FRAMEWORK FOR THE ANNUAL REPORT OF THE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

Preamble

Section 2108(a) and Section 2108(e) of the Act provides that the State and Territories *must assess the operation of the State child health plan in each Federal fiscal year, and report to the Secretary, by January 1 following the end of the Federal fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children. The State is out of compliance with CHIP statute and regulations if the report is not submitted by January 1. The State is also out of compliance if any section of this report relevant to the State's program is incomplete.

To assist States in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with States and CMS over the years to design and revise this Annual Report Template. Over time, the framework has been updated to reflect program maturation and corrected where difficulties with reporting have been identified.

The framework is designed to:

- Recognize the ***diversity*** of State approaches to CHIP and allow States ***flexibility*** to highlight key accomplishments and progress of their CHIP programs, **AND**
- Provide ***consistency*** across States in the structure, content, and format of the report, **AND**
- Build on data ***already collected*** by CMS quarterly enrollment and expenditure reports, **AND**
- Enhance ***accessibility*** of information to stakeholders on the achievements under Title XXI.

* - When "State" is referenced throughout this template, "State" is defined as either a state or a territory.

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DO NOT CERTIFY YOUR REPORT UNTIL ALL SECTIONS ARE COMPLETE.

State/Territory: **LA**
(Name of State/Territory)

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)) and Section 2108(e).

Signature:

Stacy J. McQuillin

CHIP Program Name(s): **All, Louisiana**

CHIP Program Type:

- ☒ CHIP Medicaid Expansion Only
- ☐ Separate Child Health Program Only
- ☐ Combination of the above

Reporting Period: **2009** *Note: Federal Fiscal Year 2009 starts 10/1/08 and ends 9/30/09.*

Contact Person/Title: **Stacy J. McQuillin**

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Submission Date: **12/30/2009**

(Due to your CMS Regional Contact and Central Office Project Officer by January 1st of each year)

SECTION I: SNAPSHOT OF CHIP PROGRAM AND CHANGES

1) To provide a summary at-a-glance of your CHIP program characteristics, please provide the following information. You are encouraged to complete this table for the different CHIP programs within your state, e.g., if you have two types of separate child health programs within your state with different eligibility rules. If you would like to make any comments on your responses, please explain in narrative below this table. Please note that the numbers in brackets, e.g., **[500]** are character limits in the Children's Health Insurance Program (CHIP) Annual Report Template System (CARTS). You will not be able to enter responses with characters greater than the limit indicated in the brackets.

	CHIP Medicaid Expansion Program					**Separate Child Health Program**				
	*** Upper % of FPL are defined as <u>Up to and Including</u>**									
	Gross or Net Income: ALL Age Groups as indicated below									
	Is income calculated as gross or net income?	☒	Income Net of Disregards			**Is income calculated as gross or net income?**	☒	Gross Income		
							☐	Income Net of Disregards		
Eligibility						**From**	0	% of FPL conception to birth	200	% of FPL *
	From	133	% of FPL for **infants**	200	% of FPL *	**From**	201	% of FPL for **infants**	250	% of FPL *
	From	133	% of FPL for children ages **1 through 5**	200	% of FPL *	**From**	201	% of FPL for children ages 1 **through 5**	250	% of FPL *
	From	100	% of FPL for children ages **6 through 16**	200	% of FPL *	**From**	201	% of FPL for children ages **6 through 16**	250	% of FPL *
	From	100	% of FPL for children ages **17 and 18**	200	% of FPL *	**From**	201	% of FPL for children ages **17 and 18**	250	% of FPL *
						From		% of FPL for pregnant women ages **19 and above**		% of FPL *

Is presumptive eligibility provided for children?	☒	No	☒	No
	☐	Yes, for whom and how long? **[1000]**	☐	Yes - Please describe below: For which populations (include the FPL levels) **[1000]** Average number of presumptive eligibility periods granted per individual and average duration of the presumptive eligibility period **[1000]** Brief description of your presumptive eligibility policies **[1000]**
	☐	N/A	☐	N/A

Is retroactive eligibility available?	☐	No	☐	No
	☒	Yes, for whom and how long? **[1000]** Retroactive eligibility is available for up to three months prior to the month of application.	☒	Yes, for whom and how long? **[1000]** Louisiana has two programs that operate as a separate Child Health Programs. 1. LaCHIP Phase IV, provides prenatal care to pregnant women otherwise ineligible for Medicaid through the CHIP Unborn Option. For LaCHIP Phase IV, all children may be eligible for up to three months, but no earlier than conception, prior to month of date of application. 2. LaCHIP Phase V, also known as the LaCHIP Affordable Plan, provides benefits to children in families with income between 201-250% FPL. With the LaCHIP Affordable Plan, retroactive eligibility is not provided.
	☐	N/A	☐	N/A

Does your State Plan contain authority to implement a waiting list?	Not applicable	☒	No
		☐	Yes
		☐	N/A

Does your program have a mail-in application?	☐	No	☐	No
	☒	Yes	☒	Yes
	☐	N/A	☐	N/A

Can an applicant apply for your program over the phone?	☐	No	☐	No
	☒	Yes	☒	Yes
	☐	N/A	☐	N/A

Does your program have an application on your website that can be printed, completed and mailed in?	☐	No	☐	No
	☒	Yes	☒	Yes
	☐	N/A	☐	N/A

Can an applicant apply for your program on-line?	☐	No	☐	No
	☒	Yes – please check all that apply	☒	Yes – please check all that apply
	☐	Signature page must be printed and mailed in	☐	Signature page must be printed and mailed in
	☐	Family documentation must be mailed (i.e., income documentation)	☐	Family documentation must be mailed (i.e., income documentation)
	☒	Electronic signature is required	☒	Electronic signature is required
			☐	No Signature is required
	☐	N/A	☐	N/A

Does your program require a face-to-face interview during initial application	☒	No	☒	No
	☐	Yes	☐	Yes
	☐	N/A	☐	N/A

Does your program require a child to be uninsured for a minimum amount of time prior to enrollment (waiting period)?	☒	No	☐	No
	☐	Yes	☒	Yes
	Specify number of months		Specify number of months	12
			To which groups (including FPL levels) does the period of uninsurance apply? **[1000]** The wait period applies to the LaCHIP Affordable Plan, 201 - 250% FPL. The wait period does not apply to the Unborn Option.	

			List all exemptions to imposing the period of uninsurance **[1000]** 1. Lost insurance due to divorce or death of parent, 2. Lifetime maximum reached, 3. COBRA coverage ends, 4. Insurance ended due to lay-off or business closure, 5. Changed jobs; new employer does not offer dependent coverage, 6. Employer no longer provides dependent coverage, 7. Monthly family premium exceeds 10% of gross income.	
	☐	N/A	☐	N/A

Does your program match prospective enrollees to a database that details private insurance status?	☐	No	☐	No
	☒	Yes	☒	Yes
			If yes, what database? **[1000]** During the eligibility determination process, analysts have access the to Health Management Systems (HMS) COB Match. HMS has data match agreements with the majority of Health insurance carriers. Using that information they have built a national carrier file of health insurance and have developed a product that they call COB Match to determine private health insurance coverage. COB Match captures retroactive private insurance status and helps to ensure that CHIP provisions regarding the 12 month wait period are appropriately applied. HMS uses their proprietary matching techniques to determine if private insurance coverage exists for our applicants and enrollees. If determined they do, follow up is conducted by eligibility worker at renewal and steps are taken to close the CHIP Case if information is proven accurate and if the recipient is not income eligible for Title XIX coverage.	
	☐	N/A	☐	N/A

Does your program provide period of continuous coverage <u>regardless of income changes?</u>	☐	No		☐	No
	☒	Yes		☒	Yes
	Specify number of months		12	Specify number of months	12
	Explain circumstances when a child would lose eligibility during the time period in the box below **[1000]**			Explain circumstances when a child would lose eligibility during the time period in the box below **[1000]**	
	1. family moves out of state, 2. death, 3. child reaches age 19, 4. requests closure, 5. children originally ineligible and certified under fraudulent or misleading circumstances.			1. family moves out of state, 2. death, 3. fails to pay premium, 4. child reaches age 19, 5. requests closure, 6. children originally ineligible and certified under fraudulent or misleading circumstances.	
	☐	N/A		☐	N/A

Does your program require premiums or an enrollment fee?	☒	No		☐	No
	☐	Yes		☒	Yes
	Enrollment fee amount			Enrollment fee amount	0
	Premium amount			Premium amount	50
	Yearly cap			Yearly cap	
	If yes, briefly explain fee structure in the box below **[500]**			If yes, briefly explain fee structure in the box below (including premium/enrollment fee amounts and include Federal poverty levels where appropriate) **[500]**	
				The Unborn Option has no enrollment fee amounts, premium amount, or yearly cap. In LaCHIP Affordable Plan for families over 200% FPL (Phase V) the monthly premium is $50 per family to provide coverage to all eligible children. The yearly cap is calculated as 5% of the family's gross income.	
	☐	N/A		☐	N/A

Does your program impose copayments or coinsurance?	☒	No	☐	No
	☐	Yes	☒	Yes
	☐	N/A	☐	N/A

Does your program impose deductibles?	☒	No	☒	No
	☐	Yes	☐	Yes
	☐	N/A	☐	N/A

Does your program require an assets test?	☒	No	☒	No
	☐	Yes	☐	Yes
	If Yes, please describe below **[500]**		If Yes, please describe below **[500]**	

	☐	N/A	☐	N/A
	If Yes, do you permit the administrative verification of assets?		If Yes, do you permit the administrative verification of assets?	
	☐	No	☐	No
	☐	Yes	☐	Yes
	☐	N/A	☐	N/A

Does your program require income disregards? **(Note: if you checked off net income in the eligibility question, you must complete this question)**	☐	No	☐	No
	☒	Yes	☒	Yes
	If Yes, please describe below **[1000]**		If Yes, please describe below **[1000]**	
	Louisiana utilizes the standard Medicaid income deductions for children in our CHIP Medicaid expansion program including: $90 for each working parent, $50 of all child support received, All child support paid outside of the home, and $175/$200 for child care expenses.		For the CHIP Unborn Option, Louisiana utilizes the standard Medicaid income deductions for children in our CHIP Medicaid expansion program including: $90 for each working parent, $50 of all child support received, all child support paid outside of the home, and $175/$200 for child care expenses. For LaCHIP Affordable Plan, there are no income disregards.	
	☐	N/A	☐	N/A

Which delivery system(s) does your program use?	☐	Managed Care	☐	Managed Care
	☒	Primary Care Case Management	☐	Primary Care Case Management
	☐	Fee for Service	☒	Fee for Service
	Please describe which groups receive which delivery system **[500]**		Please describe which groups receive which delivery system **[500]** Louisiana's Unborn Option uses the Medicaid Model delivery system for benefits. For LaCHIP Phase V (LaCHIP Affordable Plan), benefits are provided via third party contract with the agency that administers the state employees health plan.	

Is a preprinted renewal form sent prior to eligibility expiring?	☐	No	☒	No
	☐	Yes	☐	Yes
	☐	We send out form to family with their information pre-completed and ask for confirmation	☐	We send out form to family with their information pre-completed and ask for confirmation
	☐	We send out form but do not require a response unless income or other circumstances have changed	☐	We send out form but do not require a response unless income or other circumstances have changed
	☒	N/A	☐	N/A

Comments on Responses in Table:

2. Is there an assets test for children in your Medicaid program? ☐ Yes ☒ No ☐ N/A

3. Is it different from the assets test in your separate child health program? ☐ Yes ☐ No ☒ N/A

4. Are there income disregards for your Medicaid program? ☒ Yes ☐ No ☐ N/A

5. Are they different from the income disregards in your separate child health program? ☐ Yes ☐ No ☒ N/A

6. Is a joint application (i.e., the same, single application) used for your Medicaid and separate child health program? ☒ Yes ☐ No ☐ N/A

7. If you have a joint application, is the application sufficient to determine eligibility for both Medicaid and CHIP? ☒ Yes ☐ No ☐ N/A

8. Indicate what documentation is required at initial application

	Self-Declaration	Self-Declaration with internal verification	Documentation Required
Income	☐	☒	☐
Citizenship	☐	☒	☐
Insured Status	☐	☒	☐

9. Have you made changes to any of the following policy or program areas during the reporting period? Please indicate "yes" or "no change" by marking appropriate column.

	Medicaid Expansion CHIP Program			**Separate Child Health Program**		
	Yes	No Change	N/A	Yes	No Change	N/A
a) Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)	☐	☒	☐	☐	☒	☐
b) Application	☐	☒	☐	☐	☒	☐
c) Application documentation requirements	☐	☒	☐	☐	☒	☐
d) Benefits	☐	☒	☐	☐	☒	☐
e) Cost sharing (including amounts, populations, & collection process)	☐	☒	☐	☒	☐	☐
f) Crowd out policies	☐	☒	☐	☒	☐	☐

g)	Delivery system	☐	☒	☐	☐	☒	☐
h)	Eligibility determination process (including implementing a waiting lists or open enrollment periods)	☐	☒	☐	☐	☒	☐
i)	Eligibility levels / target population	☐	☒	☐	☐	☒	☐
j)	Assets test in Medicaid and/or CHIP	☐	☒	☐	☐	☒	☐
k)	Income disregards in Medicaid and/or CHIP	☐	☒	☐	☐	☒	☐
l)	Eligibility redetermination process	☒	☐	☐	☐	☒	☐
m)	Enrollment process for health plan selection	☐	☐	☒	☐	☐	☒
n)	Family coverage	☐	☐	☒	☐	☐	☒
o)	Outreach (e.g., decrease funds, target outreach)	☒	☐	☐	☒	☐	☐
p)	Premium assistance	☐	☐	☒	☐	☐	☒
q)	Prenatal care eligibility expansion (Sections 457.10, 457.350(b)(2), 457.622(c)(5), and 457.626(a)(3) as described in the October 2, 2002 Final Rule)	☐	☐	☒	☐	☒	☐
r)	Expansion to “Lawfully Residing” children	☐	☐	☒	☐	☐	☒
s)	Expansion to “Lawfully Residing” pregnant women	☐	☐	☒	☐	☐	☒
t)	Pregnant Women State Plan Expansion	☐	☐	☒	☐	☐	☒
u)	Waiver populations (funded under title XXI)						
	Parents	☐	☐	☒	☐	☐	☒
	Pregnant women	☐	☐	☒	☐	☐	☒
	Childless adults	☐	☐	☒	☐	☐	☒
v)	Methods and procedures for prevention, investigation, and referral of cases of fraud and abuse	☐	☒	☐	☐	☒	☐
w)	Other – please specify						
	a. _____	☐	☐	☐	☐	☐	☐
	b. _____	☐	☐	☐	☐	☐	☐
	c. _____	☐	☐	☐	☐	☐	☐

10. For each topic you responded yes to above, please explain the change and why the change was made, below:

a) Applicant and enrollee protections	

(e.g., changed from the Medicaid Fair Hearing Process to State Law)	
b) Application	
c) Application documentation requirements	
d) Benefits	
e) Cost sharing (including amounts, populations, & collection process)	LaCHIP Phase V (LaCHIP Affordable Plan) mental health benefits were changed to comply with section 502 of CHIPRA legislation. The mental health and substance abuse benefit deductibles were removed, and the co payments were all reduced to 10% of the contracted rate.
f) Crowd out policies	Analysts have access the to Health Management Systems (HMS) COB Match which has data match agreements with the majority of Health insurance carriers. Using that information they have built a national carrier file of health insurance and have developed a product that they call COB Match to determine private health insurance coverage.
g) Delivery system	
h) Eligibility determination process (including implementing a waiting lists or open enrollment periods)	
i) Eligibility levels / target population	
j) Assets test in Medicaid and/or CHIP	
k) Income disregards in Medicaid and/or CHIP	
l) Eligibility redetermination process	Louisiana's administrative renewal process was expanded to include CHIP certifications that have countable income less than 150% of the FPL less than 75% of the maximum income for eligibility.
m) Enrollment process for health plan selection	
n) Family coverage	
o) Outreach	Please see Outreach summary in Section III

	Please see Outreach summary in Section III
p) Premium assistance	
q) Prenatal care eligibility expansion (Sections 457.10, 457.350(b)(2), 457.622(c)(5), and 457.626(a)(3) as described in the October 2, 2002 Final Rule)	
r) Expansion to "Lawfully Residing" children	
s) Expansion to "Lawfully Residing" pregnant women	
t) Pregnant Women State Plan Expansion	
u) Waiver populations (funded under title XXI)	
Parents	
Pregnant women	
Childless adults	
v) Methods and procedures for prevention, investigation, and referral of cases of fraud and abuse	
w) Other – please specify	
a.	
b.	
c.	

Enter any Narrative text below. **[7500]**

SECTION II: PROGRAM'S PERFORMANCE MEASUREMENT AND PROGRESS

This section consists of three subsections that gather information on the core performance measures for the CHIP program as well as your State's progress toward meeting its general program strategic objectives and performance goals. Section IIA captures data on the core performance measures to the extent data is available. Section IIB captures your enrollment progress as well as changes in the number and/or rate of uninsured children in your State. Section IIC captures progress towards meeting your State's general strategic objectives and performance goals.

SECTION IIA: REPORTING OF CORE PERFORMANCE MEASURES

CMS is directed to examine national performance measures by the CHIP Final Rules of January 11, 2001. To address this CHIP directive, and to address the need for performance measurement in Medicaid, CMS, along with other Federal and State officials, developed a core set of performance measures for Medicaid and CHIP. The group focused on well-established measures whose results could motivate agencies, providers, and health plans to improve the quality of care delivered to enrollees. After receiving comments from Medicaid and CHIP officials on an initial list of 19 measures, the group recommended seven core measures, including four core child health measures:

- Well child visits in the first 15 months of life
- Well child visits in the 3rd, 4th, 5th, and 6th years of life
- Use of appropriate medications for children with asthma
- Children's access to primary care practitioners

These measures are based on specifications provided by the Health Plan Employer Data and Information Set (HEDIS®). HEDIS® provides a useful framework for defining and measuring performance. However, use of HEDIS® methodology is not required for reporting on your measures. The HEDIS® methodology can also be modified based on the availability of data in your State.

This section contains templates for reporting performance measurement data for each of the core child health measures. Please report performance measurement data for the three most recent years (to the extent that data are available). In the first and second column, data from the previous two years' annual reports (FFY 2007 and FFY 2008) will be populated with data from previously reported data in CARTS, enter data in these columns only if changes must be made. If you previously reported no data for either of those years, but you now have recent data available for them, please enter the data. In the third column, please report the most recent data available at the time you are submitting the current annual report (FFY 2009). Additional instructions for completing each row of the table are provided below.

If Data Not Reported, Please Explain Why:
If you cannot provide a specific measure, please check the box that applies to your State for each performance measure as follows:

- Population not covered: Check this box if your program does not cover the population included in the measure.
- Data not available: Check this box if data are not available for a particular measure in your State. Please provide an explanation of why the data are currently not available.
- Small sample size: Check this box if the sample size (i.e., denominator) for a particular measure is less than 30. If the sample size is less than 30, your State is not required to report data on the measure. However, please indicate the exact sample size in the space provided.
- Other: Please specify if there is another reason why your state cannot report the measure.

Status of Data Reported:
Please indicate the status of the data you are reporting, as follows:

- Provisional: Check this box if you are reporting data for a measure, but the data are currently being modified, verified, or may change in any other way before you finalize them for FFY 2009.
- Final: Check this box if the data you are reporting are considered final for FFY 2009.

- Same data as reported in a previous year's annual report: Check this box if the data you are reporting are the same data that your State reported in another annual report. Indicate in which year's annual report you previously reported the data.

Measurement Specification:
For each performance measure, please indicate the measurement specification (i.e., were the measures calculated using the HEDIS® technical specifications, HEDIS®-like specifications, or some other source with measurement specifications unrelated to HEDIS®). If the measures were calculated using HEDIS® or HEDIS®-like specifications, please indicate which version was used (e.g., HEDIS® 2007). If using HEDIS®-like specifications, please explain how HEDIS® was modified.

Data Source:
For each performance measure, please indicate the source of data – administrative data (claims) (specify the kind of administrative data used), hybrid data (claims and medical records) (specify how the two were used to create the data source), survey data (specify the survey used), or other source (specify the other source). If another data source was used, please explain the source.

Definition of Population included in the Measure:
Please indicate the definition of the population included in the denominator for each measure (such as age, continuous enrollment, type of delivery system). Check one box to indicate whether the data are for the CHIP population only, or include both CHIP and Medicaid (Title XIX) children combined. Also provide a definition of the numerator (such as the number of visits required for inclusion).

Note: You do not need to report data for all delivery system types. You may choose to report data for only the delivery system with the most enrollees in your program.

Year of Data:
Please report the year of data for each performance measure. The year (or months) should correspond to the *period in which utilization took place*. Do *not* report the year in which data were collected for the measure, or the version of HEDIS® used to calculate the measure, both of which may be different from the period corresponding to utilization of services.

