatory surgical centers including rural health clinics, Federally Qualified Health Centers (FQHC's) or other settings. Total expenditures for SFY 1998/99 for physicians were $244,861,014. The total units of services provided were 10,219,820, yielding an average cost per service of $23.96.

Mental Retardation and Developmental Disability Waiver (MR/DD)

MR/DD provide services to recipients in a community or home setting. Services could include but are not limited to the following: sitting, bathing, preparing meals, administering medications. This type of service enables recipients to remain in their homes rather than being institutionalized in some cases. Total expenditures for SFY 1998/99 for MR/DD waivers were $74,520,738. The total units of services provided were 7,437,327, yielding an average cost per service of $10.02.

PERSONAL CARE ATTENDANT

Personal care attendants provide services within the recipients' homes. Services could include but are not limited to the following: sitting, bathing, preparing meals, and administering medications. This type of service enables recipients to remain in their homes rather than being institutionalized in some cases. The total expenditures for SFY 1998/99 for personal care attendants were $33,664,936. The total units of services provided were 3,720,823, yielding an average cost per service of 9.05.

DURABLE MEDICAL EQUIPMENT (DME)

Durable medical equipment products include wheelchairs, oxygen concentrators, prostheses and other medical devices. Total expenditures for SFY 1998/99 for durable medical equipment were $32,423,338. The total units of services provided were 11,735,366, yielding an average cost per service of $2.76.

DISTINCT PART PSYCHIATRIC

Services must be provided according to a mental health rehabilitation plan that is developed by a licensed professional who is a qualified mental health provider in conjunction with a physician and be pre-authorized by state staff. The attending physician must document that the recipient meets the definition of disability required to receive this type of service and must order the rehabilitation plan. Services may not be provided to inpatients of a mental institution or a psychiatric unit in an acute hospital. Total expenditures for SFY 1998/99 for distinct part units were $22,082,841. The total units of services provided were 61,944, yielding an average cost per services of $356.50

DENTAL SERVICES

Dental services include both emergency and regularly scheduled check-ups for both general and surgical procedures. The Total dental expenditures for SFY 1998/99 for dentists were $21,315,265. The total units of services provided were 798,627, yielding an average cost per services of $356.50.

TOP TEN SERVICES BY RECIPIENTS

PROVIDER	RECIPIENTS SERVED	AVERAGE COST PER RECIPIENT ($)	TOTAL PAYMENTS ($)
HOSPITAL	447,109	1,505	672,868,350
LONG-TERM CARE	38,484	13,111	504,552,953
ICF/MR	6,225	54,119	336,893,650
PHARMACY SERVICES	680,147	472	320,789,257
PHYSICIAN SERVICES	726,408	337	244,861,014
MR/DD WAIVER	2,994	24,890	74,520,738
PERSONAL CARE ATTENDANT	3,121	10,787	33,664,936
DME PROVIDERS	44,243	733	32,423,338
DISTINCT PART PSYCHIATRIC	6,691	3,300	22,082,841
DENTAL SERVICES	130,299	164	21,315,265

LOUISIANA'S WAIVER PROGRAMS

Louisiana's Department of Health and Hospitals currently operates four waiver programs. The four waiver programs are (1) Adult Day Health Care; (2) Mental Retardation/Developmental Disability (MR/DD), (3) Elderly and Disabled, and (4) Personal Care Attendant (PCA).

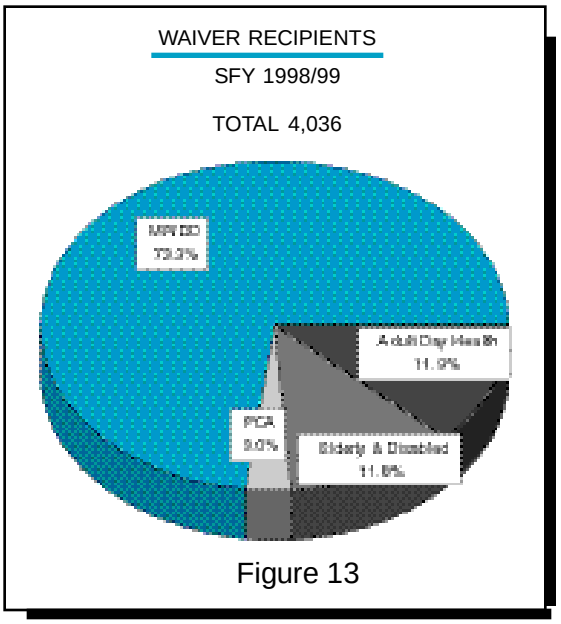


Figure 13

ADULT DAY HEALTH CARE WAIVER

The Adult Day Health Care Waiver was implemented January 1, 1985. 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. There were 485 recipients participating in the Adult Day Health Care Waiver program.

ELDERLY AND DISABLED ADULT WAIVER

The 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 as an alternative to nursing home placement. On April 1, 1997 the waiver was amended to include disabled adults age 21 through 64 in addition to elderly and disabled age 65 and over. An average daily cost cap of $35 per day was established for waiver services to ensure continued cost effectiveness. There were 433 recipients participating in the Elderly and Disabled Adult Waiver program.

MENTAL RETARDATION AND DEVELOPMENTAL DISABILITY (MR/DD) WAIVER

The MR/DD Waiver is the Louisiana's largest home and community-based program. This program began in June of 1990 and serves citizens who are mentally retarded or developmentally disabled between 0 up to 65 years of age. The MR/DD Waiver combines a variety of Medicaid services to allow an individual who qualifies for institutional care to receive services in a home or community setting. There were 2,994 recipients participating in the MR/DD Waiver program.