Performance Measurement Data (HEDIS® or Other):
In this section, please report the numerators, denominators, and rates for each measure (or component). The template provides two sections for entering the performance measurement data, depending on whether you are reporting using HEDIS® or HEDIS®-like methodology or a methodology other than HEDIS®. The form fields have been set up to facilitate entering numerators, denominators, and rates for each measure. If the form fields do not give you enough space to fully report on your measure, please use the "additional notes" section.

Note: CARTS will calculate the rate if you enter the numerator and denominator. Otherwise, if you only have the rate, enter it in the rate box.

If you typically calculate separate rates for each health plan, report the aggregate state-level rate for each measure (or component). The preferred method is to calculate a "weighted rate" by summing the numerators and denominators across plans, and then deriving a single state-level rate based on the ratio of the numerator to the denominator. Alternatively, if numerators and denominators are not available, you may calculate an "unweighted average" by taking the mean rate across health plans.

Explanation of Progress:
The intent of this section is to allow your State to highlight progress and describe any quality improvement activities that may have contributed to your progress. If improvement has not occurred over time, this section can be used to discuss potential reasons for why progress was not seen and to describe future quality improvement plans. In this section, your State is also asked to set annual performance objectives for FFY 2010, 2011, and 2012. Based on your recent performance on the measure (from FFY 2007 through 2009), use a combination of expert opinion and "best guesses" to set objectives for the next three years. Please explain your rationale for setting these objectives. For example, if your rate has been increasing by 3 or 4 percentage points per year, you might project future increases at a similar rate. On the other hand, if your rate has been stable over time, you might set a target that projects a small increase over time. If the rate has been fluctuating over time, you might look more closely at the data to

ensure that the fluctuations are not an artifact of the data or the methods used to construct a rate. You might set an initial target that is an average of the recent rates, with slight increases in subsequent years.

In future annual reports, you will be asked to comment on how your actual performance compares to the objective your State set for the year, as well as any quality improvement activities that have helped or could help your State meet future objectives.

Other Comments on Measure:
Please use this section to provide any other comments on the measure, such as data limitations or plans to report on a measure in the future.

NOTE: Please do not reference attachments in this table. If details about a particular measure are located in an attachment, please summarize the relevant information from the attachment in the space provided for each measure.

MEASURE: Well Child Visits in the First 15 Months of Life

FFY 2007	FFY 2008	FFY 2009
Did you report on this goal? ☒ Yes ☐ No **If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:	**Did you report on this goal?** ☒ Yes ☐ No **If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:	**Did you report on this goal?** ☒ Yes ☐ No **If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:
Status of Data Reported: ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: 2008	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: 2009	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: 2010
Data Source: ☒ Administrative (claims data). *Specify*: ☐ Hybrid (claims and medical record data). *Specify*: ☐ Survey data. *Specify*: ☐ Other. *Specify*: MMIS	**Data Source:** ☒ Administrative (claims data). *Specify*: ☐ Hybrid (claims and medical record data). *Specify*: ☐ Survey data. *Specify*: ☐ Other. *Specify*: MMIS	**Data Source:** ☒ Administrative (claims data). *Specify*: ☐ Hybrid (claims and medical record data). *Specify*: ☐ Survey data. *Specify*: ☐ Other. *Specify*: MMIS
Definition of Population Included in the Measure: Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). Definition of numerator: As of March 30, 2007, the number of unique recipients who were enrolled for at least 14 of the last 15 months who visited primary care practitioners at least once (twice, three times, four times, fives times or six or more times) in their first 15 months of life.	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). Definition of numerator: As of March 30, 2008, the number of unique recipients who were enrolled for at least 14 of the last 15 months who visited a primary care practitioner at least once (twice, three times, four times, five times, six times, or more times) in their first 15 months of life.	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). Definition of numerator: As of March 30, 2009 the number of unique recipients who were enrolled for at least 14 of the last 15 months who visited primary care practitioners at least once (twice, three times, four times, five times, or six or more times) in their first 15 months of life.
Year of Data: 2007	**Year of Data:** 2008	**Year of Data:** 2009

Well Child Visits in the First 15 Months of Life (continued)

FFY 2007	FFY 2008	FFY 2009
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Percent with specified number of visits <u>0 visits</u> Numerator: 1677 Denominator: 36399 Rate: 4.6 <u>1 visit</u> Numerator: 1928 Denominator: 36399 Rate: 5.3 <u>2 visits</u> Numerator: 2618 Denominator: 36399 Rate: 7.2 <u>3 visits</u> Numerator: 3279 Denominator: 36399 Rate: 9 <u>4 visits</u> Numerator: 4622 Denominator: 36399 Rate: 12.7 <u>5 visits</u> Numerator: 6111 Denominator: 36399 Rate: 16.8 <u>6+ visits</u> Numerator: 16164 Denominator: 36399 Rate: 44.4 Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent with specified number of visits <u>0 visits</u> Numerator: 1309 Denominator: 38972 Rate: 3.4 <u>1 visit</u> Numerator: 1466 Denominator: 38972 Rate: 3.8 <u>2 visits</u> Numerator: 2134 Denominator: 38972 Rate: 5.5 <u>3 visits</u> Numerator: 3095 Denominator: 38972 Rate: 7.9 <u>4 visits</u> Numerator: 4740 Denominator: 38972 Rate: 12.2 <u>5 visits</u> Numerator: 6420 Denominator: 38972 Rate: 16.5 <u>6+ visits</u> Numerator: 19808 Denominator: 38972 Rate: 50.8 Additional notes on measure: As children under 19 enrolled in Medicaid are included in this data set, we believe that a percentage of the total number with 0 visits are likely those recipients with TPL. Since Medicaid serves as only a payer of last resort, we suspect that Medicaid children who have TPL don't have administrative claims data on the MMIS because of reimbursement policy. We also began capturing FQHC/RHC claims for inclusion in our 2008 data.	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent with specified number of visits <u>0 visits</u> Numerator: 1386 Denominator: 41725 Rate: 3.3 <u>1 visit</u> Numerator: 1701 Denominator: 41725 Rate: 4.1 <u>2 visits</u> Numerator: 2323 Denominator: 41725 Rate: 5.6 <u>3 visits</u> Numerator: 3148 Denominator: 41725 Rate: 7.5 <u>4 visits</u> Numerator: 4812 Denominator: 41725 Rate: 11.5 <u>5 visits</u> Numerator: 6939 Denominator: 41725 Rate: 16.6 <u>6+ visits</u> Numerator: 21416 Denominator: 41725 Rate: 51.3 Additional notes on measure: As children under 19 enrolled in Medicaid are included in this data set, we believe that a %age of the total number with 0 visits are likely those recipients with TPL. Since Medicaid serves as only a payer of last resort, we suspect that Medicaid children who have TPL don't have administrative claims data on the MMIS b/c of reimbursement policy. This measure includes FQHC/RHC claims data. Does not include the Phase V population but is working to develop HEDIS measures for this group.
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:

Explanation of Progress:

How did your performance in 2009 compare with the Annual Performance Objective documented in your 2008 Annual Report? Louisiana fell just short of the goal of increasing the number 6+ visits to 51.8%.

What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal? Several initiatives to raise awareness as to the importance of well-child visits and targeted reviews of children have decreased the number of children with zero visits from 3.4% in FFY08 to 3.3% in FFY09. An immunization administration rate increase effective for August 2008 was implemented and may have also contributed. A Pay for Performance (P4P) rewards systems was implemented and for the past three years, we have rewarded Primary Care Physicians/Pediatricians, who are enrolled in the CommunityCARE program, for participating in the immunization program. Further, those physicians who have high outcomes in terms of the number of children who receive immunizations received additional compensation.

Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.

Annual Performance Objective for FFY 2010: By FFY 10, we are hopeful to have increased our PFP initiatives and build upon the other quality initiatives already in place. In addition to these, we will perform targeted reviews of those children who have had zero visits per the HEDIS reporting data and work to intervene in order to maintain the percentage below 3.3% in FFY10. We also hope to increase the number of 6+ well child visits to 52.0% in FFY10 in an effort to move toward the HEDIS national mean for Medicaid.

Annual Performance Objective for FFY 2011: By FFY 11, we are hopeful to have increased our PFP initiatives and build upon the other quality initiatives already in place. In addition to these, we will perform targeted reviews of those children who have had zero visits per the HEDIS reporting data and work to intervene in order to maintain the percentage below 3.3% in FFY11. We also hope to increase the number of 6+ well child visits to 57.0% in FFY11 in an effort to surpass the HEDIS national mean for Medicaid.

Annual Performance Objective for FFY 2012: By FFY 12, we are hopeful to have increased our PFP initiatives and build upon the other quality initiatives already in place. In addition to these, we will perform targeted reviews of those children who have had zero visits per the HEDIS reporting data and work to intervene in order to maintain the percentage below 3.3% in FFY12. We also hope to maintain the number of 6+ well child visits at 62.0% in FFY12, which is above the HEDIS national mean for Medicaid.

Explain how these objectives were set: A workgroup of our clinical Medicaid staff and contractors was developed to advise CHIP management on tracking these HEDIS measures and other quality indicators, including those set in the 2011 Medicaid Operational Plan. The workgroup consists of nurses and pharmacists who are intimately involved in these initiatives and use their expertise to advise CHIP management of the progress made and planned direction for these quality initiatives.

Other Comments on Measure: Claims data from Separate CHIP (LaCHIP Phase V) is too new as the program was implemented in June 2008 and not available for inclusion in this measure yet. Data for other phases of LaCHIP is based on March 2009.

MEASURE: Well-Child Visits in Children the 3rd, 4th, 5th, and 6th Years of Life

FFY 2007	FFY 2008	FFY 2009
Did you report on this goal? ☒ Yes ☐ No **If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30) *Specify sample size*: ☐ Other. *Explain*:	**Did you report on this goal?** ☒ Yes ☐ No **If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:	**Did you report on this goal?** ☒ Yes ☐ No **If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:
Status of Data Reported: ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: 2008	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: 2009	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: 2010
Data Source: ☒ Administrative (claims data). *Specify*: ☐ Hybrid (claims and medical record data). *Specify*: ☐ Survey data. *Specify*: ☐ Other. *Specify*: MMIS	**Data Source:** ☒ Administrative (claims data). *Specify*: ☐ Hybrid (claims and medical record data). *Specify*: ☐ Survey data. *Specify*: ☐ Other. *Specify*: MMIS	**Data Source:** ☒ Administrative (claims data). *Specify*: ☐ Hybrid (claims and medical record data). *Specify*: ☐ Survey data. *Specify*: ☐ Other. *Specify*: MMIS
Definition of Population Included in the Measure: Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). Definition of numerator: As of March 30, 2007, the number of children who had at least one well-child visit during the measurement year.	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). Definition of numerator: As of March 30, 2008, the number of children who had at least one well child visit during the measurement year.	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). Definition of numerator: As of March 30, 2009, the number of children who had a least one well-child visit during the measurement year.
Year of Data: 2007	**Year of Data:** 2008	**Year of Data:** 2009
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Percent with 1+ visits Numerator: 76750	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent with 1+ visits Numerator: 81972	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent with 1+ visits Numerator: 85989

FFY 2007	FFY 2008	FFY 2009
Denominator: 130961 Rate: 58.6 Additional notes on measure: The agency is also exploring the impact of these services performed in rural health clinics and FQHCs which may not be captured in this measure because of current billing procedures.	Denominator: 134941 Rate: 60.7 Additional notes on measure: We began capturing FQHC/RHC claims for inclusion in our 2008 data.	Denominator: 142114 Rate: 60.5 Additional notes on measure: This measure includes FQHC/RHC claims data. This measure does not currently include the LaCHIP Affordable Plan (Phase V) population but is working to develop HEDIS measures for this group.

Well-Child Visits in Children the 3rd, 4th, 5th, and 6th Years of Life (continued)

FFY 2007	FFY 2008	FFY 2009
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:

Explanation of Progress:

How did your performance in 2009 compare with the Annual Performance Objective documented in your 2008 Annual Report? Louisiana fell short of the 2009 goal of 62.7% for this measure despite efforts to increase the number of children with 1+ well-child visits in the 3rd, 4th, 5th, and 6th years of life.

What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal? An immunization administration rate increase effective for August 2008 was implemented and may have contributed to increased performance. Additional initiatives, including the push for childhood immunizations of school age children by the Office of Public Health may have contributed to this increase.

Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.

Annual Performance Objective for FFY 2010: In FFY 2010 we hope to increase the rate of well-care visits by 1% to 61.5% in an effort to move toward the HEDIS national mean for Medicaid.

Annual Performance Objective for FFY 2011: In FFY 2011 we hope to increase the rate of well-care visits by 1% to 62.5% in an effort to move toward the HEDIS national mean for Medicaid.

Annual Performance Objective for FFY 2012: In FFY 2012 we hope to increase the rate of well-care visits by 1% to 63.5% in an effort to move toward the HEDIS national mean for Medicaid.

Explain how these objectives were set: A workgroup of our clinical Medicaid staff and contractors was developed to advise CHIP management on tracking these HEDIS measures and other quality indicators, including those set in the 2011 Medicaid Operational Plan. The workgroup consists of nurses and pharmacists who are intimately involved in these initiatives and use their expertise to advise CHIP management of the progress made and planned direction for these quality initiatives.

Other Comments on Measure: Claims data from Separate CHIP (LaCHIP Phase V) is too new as the program was implemented in June 2008 and not available for inclusion in this measure yet. Data for other phases of LaCHIP is based on March 2009.

MEASURE: Use of Appropriate Medications for Children with Asthma

FFY 2007	FFY 2008	FFY 2009
Did you report on this goal? ☒ Yes ☐ No **If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:	**Did you report on this goal?** ☒ Yes ☐ No **If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:	**Did you report on this goal?** ☒ Yes ☐ No **If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:
Status of Data Reported: ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: 2008	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: 2009	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: 2010
Data Source: ☒ Administrative (claims data). *Specify*: ☐ Hybrid (claims and medical record data). *Specify*: ☐ Survey data. *Specify*: ☐ Other. *Specify*: MMIS	**Data Source:** ☒ Administrative (claims data). *Specify*: ☐ Hybrid (claims and medical record data). *Specify*: ☐ Survey data. *Specify*: ☐ Other. *Specify*: MMIS	**Data Source:** ☒ Administrative (claims data). *Specify*: ☐ Hybrid (claims and medical record data). *Specify*: ☐ Survey data. *Specify*: ☐ Other. *Specify*: MMIS
Definition of Population Included in the Measure: Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). Definition of numerator: As of March 30, 2007, the number of recipients who meet the persistent asthma diagnosis for two years who have the appropriate medications over the reporting period.	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). Definition of numerator: As of March 30, 2008, the number of recipients who met the persistent asthma diagnosis for two years who have the appropriate medications over the reporting period.	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). Definition of numerator: As of March 30, 2009, the number of recipients who meet the persistent asthma diagnosis for two years who have the appropriate medications over the reporting period.
Year of Data: 2007	**Year of Data:** 2008	**Year of Data:** 2009

Use of Appropriate Medications for Children with Asthma (continued)

FFY 2007	FFY 2008	FFY 2009
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Percent receiving appropriate medications 5-9 years Numerator: Denominator: Rate: 10-17 years Numerator: Denominator: Rate: Combined rate (5-17 years) Numerator: 14424 Denominator: 15963 Rate: 90.4 Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent receiving appropriate medications 5-9 years Numerator: 6316 Denominator: 6747 Rate: 93.6 10-17 years Numerator: 5772 Denominator: 6260 Rate: 92.2 Combined rate (5-17 years) Numerator: 16751 Denominator: 18268 Rate: 91.7 Additional notes on measure: Combined rate is for all children under 19 meeting the HEDIS criteria for comparison sake as this is what was used in past years. Beginning in FFY09, we will report on appropriate age numbers for all three categories as we will have information for at least two points in time for comparison.	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent receiving appropriate medications 5-9 years Numerator: Denominator: Rate: 10-17 years Numerator: Denominator: Rate: Combined rate (5-17 years) Numerator: 17417 Denominator: 19070 Rate: 91.3 Additional notes on measure: HEDIS has changed age breakouts for this measure so 5-9 and 10-17 are not available. Combined rate is for all children under 19 meeting the HEDIS criteria for comparison sake as this is what was used in past years. This measure does not currently include the LaCHIP Affordable Plan (Phase V) population but is working to develop HEDIS measures for this group.
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:

Explanation of Progress:

How did your performance in 2009 compare with the Annual Performance Objective documented in your 2008 Annual Report? Louisiana has maintained its high rate for this measure. We were hoping to continue utilizing initiatives to increase the use of appropriate medications for children with asthma to 92%.

What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal? We will continue our efforts to improve outcomes for children with asthma including: 1) offering CEU for nurses/asthma management, 2) pilot phase of performing Quality Reviews specific to asthma management based on the Chronic Care Model with provider offices, and 3) intervention with patients for education through telephone contact and follow up with PCP's.

Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.

Annual Performance Objective for FFY 2010: In FY10 we are hoping to continue utilizing these initiatives to maintain the current level of use of appropriate medications for children with asthma which is above the HEDIS national mean for Medicaid.

Annual Performance Objective for FFY 2011: In FY11 we are hoping to continue utilizing these initiatives to maintain the current level of use of appropriate medications for children with asthma which is above the HEDIS national mean for Medicaid.

Annual Performance Objective for FFY 2012: In FY12 we are hoping to continue utilizing these initiatives to maintain the current level of use of appropriate medications for children with asthma which is above the HEDIS national mean for Medicaid.

Explain how these objectives were set: A workgroup of our clinical Medicaid staff and contractors was developed to advise CHIP management on tracking these HEDIS measures and other quality indicators, including those set in the 2011 Medicaid Operational Plan. The workgroup consists of nurses and pharmacists who are intimately involved in these initiatives and use their expertise to advise CHIP management of the progress made and planned direction for these quality initiatives.

Other Comments on Measure: Claims data from Separate CHIP (LaCHIP Phase V) is too new as the program was implemented in June 2008 and not available for inclusion in this measure yet. Data for other phases of LaCHIP is based on March 2009.

MEASURE: Children's Access to Primary Care Practitioners

FFY 2007	FFY 2008	FFY 2009
Did you report on this goal? ☒ Yes ☐ No **If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:	**Did you report on this goal?** ☒ Yes ☐ No **If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:	**Did you report on this goal?** ☒ Yes ☐ No **If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:
Status of Data Reported: ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: 2008	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: 2009	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: 2010
Data Source: ☒ Administrative (claims data). *Specify*: ☐ Hybrid (claims and medical record data). *Specify*: ☐ Survey data. *Specify*: ☐ Other. *Specify*: MMIS	**Data Source:** ☒ Administrative (claims data). *Specify*: ☐ Hybrid (claims and medical record data). *Specify*: ☐ Survey data. *Specify*: ☐ Other. *Specify*: MMIS	**Data Source:** ☒ Administrative (claims data). *Specify*: ☐ Hybrid (claims and medical record data). *Specify*: ☐ Survey data. *Specify*: ☐ Other. *Specify*: MMIS
Definition of Population Included in the Measure: Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). Definition of numerator: As of March 30, 2007, the number of unique recipients who visited PCPs by HEDIS-defined age groups and who were enrolled for a certain number of prior months per age group as defined by HEDIS.	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). Definition of numerator: As of March 30, 2008, the number of unique recipients who visited PCPs by HEDIS-defined age groups and who were enrolled for a certain number of prior months per age group as defined by HEDIS.	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). Definition of numerator: As of March 30, 2009, the number of unique recipients who visited PCPs by HEDIS-defined age groups and who were enrolled for a certain number of prior months per age group as defined by HEDIS.
Year of Data: 2007	**Year of Data:** 2008	**Year of Data:** 2009

FFY 2007	FFY 2008	FFY 2009
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Percent with a PCP visit 12-24 months Numerator: 38195 Denominator: 40053 Rate: 95.4 7-11 years Numerator: 116278 Denominator: 135481 Rate: 85.8 25 months-6 years Numerator: 139123 Denominator: 162925 Rate: 85.4 12-19 years Numerator: 152495 Denominator: 179585 Rate: 84.9 Additional notes on measure: We plan to also continue investigating during FFY08 whether our reimbursement policy relative to payment of claims for children with TPL results in our having an artificially inflated number of kids showing up without a PCP visit. The agency is also exploring the impact of these services performed in rural health clinics and FQHCs which may not be captured in this measure because of current billing procedures.	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent with a PCP visit 12-24 months Numerator: 42803 Denominator: 44649 Rate: 95.9 7-11 years Numerator: 122572 Denominator: 138158 Rate: 88.7 25 months-6 years Numerator: 147340 Denominator: 168499 Rate: 87.4 12-19 years Numerator: 158596 Denominator: 181032 Rate: 87.6 Additional notes on measure: We began capturing FQHC/RHC claims for inclusion in our 2008 data.	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent with a PCP visit 12-24 months Numerator: 44737 Denominator: 46752 Rate: 95.7 7-11 years Numerator: 131162 Denominator: 146582 Rate: 89.5 25 months-6 years Numerator: 157984 Denominator: 179663 Rate: 87.9 12-19 years Numerator: 167376 Denominator: 188662 Rate: 88.7 Additional notes on measure: This measure includes FQHC/RHC claims data. This measure does not currently include the LaCHIP Affordable Plan (Phase V) population but is working to develop HEDIS measures for this group.
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:

FFY 2007	FFY 2008	FFY 2009

Explanation of Progress:

How did your performance in 2009 compare with the Annual Performance Objective documented in your 2008 Annual Report? FFY09 data shows an increase for age groups 25 months to 6 years, 7 to 11 years, and 12 to 19 years and a slight decrease in the age group 12 to 24 months old.

What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal? An immunization administration rate increase effective for August 2008 was implemented and may have contributed to increased performance. Additional initiatives, including the push for childhood immunizations of school age children by the Office of Public Health may have also contributed to this increase.

Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.

Annual Performance Objective for FFY 2010: In FFY 2010 we hope to maintain the rate of children's access to primary care practitioners as we are currently above the HEDIS national mean for Medicaid in all age groups.

Annual Performance Objective for FFY 2011: In FFY 2011 we hope to maintain the rate of children's access to primary care practitioners as we are currently above the HEDIS national mean for Medicaid in all age groups.

Annual Performance Objective for FFY 2012: In FFY 2012 we hope to maintain the rate of children's access to primary care practitioners as we are currently above the HEDIS national mean for Medicaid in all age groups.

Explain how these objectives were set: A workgroup of our clinical Medicaid staff and contractors was developed to advise CHIP management on tracking these HEDIS measures and other quality indicators, including those set in the 2011 Medicaid Operational Plan. The workgroup consists of nurses and pharmacists who are intimately involved in these initiatives and use their expertise to advise CHIP management of the progress made and planned direction for these quality initiatives.

Other Comments on Measure: Claims data from Separate CHIP (LaCHIP Phase V) is too new as the program was implemented in June 2008 and not available for inclusion in this measure yet. Data for other phases of LaCHIP is based on March 2009.

SECTION IIB: ENROLLMENT AND UNINSURED DATA

1. The information in the table below is the Unduplicated Number of Children Ever Enrolled in CHIP in your State for the two most recent reporting periods. The enrollment numbers reported below should correspond to line 7 in your State's 4th quarter data report (submitted in October) in the CHIP Statistical Enrollment Data System (SEDS). The percent change column reflects the percent change in enrollment over the two-year period. If the percent change exceeds 10 percent (increase or decrease), please explain in letter A below any factors that may account for these changes (such as decreases due to elimination of outreach or increases due to program expansions). This information will be filled in automatically by CARTS through a link to SEDS. Please wait until you have an enrollment number from SEDS before you complete this response.

Program	FFY 2008	FFY 2009	Percent change FFY 2008-2009
CHIP Medicaid Expansion Program	159679	161136	0.91
Separate Child Health Program	5319	8345	56.89

   A. Please explain any factors that may account for enrollment increases or decreases exceeding 10 percent. **[7500]**

   The enrollment in the Separate Child Health Program has increased because the LaCHIP Affordable Plan (Phase V) was implemented in June 2008 and grew significantly during FFY09. Enrollment has since steadied, but is still increasing each month.

2. The table below shows trends in the three-year averages for the number and rate of uninsured children in your State based on the Current Population Survey (CPS), along with the percent change between 1996-1998 and 2007-2008. Significant changes are denoted with an asterisk (*). If your state uses an alternate data source and/or methodology for measuring change in the number and/or rate of uninsured children, please explain in Question #3. CARTS will fill in this information automatically, but in the meantime, please refer to the CPS data attachment that was sent with the FFY 2009 Annual Report Template.

	Uninsured Children Under Age 19 Below 200 Percent of Poverty		Uninsured Children Under Age 19 Below 200 Percent of Poverty as a Percent of Total Children Under Age 19	
Period	Number	Std. Error	Rate	Std. Error
1996 - 1998	175	26.6	14.6	2.2
1998 - 2000	161	25.8	13.7	2.0
2000 - 2002	123	18.6	9.7	1.4
2002 - 2004	106	17.5	8.6	1.4
2003 - 2005	88	15.7	7.3	1.3
2004 - 2006	85	15.0	7.4	1.3

2005 - 2007	91	16.0	8.0	1.4
fldQue2491	102	17.0	9.0	1.4
Percent change 1996-1998 vs. 2006-2008	-41.7%	NA	-38.4%	NA

A. Please explain any activities or factors that may account for increases or decreases in your number and/or rate of uninsured children. **[7500]**

Claims data from Separate CHIP (LaCHIP Phase V) is too new as the program was implemented in June 2008 and not available for inclusion in this measure yet. Data for other phases of LaCHIP is based on March 2009.

B. Please note any comments here concerning CPS data limitations that may affect the reliability or precision of these estimates. **[7500]**

We believe that the estimates available through a small sample size are not adequate for tracking the rate of uninsured children in this state due to its being less populous. In order to obtain more reliable state specific data we commissioned a household insurance survey by our state's flagship university.

3. Please indicate by checking the box below whether your State has an alternate data source and/or methodology for measuring the change in the number and/or rate of uninsured children.

☒ Yes (please report your data in the table below)

☐ No (skip to Question #4)

Please report your alternate data in the table below. Data are required for two or more points in time to demonstrate change (or lack of change). Please be as specific and detailed as possible about the method used to measure progress toward covering the uninsured.

Data source(s)	Louisiana Health Insurance Survey conducted by the Louisiana State University Public Policy Research Lab
Reporting period (2 or more points in time)	Initial survey conducted during Summer 2003 and updated Summer 2005, Summer 2007, and Summer 2009.
Methodology	The 2009 Louisiana Health Insurance Survey (LHIS) is the fourth in a series of surveys designed to provide the most accurate and comprehensive assessment of Louisiana's uninsured populations possible. Each version of the LHIS has been based on over 10,000 Louisiana households and 27,000 Louisiana residents, thus allowing for detailed estimates of uninsured populations for each of DHH's nine regions and across very specific subpopulations (e.g. African-American children under 200% of federal poverty). Each iteration of the LHIS has also incorporated important improvements in methodology to assure that the survey results in this report reflect our best understanding of how to estimate uninsured populations. The 2005 LHIS, for example, included a survey of Medicaid recipients and corresponding adjustments to the final uninsured estimates to account for the Medicaid bias. The 2007 and 2009 LHIS took another step forward by developing an innovative methodological tool to adjust uninsured estimates for the Medicaid undercount at the

	individual level. Importantly, the technique provides results comparable to the methodology utilized in the 2005 LHIS, but has the advantage of adjusting the data based on individual-level probabilities that Medicaid eligible respondents have misreported as uninsured. The 2009 LHIS is also the first version to include a cell phone survey ensuring the most representative sample. To assure reporting is as accurate as possible, initial respondents are screened to make sure they are the most knowledgeable person in the household about family health care and health insurance. Once the most knowledgeable person in the household has been selected, respondents are asked to identify all members of the household and a series of questions asking to identify all members of the household and a series of questions asking whether members of the household are covered by particular types of insurance, purchased insurance, Medicaid, Medicare, or through the military. Respondents are asked to verify uninsured status for any individual not identified as having any form of coverage. Only household members who are identified as not having any form of coverage are included in the final estimate as uninsured. The initial sampling strategy was designed to generate responses from 10,000 Louisiana households with at least 65 households from each parish and 800 households from each DHH region. To assure adequate sampling of minority and poor residents, an over sample of 1,500 respondents from telephone prefixes where the median income was below the statewide median and where the minority population was 30 percent or greater was also conducted. Because of the sampling design employed, the probability of being selected into the final sample was dependent on the parish in which the respondent resided. To account for this, the results were weighted to adjust for sampling differences across parishes. Specifically, the sampling weight was constructed as the parish population divided by the number of individuals sampled in the parish. Because differences in response rates among different segments of the population may also result in biased estimates of uninsured rates, the data were also weighted based on demographic characteristics where sample estimates do not closely mirror census-based population estimates. In the 2009 LHIS, results are weighted to account for the most recent estimates of statewide population available, 2008 U.S. Census Estimates. Importantly, these estimates account for post-hurricane population shifts and reflect the best estimates available of current population. A comparison of unweighted and weighted sample estimates to census data is provided in Table 3. As can be seen in Table 3, the estimates provided by the 2009 LHIS nicely match the population estimates from the U.S. census. As a final adjustment, uninsured estimate are adjusted to account for the wide Medicaid bias. Empirical research has demonstrated that Medicaid recipients often misreport their insurance status. Our greatest concern in the current report is the extent that they misreport as uninsured. In this situation, estimates of uninsured populations would be biased upward and the estimates of Medicaid populations would be biased downward. The results presented in this report have been adjusted to account for this bias. The methodology used to make these adjustments is fully described in a working paper (Barnes, Goidel, and Terrell 2007). The methodology is an improvement over the methodology used in the 2005 report in that the current adjustments account for the probability that any given individual eligible for Medicaid misreported their insurance status, whereas the previous technique made aggregate adjustments to insurance status based on levels of misreporting. It is important to note that the methodology used in 2005 is consistent with other

	research that had adjusted for misreporting, that the 2007 and 2009 procedure reflects a step forward in this area, and that the difference between these two procedures are often small.
Population (Please include ages and income levels)	All Louisiana households, July 1, 2008 Census Population Estimate -- 4,410,796
Sample sizes	10,142 Louisiana households representing health insurance status on 28,581 individuals including 8,198 children under age 19.
Number and/or rate for two or more points in time	11.1% of all children were uninsured in 2003. This number decreased to 7.6% 2005, to 5.4% in 2007, and to 5.0% in 2009.
Statistical significance of results	Estimates for uninsured children are based on 8,650 Louisiana children (under 19). The margin of error for a sample of this size is +/- 0.5 percentage points.

A. Please explain why your State chose to adopt a different methodology to measure changes in the number and/or rate of uninsured children. **[7500]**
Prior to this study, estimates of the number of non-elderly uninsured in Louisiana were based on Current Population Survey's Annual Social and Economic Supplement" (also referred to as the "March Supplement"). While the CPS estimates have been invaluable as the only consistent longitudinal, statewide estimates of the uninsured, they have historically been limited in terms of the overall sample size for any given state and the geographical distribution of respondents. The CPS has since addressed some of these concerns by increasing the number of households included in the sample and diversifying the strata from which these households are drawn. CPS includes approximately 756 households from Louisiana. While the increase in sample size makes the CPS a better estimate of statewide uninsured populations, it remains limited in its capacity to generate regional and parish-level estimates.
This study also addressed what health researchers have long known—that a substantial proportion of Medicaid enrollees misreport their insurance status, often reporting themselves (or their families) as uninsured or as having private insurance. The consequence of this undercount is that survey-based estimates of the uninsured often include respondents who are actually covered through Medicaid or LaCHIP. That is, they overstate uninsured rates. Because Louisiana has a high proportion of respondents on Medicaid, particularly children enrolled in Medicaid or LaCHIP, the consequences of the Medicaid undercount are likely to be more substantial in Louisiana (and in other Southern states) than has been reported in the existing literature.
The 2009 LHIS has been designed to provide the best possible estimate of uninsured populations statewide, within each of the nine Department of Health and Hospitals regions, and across key demographic characteristics.

B. What is your State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Provide a numerical range or confidence intervals if available.) **[7500]**
Overall, there is consistent and compelling evidence that the decline in the number of uninsured children is largely related to the increase in the number of children covered by LaCHIP or Medicaid. Given the sample sizes, we have more confidence in the regional estimates and scaled the parish-level estimates so that the regional totals match those from the full report. In terms of methodology, the 2007 and 2009 LHIS improves upon work from the 2005 LHIS. The net effect of these changes is to provide more conservative (higher) and more accurate initial estimates of the uninsured. Our confidence in survey research resides not in individual point estimates but rather in confidence intervals around which we can be reasonably certain the true population parameter resides. The 2009 Survey was designed in such a way as to assure large samples by regional demographic characteristics such that we could have reasonably high confidence in our estimates. Quarterly updates of this survey also ensure the most recent and relevant data is available.

C. What are the limitations of the data or estimation methodology? **[7500]**
None that we are aware of at this time.

D. How does your State use this alternate data source in CHIP program planning? **[7500]**

State officials plan to use the data from this survey to target hard-to-reach eligible children for enrollment into LaCHIP, while at the same time make informed decisions about how to focus on policy to build coverage options for those subsets of children who remain uninsured.

4. How many children do you estimate have been enrolled in Medicaid as a result of CHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information **[7500]**

During this reporting period, October 2008 to September 2009, there has been a net increase in enrollment of children in Title XIX by 30,537, bringing the statewide enrollment total to 559,966. These enrollment figures come from two reports: Recipient CHIP Quarterly Statistic Report and Children Under 19 Recipient Statistic Report, both of which come from the mainframe and are run monthly by Production Control at Unisys.

SECTION IIC: STATE STRATEGIC OBJECTIVES AND PERFORMANCE GOALS

This subsection gathers information on your State's general strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your CHIP State Plan. (If your goals reported in the annual report now differ from Section 9 of your CHIP state plan, please indicate how they differ in "Other Comments on Measure." Also, the state plan should be amended to reconcile these differences). The format of this section provides your State with an opportunity to track progress over time. This section contains templates for reporting performance measurement data for each of five categories of strategic objectives, related to:

- Reducing the number of uninsured children
- CHIP enrollment
- Medicaid enrollment
- Increasing access to care
- Use of preventative care (immunizations, well child care)

Please report performance measurement data for the three most recent years for which data are available (to the extent that data are available). In the first two columns, report data from the previous two years' annual reports (FFY 2007 and FFY 2008) will be populated with data from previously reported data in CARTS, enter data in these columns only if changes must be made. If you previously reported no data for either of those years, but you now have recent data available for them, please enter the data. In the third column, please report the most recent data available at the time you are submitting the current annual report (FFY 2009).

Note that the term *performance measure* is used differently in Section IIA versus IIC. In Section IIA, the term refers to the four core child health measures. In this section, the term is used more broadly, to refer to any data your State provides as evidence towards a particular goal within a strategic objective. For the purpose of this section, "objectives" refer to the five broad categories listed above, while "goals" are State-specific, and should be listed in the appropriate subsections within the space provided for each objective.

NOTES: Please do not reference attachments in this section. If details about a particular measure are located in an attachment, please summarize the relevant information from the attachment in the space provided for each measure.

In addition, please do not report the same data that were reported in Sections IIA or IIB. The intent of this section is to capture goals and measures that your State did not report elsewhere in Section II.

Additional instructions for completing each row of the table are provided below.

Goal:

For each objective, space has been provided to report up to three goals. Use this section to provide a brief description of each goal you are reporting within a given strategic objective. **All new goals should include a direction and a target. For clarification only, an example goal would be**: "Increase (direction) by 5 percent (target) the number of CHIP beneficiaries who turned 13 years old during the measurement year who had a second dose of MMR, three hepatitis B vaccinations and one varicella vaccination by their 13th birthday."

Type of Goal:

For each goal you are reporting within a given strategic objective, please indicate the type of goal, as follows:

- New/revised: Check this box if you have revised or added a goal. Please explain how and why the goal was revised.

- Continuing: Check this box if the goal you are reporting is the same one you have reported in previous annual reports.

- Discontinued: Check this box if you have met your goal and/or are discontinuing a goal. Please explain why the goal was discontinued.

Status of Data Reported:
Please indicate the status of the data you are reporting for each goal, as follows:

- Provisional: Check this box if you are reporting performance measure data for a goal, but the data are currently being modified, verified, or may change in any other way before you finalize them for FFY 2009.

- Final: Check this box if the data you are reporting are considered final for FFY 2009.

- Same data as reported in a previous year's annual report: Check this box if the data you are reporting are the same data that your State reported for the goal in another annual report. Indicate in which year's annual report you previously reported the data.

Measurement Specification:
This section is included for only two of the objectives— objectives related to increasing access to care, and objectives related to use of preventative care—because these are the two objectives for which States may report using the HEDIS® measurement specification. In this section, for each goal, please indicate the measurement specification used to calculate your performance measure data (i.e., were the measures calculated using the HEDIS® specifications, HEDIS®-like specifications, or some other method unrelated to HEDIS®). If the measures were calculated using HEDIS® or HEDIS®-like specifications, please indicate which version was used (e.g., HEDIS® 2007). If using HEDIS®-like specifications, please explain how HEDIS® was modified.

Data Source:
For each performance measure, please indicate the source of data. The categories provided in this section vary by objective. For the objectives related to reducing the number of uninsured children and CHIP or Medicaid enrollment, please indicate whether you have used eligibility/enrollment data, survey data (specify the survey used), or other source (specify the other source). For the objectives related to access to care and use of preventative care, please indicate whether you used administrative data (claims) (specify the kind of administrative data used), hybrid data (claims and medical records) (specify how the two were used to create the data source), survey data (specify the survey used), or other source (specify the other source). In all cases, if another data source was used, please explain the source.

Definition of Population Included in Measure:
Please indicate the definition of the population included in the denominator for each measure (such as age, continuous enrollment, type of delivery system). Also provide a definition of the numerator (such as the number of visits required for inclusion, e.g., one or more visits in the past year).

For measures related to increasing access to care and use of preventative care , please also check one box to indicate whether the data are for the CHIP population only, or include both CHIP and Medicaid (Title XIX) children combined.

Year of Data:
Please report the year of data for each performance measure. The year (or months) should correspond to the *period in which enrollment or utilization took place*. Do *not* report the year in which data were collected for the measure, or the version of HEDIS® used to calculate the measure, both of which may be different from the period corresponding to enrollment or utilization of services.

Performance Measurement Data:
Describe what is being measured: Please provide a brief explanation of the information you intend to capture through the performance measure.

Numerator, Denominator, and Rate: Please report the numerators, denominators, and rates for each measure (or component). For the objectives related to increasing access to care and use of preventative care, the template provides two sections for entering the performance measurement data, depending on whether you are reporting using HEDIS® or HEDIS®-like methodology or a methodology other than HEDIS®. The form fields have been set up to facilitate entering numerators, denominators, and rates for each measure. If the form fields do not give you enough space to fully report on your measure, please use the "additional notes" section.

If you typically calculate separate rates for each health plan, report the aggregate state-level rate for each measure (or component). The preferred method is to calculate a "weighted rate" by summing the numerators and denominators across plans, and then deriving a single state-level rate based on the ratio of the numerator to the denominator. Alternatively, if numerators and denominators are not available, you may calculate an "unweighted average" by taking the mean rate across health plans.

Explanation of Progress:

The intent of this section is to allow your State to highlight progress and describe any quality improvement activities that may have contributed to your progress. Any quality improvement activity described should involve the CHIP program, benefit CHIP enrollees, and relate to the performance measure and your progress. An example of a quality improvement activity is a state-wide initiative to inform individual families directly of their children's immunization status with the goal of increasing immunization rates. CHIP would either be the primary lead or substantially involved in the project. If improvement has not occurred over time, this section can be used to discuss potential reasons for why progress was not seen and to describe future quality improvement plans. In this section, your State is also asked to set annual performance objectives for FFY 2010, 2011 and 2012. Based on your recent performance on the measure (from FFY 2007 through 2009), use a combination of expert opinion and "best guesses" to set objectives for the next three years. Please explain your rationale for setting these objectives. For example, if your rate has been increasing by 3 or 4 percentage points per year, you might project future increases at a similar rate. On the other hand, if your rate has been stable over time, you might set a target that projects a small increase over time. If the rate has been fluctuating over time, you might look more closely at the data to ensure that the fluctuations are not an artifact of the data or the methods used to construct a rate. You might set an initial target that is an average of the recent rates, with slight increases in subsequent years. In future annual reports, you will be asked to comment on how your actual performance compares to the objective your State set for the year, as well as any quality improvement activities that have helped or could help your State meet future objectives.

Other Comments on Measure:

Please use this section to provide any other comments on the measure, such as data limitations, plans to report on a measure in the future, or differences between performance measures reported here and those discussed in Section 9 of the CHIP state plan.