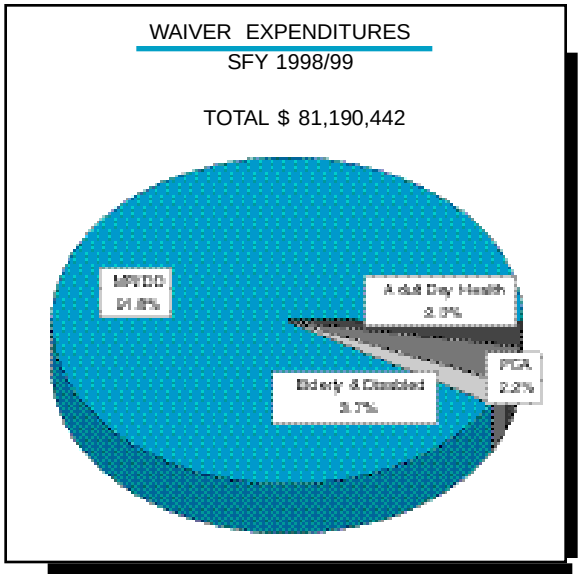


Figure 14

PERSONAL CARE ATTENDANT (PCA) WAIVER

The Personal Care Attendant Waiver was implemented July of 1989. The personal care attendant waiver serves citizens ages 18 through 55, who only require personal care attendant services to avoid institutionalization. There were 123 recipients participating in the PCA Waiver program.

LOUISIANA AND THE SOUTHERN LEGISLATIVE CONFERENCE AVERAGE EXPENDITURES PER RECIPIENT

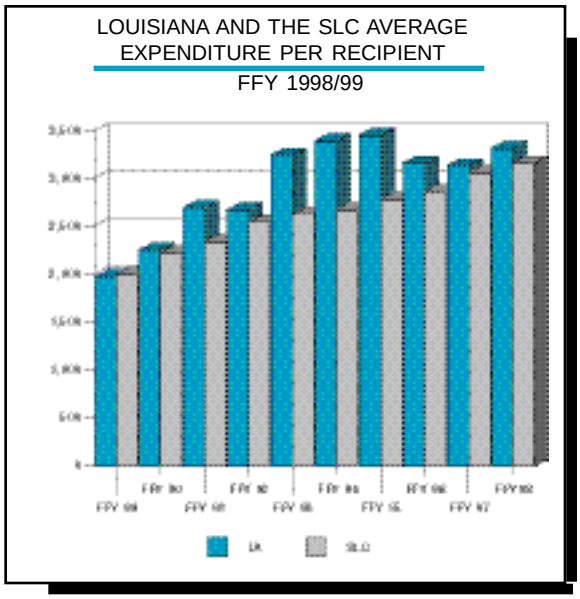


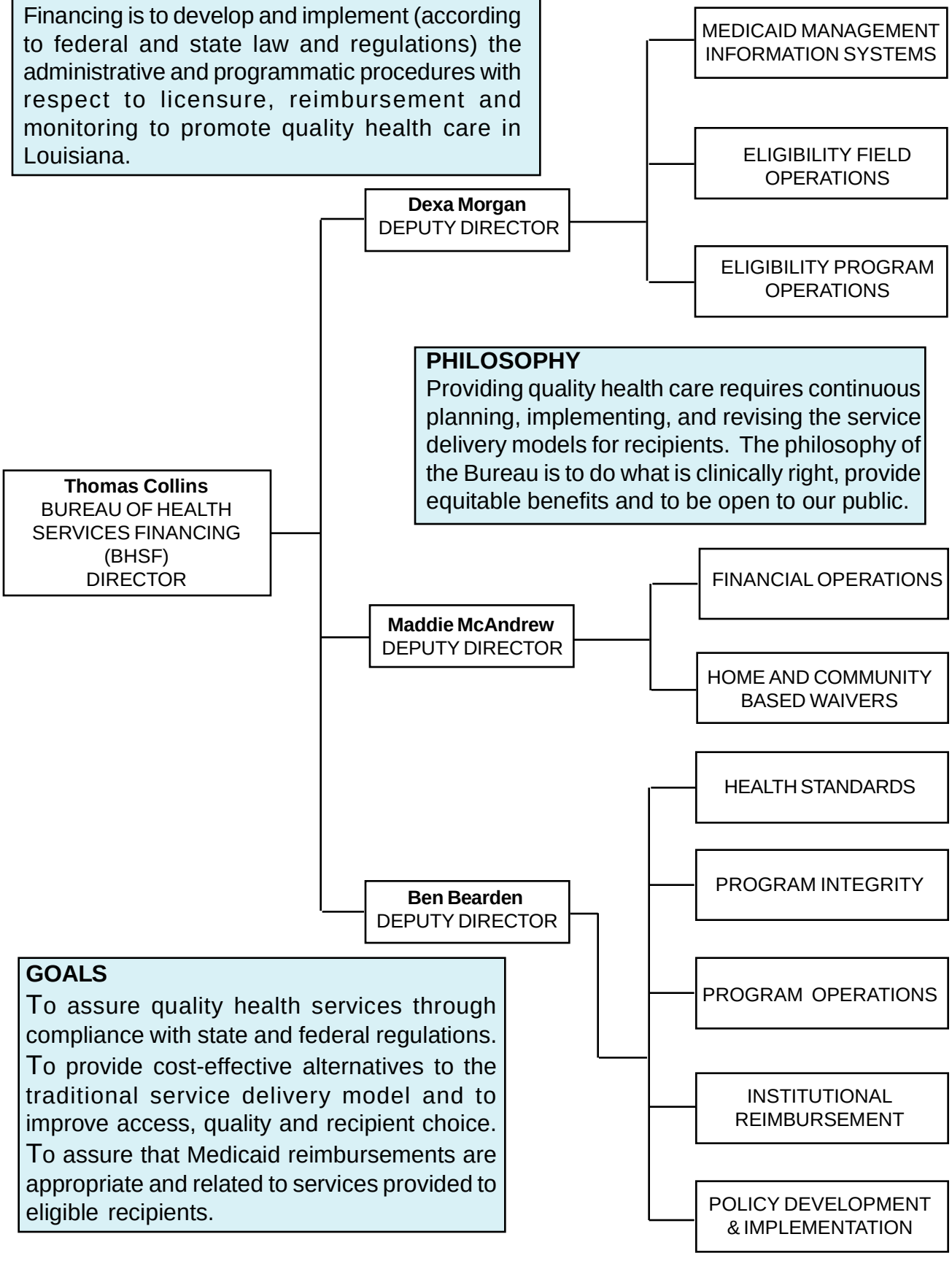
Figure 15

It has been a goal of the Bureau to bring the cost per Medicaid recipient down to the average of the 16 states in the Southern Legislative Conference (SLC). The data shows this measure decreasing from about 27 percent above the average in FFY 1993/94 to 9 percent in FFY 1997/98. In SFY 1998/99 Louisiana implemented the State Children's Health Insurance Program (SCHIP). Children that are being added to the Medicaid rolls through the SCHIP program are relatively inexpensive, therefore reducing the overall average cost per recipient. It is expected that Louisiana's success in enrolling large numbers of children as a result of LaCHIP outreach will be reflected in lower overall average expenditures per recipient in future years. Figure 15 illustrates the average expenditure per recipient of Louisiana compared to the SLC average. Average expenditure per recipient was calculated using HCFA 2082 data, which are based on the federal fiscal year and exclude disproportionate share payments.

FEDERAL FISCAL YEAR	LOUISIANA	SOUTHERN LEGISLATIVE CONFERENCE	PERCENT DIFFERENCE
	($)	($)	(%)
1988/89	1,967	1,999	(1.60)
1989/90	2,247	2,219	1.26
1990/91	2,690	2,335	15.20
1991/92	2,667	2,536	5.17
1992/93	3,239	2,623	23.48
1993/94	3,392	2,673	26.90
1994/95	3,449	2,783	23.93
1995/96	3,154	2,858	10.36
1996/97	3,129	3,055	2.42
1997/98	3,308	3,030	9.17

MISSION STATEMENT

The mission of the Bureau of Health Services Financing is to develop and implement (according to federal and state law and regulations) the administrative and programmatic procedures with respect to licensure, reimbursement and monitoring to promote quality health care in Louisiana.



PHILOSOPHY

Providing quality health care requires continuous planning, implementing, and revising the service delivery models for recipients. The philosophy of the Bureau is to do what is clinically right, provide equitable benefits and to be open to our public.

GOALS

To assure quality health services through compliance with state and federal regulations.

To provide cost-effective alternatives to the traditional service delivery model and to improve access, quality and recipient choice.

To assure that Medicaid reimbursements are appropriate and related to services provided to eligible recipients.

LOUISIANA'S MEDICAID PROGRAM

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

ORGANIZATIONAL STRUCTURE

The Bureau of Health Services Financing has 1,270 authorized positions. Of those, 1,067 are in eligibility determination, licensing and certification functions throughout the state. The remaining 203 employees are in administration, programmatic and state office support staff.

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

DIRECTOR

Functions

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

MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS)

(Susan Taskin, Section Chief)

Key Functions

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

1998/99 Highlights

- There were 38,659,305 claims processed during the year.
- Priority was placed on Year 2000 Compliance work and the interface with the new Medicaid Eligibility Data System (MEDS).

Future Issues

- HCFA mandated EDI (Electronic Data Interface) standards for claims functions.

ELIGIBILITY FIELD OPERATIONS

(Ruth Kennedy, Section Chief)

Key Functions

State Office Responsibilities:

- Supervise Regional and Parish Medicaid Offices, Medical Assistance Program (MAP) 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, redeterminations and notify applicants of decisions.
- Deliver services through direct contact with applicants and recipients of Medicaid.
- Provide assistance to the Medicaid Application Centers.

Highlights

- Established the LaCHIP Processing Center to enhance and simplify the application and enrollment processes for all children under the age of 19.
- Conducted major outreach activities to identify, inform, and enroll eligible children for health benefits.
- Training was conducted for all eligibility staff on the new Medical Eligibility Data System (MEDS).

Future Issues

- Develop and implement field operations and staff procedures for the optional Tax Equity and Fiscal Responsibility Act (TEFRA) program.
- Conduct outreach activities per federal mandate to reach potential Qualified Medicare Beneficiaries (QMB), Specified Low-Income Medicare Beneficiaries (SLMB), Qualified Individuals-Group 1 (QI-1), and Qualified Individuals-Group 2 (QI-2).
- Phase II (up to 150% of the FPL) of the expansion of Medicaid services to all children under age 19 will begin 1999/2000.

ELIGIBILITY PROGRAM OPERATIONS

(Donna Dedon, Section Chief)

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 determinaton of categorical eligibility based on disability and/or incapacity.

1997/98 Highlights

- Conducted a federally approved Quality Control Pilot Project targeting selected elements of newly certified long-term care cases.
- Implementation of the Children's Health Insurance Program (LaCHIP).
- Conducted field staff training for the Medical Eligibility Data System (MEDS).
- Provided support in development and testing of the Medicial Eligibility Data System (MEDS) for year 2000.

Future Issues

- Complying with IRS confidentiality rules and regulations regarding client information. To ensure security measures for each parish office to protect client information.
- Expansion of the LaCHIP program to 150% of Federal Poverty Level.

HEALTH STANDARDS

(Lisa Deaton, Section Chief)

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 care admission; controlled dangerous substances, and resident assessment instruments.

1998/99 Highlights

- Implemented the nursing home quality improvement plan.
- Incorporated the use of the Minimum Data Set (MDS) quality indicators in the nursing home survey process.
- Implemented the automated Outcome Assessment Information Set (OASIS) which automates the assessment of home health patients.

Future Issues

- Quality Assurance Program to conduct trend analysis for staff improvement.
- Maintain the licensing of the growing number of health care providers throughout the state.
- Review and update licensing standards for healthcare providers; establish standards for end-stage renal providers.

FINANCIAL OPERATIONS

(Darryl Johnson, Section Chief)

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.

Highlights

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

Future Issues

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

Policy Development and Implementation

(Sandra Victor, Section Chief)

Key Functions

- 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.