Objectives Related to Reducing the Number of Uninsured Children (Do not report data that was reported in Section IIB, Questions 2 and 3)

FFY 2007	FFY 2008	FFY 2009
Goal #1 (Describe) Continue to impact the rate of uninsured children in Louisiana through outreach and enrollment of families potentially eligible for LaCHIP. Prevent a reduction of the number of children covered as of the end of FFY06 thus increasing the number of uninsured eligible children by Oct. 1, 2008.	**Goal #1 (Describe)** Continue to impact the rate of uninsured children in Louisiana through outreach and enrollment of families potentially eligible for LaCHIP. Identify and enroll a net addition of 4,500 uninsured eligible children by Oct. 1, 2009 in Title XXI SCHIP.	**Goal #1 (Describe)** Continue to impact the rate of uninsured children in Louisiana through outreach and enrollment of families potentially eligible for LaCHIP. Prevent a reduction of the number of children covered as of the end of FFY09 thus increasing the number of uninsured eligible children by Oct. 1, 2010.
Type of Goal: ☒ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*: Goal revised to more accurately account for anticipated growth in FFY06 taking the known factors into account.	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☒ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☒ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☒ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:
Year of Data: 2007	**Year of Data:** 2008	**Year of Data:** 2009
Performance Measurement Data: Described what is being measured: Net change of children enrolled in LaCHIP at a point in time. Subtract the number of children enrolled at the end of FFY06 by the number enrolled in LaCHIP at the end of FFY05. The goal for stabilizing enrollment in FFY 07 to prevent further reductions was based on the last six months of FFY06 due to the impact of population shifts in the aftermath of Hurricane Katrina. Actual enrollment increased by over 4,000. Numerator: Denominator: Rate:	**Performance Measurement Data:** Described what is being measured: Net change of children enrolled in LaCHIP at a point in time. Subtract the number of children enrolled at the end of FFY07 from the number enrolled in LaCHIP at the end of FFY08. Actual enrollment increased by 13,559. Numerator: Denominator: Rate: Additional notes on measure: Continued aggressive outreach to potentially eligible children as well as the stabilization of	**Performance Measurement Data:** Described what is being measured: Net change of children enrolled in LaCHIP at a point in time. Subtract the number of children enrolled at the end of FFY08 from the number enrolled in LaCHIP at the end of FFY09. Actual enrollment decreased by 353 children. Numerator: Denominator: Rate: Additional notes on measure: The decrease in LaCHIP enrollment has coincided with a large increase of children

FFY 2007	FFY 2008	FFY 2009
Additional notes on measure: A reinvigorated outreach effort was pushed by the state after the largest dip in LaCHIP enrollment since the program's inception in 12/06. A reduction of nearly 5,500 LaCHIP children was due to the resumption of renewal process in Metro New Orleans for the first time since Katrina. Multiple initiatives include community blitzes (see outreach section of report) resulting in enrollment gains to more than negate losses related to this and other DRA Citizenship & Identity verification requirements.	the Unborn (Phase IV) program and implementation of Phase V (LaCHIP Affordable Plan) have contributed to the steady enrollment increases.	enrolled in the Medicaid program due in part to the current economic condition.
Explanation of Progress: **How did your performance in 2008 compare with the Annual Performance Objective documented in your 2007 Annual Report?** We far exceeded our goals by increasing enrollment of LaCHIP children by 4,000 despite drastic reductions out of our control in Q1 of FFY07. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**	**Explanation of Progress:** **How did your performance in 2008 compare with the Annual Performance Objective documented in your 2007 Annual Report?** We far exceeded our goals by increasing enrollment of LaCHIP children by 13,559 due to continued aggressive outreach and increasing numbers in the Unborn (Phase IV) and Phase V (LaCHIP Affordable Plan) programs. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**	**Explanation of Progress:** **How did your performance in 2009 compare with the Annual Performance Objective documented in your 2008 Annual Report?** We were unable to meet our FFY08 goal enrolling a net increase of 4,500 uninsured eligible children into LaCHIP. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** Continued aggressive outreach and simplified application/renewal processes.
Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data. **Annual Performance Objective for FFY 2008:** Identify and enroll a net addition of 4,500 uninsured eligible children by Oct. 1, 2008 in Title XXI SCHIP. **Annual Performance Objective for FFY 2009:** Identify and enroll a net addition of 4,500 uninsured eligible children by Oct. 1, 2009 in Title XXI SCHIP.	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2009:** Identify and enroll a net addition of 4,500 uninsured eligible children by Oct. 1, 2009 in Title XXI SCHIP. **Annual Performance Objective for FFY 2010:** Identify and enroll a net addition of 3,000 uninsured eligible children by Oct. 1, 2010 in Title XXI SCHIP.	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2010:** To prevent more than a 5% decline in enrollment by Oct 1, 2010 in Title XXI CHIP while continuing outreach efforts. **Annual Performance Objective for FFY 2011:** To prevent more than a 5% decline in enrollment by Oct 1, 2011 in Title XXI CHIP while continuing outreach efforts.

FFY 2007	FFY 2008	FFY 2009
Annual Performance Objective for FFY 2010: Identify and enroll a net addition of 2,250 uninsured eligible children by Oct. 1, 2010 in Title XXI SCHIP. *Explain how these objectives were set:*	**Annual Performance Objective for FFY 2011:** Identify and enroll a net addition of 1,500 uninsured eligible children by Oct. 1, 2011 in Title XXI SCHIP. *Explain how these objectives were set:* These objectives were set based on a proportion of remaining uninsured kids in this income group per the LHIS which we are targeting to add every fiscal year.	**Annual Performance Objective for FFY 2012:** To prevent more than a 5% decline in enrollment by Oct 1, 2012 in Title XXI CHIP while continuing outreach efforts. *Explain how these objectives were set:* These objectives were set based on current year enrollment data and the proportion of remaining uninsured children in this income group per the LHIS which we are targeting to add every fiscal year. Current economic conditions have also been factored in.
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

Objectives Related to Reducing the Number of Uninsured Children (Do not report data that was reported in Section IIB, Questions 2 and 3) (Continued)

FFY 2007	FFY 2008	FFY 2009
Goal #2 (Describe)	**Goal #2 (Describe)**	**Goal #2 (Describe)**
Type of Goal: ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:
Year of Data:	**Year of Data:**	**Year of Data:**
Performance Measurement Data: Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:
Explanation of Progress: **How did your performance in 2007 compare with the Annual Performance Objective documented in your 2006 Annual Report?**	**Explanation of Progress:** **How did your performance in 2008 compare with the Annual Performance Objective documented in your 2007 Annual Report?**	**Explanation of Progress:** **How did your performance in 2009 compare with the Annual Performance Objective documented in your 2008 Annual Report?**

FFY 2007	FFY 2008	FFY 2009
What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?	**What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**	**What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**
Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data. **Annual Performance Objective for FFY 2008:** **Annual Performance Objective for FFY 2009:** **Annual Performance Objective for FFY 2010:** *Explain how these objectives were set:*	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2009:** **Annual Performance Objective for FFY 2010:** **Annual Performance Objective for FFY 2011:** *Explain how these objectives were set:*	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2010:** **Annual Performance Objective for FFY 2011:** **Annual Performance Objective for FFY 2012:** *Explain how these objectives were set:*
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

Objectives Related to Reducing the Number of Uninsured Children (Do not report data that was reported in Section IIB, Questions 2 and 3) (Continued)

FFY 2007	FFY 2008	FFY 2009
Goal #3 (Describe)	**Goal #3 (Describe)**	**Goal #3 (Describe)**
Type of Goal: ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:
Year of Data:	**Year of Data:**	**Year of Data:**
Performance Measurement Data: Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:
Explanation of Progress: **How did your performance in 2007 compare with the Annual Performance Objective documented in your 2006 Annual Report?**	**Explanation of Progress:** **How did your performance in 2008 compare with the Annual Performance Objective documented in your 2007 Annual Report?**	**Explanation of Progress:** **How did your performance in 2009 compare with the Annual Performance Objective documented in your 2008 Annual Report?**

FFY 2007	FFY 2008	FFY 2009
What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal? **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2008:** **Annual Performance Objective for FFY 2009:** **Annual Performance Objective for FFY 2010:** *Explain how these objectives were set:*	**What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2009:** **Annual Performance Objective for FFY 2010:** **Annual Performance Objective for FFY 2011:** *Explain how these objectives were set:*	**What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2010:** **Annual Performance Objective for FFY 2011:** **Annual Performance Objective for FFY 2012:** *Explain how these objectives were set:*
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

Objectives Related to CHIP Enrollment

FFY 2007	FFY 2008	FFY 2009
Goal #1 (Describe)	**Goal #1 (Describe)** Increase enrollment of kids in LaCHIP Affordable Plan (Phase V).	**Goal #1 (Describe)** Increase enrollment of children in LaCHIP Affordable Plan (Phase V)
Type of Goal: ☐ New/revised. *Explain*: ☐ Continuing. ☒ Discontinued. *Explain*: Our goals for increasing SCHIP Enrollment are covered in Objective Related to Reducing the Number of Uninsured Children.	**Type of Goal:** ☒ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☒ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☒ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:
Year of Data:	**Year of Data:** 2008	**Year of Data:** 2009
Performance Measurement Data: Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Increase enrollment in separate SCHIP for children between 201-250% FPL at a point in time. Subtract the number of children enrolled in separate SCHIP at the end of FFY07 from the number enrolled in separate SCHIP at the end of FFY08. Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Increase enrollment in separate CHIP for children between 201-250% FPL at a point in time. Subtract the number of children enrolled in separate CHIP at the end of FFY08 from the number enrolled in separate CHIP at the end of FFY09. Numerator: Denominator: Rate: Additional notes on measure:

FFY 2007	FFY 2008	FFY 2009
Explanation of Progress: **How did your performance in 2007 compare with the Annual Performance Objective documented in your 2006 Annual Report?** **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**	**Explanation of Progress:** **How did your performance in 2008 compare with the Annual Performance Objective documented in your 2007 Annual Report?** This is a new Annual Performance Objective. Therefore, there is nothing available in the 2007 Annual Report for comparison. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** N/A	**Explanation of Progress:** **How did your performance in 2009 compare with the Annual Performance Objective documented in your 2008 Annual Report?** Louisiana fell short of its goal of enrolling an additional 3,500 children in FY09 by only enrolling a an additional 1,450. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** Continued aggressive outreach and simplified application/renewal processes.
Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data. **Annual Performance Objective for FFY 2008:** **Annual Performance Objective for FFY 2009:** **Annual Performance Objective for FFY 2010:** *Explain how these objectives were set:*	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2009:** Increase enrollment in separate SCHIP for children between 201-250% FPL. Identify and enroll a net addition of 3,500 uninsured eligible children by Oct. 1, 2009 in Title XXI SCHIP. **Annual Performance Objective for FFY 2010:** Identify and enroll a net addition of 1,000 uninsured eligible children by Oct. 1, 2010 in Title XXI SCHIP. **Annual Performance Objective for FFY 2011:** Identify and enroll a net addition of 500 uninsured eligible children by Oct. 1, 2011 in Title XXI SCHIP. *Explain how these objectives were set:* These objectives were set based on current year enrollment data and the proportion of remaining uninsured children in this income group per the LHIS which we are targeting to add every fiscal year. Current economic conditions have also been factored in.	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2010:** Identify and enroll a net addition of 1,344 uninsured eligible children by Oct. 1, 2010 in Phase V of Title XXI CHIP. **Annual Performance Objective for FFY 2011:** Identify and enroll a net addition of 672 uninsured eligible children by Oct. 1, 2011 in Phase V of Title XXI CHIP. **Annual Performance Objective for FFY 2012:** Identify and enroll a net addition of 336 uninsured eligible children by Oct. 1, 2012 in Phase V of Title XXI CHIP. *Explain how these objectives were set:* These objectives were set based on a proportion of remaining uninsured children in this income group per the LHIS which we are targeting to add every fiscal year. These objectives were set based on 12-month trending of actual enrollment for this group.
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

Objectives Related to CHIP Enrollment (Continued)

FFY 2007	FFY 2008	FFY 2009
Goal #2 (Describe)	**Goal #2 (Describe)**	**Goal #2 (Describe)**
Type of Goal: ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:
Year of Data:	**Year of Data:**	**Year of Data:**
Performance Measurement Data: Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:
Explanation of Progress: **How did your performance in 2007 compare with the Annual Performance Objective documented in your 2006 Annual Report?**	**Explanation of Progress:** **How did your performance in 2008 compare with the Annual Performance Objective documented in your 2007 Annual Report?**	**Explanation of Progress:** **How did your performance in 2009 compare with the Annual Performance Objective documented in your 2008 Annual Report?**

FFY 2007	FFY 2008	FFY 2009
What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?	**What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**	**What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**
Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data. **Annual Performance Objective for FFY 2008:** **Annual Performance Objective for FFY 2009:** **Annual Performance Objective for FFY 2010:** *Explain how these objectives were set:*	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2009:** **Annual Performance Objective for FFY 2010:** **Annual Performance Objective for FFY 2011:** *Explain how these objectives were set:*	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2010:** **Annual Performance Objective for FFY 2011:** **Annual Performance Objective for FFY 2012:** *Explain how these objectives were set:*
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

Objectives Related to CHIP Enrollment (Continued)

FFY 2007	FFY 2008	FFY 2009
Goal #3 (Describe)	**Goal #3 (Describe)**	**Goal #3 (Describe)**
Type of Goal: ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:
Year of Data:	**Year of Data:**	**Year of Data:**
Performance Measurement Data: Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:
Explanation of Progress: **How did your performance in 2007 compare with the Annual Performance Objective documented in your 2006 Annual Report?**	**Explanation of Progress:** **How did your performance in 2008 compare with the Annual Performance Objective documented in your 2007 Annual Report?**	**Explanation of Progress:** **How did your performance in 2009 compare with the Annual Performance Objective documented in your 2008 Annual Report?**

FFY 2007	FFY 2008	FFY 2009
What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?	**What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**	**What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**
Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data. **Annual Performance Objective for FFY 2008:** **Annual Performance Objective for FFY 2009:** **Annual Performance Objective for FFY 2010:** *Explain how these objectives were set:*	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2009:** **Annual Performance Objective for FFY 2010:** **Annual Performance Objective for FFY 2011:** *Explain how these objectives were set:*	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2010:** **Annual Performance Objective for FFY 2011:** **Annual Performance Objective for FFY 2012:** *Explain how these objectives were set:*
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

Objectives Related to Medicaid Enrollment

FFY 2007	FFY 2008	FFY 2009
Goal #1 (Describe) Continue to impact the rate of uninsured children in Louisiana through outreach and enrollment of families potentially eligible for Medicaid. As in LaCHIP, we are hopeful that we are able to maintain the enrollment level seen at the end of FFY07 by October 2008 without greater enrollment reductions.	**Goal #1 (Describe)** Continue aggressive outreach to the rate of uninsured children in Louisiana through outreach and enrollment of families potentially eligible for Medicaid. Identify and enroll a net addition of 15,000 uninsured eligible children by Oct. 1, 2009 in Title XIX Medicaid programs.	**Goal #1 (Describe)** Continue aggressive outreach to the rate of uninsured children in Louisiana through outreach and enrollment of families potentially eligible for Medicaid. Identify and enroll a net addition of 30,537 uninsured eligible children by October 1, 2010 in Title XIX Medicaid programs.
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☒ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☒ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☒ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:
Year of Data: 2007	**Year of Data:** 2008	**Year of Data:** 2009

FFY 2007	FFY 2008	FFY 2009
Performance Measurement Data: Described what is being measured: The goal to maintain enrollment levels as of the end of FFY06 during this enrollment period was based on the trends with enrollment reductions due to significant population shifts in Louisiana post-Katrina. Actual enrollment of children in Medicaid Under 19 as of September 30, 2006 is compared to enrollment on September 30, 2007. Numerator: Denominator: Rate: Additional notes on measure: As anticipated we experienced a net decrease in enrollment of children covered by Medicaid in FFY07. Actual enrollment dropped by nearly 35,000. This was a result of outmigration from Hurricanes Katrina & Rita as well as the loss of citizen children who failed to meet the new rigorous requirements of the DRA Citizenship/Identity verificant changes in Q1 of FFY07. In fact, in the last three quarters of FFY07, Medicaid enrollment grew by over 20,000.	**Performance Measurement Data:** Described what is being measured: Net change of children enrolled in Medicaid at a point in time. Subtract the number of children enrolled at the end of FFY08 from the number enrolled in Medicaid at the end of FFY07. Actual net enrollment increased by 25,187. Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Net change of children enrolled in Medicaid at a point in time. Subtract the number of children enrolled at the end of FFY09 from the number enrolled in Medicaid at the end of FFY08. Actual net enrollment increased by 30,537. Numerator: Denominator: Rate: Additional notes on measure:
Explanation of Progress: **How did your performance in 2007 compare with the Annual Performance Objective documented in your 2006 Annual Report?** Due to factors out of our control we were unable to keep enrollment at the same levels it was at the end of FFY06. However, significant progress was made on increasing enrollment of Medicaid children in the last three quarters of FFY07 to negate many of those losses related to Katrina and the DRA that we anticipate to continue in FFY08. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**	**Explanation of Progress:** **How did your performance in 2008 compare with the Annual Performance Objective documented in your 2007 Annual Report?** We far exceeded our goal by increasing enrollment of Title XIX Medicaid by 25,000 kids. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**	**Explanation of Progress:** **How did your performance in 2009 compare with the Annual Performance Objective documented in your 2008 Annual Report?** We far exceeded our goal by increasing enrollment of Title XIX Medicaid by increasing net enrollment by more than 28,000 children. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** Continued aggressive outreach and simplified application/renewal processes.

FFY 2007	FFY 2008	FFY 2009
Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data. **Annual Performance Objective for FFY 2008:** Identify and enroll a net addition of 15,000 uninsured eligible children by Oct. 1, 2008 in Title XIX Medicaid programs. **Annual Performance Objective for FFY 2009:** Identify and enroll a net addition of 15,000 uninsured eligible children by Oct. 1, 2009 in Title XIX Medicaid programs. **Annual Performance Objective for FFY 2010:** Identify and enroll a net addition of 15,000 uninsured eligible children by Oct. 1, 2010 in Title XIX Medicaid programs. *Explain how these objectives were set:*	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2009:** Identify and enroll a net addition of (Medicaid eligible children shows increase of 10,000 uninsured eligible children by Oct. 1, 2009 in Title XIX Medicaid. **Annual Performance Objective for FFY 2010:** Identify and enroll a net addition of 7,500 uninsured eligible children by Oct. 1, 2010 in Title XIX Medicaid programs. **Annual Performance Objective for FFY 2011:** Identify and enroll a net addition of 5,000 uninsured eligible children by Oct. 1, 2011 in Title XIX Medicaid programs. *Explain how these objectives were set:* These objectives were set based on a proportion of remaining uninsured kids in this income group per the LHIS which we are targeting to add every fiscal year. Also, the weakening economy will likely mean a greater proportion of enrollees into Medicaid.	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2010:** Identify and enroll a net addition of 30,537 uninsured eligible children by Oct. 1, 2010 in Title XXI Medicaid programs by using Express Lane Eligibility. **Annual Performance Objective for FFY 2011:** Identify and enroll a net addition of 15,269 uninsured eligible children by Oct. 1, 2011 in Title XXI Medicaid programs by using Express Lane Eligibility. **Annual Performance Objective for FFY 2012:** Identify and enroll a net addition of 7,634 uninsured eligible children by Oct. 1, 2012 in Title XXI Medicaid programs by using Express Lane Eligibility. *Explain how these objectives were set:* These objectives were set based on current year enrollment data and the proportion of remaining uninsured children in this income group per the LHIS which we are targeting to add every fiscal year. Current economic conditions have also been factored in.
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

Objectives Related to Medicaid Enrollment (Continued)

FFY 2007	FFY 2008	FFY 2009
Goal #2 (Describe)	**Goal #2 (Describe)**	**Goal #2 (Describe)**
Type of Goal: ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:
Year of Data:	**Year of Data:**	**Year of Data:**
Performance Measurement Data: Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:
Explanation of Progress: **How did your performance in 2007 compare with the Annual Performance Objective documented in your 2006 Annual Report?**	**Explanation of Progress:** **How did your performance in 2008 compare with the Annual Performance Objective documented in your 2007 Annual Report?**	**Explanation of Progress:** **How did your performance in 2009 compare with the Annual Performance Objective documented in your 2008 Annual Report?**

FFY 2007	FFY 2008	FFY 2009
What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?	**What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**	**What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**
Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data. **Annual Performance Objective for FFY 2008:** **Annual Performance Objective for FFY 2009:** **Annual Performance Objective for FFY 2010:** *Explain how these objectives were set:*	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2009:** **Annual Performance Objective for FFY 2010:** **Annual Performance Objective for FFY 2011:** *Explain how these objectives were set:*	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2010:** **Annual Performance Objective for FFY 2011:** **Annual Performance Objective for FFY 2012:** *Explain how these objectives were set:*
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

Objectives Related to Medicaid Enrollment (Continued)

FFY 2007	FFY 2008	FFY 2009
Goal #3 (Describe)	**Goal #3 (Describe)**	**Goal #3 (Describe)**
Type of Goal: ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:
Year of Data:	**Year of Data:**	**Year of Data:**
Performance Measurement Data: Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:
Explanation of Progress: **How did your performance in 2007 compare with the Annual Performance Objective documented in your 2006 Annual Report?**	**Explanation of Progress:** **How did your performance in 2008 compare with the Annual Performance Objective documented in your 2007 Annual Report?**	**Explanation of Progress:** **How did your performance in 2009 compare with the Annual Performance Objective documented in your 2008 Annual Report?**