1998/99 Highlights

- Promulgated rules to restructure the delivery of case management services and issued a revised provider manual.
- Promulgated the revised standards for payment for intermediate care facilities for the mentally retarded.
- Initiated activities to develop two new service programs: hospice services and assisted living pilot project.
- Promulgated minimum licensure standards for hospices.
- Secured HCFA approval of 21 state plan amendments.

Future Issues

- Finalize the promulgation of the minimum licensure standards for rural health clinics and alcohol and substance abuse clinics.
- Develop procedures for the implementation of the TEFRA eligibility category.
- Implement the hospice services program.
- Implement the assisted living pilot project.

Program Integrity

(Don Gregory, Section Chief)

Key Functions

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

1998/99 Highlights

- The Medical Assistance Program Integrity Law (MAPIL), R.S. 46:437.2-46:440.3, established effective civil and anti-fraud and abuse remedies including triple damages and fines up to $10,000 per violation, non-dischargability of debt through bankruptcy, forfeiture of property to satisfy debts, and a State Qui Tam provision.
- MAPIL implemented enrollment and bonding provisions that provide for the posting of bonds up to $50,000 to enroll and set conditions for providers to participate in the program.
- Increased the number of Surveillance Utilization Review (SURS) investigations from 200 to 900 per year.
- Implemented a new on-line PC based profiling system.

PROGRAM OPERATIONS

(Bruce Gomez, Section Chief)

Key Functions

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

1998/99 Highlights

- Successfully implemented and monitored the Psychiatric Hospital Diversion program aimed at preventing recidivism by having inpatient psychiatric admits.
- Conducted a dispensing fee survey and an ingredient cost survey for the pharmacy program.
- Initiated a home health task force to develop policy issues and reimbursements to home health agencies.
- Increase codes payable to nurse practitioners.
- Implemented coverage of cochlear implants and intrathecalbaclofen pumps within the Durable Medical Equipment program.
- Completed a study conducted by the firm of Enquist and Pellerin on the issue of "Access to Care" within Medicaid.
- Conducted a satisfaction survey of recipients using the Personal Care Services portion of the EPSDT program.

Future Issues

- To implement a TEFRA program by January 2000.
- To update as many of the Medical Assistance Provider manuals as possible in the upcoming year.
- To create a Health Benefits Manual for Medicaid recipients outlining the covered and excluded items in the program.
- To implement a new outpatient hospital reimbursement methodology by June 2001.

INSTITUTIONAL REIMBURSEMENT

(John Marchand, Section Chief)

Key Functions

- Administer Medicaid reimbursements to institutional providers (i.e., hospitals, ICF/MRs, and nursing homes) in compliance with federal and state regulations.
- Manage accountability of provider expenditures in compliance with federal and state regulations.
- Perform desk reviews and cost settlements of home health cost reports in-house.

1998/99 Highlights

- Developed rules and regulations to allow large rural service district hospitals to receive 100% Federal Fund Participation for uncompensated costs through Medicaid Disproportionate Share Funding.
- Participated in the development of new admission and length-of-stay criteria for long term care hospitals.
- Initiated electronic cost reporting capabilities for nursing homes and ICF-MR.

Future Issues

- Development of a reimbursement methodology in association with the adoption of the Inventory for Client and Agency Planning (ICAP) for ICF/MR.
- Amend deficiencies in the current reimbursement methodology for teaching hospitals.
- Clarify and refine reimbursement methodologies for various providers to update changes in services and federal mandates.
- Develop a "General Reimbursement Manual" giving clear and concise requirements for cost reporting, allowable costs, record keeping and auditing processes and clearly delineating sanctions for failure to comply.
- Assume audit responsibilities (SFY2000) related to the Office of Public Health "Nurse Visitation Program".
- Assume responsibilities (SFY2000) for cost report preparation for all DHH operated facilities.

PREPARING LOUISIANA FOR THE FUTURE

Y2K Readiness

Information screens used by the DHH and Unisys staffs to assist with inquiries have undergone the necessary changes to accommodate required Y2K data. This will allow the department to continue to provide accurate and up-to-date information for the coming year. The General Accounting Office (GAO) has defined a multi-phased approach that describes the program and project management activities necessary to achieve Y2K readiness. DHH and Unisys have adopted this approach for the remediation and testing phase of the Y2K readiness project. The required system changes in the remediation phase which impacted program logic, processes, reporting was tested and implemented.

The "end-to-end" testing phase is now underway. This means that the department is taking each process (claims, hospital precertification, prior authorization, etc.) and submitting Y2K test data from the initial point of entry into the system. The test data will travel through the entire process to the final disposition; thus, "end-to-end." The resulting output data are being reviewed for errors and problems which are corrected with additional validation tests. As part of the outreach program, during the Y2K "end-to-end" testing phase, the department will conduct cross-sectional testing with targeted providers in order to validate major interfaces. This testing will also verify that claims are properly processed by the remediated system, thus assuring the provider community that proper payments will be rendered in a timely manner.

Medicaid Eligibility Data System (MEDS)

MEDS replaces the 32-year-old Welfare Information System (WIS). The primary function of the MEDS application is to capture Medicaid eligibility data. While actual determination of eligibility is a function performed by the eligibility worker rather than the system, the system records the results of the determination and also provides assistance in making the determination.

The contract start date was December 1, 1997 and MEDS was implemented statewide on July 6, 1999. Although not all interfaces were included in the implementation, the major interfaces (Medicaid Management Information System, Louisiana Automated Management Information System, and State Data Exchange) and several other interfaces were running at implementation. The conversion success rate was over 95% and the system is currently being used statewide.

GLOSSARY OF TERMS

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

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

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

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

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

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

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

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

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

DISPROPORTIONATE SHARE (DSH) - UNCOMPENSATED CARE
Compensation for care of individuals in hospitals who do not qualify for Medicaid, but are not financially capable of paying for medical services received. Hospitals must qualify in order to receive payments for administering indigent medical care.

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

EMERGENCY MEDICAL SERVICES FOR ILLEGAL AND LEGAL ALIENS
Legal and illegal aliens who do not meet Medicaid alien status requirements may be eligible for life threatening emergency services only. Emergency services include labor and delivery of a newborn.

EXTENDED MEDICAID
Medicaid coverage is protected for the following applicants/recipients who lose SSI/MSS eligibility and who continue to meet all eligibility requirements.

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

DISABLED WIDOWS/WIDOWERS
Covers disabled widows/widowers (between the ages of 50 and 59) who would be eligible for SSI had there been no elimination of the reduction factor in the federal formula and no subsequent cost-of-living adjustments.

EARLY WIDOWS/WIDOWERS
Covers individuals who receive SSI prior to the age of 60 and lose SSI eligibility as a result of being a recipient of Retirement and Survivors Disability Insurance (RSDI) early widow/widower's benefits.

DISABLED WIDOWS/WIDOWERS AND DIVORCED SPOUSES
Covers individuals who are unable to perform any substantial gainful activity and have lost SSI because of receipt of RSDI as a result of the change in the disability definition.

FEDERAL FISCAL YEAR (FFY)
The federal fiscal year starts October 1 and ends September 30 each year.

HCFA (HEALTH CARE FINANCING ADMINISTRATION)
A federal agency charged with overseeing and approving states' implementation and administration of the Medicaid program.

HOME & COMMUNITY-BASED WAIVER SERVICES (MR/DD, ADHC, PCA, HOME CARE FOR THE ELDERLY)
Provides reimbursement for services to individuals living in the community who would otherwise require services in an institution.

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

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

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

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

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

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

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

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

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

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

Qualified Disabled Working Individuals
Provides Medicare Part A Buy-in for certain non-aged individuals who lost Social Security disability benefits and premium-free Part A Medicare coverage because of substantial gainful activity.

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

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

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

QUALIFYING INDIVIDUALS (1)
Qualifying Individuals (QI-1) went in 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, having income of 120 percent -135 percent FPL, resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for Medicaid.

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

QUI TAM
Qui Tam is a provision of the Federal Civil False Claims Act that allows a private citizen to file a suit in the name of the U.S. Government charging fraud by government contractors and other entities who receive or use government funds, and share in any money recovered.

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

SPECIFIED LOW-INCOME MEDICARE BENEFICIARY
Provides for Medicare Part B Premium, only. The eligibility requirements are the same as the Qualified Medicare Beneficiary (QMB) except that income exceeds the QMB income limit of 100 percent of the Federal Poverty Level (FPL).

STATE FISCAL YEAR (SFY)
The state fiscal year starts July 1 and ends June 30 each year.

STATE PLAN
A plan which sets the policies for the Bureau to follow in accordance with the HCFA requirements. Changes to the State Plan must be submitted to HCFA by the end of the quarter in which the change occurs.

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

TRAUMA/TOA RECOVERY

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

UTILIZATION

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

Appendix 2 - Acronyms

CM	Case Management
DEFRA	Deficit Reduction Act of 1984
DAC	Disabled Adult Children
FOC	Freedom of Choice
HCBWS	Home and Community-Base Waiver Services
MNP	Medical Needy Program
NF	Nursing Facilities
NRTP	Neurological Rehabilitation Treatment Program
PCP	Primary Care Physician
PCS	Personal Care Services
PT	Physicial Therapy
OBRA	Omnibus Budget Reconciliation Act
OT	Occupational Therapy
SNF	Skilled Nursing Facility

READER NOTES

APPENDIX 1

PARISH	POPULATION	RANK	ELIGIBLES	RANK	RECIPIENTS	(%) POP. COVERED BY MEDICAID
ACADIA	58,249	19	12,182	14	12,091	20.91
ALLEN	24,242	38	4,146	42	4,147	17.1
ASCENSION	71,825	17	8,292	24	7,945	11.54
ASSUMPTION	23,006	41	4,245	41	3,973	18.45
AVOYELLES	41,860	28	9,738	20	9,630	23.25
BEAUREGARD	31,164	34	4,491	40	4,518	14.41
BIENVILLE	15,657	52	3,503	51	3,684	22.37
BOSSIER	94,393	12	10,109	18	9,317	10.71
CADDO	241,587	4	42,468	4	39,188	17.57
CALCASIEU	181,799	7	23,216	5	22,112	12.77
CALDWELL	10,666	59	1,952	62	1,855	18.3
CAMERON	9,040	62	870	64	865	9.62
CATAHOULA	10,728	58	2,580	57	2,451	24.05
CLAIBORNE	17,136	51	3,507	50	3,730	20.47
CONCORDIA	21,310	44	4,957	37	4,658	23.26
DESOTO	24,735	37	4,832	39	4,890	19.54
EAST BATON ROUGE	396,556	3	48,072	3	45,737	12.12
EAST CARROLL	8,770	47	3,905	46	4,033	44.53
EAST FELICIANA	20,837	63	3,614	48	3,517	17.34
EVANGELINE	34,373	31	10,020	19	10,185	29.15
FRANKLIN	21,935	43	5,602	33	5,318	25.54
GRANT	18,755	49	3,220	54	3,156	17.17
IBERIA	72,982	16	13,893	13	13,375	19.04
IBERVILLE	30,660	36	6,419	29	6,144	20.94
JACKSON	15,601	53	2,773	56	2,886	17.77
JEFFERSON	453,185	2	52,660	2	51,851	11.62
JEFFERSON DAVIS	31,464	32	5,507	35	5,682	17.5
LAFAYETTE	194,521	5	21,688	9	20,646	11.75
LAFOURCHE	88,269	13	11,808	15	11,365	13.38
LASALLE	14,111	54	2,291	59	2,093	16.24
LINCOLN	41,635	29	6,121	31	5,727	14.7
LIVINGSTON	87,311	14	9,448	21	8,811	10.82