FFY 2007	FFY 2008	FFY 2009
What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?	**What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**	**What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**
Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data. **Annual Performance Objective for FFY 2008:** **Annual Performance Objective for FFY 2009:** **Annual Performance Objective for FFY 2010:** *Explain how these objectives were set:*	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2009:** **Annual Performance Objective for FFY 2010:** **Annual Performance Objective for FFY 2011:** *Explain how these objectives were set:*	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2010:** **Annual Performance Objective for FFY 2011:** **Annual Performance Objective for FFY 2012:** *Explain how these objectives were set:*
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

Objectives Increasing Access to Care (Usual Source of Care, Unmet Need)

FFY 2007	FFY 2008	FFY 2009
Goal #1 (Describe) To maintain a high level of recipient satisfaction with the medical home provided through Louisiana Medicaid's PCCM, CommunityCARE.	**Goal #1 (Describe)** To maintain a high level of recipient satisfaction with the medical home provided through Louisiana Medicaid's PCCM, CommunityCARE.	**Goal #1 (Describe)** To maintain a high level of recipient satisfaction with the medical home provided through Louisiana Medicaid's PCCM, CommunityCARE.
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2007	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☒Other. *Explain*: CAHPS-like Survey: Consumer Assessment of Health Plans Survey (CAHPS®) methodologies as well as input from program management were taken into account to meet particular needs of monitoring progress.	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☒Other. *Explain*: CAHPS-like Survey: Consumer Assessment of Health Plans Survey (CAHPS) methodologies as well as input from program management were taken into account to meet particular needs of monitoring progress.	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☒Other. *Explain*: CAHPS-like Survey: Consumer Assessment of Health Plan Survey (CAHPS®) methodologies as well as input from program management were taken into account to meet particular needs of monitoring progress.
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☒ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☒ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☒ Survey data. *Specify*: ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). Definition of numerator:
Year of Data: 2005	**Year of Data:** 2005	**Year of Data:** 2009
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure:

FFY 2007	FFY 2008	FFY 2009
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure: Data reported for FFY07 is the same as FFY05 and FFY06 due to the fact that survey is only conducted bi-annually and will not be available until Spring 2008 due to other priorities related to the impact of Hurricane Katrina which prevented this survey from being repeated as planned in 2007.	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure: Data reported for FFY08 is the same as FFY05, FFY06, and FFY07 due the survey only conducted bi-annually. The state is currently working to draft a new survey to be completed in the coming months.	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure: Individuals enrolled in Medicaid PCCM. CommunityCARE, Louisiana Medicaid's PCCM has been in place statewide since 12/2003. In 2009 survey, for the question: Please rate your satisfaction with all of your child's health care in the last 6 months, 56.8 percent (120 of the 237 respondents) responded "Very Satisfied" and 40.7% (or 109 of 237 respondents) replied that they were neither satisfied nor disatisfied.
Explanation of Progress: **How did your performance in 2007 compare with the Annual Performance Objective documented in your 2006 Annual Report?** Still awaiting data from updated survey in order to complete response on this measure. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2008:** **Annual Performance Objective for FFY 2009:** **Annual Performance Objective for FFY 2010:** *Explain how these objectives were set:*	**Explanation of Progress:** **How did your performance in 2008 compare with the Annual Performance Objective documented in your 2007 Annual Report?** Still awaiting data from updated survey in order to complete response on this measure. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2009:** **Annual Performance Objective for FFY 2010:** **Annual Performance Objective for FFY 2011:** *Explain how these objectives were set:*	**Explanation of Progress:** **How did your performance in 2009 compare with the Annual Performance Objective documented in your 2008 Annual Report?** We see a high level of satisfaction with PCCM program in FFY09 study as we did in FFY05. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2010:** To maintain a high level of recipient satisfaction with the medical home provided through Louisiana Medicaid's PCCM, CommunityCARE. **Annual Performance Objective for FFY 2011:** To maintain a high level of recipient satisfaction with the medical home provided through Louisiana Medicaid's PCCM, CommunityCARE. **Annual Performance Objective for FFY 2012:** To maintain a high level of recipient satisfaction with the medical home provided through Louisiana Medicaid's PCCM, CommunityCARE. *Explain how these objectives were set:*

FFY 2007	FFY 2008	FFY 2009
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:** The state is currently conducting a CAHPS® Survey for enrollees in the LaCHIP Affordable Plan (Phase V) and the results will be reported on in the 2010 Annual Report.

Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need) (Continued)

FFY 2007	FFY 2008	FFY 2009
Goal #2 (Describe) To provide more LaCHIP and Medicaid children have annual dental exams by ensuring greater access to preventative dental services.	**Goal #2 (Describe)** To provide more LaCHIP and Medicaid children to have annual dental exams by ensuring greater access to preventative dental services.	**Goal #2 (Describe)** To provide more LaCHIP and Medicaid children have annual dental exams by ensuring greater access to preventative dental services.
Type of Goal: ☒ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: 2008	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: 2009	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: 2010
Data Source: ☒ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☒ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☒ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). Definition of numerator: The percentage of enrolled members 2-18 years of age who had at least one dental visit during the measurement year.	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). Definition of numerator: The number of enrolled members 2-21 years of age who had at least one dental visit during the measurement year.	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). Definition of numerator: The percentage of enrolled members 2-18 years of age who had at least one dental visit during the measurement year.
Year of Data: 2007	**Year of Data:** 2008	**Year of Data:** 2009
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: 196158 Denominator: 497513 Rate: 39.4 Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: 212359 Denominator: 536621 Rate: 39.6 Additional notes on measure: We began capturing FQHC/RHC claims for inclusion in our 2008 data.	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: 244574 Denominator: 569419 Rate: 43 Additional notes on measure: Measure includes FQHC/RHC claims data. This measure does not currently include the

FFY 2007	FFY 2008	FFY 2009
		LaCHIP Affordable Plan (Phase V) population but is working to develop HEDIS measures for this group.
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:
Explanation of Progress: **How did your performance in 2007 compare with the Annual Performance Objective documented in your 2006 Annual Report?** N/A **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** N/A **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2008:** In FFY 2008 we will strive for increased access to preventative dental care for members who are 2-18 years of age in order that at least 39% of members have at least one detanl visit during the year. **Annual Performance Objective for FFY 2009:** In FFY 2009 we will strive for increased access to preventative dental care for members who are 2-18 years of age in order that at least 39.5% of members have at least one detanl visit during the year. **Annual Performance Objective for FFY 2010:** In	**Explanation of Progress:** **How did your performance in 2008 compare with the Annual Performance Objective documented in your 2007 Annual Report?** The FFY 08 goal of 39% of members having at least one dental visit during the year was reached. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**A rate increase for providers that was implemented may have contributed to increased performance. **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2009:** In FFY 2009 we hope to increase the rate by 1% to 40.57% in an effort to move toward the HEDIS audit means for Medicaid. **Annual Performance Objective for FFY 2010:** In FFY 2010 we hope to increase the rate by 1% to 41.57% in an effort to move toward the HEDIS audit means for Medicaid.	**Explanation of Progress:** **How did your performance in 2009 compare with the Annual Performance Objective documented in your 2008 Annual Report?** The FFY09 goal of 40.57% of member having at least one dental visit during the year was exceeded. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**A rate increase implemented in December 2008 for providers may have contributed to increased performance. **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2010:** In FFY 2010 we hope to maintain the rate of 43.0% despite anticipated provider rate cuts and budget contraints. **Annual Performance Objective for FFY 2011:** In FFY 2011 we hope to maintain the rate of 43.0% despite anticipated provider rate cuts and budget contraints.

FFY 2007	FFY 2008	FFY 2009
FFY 2010 we will strive for increased access to preventative dental care for members who are 2-18 years of age in order that at least 40% of members have at least one detanl visit during the year. *Explain how these objectives were set:*	**Annual Performance Objective for FFY 2011:** In FFY 2011 we hope to increase the rate by 1% to 42.57% in an effort achieve toward the HEDIS audit means for Medicaid. *Explain how these objectives were set:* A workgroup of our clinical Medicaid staff and contractors was developed to adivse SCHIP management on tracking these HEDIS measures and other quality indicators. The workgroup consists of nurses and pharmacists who are intimately involved in these initiatives and use their expertise to advise SCHIP management of the progress made and planned direction for these quality initiatives.	**Annual Performance Objective for FFY 2012:** In FFY 2012 we hope to maintain the rate of 43.0% despite anticipated provider rate cuts and budget contraints. *Explain how these objectives were set:* A work group of our clinical Medicaid staff and contractors was developed to advise CHIP management on tracking these HEDIS measures and other quality indicators, including those set in the 2011 Medicaid Operational Plan. The workgroup consists of nurses and pharmacists who are intimately involved in these initiatives and use their expertise to advise CHIP management of the progress made and planned direction for these quality initiatives.
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need) (Continued)

FFY 2007	FFY 2008	FFY 2009
Goal #3 (Describe)	**Goal #3 (Describe)**	**Goal #3 (Describe)**
Type of Goal: ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: ☐ Denominator includes CHIP population only. ☐ Denominator includes CHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes CHIP population only. ☐ Denominator includes CHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes CHIP population only. ☐ Denominator includes CHIP and Medicaid (Title XIX). Definition of numerator:
Year of Data:	**Year of Data:**	**Year of Data:**
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure:

FFY 2007	FFY 2008	FFY 2009
Other Performance Measurement Data: Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:
Explanation of Progress: **How did your performance in 2007 compare with the Annual Performance Objective documented in your 2006 Annual Report?** **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2008:** **Annual Performance Objective for FFY 2009:** **Annual Performance Objective for FFY 2010:** *Explain how these objectives were set:*	**Explanation of Progress:** **How did your performance in 2008 compare with the Annual Performance Objective documented in your 2007 Annual Report?** **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2009:** **Annual Performance Objective for FFY 2010:** **Annual Performance Objective for FFY 2011:** *Explain how these objectives were set:*	**Explanation of Progress:** **How did your performance in 2009 compare with the Annual Performance Objective documented in your 2008 Annual Report?** **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2010:** **Annual Performance Objective for FFY 2011:** **Annual Performance Objective for FFY 2012:** *Explain how these objectives were set:*
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

Objectives Related to Use of Preventative Care (Immunizations, Well Child Care)

FFY 2007	FFY 2008	FFY 2009
Goal #1 (Describe) Increase the number of well-care visits by adolescents to ensure preventative care is provided to this hard-to-reach age group.	**Goal #1 (Describe)** Increase the number of well-care visits by adolescents to ensure preventative care is provided to this hard-to-reach age group.	**Goal #1 (Describe)** Increase the number of well-care visits by adolescents to ensure preventative care is provided to this hard-to-reach age group.
Type of Goal: ☒ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: 2008	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: 2009	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: 2010
Data Source: ☒ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☒ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☒ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). Definition of numerator: The percentage of enrolled members who were 12-21 years of age and who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). Definition of numerator: The percentage of enrolled members who were 12-21 years of age and who had at least one comprehensive well-care visit during the measurement year.	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes CHIP population only. ☒ Denominator includes CHIP and Medicaid (Title XIX). Definition of numerator: The percentage of enrolled members who were 12-21 years of age and who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.
Year of Data: 2007	**Year of Data:** 2008	**Year of Data:** 2009
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: 67427 Denominator: 204717 Rate: 32.9 Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: 73294 Denominator: 213754 Rate: 34.3 Additional notes on measure: We began capturing	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: 78567 Denominator: 225899 Rate: 34.8 Additional notes on measure: Measure includes FQHC/RHC

FFY 2007	FFY 2008	FFY 2009
	FQHC/RHC claims for inclusion in our 2008 data.	claims data. This measure does not currently include the LaCHIP Affordable Plan (Phase V) population but is working to develop HEDIS measures for this group.
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:
Explanation of Progress: **How did your performance in 2007 compare with the Annual Performance Objective documented in your 2006 Annual Report?** N/A. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** N/A **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2008:** In FFY 2008 we hope to maintain the rate of well-care visits by adolescents to 32.5%. **Annual Performance Objective for FFY 2009:** In FFY 2009 we hope to increase the rate of well-care visits by adolescents to 33%. **Annual Performance Objective for FFY 2010:** In FFY 2010 we hope to increase the rate of well-care visits by adolescents to 33.5%. *Explain how these objectives were set:* We plan to use the school-based health centers to make sure more adolescents have access to preventative care.	**Explanation of Progress:** **How did your performance in 2008 compare with the Annual Performance Objective documented in your 2007 Annual Report?** We exceeded our goal by not only maintaining our rate of 32.9%, but increasing it to 34.29%. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** A rate increase for providers that was implemented in 2008 may have contributed to increased performance. **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2009:** In FFY 2009 we hope to increase the rate of well-care visits by adolescents to by .5% to 34.79% in an effort to move toward the HEDIS national mean for Medicaid. **Annual Performance Objective for FFY 2010:** In FFY 2010 we hope to increase the rate of well-care visits by adolescents to by .5% to 35.29% in an effort to move toward the HEDIS national mean for Medicaid.	**Explanation of Progress:** **How did your performance in 2009 compare with the Annual Performance Objective documented in your 2008 Annual Report?** We met our goal by increasing the percentage of adolescents with at least one well-care visit to 34.8%. **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** Continued aggressive outreach and simplified application/renewal processes. A rate increase for providers that was implemented in 2008 may have contributed to this increased performance. **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2010:** In FFY2010 we hope to increase the rate of well-care visits by adolescents by 1% to 35.8% in an effort to move toward the HEDIS national mean for Medicaid. **Annual Performance Objective for FFY 2011:** In FFY2011 we hope to increase the rate of well-care visits by adolescents by 1% to 36.8% in an effort to move toward the HEDIS national mean for Medicaid.

FFY 2007	FFY 2008	FFY 2009
	Annual Performance Objective for FFY 2011: In FFY 2011 we hope to increase the rate of well-care visits by adolescents to by .5% to 35.79% in an effort to move toward the HEDIS national mean for Medicaid. *Explain how these objectives were set:* A workgroup of our clinical Medicaid staff and contractors was developed to advise SCHIP management on tracking these HEDIS measures and other quality indicators. The workgroup consists of nurses and pharmacists who are intimately involved in these initiatives and use their expertise to advise SCHIP management of the progress made and planned direction for these quality initiatives.	**Annual Performance Objective for FFY 2012:** In FFY2012 we hope to increase the rate of well-care visits by adolescents by 1% to 37.8% in an effort to move toward the HEDIS national mean for Medicaid. *Explain how these objectives were set:* A work group of our clinical Medicaid staff and contractors was developed to advise CHIP management on tracking these HEDIS measures and other quality indicators, including those set in the 2011 Medicaid Operational Plan. The workgroup consists of nurses and pharmacists who are intimately involved in these initiatives and use their expertise to advise CHIP management of the progress made and planned direction for these quality initiatives.
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

Objectives Related to Use of Preventative Care (Immunizations, Well Child Care) (Continued)

FFY 2007	FFY 2008	FFY 2009
Goal #2 (Describe)	**Goal #2 (Describe)**	**Goal #2 (Describe)**
Type of Goal: ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: ☐ Denominator includes CHIP population only. ☐ Denominator includes CHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes CHIP population only. ☐ Denominator includes CHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes CHIP population only. ☐ Denominator includes CHIP and Medicaid (Title XIX). Definition of numerator:
Year of Data:	**Year of Data:**	**Year of Data:**
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure:

FFY 2007	FFY 2008	FFY 2009
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:
Explanation of Progress: **How did your performance in 2007 compare with the Annual Performance Objective documented in your 2006 Annual Report?** **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2008:** **Annual Performance Objective for FFY 2009:** **Annual Performance Objective for FFY 2010:** *Explain how these objectives were set:*	**Explanation of Progress:** **How did your performance in 2008 compare with the Annual Performance Objective documented in your 2007 Annual Report?** **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2009:** **Annual Performance Objective for FFY 2010:** **Annual Performance Objective for FFY 2011:** *Explain how these objectives were set:*	**Explanation of Progress:** **How did your performance in 2009 compare with the Annual Performance Objective documented in your 2008 Annual Report?** **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2010:** **Annual Performance Objective for FFY 2011:** **Annual Performance Objective for FFY 2012:** *Explain how these objectives were set:*
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

Objectives Related to Use of Preventative Care (Immunizations, Well Child Care) (Continued)

FFY 2007	FFY 2008	FFY 2009
Goal #3 (Describe)	**Goal #3 (Describe)**	**Goal #3 (Describe)**
Type of Goal: ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: ☐ Denominator includes CHIP population only. ☐ Denominator includes CHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes CHIP population only. ☐ Denominator includes CHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes CHIP population only. ☐ Denominator includes CHIP and Medicaid (Title XIX). Definition of numerator:
Year of Data:	**Year of Data:**	**Year of Data:**
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure:

FFY 2007	FFY 2008	FFY 2009
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:
Explanation of Progress: **How did your performance in 2007 compare with the Annual Performance Objective documented in your 2006 Annual Report?** **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2008:** **Annual Performance Objective for FFY 2009:** **Annual Performance Objective for FFY 2010:** *Explain how these objectives were set:*	**Explanation of Progress:** **How did your performance in 2008 compare with the Annual Performance Objective documented in your 2007 Annual Report?** **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2009:** **Annual Performance Objective for FFY 2010:** **Annual Performance Objective for FFY 2011:** *Explain how these objectives were set:*	**Explanation of Progress:** **How did your performance in 2009 compare with the Annual Performance Objective documented in your 2008 Annual Report?** **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2010:** **Annual Performance Objective for FFY 2011:** **Annual Performance Objective for FFY 2012:** *Explain how these objectives were set:*
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

1. What other strategies does your State use to measure and report on access to, quality, or outcomes of care received by your CHIP population? What have you found? **[7500]**

None other than those outlined above.

2. What strategies does your CHIP program have for future measurement and reporting on access to, quality, or outcomes of care received by your CHIP population? When will data be available? **[7500]**

The Medicaid/CHIP Quality Unit intends to establish both baselines and benchmarks for the new CHIPRA child health quality measures. Baseline data will be available in 2010.

3. Have you conducted any focused quality studies on your CHIP population, e.g., adolescents, attention deficit disorder, substance abuse, special heath care needs or other emerging health care needs? What have you found? **[7500]**

No

4. Please attach any additional studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your CHIP program's performance. Please list attachments here and summarize findings or list main findings. **[7500]**

Attachment 1) Robert Wood Johnson Foundation: Enrolling Eligible People in Medicaid and SCHIP

Attachment 2) La Medicaid Eligibility Diagnostic Assessment (Prepublication 10/30/09)

Attachment 3) Georgetown University - The Louisiana Experience

Enter any Narrative text below **[7500]**.

SECTION III: ASSESSMENT OF STATE PLAN AND PROGRAM OPERATION

Please reference and summarize attachments that are relevant to specific questions

A. OUTREACH

1. How have you redirected/changed your outreach strategies during the reporting period? **[7500]**

Louisiana Medicaid has broadened outreach efforts during this past reporting period through expansion of the Outreach Blitz Campaign Model. This model uses a business to business approach coupled with on-site community enrollment events in a specific region or parish. These campaigns have been conducted in rural and urban areas around the state with positive results in all areas where it has been implemented. Experienced outreach workers from DHH along with Covering Kids & Families (CKF) staff and interested community partners have blanketed areas with this type of door to door outreach effort. During a Blitz, LaCHIP applications are distributed in counter top take one application holders.

An outreach blitz was conducted in all nine of the DHH regions across the state of Louisiana during 2009. A first for this year was the introduction of a kick-off press conference held before each of the nine regional outreach blitz initiatives. Other media appearances were made on morning television shows and radio interviews were conducted to raise awareness about the blitz activities. These media activities were made possible through the marketing contract which was in place this year. This added media coverage assisted in informing the general public about the services provided during the outreach blitz such as on-site community enrollment events.

Since the inception of the Blitz Model of outreach in the Greater New Orleans Area, outreach staff has revisited the area twice to reinforce the partnerships that were built in the original blitz. A full scale blitz was conducted in New Orleans during this reporting period. This effort allowed outreach workers to build partnerships with new businesses and organizations who have recently returned to the area. Not only has this type of initiative been successful at getting information about LaCHIP into the hardest to reach areas of the state but it has also served as a very successful public awareness tool.

Outreach staff has continued to work hard at building relationships with private businesses and employers throughout the state to deliver information about LaCHIP to their employees who either do not have access to private health insurance or cannot afford the coverage that is available to them. This has been accomplished through employee benefits fairs and also through direct distribution of applications and literature to new hires on an individual basis. Outreach workers have also been able to get payroll stuffers with LaCHIP information placed in employee pay check envelopes in businesses around the state.

Funding for eleven Covering Kids & Families Regional Contractors to cover the entire state has been maintained. These agencies around the state are under contract to develop regional coalitions of stakeholders and conduct outreach initiatives, in collaborations with Regional DHH outreach staff. These regional coalitions have grown over this past reporting period and this was shown through the attendance at the Fall Louisiana Covering Kids & Families Statewide Coalition Meeting in which over one hundred community partners participated. Growth in these regional coalitions has been made possible by the work that the contractors are doing to build relationships with city and parish governments, employers, non-profit organizations, school systems and faith based organizations in their respective coverage areas. The outreach efforts of these community based organizations augment those of our reduced Medicaid Eligibility outreach staff.

The LaCHIP budget for the period beginning July 2009 provided funding for a major LaCHIP marketing campaign, a large LaCHIP outreach conference and many other initiatives to increase enrollment and retention of eligible children in LaCHIP and Medicaid. The LaCHIP conference was held in November of this year. There were over 350 registrants who participated including representatives from community partners, medical providers, faith-based organizations, other government agencies and social workers from across the state. One new aspect that was added to the conference this year was the ability to offer continuing education credits to social workers who attended select sessions. Over 100 social workers registered for these sessions. This enabled our agency to get accurate information on LaCHIP into the hands of social workers who have direct access to the target audience of low-income families with children.

Both CKF and Medicaid Eligibility outreach workers have been able to successfully promote the Public Access On-line application. The on-line application center allows potential clients to apply for LaCHIP and Medicaid coverage via the DHH website. Current clients can also update their contact information and request replacement Medicaid cards through the on-line application center. This has been done through the use of outstation equipment during regular outreach practices by the Medicaid staff. The CKF Contractors have built relationships with local government agencies and parish libraries to place shortcuts to the LaCHIP on-line application on public access computers in their service areas. The contractors have also begun using their laptops to assist potential clients with the on-line application while attending outreach events.

Another important statewide outreach practice in this reporting period is the continued involvement of Medicaid Eligibility workers in outreach around the state. This involvement has been accomplished even with the reduction of Medicaid Eligibility staff statewide by continued encouragement from regional and state office management. Eligibility workers have also been able to see the results of their outreach efforts in higher enrollment numbers statewide and greater retention rates of children in LaCHIP and Medicaid in their service areas.

The new-look LaCHIP website is more visually appealing and user-friendly to better inform the public about this valuable program. Now visitors to the site can browse through information about LaCHIP, the LaCHIP Affordable Plan or learn more about how to become a part of the community that spreads the word about LaCHIP.

2. What methods have you found most effective in reaching low-income, uninsured children (e.g., T.V., school outreach, word-of-mouth)? How have you measured effectiveness? **[7500]**

   Again this year DHH partnered with school systems in providing over 900,000 children with information about the program, piggy backing with the free/reduced lunch program in sending literature home. Effectiveness of this outreach is measured by monitoring the application origination report which gives outreach staff a view of how applications are received by potential clients.

Positive word of mouth outreach has continued to be an important method of getting information to potential clients. This has been accomplished by DHH and CKF Contractors conducting in-service trainings to non-profit organizations, faith based organizations, private employers and other government agencies. These trainings provide a clear, consistent message about LaCHIP and the benefits that the program has to offer. Effectiveness can be measured through increased enrollment in the program in areas of the state that have traditionally had higher uninsured rates for children and families.

3. Which of the methods described in Question 2 would you consider a best practice(s)**? [7500]**

   The CKF local coalition model coupled with Medicaid eligibility employees and the blitze outreach model are both unique to Louisiana and what we consider to be out best practices. Through greater awareness of the program and program benefits by community partners this will continue to increase enrollment and retention rates in LaCHIP and Medicaid.

4. Is your state targeting outreach to specific populations (e.g., minorities, immigrants, and children living in rural areas)?

   ☒ Yes

   ☐ No

   Have these efforts been successful, and how have you measured effectiveness? **[7500]**

   The bilingual Strategic Enrollment Unit that services the Spanish and Vietnamese speaking populations around the state has continued to increase their outreach efforts. This unit is centrally located in Baton Rouge. Outreach to migrant farming communities has been conducted to increase awareness of LaCHIP and increase enrollment in LaCHIP and Medicaid for families who have traditionally perceived that they were not eligible for coverage in these programs. There continues to be a tremendous increase in the Spanish speaking community in the Greater New Orleans Area due to the growth of the construction industry in the area. Workers have conducted targeted outreach initiatives to these communities.

   Rural areas have been targeted with Outreach Blitz initiatives that have proved to be successful in these communities. During these campaigns several experienced Medicaid Eligibility outreach workers along with CKF staff members and community partners blanket a target area with business to business outreach efforts where LaCHIP applications are distributed and on-site enrollment events. This is an effective means of getting information about LaCHIP and Medicaid into the hands of potentially eligible clients in rural areas. It is also a great public relations tool. Communities see that they do not necessarily have to come to the local Medicaid office to apply for coverage or ask questions about their existing case, Medicaid staff will come to them where they live, shop and worship.

5. What percentage of children below 200 percent of the Federal poverty level (FPL) who are eligible for Medicaid or CHIP have been enrolled in those programs? [5] 94.7

   (Identify the data source used). **[7500]**

   The percentage of uninsured children in the state of Louisiana who are eligible for but not enrolled in Medicaid or LaCHIP is 5.3%. This figure is down from 5.5% in 2007. In actual numbers of children this number is down from 41,595 children in 2007 to 39,765 children in 2009. This information was made available through the 2007 Louisiana Household Insurance Survey that was conducted by the Louisiana State University Public Policy Research Lab. A sampling of over 10,000 households which

included 28,000+ Louisiana residents was used to calculate the percentage of uninsured children in Louisiana.

B. SUBSTITUTION OF COVERAGE (CROWD-OUT)

All states should answer the following questions. Please include percent calculations in your responses when applicable and requested.

1. Do you have substitution prevention policies in place?

   ☒ Yes
   ☐ No

   If yes, indicate if you have the following policies:
   ☒ Imposing waiting periods between terminating private coverage and enrolling in CHIP
   ☒ Imposing cost sharing in approximation to the cost of private coverage
   ☒ Monitoring health insurance status at the time of application
   ☐ Other, please explain **[7500]**

2. Describe how substitution of coverage is monitored and measured and how the State evaluates the effectiveness of its policies. **[7500]**

For LaCHIP Phase V (LaCHIP Affordable Plan) all three of the substitution of coverage policies listed above are in place. There is a one year wait period between termination of private coverage and enrollment in LaCHIP Phase V, unless one of the hardship exemptions are met. The program also imposes a cost sharing mechanism that requires families to pay a $50 per family per month premium for enrollment of children. Prescription and medical service co-payments are in effect. Health insurance status is monitored at the time of application through applicant questions. We also monitor through our agency's Third Party Liability program.

3. Identify the trigger mechanism or point at which your substitution prevention policy is instituted or modified if you currently have a substitution policy. **[7500]**

   Monthly reports provide data on application rejections. This enables the agency to track the number of applicants that were denied coverage due to health insurance coverage.

All States must complete the following questions

4. At the time of application, what percent of CHIP applicants are found to have Medicaid [(# applicants found to have Medicaid/total # applicants) * 100] **[5]** 1.3
   and what percent of applicants are found to have other insurance [(# applicants found to have other insurance/total # applicants) * 100] **[5]**? 4.8
   Provide a combined percent if you cannot calculate separate percentages. **[5]**

5. Describe the incidence of substitution. What percent of applicants drop group health plan coverage to enroll in CHIP (i.e., (# applicants who drop coverage/total # applicants) * 100)? **[5]**

   Please enter any narrative discussion: **[7500]**

   For our Medicaid expansion CHIP Program without a Section 1115 Waiver, we are precluded from implementing a waiting period if a person drops private health coverage in order to become eligible for and enroll in LaCHIP. When the final CHIP regulations were published, Louisiana was directed to remove the three month waiting period that had been established in 1998.

For LaCHIP Phase V (LaCHIP Affordable Plan), an applicant cannot drop group health plan coverage in order to enroll since the program requires applicants to be uninsured for one year prior to enrolling in the program.

a. Of those found to have had other, private insurance and have been uninsured for only a portion of the state's waiting period, what percent meet your state's exemptions to the waiting period (if your state has a waiting period and exemptions) [(# applicants who are exempt/total # of new applicants who were enrolled)*100]? **[5]**

1.8

b. Of those found to have other, private insurance, what percent must remain uninsured until the waiting period is met [(# applicants who must complete waiting period/total # of new applicants who were enrolled)*100]? **[5]**

2.2

6. Does your State have an affordability exception to its waiting period?

☒ Yes
☐ No

If yes, please respond to the following questions. If no, skip to question 7.

a. Has the State established a specific threshold for defining affordability (e.g., when the cost of the child's portion of the family's employer-based health insurance premium is more than X percent of family income)?

☒ Yes
☐ No

If the State has established a specific threshold, please provide this figure and whether this applies to net or gross income. If no, how does the State determine who meets the affordability exception? **[7500]**

An affordability exception exists if the monthly health insurance premium exceeds 10% of gross household income.

b. What expenses are counted for purposes of determining when the family exceeds the affordability threshold? (e.g., Does the State consider only premiums, or premiums and other cost-sharing charges? Does the State base the calculation on the total premium for family coverage under the employer plan or on the difference between the amount of the premium for employee-only coverage and the amount of the premium for family coverage? Other approach?) **[7500]**

Louisiana considers only the amount of the total family premium in determining the affordability threshold.

c. What percentage of enrollees at initial application qualified for this exception in the last Federal Fiscal Year? (e.g., Number of applicants who were exempted because of affordability exception/total number of applicants who were enrolled). **[5]**

d. Does the State conduct surveys or focus groups that examine whether affordability is a concern?

☐ Yes
☒ No

If yes, please provide relevant findings. **[7500]**

7. If your State does not have an affordability exception, does your State collect data on the cost of health insurance for an individual or family? **[7500]**

n/a

8. Does the State's CHIP application ask whether applicants have access to private health insurance?

☒ Yes
☐ No

If yes, do you track the number of individuals who have access to private insurance?

☒ Yes
☐ No

If yes, what percent of individuals that enrolled in CHIP had access to private health insurance at the time of application during the last Federal Fiscal Year [(# of individuals that had access to private health insurance/total # of individuals enrolled in CHIP)*100]? **[5]**
1.3

C. ELIGIBILITY

(This subsection should be completed by all States)
Medicaid Expansion states should complete applicable responses and indicate those questions that are non-applicable with N/A.

Section IIIC: Subpart A: Overall CHIP and Medicaid Eligibility Coordination

1. Does the State use a joint application for establishing eligibility for Medicaid or CHIP?

☒ Yes
☐ No

If no, please describe the screen and enroll process. **[7500]**

2. Please explain the process that occurs when a child's eligibility status changes from Medicaid to CHIP and from CHIP to Medicaid. Have you identified any challenges? If so, please explain. **[7500]**

Yes, Louisiana has identified challenges and is working to address them. Since the delivery model and benefits for Medicaid and CHIP below 200% (Phases I-IV) are the same, recipients are not made aware of the change and it appears seamless. For changes between Medicaid Expansion CHIP to the Separate CHIP (LaCHIP Affordable Plan), families are notified of the change in advance of the actual change taking place. Parents of children who move to the Separate CHIP Program are informed that cost sharing is involved with their participation in the

program, as well as a change in benefits. When a recipient moves from the Separate CHIP Program (Phase V) to Medicaid/Medicaid Expansion (Phases I-IV), they are again notified in writing to explain they are eligible for a no cost program with different benefits and delivery model.

3. Are the same delivery systems (such as managed care or fee for service,) or provider networks used in Medicaid and CHIP? Please explain. **[7500]**

☐ Yes

☒ No

If no, please explain. **[7500]**

The delivery system and provider network for Medicaid and CHIP for children to 200% FPL is the same: Primary Care Case Management model known in Louisiana as CommunityCARE. For LaCHIP Affordable Plan, the Office of Group Benefits PPO fee for service provider network is used (same as that of state employees).

4. Are you utilizing the Express Lane option in making eligibility determinations and/or renewals for both Medicaid and CHIP?

☐ Yes
☒ No

a. If yes, which Express Lane Agencies are you using?

☐ Supplemental Nutrition Assistance Program (SNAP), formerly Food Stamps

☐ Tax/Revenue Agency

☐ Unemployment Compensation Agency

☐ Women, Infants, and Children (WIC)

☐ Free, Reduced School Lunch Program

☐ Subsidized Child Care Program

☐ Other, please explain. **[7500]**

b. If yes, what information is the Express Lane Agency providing?

☐ Income

☐ Resources

☐ Residency

☐ Age

☐ Citizenship

☐ Other, please explain. **[7500]**

Section IIIC: Subpart B: Initial Eligibility, Enrollment, and Renewal for CHIP (Title XXI) and Medicaid (Title XIX) Programs

Table B1

This section is designed to assist CMS and the States track and determine eligibility for a CHIPRA performance bonus payment by meeting the required "5 out of 8" eligibility and enrollment milestones.

Question	Medicaid	CHIP
1. Does the State provide continuous eligibility for 12 months for children regardless of changes in circumstances other than the situations identified below: a. child is no longer a resident of the State; b. death of the child; c. child reaches the age limit; d. child/representative requests disenrollment; e. child enrolled in a separate CHIP program files a Medicaid application, is determined eligible for Medicaid and is enrolled in Medicaid without a coverage gap.	In accordance with section 1902(e)(12) of the Act ☒ Yes ☐ No	☒ Yes ☐ No
2. Does the State have an assets test?	☐ Yes ☒ No	☐ Yes ☒ No
3. If there is an asset test, does the State allow administrative verification of assets?	☐ Yes ☐ No ☒ N/A	☐ Yes ☐ No ☒ N/A
4. Does the State require an in-person interview to apply?	☐ Yes ☒ No	☐ Yes ☒ No
5. Does the State use the same application form, supplemental forms, and information verification process for *establishing* eligibility for Medicaid and CHIP?	☒ Yes ☐ No	
6. Does the State provide presumptive eligibility to children who appear to be eligible for Medicaid and CHIP to enroll pending a full determination of eligibility?	☐ Yes ☒ No	
7. Has the State implemented premium assistance as added or modified by CHIPRA?	In accordance with section1906A of the Act, as added by section 301(b) of CHIPRA. ☐ Yes ☒ No	In accordance with section 2105(c)(10) of the Act, as added by section 301(a)(1) of CHIPRA. ☐ Yes

		☒ No
8. For renewals of Medicaid or CHIP eligibility, does the State provide a preprinted form populated with eligibility information available to the State, to the child or the child's parent or other representative, along with a notice that eligibility will be renewed and continued based on such information unless the State is provided other information that affects eligibility?	☐ Yes ☒ No	☐ Yes ☒ No
9. Does the State do an ex parte renewal? Specifically, does the State renew Medicaid or CHIP eligibility to the maximum extent possible based on information contained in the individual's Medicaid file or other information available to the State, before it seeks any information from the child's parent or representative?	☒ Yes ☐ No	☒ Yes ☐ No
10. Has the State eliminated an in-person requirement for renewal of CHIP eligibility?	☒ Yes ☐ No	☒ Yes ☐ No
11. Does the State use the same application form, supplemental forms, and information verification process for *renewing* eligibility for Medicaid and CHIP?	☒ Yes ☐ No	

Section IIIC: Subpart C: Eligibility Renewal and Retention

CHIP (Title XXI) and Medicaid (Title XIX) Programs

1. What additional measures, besides those described in Tables B1 or C1, does your State employ to simplify an eligibility renewal and retain eligible children in CHIP?

☒ Conducts follow-up with clients through caseworkers/outreach workers

☐ Sends renewal reminder notices to all families

- How many notices are sent to the family prior to disenrolling the child from the program? **[500]**

- At what intervals are reminder notices sent to families (e.g., how many weeks before the end of the current eligibility period is a follow-up letter sent if the renewal has not been received by the State?) **[500]**

☒ Other, *please explain*: **[500]**

Administrative renewals for cases identified as low risk for ineligibility. Notice is mailed to household requesting that they report any changes that have occurred. If no changes are reported, eligibility is automatically extended. A signed renewal form is not required. Ex Parte renewals—for any child enrolled in SNAP (age 6 thru 18 with income over 100% FPL), income from the SNAP record is used to calculate the CHIP eligibility or State quarterly tax data is used in select cases. A signed renewal form is not required. Telephone renewals—When an administrative renewal or ex parte renewal is not possible, the caseworker attempts to complete the required annual review of eligibility by telephone. A signed renewal form is not required. An available option is to renew via Interactive Voice Response using the Toll Free Hotline that can be accessed 24/7/365.Families may also renew by completing the web-based application again.

2. Which of the above strategies appear to be the most effective? Have you evaluated the effectiveness of any strategies? If so, please describe the evaluation, including data sources and methodology. **[7500]**

   All are highly effective and have resulted in fewer than 1% of children being closed at renewal for a paperwork related reason.

   The effectiveness of various strategies differs by type case, CHIP vs. CHAMP, paralleling differences in state policy and procedure that determine which strategies can be used on which type cases.

   CHIP

   In June 2009, the single most effective renewal strategy for CHIP children was telephone renewals, with 37% of all CHIP kids renewals for the month completed by phone. Telephone renewals begins with either a notice to mailed to the enrollee asking them to call an eligibility worker to renew (no renewal form is mailed) or an attempt to contact the enrollee by phone prior to sending the notice. Some offices find the call first method more efficient, while others favor the notice first method. Preferences appear to reflect primarily the mobility of enrollees and related likelihood of having mail returned. Generally, it is a rural/urban divide, compounded by the dislocation impact of hurricanes Katrina and Rita (2005) and Gustav and Ike (2008). Regardless of the first contact method (phone or notice by mail), the option of providing information needed for eligibility determination by phone has proven more effective and efficient than renewal form by mail solicitations. Enrollees are simply far more responsive. They make contact at higher rates and earlier in the renewal month by phone than by mail in renewal form. From an administrative efficiency stand point, telephone renewals reduce postage and printing costs, as well as labor costs and equipment wear and tear from scanning and shredding paper forms.

   Second was exparte renewals, accounting for 31% of the total number of CHIP kids renewals in June 2009. The exparte policy allows eligibility workers to determine Medicaid/CHIP eligibility for children enrolled in SNAP based on income data in the SNAP record accessed online by the worker. Online wage data (e.g., State Department of Labor, The Work Number) may be used in selected cases. Neither a signed renewal form nor enrollee contact is required.

   Third was the renewal form at 10% of the CHIP total for June 09. Renewal form return rates have always be chronically low, paralleling low mail solicitation response rates in other industries. Test and after test varying the format of the cover letter included with the form, the envelope size, etc. failed to improve enroll response rates to requests to renew by mail in form. Form use by eligibility workers and customers drops with each addition of more convenient alternatives.

Fourth and fifth were administrative renewals and online renewals at 5% and 4% respectively. Administrative renewals are used for cases identified as low risk for ineligibility. Notice is mailed to household requesting that they report any changes that have occurred. If no changes are reported, eligibility is automatically extended. A signed renewal form is not required.

CHAMP

For CHAMP kids, the ranking of strategies by effectiveness differs. Administrative renewals top the list at nearly half (47%) of the total in June. Exparte ranks second at 31%. Telephone renewals are third at 14%, paper forms fifth at 6%, and online last at 1%.

However, the above data reflect renewal strategy trends in June 2009 (SFY08/09 end). More recent data reflect a Fall 2009 expansion of administrative renewal use for CHIP kids. In 11/09, administrative renewals for CHIP kids was up to 43% while telephone, exparte and form renewals were down to 24%, 17% and 6% respectively. By contrast, CHAMP kids' paths to renewal remain virtually identical in 11/09 as in 6/09, reflecting a lack of change in renewal strategy policy and procedures for that type case group.

The primary evaluation method for renewal strategies has been the Plan-Do-Study-Act model taught by the Southern Institute on Children and Families through the Robert Wood Johnson Foundation-funded Louisiana Eligibility Process Improvement Collaborative in 2006-07. The above lessons learned/best practices the result of scores of small scale tests by frontline eligibility workers in local offices across the state over a period of at least 2 years. Also important has been data from our mainframe Medicaid Eligibility Determination System (MEDS) through which procedural closure rates and paths to renewal are tracked.

Lastly, key to Louisiana's retention success is its "three calls" policy. The policy requires eligibility workers to attempt phone contact with enrollees who have failed to respond to renewal mailings and document to contact attempts in the Electronic Case Record. It also requires supervisory review of the case record and contact attempts and supervisory approval prior to closing a case for procedural (paperwork, i.e., failure to reply) reasons. Our most telling test of the effectiveness of this policy was in 2006 when it was suspended as a work relief measure in the face of the new, onerous federal citizenship and identity verification requirements. The rate of procedural closures increased sharply, only to decrease just as sharply after the trend was identified and policy reinstated. Currently, and consistently for the past several years, less than 1% of CHIP/CHAMP kids' are closed at renewal for paperwork reasons.