EXPENDITURES	RANK	PER CAPITA ($)	RANK	PER ELIGIBLE ($)	RANK	PER RECIPIENT ($)	RANK
50,189,943	12	862	13	4,120	8	4,151	9
14,820,094	37	611	29	3,575	21	3,574	20
24,510,117	27	341	57	2,956	43	3,085	38
12,230,301	45	532	40	2,881	47	3,078	37
37,863,206	17	905	10	3,888	10	3,932	11
14,611,042	38	469	46	3,253	30	3,234	32
13,489,824	43	862	14	3,851	12	3,862	15
45,217,830	13	479	45	4,473	5	4,853	5
128,617,448	5	532	39	3,029	39	3,282	28
87,329,428	6	480	44	3,782	17	3,949	10
10,625,952	53	996	7	5,444	3	5,728	3
3,051,229	64	338	58	3,507	22	3,527	22
8,818,875	57	822	15	3,418	28	3,598	18
12,612,768	44	736	20	3,596	19	3,381	25
13,986,843	41	656	25	2,822	51	3,003	42
13,849,756	42	560	35	2,995	50	2,832	48
150,280,558	4	379	54	3,126	32	3,286	27
12,168,484	46	1,388	1	3,116	34	3,017	40
19,550,110	34	938	9	5,410	4	5,559	4
38,124,198	16	1,109	3	3,805	14	3,743	13
23,384,544	30	1,066	5	4,174	7	4,397	7
11,041,383	50	589	34	3,429	25	3,499	23
40,797,278	15	559	36	2,937	44	3,050	39
16,597,017	35	541	38	2,588	57	2,701	54
10,636,595	52	682	24	3,836	13	3,686	14
159,590,982	2	352	56	3,031	38	3,078	36
19,701,441	33	626	27	3,578	20	3,467	24
73,387,421	8	398	52	3,382	27	3,555	21
37,453,830	18	424	49	3,172	31	3,296	26
9,667,705	56	685	22	4,220	6	4,841	6
24,959,840	25	599	33	4,078	9	4,358	8
27,723,590	23	318	60	2,934	45	3,146	35

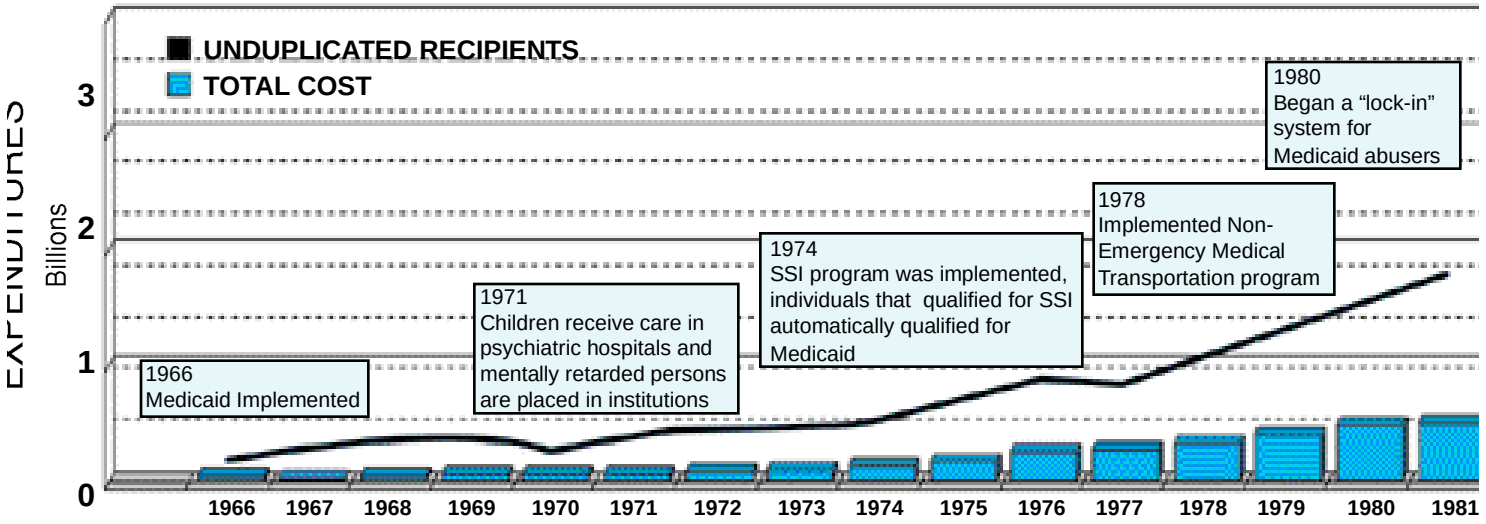
APPENDIX 1

PARISH	POPULATION	RANK	ELIGIBLES	RANK	RECIPIENTS	(%) POP. COVERED BY MEDICAID
MADISON	13,058	56	3,843	47	4,171	29.43
MOREHOUSE	31,438	33	7,594	25	7,831	24.16
NATCHITOCHES	37,744	30	7,312	28	7,558	19.37
ORLEANS	498,124	1	124,701	1	124,064	26.64
OUACHITA	147,657	8	22,665	7	22,645	15.35
PLAQUEMINES	26,407	36	4,117	43	4,225	15.59
POINTE COUPEE	23,316	40	4,833	38	4,921	20.73
RAPIDES	126,901	9	23,020	6	23,289	18.14
RED RIVER	9,877	60	2,068	61	2,169	20.94
RICHLAND	20,673	46	5,568	34	5,820	26.68
SABINE	23,615	39	3,957	45	4,273	16.62
ST. BERNARD	67,264	18	7,348	27	7,741	10.92
ST. CHARLES	48,015	23	4,972	39	5,439	10.36
ST. HELENA	9,576	61	2,440	59	2,345	25.48
ST. JAMES	21,289	45	3,958	44	3,956	18.59
ST. JOHN	42,242	27	6,214	30	5,897	14.71
ST. LANDRY	82,392	15	21,214	10	21,946	25.75
ST. MARTIN	47,439	24	8,695	22	8,645	18.33
ST. MARY	57,322	20	10,984	16	10,901	19.16
ST. TAMMANY	183,727	6	15,410	12	15,380	8.39
TANGIPAHOA	95,510	11	21,987	8	22,255	23.02
TENSAS	6,221	64	2,226	60	2,230	35.78
TERREBONNE	103,964	10	16,211	11	15,719	15.59
UNION	22,020	42	3,472	52	3,892	15.77
VERMILION	51,244	22	8,542	23	8,588	16.67
VERNON	51,894	21	5,682	32	6,031	10.96
WASHINGTON	44,341	25	10,753	17	11,070	24.25
WEBSTER	42,658	26	7,490	26	7,973	17.56
WEST BATON ROUGE	20,638	48	3,271	53	3,478	15.85
WEST CARROLL	12,209	57	2,856	55	3,013	23.23
WEST FELICIANA	13,480	55	1,469	63	1,496	10.9
WINN	17,970	50	3,519	49	3,472	19.58
TOTAL	4,368,967		726,500		717,813	