Section IIIC: Subpart D: Eligibility Data

1. What percentage of children who apply for the program are denied eligibility for enrollment? (i.e., (# of children denied/total # of children who apply) * 100). **[5]**

   8

2. What percentage of children in the program are retained in the program at redetermination (i.e., (# children retained/total # children up for redetermination) * 100) **[5]**? 88.4
   What percentage of children in the program are disenrolled at redetermination (i.e., (# children disenrolled/total # children up for redetermination) * 100). **[5]** 11.6

3. Does your State generate monthly reports or conduct assessments that track the outcomes of individuals who disenroll, or do not reenroll, in CHIP (e.g., how many obtain other public or private coverage, how many remain uninsured, how many age-out, how many move to a new geographic area)

   ☒ Yes
   ☐ No
   ☐ N/A

   a. When was the monthly report or assessment last conducted? **[7500]**

   September 2009. Note that the "Other" column below includes all remaining children who were disenrolled for reasons other than those listed below.

   b. If you responded yes to the question above, please provide a summary of the most recent findings (in the table below) from these reports and/or assessments.

Findings from Report/Assessment on Individuals Who Disenroll, or Do Not Reenroll in CHIP

Total Number of Dis-enrollees	**Obtain other public or private coverage**		**Remain uninsured**		**Age-out**		**Move to new geographic area**		**Other (specify)**	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
2895	2394	27	77	.9	168	1.9	145	5.0	111	3.8

   c. Please describe the data source (e.g., telephone or mail survey, focus groups) used to derive this information. Include the time period reflected in the data (e.g., calendar year, fiscal year, one month, etc.) **[7500]**.

   September monthly production report

D. COST SHARING

1. Describe how the State tracks cost sharing to ensure enrollees do not pay more than 5 percent aggregate maximum in the year?

   a. Cost sharing is tracked by:

   ☐ Enrollees (shoebox method)
   ☐ Health Plan(s)
   ☐ State
   ☒ Third Party Administrator
   ☐ N/A (No cost sharing required)
   ☐ Other, please explain. **[7500]**

If the State uses the shoebox method, please describe informational tools provided to enrollees to track cost sharing. **[7500]**

2. Please describe how providers are notified that no cost sharing should be charged to enrollees exceeding the 5% cap. **[7500]**
   When a plan member reaches their annual maximum out of pocket expenditure, they are automatically changed to a no cost sharing plan within the TPA eligibility system. When providers verify coverage, they are provided the plan type which determines whether or not a co-pay is charged.

3. Please provide an estimate of the number of children that exceeded the 5 percent cap in the State's CHIP program during the Federal fiscal year. **[500]**
   8 families met the 5% cap for out of pocket expenditures during the Federal fiscal year. These 8 families were comprised of 19 children

4. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in CHIP?
   ☐ Yes
   ☒ No

   If so, what have you found? **[7500]**

5. Has your State undertaken any assessment of the effects of cost sharing on utilization of health services in CHIP?
   ☐ Yes
   ☒ No

   If so, what have you found? **[7500]**

6. If your state has increased or decreased cost sharing in the past federal fiscal year, has the state undertaken any assessment of the impact of these changes on application, enrollment, disenrollment, and utilization of health services in CHIP. If so, what have you found? **[7500]**

   LaCHIP Phase V (LaCHIP Affordable Plan) mental health benefits were changed to comply with section 502 of CHIPRA legislation. The mental health and substance abuse benefit deductibles were removed, and the co payments were all reduced to 10% of the contracted rate. At this time, the state has not conducted a formal review of the impact this may have had on utilization.

E. EMPLOYER SPONSORED INSURANCE PROGRAM (INCLUDING PREMIUM ASSISTANCE PROGRAM(S)) UNDER THE CHIP STATE PLAN OR A SECTION 1115 TITLE XXI DEMONSTRATION

1. Does your State offer an employer sponsored insurance program (including a premium assistance program) for children and/or adults using Title XXI funds?

   ☒ Yes, please answer questions below.
   ☐ No, skip to Program Integrity subsection.

Children

☒ Yes, Check all that apply and complete each question for each authority.

☐ Family Coverage Waiver under the State Plan
☐ CHIP Section 1115 Demonstration
☐ Medicaid Section 1115 Demonstration
☐ Health Insurance Flexibility & Accountability Demonstration

Adults

☒ Yes, Check all that apply and complete each question for each authority.

☐ Family Coverage Waiver under the CHIP State Plan
☐ CHIP Section 1115 Demonstration Title XXI
☐ Health Insurance Flexibility & Accountability Demonstration
☒ Premium Assistance option under the Medicaid State Plan (Section 1906 HIPP)

2. Please indicate which adults your State covers with premium assistance. (Check all that apply.)

☒ Parents and Caretaker Relatives
☐ Childless Adults
☒ Pregnant Women

3. Briefly describe how your program operates (e.g., is your program an employer sponsored insurance program or a premium assistance program, how do you coordinate assistance between the state and/or employer, who receives the subsidy if a subsidy is provided, etc.) **[7500]**

LaCHIP considers Title XXI children for premium reimbursement under Section 1906 (HIPP) authority if they are uninsured at the time of application and employer sponsored insurance is available.

4. What benefit package does the ESI program use? **[7500]**

N/A for Section 1906

5. Are there any minimum coverage requirements for the benefit package?

☒ Yes
☐ No

6. Does the program provide wrap-around coverage for benefits or cost sharing?

☒ Yes
☐ No

7. Are there any limits on cost sharing for children in your ESI program?

☐ Yes
☒ No

8. Are there any limits on cost sharing for adults in your ESI program?

☐ Yes
☒ No

9. Identify the total number of children and adults enrolled in the ESI program for whom Title XXI funds are used during the reporting period (provide the number of adults enrolled in this program even if they were covered incidentally, i.e., not explicitly covered through a demonstration).

0	Number of childless adults ever-enrolled during the reporting period
286	Number of adults ever-enrolled during the reporting period
689	Number of children ever-enrolled during the reporting period

10. Identify the estimated amount of substitution, if any, that occurred or was prevented as a result of your employer sponsored insurance program (including premium assistance program). Discuss how was this measured? **[7500]**

No substitution exists. Child cannot have private coverage at the time of CHIP enrollment and can only be enrolled in HIPP if it will result in a cost savings to the agency.

11. During the reporting period, what has been the greatest challenge your ESI program has experienced? **[7500]**

Identifying the cases most suitable for HIPP and locating the resources to establish eligibility and enroll, even with a maximum degree of automation, as it is a labor intensive process and difficult for a small staffing unit.

12. During the reporting period, what accomplishments have been achieved in your ESI program? **[7500]**

Continued enrollment increase

13. What changes have you made or are planning to make in your ESI program during the next fiscal year? Please comment on why the changes are planned. **[7500]**

Louisiana is exploring various mechanisms to increase enrollment.

14. What do you estimate is the impact of your ESI program (including premium assistance) on enrollment and retention of children? How was this measured? **[7500]**

None at this point.

15. Identify the total state expenditures for providing coverage under your ESI program during the reporting period. **[7500]**

We do not capture the amount that the employer/employee/state pays toward the coverage. We are only concerned that it is cost effective for us to pay the employee share for the coverage. Therefore, the total state expenditures and average amount each entity pays towards coverage is not available.

16. Provide the average amount each entity pays towards coverage of the beneficiary under your ESI program:

State: 1235874

Employer: _____

Employee: _____

17. If you offer a premium assistance program, what, if any, is the minimum employer contribution? **[500]**

    N/A for Section 1906 HIPP

18. Do you have a cost effectiveness test that you apply in determining whether an applicant can receive coverage (e.g., the state's share of a premium assistance payment must be less than or equal to the cost of covering the applicant under CHIP or Medicaid)?

    ☒ Yes
    ☐ No

19. Is there a required period of uninsurance before enrolling in your program? If yes, what is the period of uninsurance? **[500]**

    ☐ Yes
    ☒ No

20. Do you have a waiting list for your program?

    ☐ Yes
    ☒ No

21. Can you cap enrollment for your program?

    ☐ Yes
    ☒ No

F. PROGRAM INTEGRITY (COMPLETE ONLY WITH REGARD TO SEPARATE CHIP PROGRAMS (I.E. THOSE THAT ARE NOT MEDICAID EXPANSIONS)

1. Does your state have a written plan that has safeguards and establishes methods and procedures for:

   (1) prevention: ☒ Yes ☐ No

   (2) investigation: ☒ Yes ☐ No

   (3) referral of cases of fraud and abuse? ☒ Yes ☐ No

   Please explain: **[7500]**

   For Medicaid Expansion, we use the federal rules and regulations and the authority provider in our Medical Assistance Program Integrity Law (MAPIL) LA RS 46:437.1 – 440.1 and the Surveillance and Utilization Review System (SURS Rule) Louisiana Register, Vol. 29, No. 04, April 20, 2003 pp. 583 – 604 as our general procedures. Specific procedures and process are covered in the SURS Manual. Procedures can also be found in the Provider Enrollment application: PE 50 & Addendum and our MOU with the Attorney General's Medicaid Fraud Control Unit.

   The same plan in place for our Medicaid program exists for children covered through the Unborn Option.

Fraud and Abuse for the recently implemented LaCHIP Phase V (LaCHIP Affordable Plan) are handled by our third party administrator, the state employees health plan. Every employee referral, hotline referral, website referral, or provider referral are reviewed by the Director of Fraud and Abuse to determine the legitimacy of the information. Review includes review of claims data and/or data mining activities. The legal division of our third party administrator, through the compliance investigator and the deputy general counsel coordinates anti fraud activities. The internal audit section, the plan administration section , the eligibility section and the provider contracting section all work with different aspects of fraud prevention. All employees of the third party administrator have some involvement with fraud prevention. The legal division is primarily responsible for investigation and fraud referral.

If the state does not have a written plan, do managed health care plans with which your program contracts have written plans?

☐ Yes

☒ No

Please Explain: **[500]**

n/a

2. For the reporting period, please indicate the number of cases investigated, and cases referred, regarding fraud and abuse in the following areas:

Provider Credentialing

0 Number of cases investigated

0 Number of cases referred to appropriate law enforcement officials

Provider Billing

1085 Number of cases investigated

191 Number of cases referred to appropriate law enforcement officials

Beneficiary Eligibility

621 Number of cases investigated

_____ Number of cases referred to appropriate law enforcement officials

Are these cases for:

CHIP ☐

Medicaid and CHIP Combined ☒

3. Does your state rely on contractors to perform the above functions?

☒ Yes, please answer question below.

☐ No

4. If your state relies on contractors to perform the above functions, how does your state provide oversight of those contractors? Please explain : **[7500]**

DHH's Program Integrity section conducts oversight of the contractor, Unisys for the Surveillance and Utilization Review Systems [SURS] unit and the Provider Enrollment (PE) unit. Program Integrity has one state staff physically located at Unisys' SURS unit; this staff member conducts case direction and makes all final determinations as to issuing notices of sanctions, and reviews various reports related to complaint and referrals by Unisys' SURS unit. The PE unit is monitored by staff located at State office.

For LaCHIP Phase V, the DHH contract monitor works closely with key personnel from the state employees health plan to accurately oversee this function of the program. Our third party administrator also uses its own eligibility staff, legal staff, compliance investigator, internal audit staff, hospital audit staff , provider contracting, and computer claims analysis staff to monitor and detect possible fraud and or overpayment events.

5. Do you contract with managed care health plans and/or a third party contractor to provide this oversight?

☐ Yes

☒ No

Please explain: **[500]**

We do not have managed care for SCHIP. We only have the Program of All Inclusive Care for the Elderly (PACE).

In responding to #2 above, it should be noted that data was not able to be separated between Provider Credentialing and Provider Billing; therefore they are reported together under Provider Billing.

Enter any Narrative text below. **[7500]**

2.a) We deny enrollment of providers who are not credentialed.

2.b) Time period: 01/10/2009 to 12/29/2009

2.c) Benficiary Eligibility - Number of cases referred to appropriate law enforcement officials: Unknown; these referrals are done at the Parish Office level.

SECTION IV: PROGRAM FINANCING FOR STATE PLAN

1. Please complete the following table to provide budget information. Describe in narrative any details of your planned use of funds below, including the assumptions on which this budget was based (per member/per month rate, estimated enrollment and source of non-Federal funds). (*Note: This reporting period =Federal Fiscal Year 2009. If you have a combination program you need only submit one budget; programs do not need to be reported separately.)*

COST OF APPROVED CHIP PLAN

Benefit Costs	**2009**	**2010**	**2011**
Insurance payments			
Managed Care			
Fee for Service	208142408	212185030	218443841
Total Benefit Costs	208142408	212185030	218443841
(Offsetting beneficiary cost sharing payments)	-151817	-317425	-457136
Net Benefit Costs	$ 207990591	$ 211867605	$ 217986705

Administration Costs			
Personnel	3797068	3895269	4014171
General Administration	12502250	12825587	13217085
Contractors/Brokers (e.g., enrollment contractors)	438283	449618	463342
Claims Processing	1007952	1034020	1065583
Outreach/Marketing costs	2413480	2475898	2551474
Other (e.g., indirect costs)	0	0	0
Health Services Initiatives	0	0	0
Total Administration Costs	20159033	20680392	21311655
10% Administrative Cap (net benefit costs ÷ 9)	23110066	23540845	24220745

Federal Title XXI Share	182337180	179829366	185049422
State Share	45812444	52718631	54248938

TOTAL COSTS OF APPROVED CHIP PLAN	228149624	232547997	239298360

2. What were the sources of non-Federal funding used for State match during the reporting period?

- ☒ State appropriations
- ☐ County/local funds
- ☐ Employer contributions
- ☒ Foundation grants
- ☐ Private donations
- ☐ Tobacco settlement
- ☐ Other (specify) **[500]**

3. Did you experience a short fall in CHIP funds this year? If so, what is your analysis for why there were not enough Federal CHIP funds for your program? **[1500]**

No

4. In the table below, enter 1) number of eligibles used to determine per member per month costs for the current year and estimates for the next two years; and, 2) per member per month cost rounded to a whole number. If you have CHIP enrollees in a fee for service program, per member per month cost will be the average cost per month to provide services to these enrollees.

	2009		2010		2011	
	# of eligibles	$ PMPM	# of eligibles	$ PMPM	# of eligibles	$ PMPM
Managed Care		$		$		$
Fee for Service	124499	$ 139	122038	$ 145	120802	$ 151

Enter any Narrative text below. **[7500]**

For children covered through the Unborn option, the PMPM is significantly higher in FFY09, 10 and 11 and is not taken into account for the chart above. The number of eligibles and PMPM are based on CHIP enrollees under 250% FPL. The number of eligibles in chart above is from points in time at the end of the three fiscal years. The decrease in enrollment from FFY09 to FFY10 and 11 is due, in part, to recent economic conditions and has coincided with a larger than average increase of children into Louisiana's regular Medicaid program.

SECTION V: 1115 DEMONSTRATION WAIVERS (FINANCED BY CHIP)

Please reference and summarize attachments that are relevant to specific questions.

1. If you do not have a Demonstration Waiver financed with CHIP funds skip to Section VI. If you do, please complete the following table showing whom you provide coverage to.

	CHIP Non-HIFA Demonstration Eligibility					HIFA Waiver Demonstration Eligibility				
	* Upper % of FPL are defined as Up to and Including									
Children	From		% of FPL to		% of FPL *	From		% of FPL to		% of FPL *
Parents	From		% of FPL to		% of FPL *	From		% of FPL to		% of FPL *
Childless Adults	From		% of FPL to		% of FPL *	From		% of FPL to		% of FPL *
Pregnant Women	From		% of FPL to		% of FPL *	From		% of FPL to		% of FPL *

2. Identify the total number of children and adults ever enrolled (an unduplicated enrollment count) in your CHIP demonstration during the reporting period.

_____ Number of **children** ever enrolled during the reporting period in the demonstration

_____ Number of **parents** ever enrolled during the reporting period in the demonstration

_____ Number of **pregnant women** ever enrolled during the reporting period in the demonstration

_____ Number of **childless adults** ever enrolled during the reporting period in the demonstration

3. What have you found about the impact of covering adults on enrollment, retention, and access to care of children? You are required to evaluate the effectiveness of your demonstration project, so report here on any progress made in this evaluation, specifically as it relates to enrollment, retention, and access to care for children. **[1000]**

4. Please provide budget information in the following table for the years in which the demonstration is approved. *Note: This reporting period (Federal Fiscal Year 2009 starts 10/1/08 and ends 9/30/09).*

COST PROJECTIONS OF DEMONSTRATION (SECTION 1115 or HIFA)	2009	2010	2011	2012	2013
Benefit Costs for Demonstration Population #1 (e.g., children)					
Insurance Payments					
Managed care per member/per month rate @ # of eligibles					
Fee for Service Average cost per enrollee in fee for service					
Total Benefit Costs for Waiver Population #1					

Benefit Costs for Demonstration Population #2

(e.g., parents)					
Insurance Payments					
Managed care per member/per month rate for managed care					
Fee for Service Average cost per enrollee in fee for service					
Total Benefit Costs for Waiver Population #2					

Benefit Costs for Demonstration Population #3 (e.g., pregnant women)					
Insurance Payments					
Managed care per member/per month rate for managed care					
Fee for Service Average cost per enrollee in fee for service					
Total Benefit Costs for Waiver Population #3					

Benefit Costs for Demonstration Population #4 (e.g., childless adults)					
Insurance Payments					
Managed care per member/per month rate for managed care					
Fee for Service Average cost per enrollee in fee for service					
Total Benefit Costs for Waiver Population #3					

Total Benefit Costs					
(Offsetting Beneficiary Cost Sharing Payments)					
Net Benefit Costs (Total Benefit Costs - Offsetting Beneficiary Cost Sharing Payments)					

Administration Costs					
Personnel					
General Administration					
Contractors/Brokers *(e.g., enrollment contractors)*					
Claims Processing					
Outreach/Marketing costs					
Other *(specify)*					
Total Administration Costs					
10% Administrative Cap (net benefit costs ÷ 9)					

Federal Title XXI Share					
State Share					

TOTAL COSTS OF DEMONSTRATION					

When was your budget last updated (please include month, day and year)? **[500]**

Please provide a description of any assumptions that are included in your calculations. **[7500]**

Other notes relevant to the budget: **[7500]**

SECTION VI: PROGRAM CHALLENGES AND ACCOMPLISHMENTS

1. For the reporting period, please provide an overview of your state's political and fiscal environment as it relates to health care for low income, uninsured children and families, and how this environment impacted CHIP. **[7500]**

   While the political environment continues to be favorable as it relates to increasing health care coverage for low income, uninsured children through CHIP and Medicaid, the fiscal environment in Louisiana has rapidly deteriorated However, in making both SFY 09 mid-year and SFY 10 provider rate cuts, the Administrative tried to minimize the impact on children. As an example, physician rates cuts are not applicable to primary care services for children under age 16. However budget constraints have deferred increasing coverage to 300% FPL which we have legislative authority to do or the new CHIPRA option to cover legal immigrant children.

   Governor Jindal's appointee to head the Department of Health & Hospitals (DHH) Secretary Levine, as well as DHH Undersecretary Charles Castille and Medicaid Director Jerry Phillips, want outreach to continue at a high level. The Administration authorized the Department to apply for a CHIPRA Outreach & Enrollment grant, with Governor Jindal providing a strong Letter of Support. We have not seen cuts in state funding for outreach.

   Secretary Levine is vocal in his support for the goal of not only enrolling all eligible children in public coverage but improving quality and access once they are enrolled through delivery system reform. This Administration has placed greater emphasis on quality than preceding Administrations.

2. During the reporting period, what has been the greatest challenge your program has experienced? **[7500]**

   A major challenge was (and continues to be) the hiring freeze, reduction in positions, and permanent loss of about 15% of our eligibility employees in the last 18 months. Our LaCHIP and Medicaid eligibility operation in Louisiana is more nimble than most as a result of our totally electronic financial eligibility case records which allow work to be remotely shifted throughout the state, paperless renewal processes, and a centralized call center, and streamlined processes like administrative renewals. The fact remains that it is challenging to maintain application processing times well under 10 days, continue proactive community outreach by eligibility staff throughout the state, and provide a high level of customer service in the face of the steady reduction in staff .

   Louisiana continues find the CPS numbers for uninsured children to be dramatically different from those produced by our state specific survey which is conducted by the LSU Policy Research Lab and has a much larger sample size. The result is that while our data shows 5.4% of Louisiana children without health insurance, CPS data released in August 2008 showed the State with 8.6% uninsured children and ranking 45 among all states. We believe that CPS data greatly overstates the number and percentage of uninsured children in the state. The reason this is challenging is that it makes it appear that will all the resources that have been invested in reducing the number of uninsured children in the last eleven years and the virtual elimination of procedural closures at renewal, we have only improved by three positions in state rankings.

3. During the reporting period, what accomplishments have been achieved in your program? **[7500]**

   Ultimately the goal is not to increase enrollment in SCHIP and Medicaid but to decrease the number and percentage of uninsured children in the state. The 2009 Louisiana Household Insurance Survey

(LHIS) showed that the percentage of low income uninsured children had decreased to 5.0% (from 5.4% in 2007).