EXPENDITURES	RANK	PER CAPITA ($)	RANK	PER ELIGIBLE ($)	RANK	PER RECIPIENT ($)	RANK
9,787,383	55	750	17	2,547	58	2,347	60
28,079,090	22	893	11	3,698	18	3,586	19
22,755,036	31	603	32	3,112	35	3,011	41
327,449,075	1	699	21	2,626	56	2,639	55
65,277,206	9	442	47	2,860	48	2,883	47
28,616,656	21	1,084	4	6,951	1	6,773	1
14,562,513	39	625	28	3,013	40	2,959	43
152,525,522	3	1,202	2	6,626	2	6,549	2
6,268,192	60	635	26	3,031	37	2,890	46
21,081,373	32	1,010	6	3,786	16	3,622	17
11,699,560	49	491	43	2,957	42	2,738	52
24,432,832	28	363	55	3,325	28	3,156	34
12,013,779	48	250	64	2,416	60	2,209	63
5,839,544	62	610	31	2,393	61	2,490	57
8,749,567	58	411	51	2,211	64	2,206	64
14,194,626	40	336	59	2,284	62	2,407	59
61,719,083	10	749	18	2,909	46	2,812	50
23,993,244	29	506	41	2,759	52	2,775	51
24,752,502	26	432	48	2,254	63	2,271	62
50,258,528	11	274	63	3,261	29	3,268	29
83,318,859	7	872	12	3,789	15	3,744	12
5,871,386	61	944	8	2,638	54	2,633	56
42,848,542	14	412	50	2,643	53	2,726	53
12,042,911	47	547	37	3,469	23	3,262	30
25,367,755	24	495	42	2,970	41	2,954	44
14,983,798	36	289	62	2,637	55	2,484	58
32,697,056	19	737	19	3,041	36	2,954	45
29,115,581	20	683	23	3,887	11	3,652	16
8,003,032	59	388	53	2,447	59	2,301	61
9,807,737	54	803	16	3,458	24	3,255	31
4,214,333	63	313	61	2,869	49	2,817	49
10,970,891	51	611	30	3,118	33	3,160	33
2,360,186,822		540		3,249		3,298	

PPENDIX 2

OUISIANA'S MEDICAID PROGRAM RECIPIENTS, EXPENDITURES AND OLICIES THAT HAVE SHAPED THE PROGRAM OVER TIME



e 1960s

66

der the Social Security Act of 1965, Louisiana's Medicaid program tle XIX) was implemented in 1966 to provide medical services for lfare mothers and children, disabled, and impoverished elderly rsons.

e 1970s

71

ychiatric hospitals expanded services to children under age 21.
dicaid allowed mentally retarded persons to be placed in an titution.

74

e SSI program implemented automatic Medicaid eligibility.

77

dically needy "spend-down" was established setting a 133 1/3% DC flat grant limit (approximately 10% of FPL).
ited outpatient visits to 12 per year and inpatient visits to 15 per year h provisions for an extension.

78

plemented Non-Emergency Transportation (NEMT) which established icy to assure provision of medically necessary.
plemented policy and procedures for the approval of dentures.

79

spital emergency room coverage was limited to 3 visits per calendar ar.

e 1980s

80

ministration sanctions required a lock-in system for Medicaid abusers.
panded inpatient physician services to 15 per year.

82

me and Community-based Services Waiver was implemented to vide adult day health care and habilitation services.

1984

DEFRA was established.
Mandatory coverage of Qualified Pregnant Women and Children.
Newborns were deemed eligible without an application.
Voluntary Family Responsibility Program was established to provide state income tax credit for relatives.
Nurse Midwives were added as a covered service.
Carve-out units were established for hospital reimbursement neonatal and pediatric extensive care and burn units.
Established prospective reimbursement methodology for nursing homes cost settlement.
Mandatory assignment of medical support/third-party resources was implemented.
Small rural hospitals were allowed to provide SNF services under certain circumstances.
Optometrists services received the same reimbursement ratio as physicians.

1985

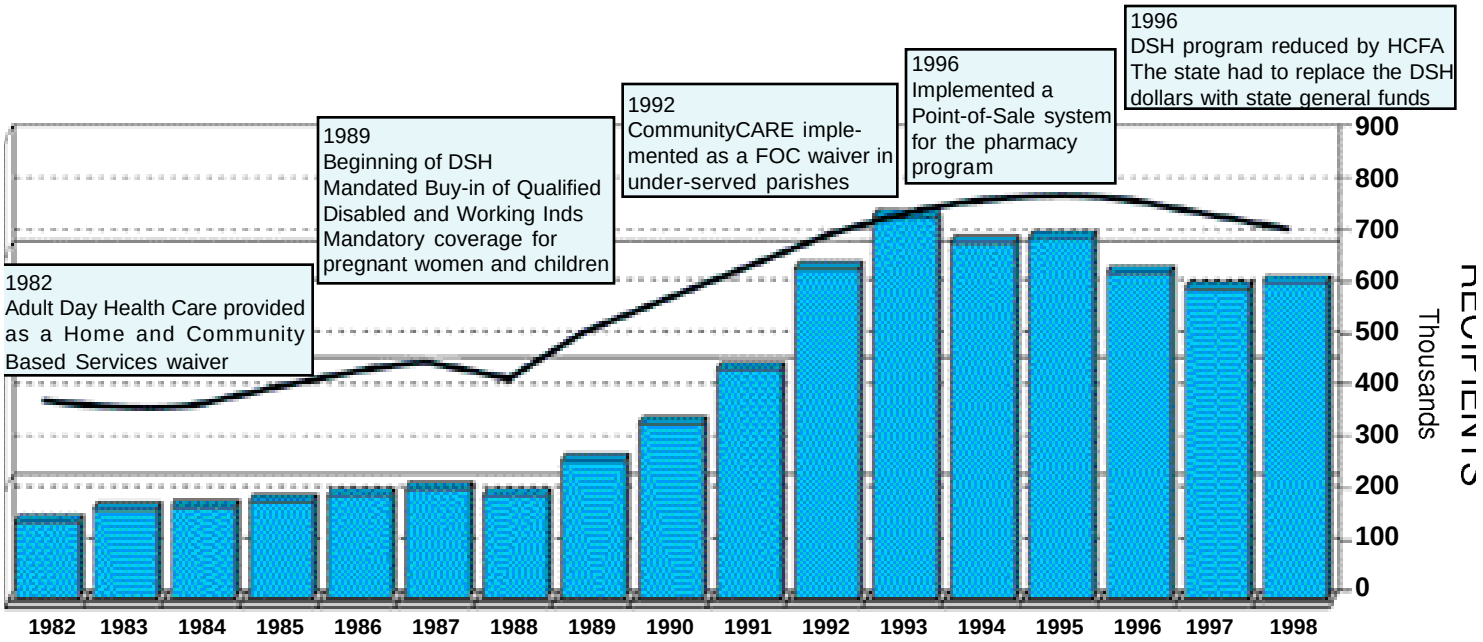
Buy-in was established for recipients receiving money under Title XVI of the Social Security Act.
Reimbursement methodology for inpatient hospital services: transpl costs are excluded from cost per discharge limitation.
Revised eligibility requirements for extended Medicaid to comply w federal court order.
Certain surgeries are reimbursable only when performed in outpatient setting.

1986

Implemented emergency care for illegal Immigrants, includ childbirth.
Payment for case management services were established.

1987

Medicare Patient and Program Protection Act of 1987 was enacte
Disproportionate Share payments to hospitals became mandator
Restructured reimbursement for physicians to a flat fee and adjus the way Medicare cross overs were paid for dual eligibles.
DAC was established which mandated coverage of disabled adu



hildren who lose SSI upon entitlement to Title II childhood disability enefits.

989

)ualified Medical Benefits (QMBs) were established to allow Medicaid o pay Medicare premiums, co-payments and deductibles of poor lderly.

'regnant women and infants with income at 100% of FPL were overed.

Mandatory EPSDT services for children with mental or physical lnesses.

nplemented SNF for infectious diseases.

nplemented reimbursement for TBI or Head Injury Units in SNF or IRTP.

he 1990s

990

Medicaid coverage was expanded to pregnant women and children nder 6 years of age at or below 133 percent of the FPL with option to over children age 6 to 8 (and born after September 30, 1983) at or elow 100 percent of the FPL.

'amily Support Act of 1988 converted 4-month continued Medicaid to -month extended Medicaid with a possible 6-month extension.

Mandated coverage for unemployed parents.

:ontinued eligibility for pregnant women despite changes in income.

:xpanded newborn coverage to children of women who "would, if regnant," remain eligible for Medicaid.

MR/DD waiver was implemented.

'T, OT, ST maintenance services covered for children medical.

991

'rovided eligibility for persons who had been determined to meet all ligibility criteria under AFDC.

Moratorium was established for home health agencies under OBRA.

992

:ommunityCARE was implemented as a FOC waiver for PCP CM.

'CA waiver was implemented.

SN/NRTP reimbursed rate was established at the prospective interim ate based on budget cost data without cost settlement.

NF services were included as MNP services.

Medicaid enrollment centers were authorized.

1993

Eligibility was established for Specified Low Income Medica Beneficiaries (SLMBs).

Home Care for the Elderly waiver was implemented.

Deferred Compensation Plan for Medicaid physician was implement

OBRA added optional coverage for certain TB infections.

1994

Preadmission screening and length-of-stay assignments for hospit was implemented.

Non-emergency medical transportation program reformed.

1995

PCS was added as an EPSDT service.

Implemented Medicaid Estate Recovery Program to recover Medic payments for NF, HCBWS, hospital, and prescription drugs.

Pharmacy lock-in program expanded.

1996

LIFC - Low Income Families with Children replaced AFDC eligibility

Implemented Management System Point-of-Sale for Pharmacy.

AFDC-M and SSI-M was discontinued.

Federally Funded Medically Needy Program (MNP) was discontinu

1997

Federally Funded MNP was re-implemented. Services were limited MNP clients.

Welfare Reform Act - (Affected Children) Children who lost SSI bas on change in definition of disability became eligible.

Implemented full payment of deductible and coinsurance for portable ray claims for recipients with Medicare Part B.

Initiated disease management in the pharmacy program.

1998

Ceased participation in interstate residency agreements.

Added two new mandatory eligibility groups (QI1s and QI2s).

Invoked continuous 12-month eligibility for children.

LaCHIP was implemented for uninsured children.

TECHNICAL NOTES

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

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

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

(2) provider billing habits — some providers hold on to claims for several months and submit them all at once. For example, a recipient receives a service in June 1998 and the provider doesn't submit the claim until May 1999 (providers have a one-year timely filing limit). The recipient will not be counted during SFY 1997/98, but will be counted as an eligible during SFY 1997/98, but will be counted as a recipient in SFY 1998/99. However, the recipient might not be eligible in 1998/99 which would create one more recipient than eligible.

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

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LaCHIP Enrollees
November 1998 through June 1999