Our separate state SCHIP program (LaCHIP Affordable Plan) which was implemented effective 6/1/08 continues to grow with almost 3,000 children now enrolled. These are children who would be uninsured if the program did not exist.

Louisiana eligibility caseworkers continued to close fewer than 1% of SCHIP children at renewal for procedural reasons (failure to complete renewal process, unable to locate). This impacts not only overall enrollment numbers but stability and continuity of coverage for eligible children.

We continued to fund ten local initiatives throughout the State to provide outreach and enrollment assistance through Louisiana Covering Kids & Families. The Robert Wood Johnson Foundation (RWJF) Covering Kids & Families model of funding organizations who then engage local stakeholders in regional coalitions has worked well in Louisiana.

The Department applied for and was awarded a CHIPRA Outreach and Enrollment grant in the amount or $955,681. The grant will increase our capacity to outreach Hispanic, rural, and cross-border populations through contracts with additional non-profit organizations.

The “blitz” model for outreach which originated in New Orleans in April of 2007 continues to be replicated throughout the state in all regions and/or parishes. An outreach blitz is a concentrated effort (for a day to a week) in a defined geographic area by eligibility staff and community partners to identify, inform, and enroll uninsured children into LaCHIP. In larger blitzes, eligibility staff from other geographic areas of the state participate. Thousands of applications in take-one holders are distributed, on-site applications and renewal assistance events are held, and earned media is generated. It is a highly effective way to increase visibility of the program and reach children who would otherwise remain unenrolled.

Louisiana is one of the eight states awarded a MaxEnroll grant (Robert Wood Johnson Foundation funded grants to improve enrollment in SCHIP and Medicaid which is administered by the National Academy for State Health Policy). Many hours were spent in preparing for and participating in an onsite diagnostic assessment intended to identify areas for possible improvement.

4. What changes have you made or are planning to make in your CHIP program during the next fiscal year? Please comment on why the changes are planned. **[7500]**

Louisiana intends to submit a State Plan Amendment to change the Medicaid delivery model (including Medicaid expansion SCHIP) from PCCM to MCOs and Enhanced PCCM networks. While actual implementation is not anticipated until January 2011, design and development will be a major focus. One of the primary reasons for the change is to improve quality of care for children.

Presumptive eligibility for children in SCHIP as well as Medicaid was unanimously approved by the legislature in 2007. The details for how this can be operationalized to accelerate enrollment and access to health care will be worked out through our MaxEnroll initiative and a CHIP State Plan Amendment submitted to CMS for approval. (The Medicaid SPA has already been approved).

The Hispanic population in Louisiana and particularly New Orleans is rapidly growing and through CHIPRA, even greater focus will be placed on identifying, informing, and enrolling eligible children through funding form the CHIPRA Outreach and Enrollment grant.

The basic format and style of the LaCHIP Application Form is now 11 years old. It has gone through many revisions and while it is simpler than pre-1998 it is still not “simple.” A major facelift and update to the application form is planned to further reduce the barrier that completion of the form as a condition of a child getting coverage presents.

We are pursuing Express Lane Eligibility enrollment in CHIP for children receiving or applying for Child Care Assistance, WIC, and Free and Reduced Lunch. All children identified using SNAP data will be enrolled in Medicaid rather than CHIP.

Enter any Narrative text below. **[7500]**

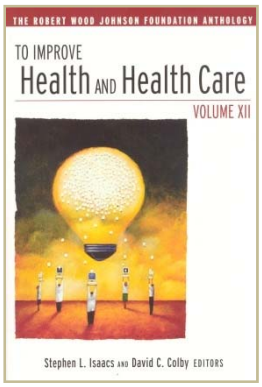
Enrolling Eligible People in Medicaid and the State Children's Health Insurance Program

Robert Wood Johnson Foundation

IRENE M. WIELAWSKI

Chapter Three, excerpted from the Robert Wood Johnson Foundation Anthology:

To Improve Health and Health Care, Volume XII



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Editors' Introduction

Although Congress has never been able to agree on legislation that would provide insurance coverage to all, or virtually all, Americans, it has been able to enact laws that provide piecemeal coverage. Medicare, passed in 1965, covers 44 million people over sixty-five and those of any age with disabilities.[1] Medicaid, also passed in 1965, covers the medical care of 59 million low-income people.[2] The State Children's Health Insurance Program (SCHIP), passed in 1997, covers 6 million children from low-income families.[3] SCHIP became something of a political football in 2007: it was extended in 2008 only after President George W. Bush vetoed two bipartisan bills to expand the program and after the Department of Health and Human Services had issued a regulation that made it difficult for states to raise eligibility limits.

Passage of a law making coverage available is not enough; six out of every ten uninsured children are eligible for Medicaid or SCHIP coverage but are not enrolled.[4] There are many reasons that individuals and families do not take advantage of health insurance benefits to which they are entitled. Probably the most common is that they are simply not aware that they or their children might be eligible. But even when families do recognize their eligibility and try to sign up, they face significant barriers. Forms are often long and complicated; eligibility requirements vary among programs and change frequently; documentation requirements can be onerous; legal immigrants face both language and cultural problems; and intake workers, concerned about fraud, can make the enrollment process difficult. Once enrolled, benefits last only for a limited period of time before eligible people have to go through the whole enrollment process again. Moreover, the greater the number of people enrolled in Medicaid and SCHIP, the greater the strain on state budgets, giving state governments an incentive to keep enrollment low, especially in hard economic times.

Since 1997, the Robert Wood Johnson Foundation has made substantial investments in a variety of programs to make families aware that their children might be eligible for SCHIP or Medicaid benefits and to address the practical obstacles to enrollment and renewal. In this chapter, the journalist Irene Wielawski, who is a frequent contributor to *The Robert Wood Johnson Foundation Anthology* series, examines the major Foundation-funded programs with this focus. Through her visits to two sites, she offers an on-the-ground look at the way different locales have worked to enroll eligible people and what the programs have and—not surprisingly, given the many practical challenges to enrollment—

have not accomplished.

The editors note with sadness the death in April of Sarah Schuptrine, the program director of the programs discussed in this chapter. We wish to recognize her many contributions to the field.

Notes

1. Centers for Medicare & Medicaid Services. *Data Compendium, Population*, 2007. (http://www.cms.hhs.gov/DataCompendium/17_2007_Data_Compendium.asp#TopOfPage)

2. Centers for Medicare & Medicaid Services: *MSIS Table FY 2004*, June 2007. (http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/msistables2004.pdf)

3. The Kaiser Commission on Medicaid and the Uninsured. "President's FY 2009 Budget and SCHIP." *Fact Sheet*, February 2008. (http://www.kff.org/medicaid/upload/7758.pdf)

4. Dorn, S. *Eligible but not Enrolled: How SCHIP Reauthorization Can Help*. Washington, D. C.: Urban Institute, September 2007.

Hey there," Angie Huval says brightly to the cashier as she bounds over to the deli counter at Guidroz's Food Center in Lafayette, Louisiana, to order *boudin*—a Cajun delicacy made of "dirty" spiced rice and fried pork innards stuffed in a loop of pig intestine. Huval, a serious foodie, wants details on Guidroz's recipe, and her curiosity gets the cook out from the kitchen, hooks the counterman, and draws several other customers into a discussion of seasoning and simmer time.

It's all in a day's work for Huval, who deploys her natural effervescence and gift of gab for serious purpose: finding poor and low-income families whose children qualify for Louisiana's combined Medicaid and State Children's Health Insurance Program, called LaCHIP.

Like a traveling saleswoman, Huval cultivates the relationships needed to get literature on LaCHIP and other state health programs prominently displayed among the businesses that ring Lafayette's low-income neighborhoods—family-owned markets like Guidroz's, convenience stores, gas stations, and luncheonettes. In the process, she adroitly extends her personal reach by converting store workers to the cause of getting this information into the hands of poor families.

"A lot of people here are related, and they know who the families are even if I don't, so I need them on my side," Huval says. "It's not just about getting people signed up; it's making sure the kids stay in the program. So when they're up for renewal and the phone's shut off or the mail gets returned, I've got people I can ask to find where those families are at so I can get the paperwork to them. The point is not to lose the kids."

In her attitude, no less than her hands-on proselytizing, Huval represents the leading edge of efforts across the United States to reach more than 6 million children eligible for government-sponsored health insurance but not enrolled.

The work, spanning more than a decade, utilizes a wide range of strategies to promote the benefits of health insurance and make it easier for families to sign up. It was significantly aided by three Robert Wood Johnson Foundation initiatives: the $43 million Covering Kids (1997–2001), the $65 million Covering Kids and Families (2001–2007), and the $5.9 million Supporting Families after Welfare Reform (2000–2004). Collectively, these programs reached into all fifty states and the District of Columbia, offering technical assistance to simplify enrollment as well as strategies to engage

community leaders, schools, businesses, churches, and civic groups in getting the word out to eligible families.

The result has been a dramatic shift in the attitude and function of government vis-à-vis needy citizens—a far cry from Medicaid's early days, when eligibility workers like Huval got more credit for denying benefits than for helping applicants clear procedural hurdles.

How states revitalized the Medicaid workforce while launching community-based ventures to build public trust and operational efficiency is worth examining as much for the stimulus of unforeseen events—an ill wind called Katrina, for instance—as for the incremental steps grantees took to make Medicaid and SCHIP more user friendly. The uneven road they traveled illustrates both the complexity of changing institutional mindsets and the creativity unleashed by doing so—lessons with applicability well beyond the health care sector.

How We Got Here

Almost from the day it was signed into law in 1965, Medicaid took heat for an unwelcoming attitude toward the very people Congress set out to help.

Critics compared the thick application packet used by most states to the Internal Revenue Service's onerous 1040 long form. Designed to weed out undeserving applicants and safeguard taxpayers' money, the application also discouraged eligible families who found the instructions confusing or didn't grasp the value of health insurance for their children. Michigan's program, for example, had a twenty-eight-page application that tiered eligibility in a way that left some family members insured, others not. If family income came in at or below 185 percent of the federal poverty level, pregnant women and babies qualified for coverage, but children ages one to fifteen didn't. The older children got in only if family income fell to 150 percent of poverty. Coverage for children sixteen to eighteen years old commenced at or below 100 percent of poverty.[1]

Proving eligibility was also daunting. States required many corroborating documents—birth certificates, pay stubs, utility bills, bank statements, residency proofs, and asset evidence such as car titles, deeds, and mortgage documents—as well as in-person interviews at government offices. The sometimes multiple visits needed to satisfy requirements deterred applicants who couldn't spare the

time from work, observers say. Treatment by state workers discouraged others.

"It was a you-go-get-it-and-bring-it-to-me system," said the late Sarah Shuptrine, former president of the Southern Institute on Children and Families in Columbia, South Carolina, and a long-time advocate for Medicaid reform, who led the Robert Wood Johnson Foundation's effort to change this situation.* "The eligibility worker just gave them a list of things they wanted—documentation, verification, and often a list of things that was more than the law required them to ask for. If the applicant couldn't find something, the worker had grounds to deny them for failure to comply. The system was biased in favor of denials, because eligibility workers were reviewed and rewarded for how many people they kept out. You were never asked how many people you helped get coverage." Another deterrent was a widespread public perception of Medicaid as a welfare program, even though Congress in 1986 opened it to working, low-income pregnant women and their children. Some working parents simply assumed that their children were ineligible. Others feared stigma and shunned Medicaid because they didn't want to be seen by their neighbors as charity cases. Still others worried that government officials would misuse the personal information required on Medicaid applications.

Lori Grubstein, a program officer at the Robert Wood Johnson Foundation, who has worked on Medicaid-related initiatives, said the wariness was justified. "There were some intentional efforts over the years by state governments to use the information on the application to push people off Medicaid in a low-budget year," she said.

All of these factors contribute to Medicaid-eligible children remaining uninsured and vulnerable to health consequences from delayed or inadequate care. Studies have shown that parents of uninsured children are slow to take them to the doctor because of cost concerns. Uninsured children also are less likely than insured children to have a regular doctor or dentist or place of care. Well-child visits and preventive care get short shrift, but in cases where parents repeatedly seek crisis care in hospital emergency rooms, overall costs to the health care system may actually be higher than the cost of Medicaid coverage.

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* Sarah Shuptrine died on August 18, 2008, after having been interviewed for this chapter.

Such analyses of both the human and systemic consequences of inadequate insurance coverage fueled national momentum in the early 1990s to overhaul the health care system. President Clinton devoted the first two years of his presidency to shepherding an ambitious universal insurance proposal. Its failure in 1994 fundamentally changed the conversation about ways and means to improve conditions for uninsured Americans. The wiser course politically became "incremental reform," through which existing sources of coverage such as employer-sponsored insurance, Medicaid, and the Medicare program could be adjusted to benefit more Americans.

With political emphasis shifting to incremental reform, the Foundation intensified its focus on improving access to existing public insurance and health assistance programs. In July 1997, the Foundation's board authorized a $13 million experiment to improve Medicaid enrollment in fifteen states; it was called Covering Kids: A National Health Access Initiative for Low-Income Uninsured Children. At the time, an estimated 10.6 million children in the United States lacked health insurance, of whom 5 million were believed to be eligible for Medicaid.[2]

With Covering Kids, the Foundation hoped to stimulate improvements in Medicaid outreach and administrative practices so that states could "max out," meaning enroll 100 percent of eligible children. The means to achieve this was through community-based coalitions made up of key government (including Medicaid) officials and community leaders and organizations. Specific strategies included making paperwork and proof of eligibility less onerous for applicants, accelerating the process of approval, and reducing the chances of children falling off the rolls solely for procedural reasons.

Congress and the Clinton administration were on a parallel track, honing in on better coverage for children as a means to redirect the political energy of health reformers. Their focus became children of the working poor, whose parents earned too much to qualify for Medicaid but not enough to buy private insurance. The proposed State Children's Health Insurance Program (SCHIP) shrewdly sidestepped the contentious issues that had undermined support for universal reform three years before, notably administration and cost. The mechanism to expand coverage—state Medicaid programs—was already in place, and children, studies showed, were relatively inexpensive to insure. The political strategy worked. Barely a month after the Foundation authorized Covering Kids, Congress passed SCHIP, tucking it into the Balanced Budget Act of 1997 with an allocation of $48

billion in new money for states over ten years. Like Medicaid and other health programs that are jointly funded by federal and state governments, SCHIP's federal share would be distributed through block grants. States could use it to expand Medicaid eligibility, to create an adjunct SCHIP insurance program, or to combine SCHIP insurance with Medicaid expansion.

Covering Kids was suddenly a very hot program. Medicaid officials scrambled to submit applications, hoping to garner ideas and expertise that would aid their states' rollouts of SCHIP. Foundation staff members scrambled in turn, hoping to reposition Covering Kids to take maximum advantage of the SCHIP platform. The program's scope was quickly deemed too modest, given SCHIP incentives to imbue coverage expansions with stigma-free, client-friendly features. A revised proposal was approved, swelling Covering Kids from a targeted $13 million experiment to a $44 million national investment covering all fifty states and the District of Columbia.

In May 2001, the Foundation continued Covering Kids through a $65 million successor program called Covering Kids & Families (2001–2007). The added emphasis on families aimed at taking advantage of new coverage options for low-income parents under Medicaid and SCHIP and at responding to research showing that when parents are insured, they're more likely to seek timely care for their children. Simultaneously, the Foundation authorized $5.9 million for Supporting Families after Welfare Reform to combat a national trend in which families moving from welfare to work automatically lost health insurance and other public benefits, even though some of them were still eligible.

Searching for Common Ground

The task of managing these gigantic, multistate programs—Covering Kids, Covering Kids & Families, and Supporting Families after Welfare Reform—fell to the Southern Institute on Children and Families. Shuptrine, its president at the time, became national program director for all three. Since in some way they all targeted Medicaid and SCHIP administrative processes, it seemed logical to group them under one roof.

"It was very, very important that we put Medicaid and SCHIP out there in a way that people could accept them without feeling ashamed," Shuptrine said. "We needed to open the door, reduce the barriers, get rid of the hoops that we were requiring them to jump through, and give them a chance

to come in."

But the leap from the conceptual to the practical was a big one. The administrative landscape that the Foundation sought to tame was kaleidoscopically diverse. Unlike Medicare, which covers everybody over age sixty-five and is administered according to a common set of federal rules, Medicaid eligibility and benefits vary from state to state and fluctuate from year to year, reflecting the myriad economic and sociopolitical forces that shape policy decisions at state and local levels of government. People can be eligible one year and, with no change in household income, lose benefits the next. A fifty-state jurisdiction for a program like Covering Kids translates into at least fifty different histories, health care delivery systems, population characteristics, and Medicaid benefit packages.

Despite these differences, there are many regional similarities. The New England states, for example, generally have low numbers of uninsured residents, high enrollment in public health and assistance programs, an easily accessible primary care and hospital infrastructure, relatively homogeneous populations, and liberal social policy, especially toward children. Deep Southern states, on the other hand, have extensive rural poverty, some of the nation's worst population health statistics, relatively low levels of employer-sponsored health insurance, and governments heavily focused on economic development as the means to improve living conditions. A similar bootstrap mentality underlies public policy in many Western states.

Yet even with such similarities, these were difficult programs to manage regionally. Unlike broad-brush policy initiatives, Covering Kids and its companion programs targeted the details of procedure and the demeanor of workers taking applications. This requires exhaustive knowledge of individual state systems in order to creditably address problems in procedure, forms, training, performance incentives, even office design. The Southern Institute's Covering Kids staff—all five of them—embraced a workload that included monitoring federal regulations, the rollout of new SCHIP programs, state Medicaid changes, and community outreach activities at 170 local sites.

"We didn't have the staffing that we got later with Covering Kids & Families," Nicole Ravenell, the Southern Institute's current president and CEO, said ruefully. Ravenell came on board in 2000 as deputy director for policy and research and, among other duties, worked to get Medicaid chiefs and

community leaders talking across state lines. The idea was to stimulate idea trading about common challenges, whether it was enrolling children of new immigrants, tracking homeless and other transient populations, or reaching families in isolated rural areas. "We quickly realized that, first, there isn't one single way of dealing with enrollment and retention problems, and second, that what worked in one area did not work in another."

Covering Kids and Covering Kids & Families required grantees to organize and work through coalitions that included state and local government representatives as well as leaders from relevant community organizations such as schools, churches, and civic groups. By structuring the initiatives in this fashion, the Foundation hoped to engage a broad cross section of knowledgeable people in each state who could cross-fertilize the public and private sectors with fresh ideas about how to bolster Medicaid and SCHIP enrollment. A subtler goal was to disrupt the age-old pattern of finger-pointing between government and private sector child welfare entities and build rapport for future collaboration.

"Covering the uninsured is a social issue and requires social change," said John Lumpkin, a Foundation senior vice president, who has grappled with problems of health care access from both sides, having served as state public health director in Illinois. "Our investment in the coalitions was part of initiating that social change."

In the process of working with the coalitions, which included state government representatives, the Robert Wood Johnson Foundation underwent a social change of its own and came to better understand the challenge of reorienting complex programs in the context of austere and often volatile state budgets. The insights, spurred notably by complaints from Supporting Families after Welfare Reform grantees about unrealistic Foundation expectations, led to significant changes in that program and helped foster better working relationships generally between Foundation and Southern Institute staff and state government partners. (Like Covering Kids and Covering Kids & Families, Supporting Families sought to improve administrative processes and retain people eligible for state aid.)

Supporting Families (the full name of the program was Supporting Families After Welfare Reform: Access to Medicaid, SCHIP and Food Stamps) focused on families moving from welfare to work as a

result of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, otherwise known as "welfare reform." In many states, these families were automatically losing Medicaid, SCHIP, and food stamps as soon as they left welfare, even though some were still eligible. To get benefits restored, the families had to reapply to each program. Some didn't, surveys showed, believing that their loss of health insurance or food stamps meant they no longer qualified. Halting such "procedural" denials required extensive administrative retooling and new links between social service and medical assistance agencies. Eight states and three large counties successfully applied for grants under Supporting Families to undertake this work, but they became disenchanted with what they considered unreasonable pressure to show coverage improvements quickly, especially in the harsh budgetary environment in which grantees worked after 2000, according to a midterm report of the program evaluator, Carolyn Needleman of Bryn Mawr College.[3]

"Extracting key facts from state administrative data—a step that everyone had assumed would be a fairly simple starting point—was actually a major undertaking in itself," Needleman wrote in her January 2003 report. "The National Program Office wanted very much to believe that it wasn't really that difficult after all, and continued to urge grantees to try harder and drill down into their data." Foundation staff members revised these assumptions as evidence mounted of both the difficulties of the task and the harsh budgetary environment in which grantees worked. Needleman recounted the experience of one grantee who got a phone call at a regional Supporting Families meeting in late 2002 to alert her to an unexpected $1 million cut in her agency's budget. Another grantee said she faced staff cuts as high as 40 percent because of the impact on state budgets of a growing national recession. In response, the Foundation dropped the goal of large-scale reform and refocused Supporting Families on laying the groundwork for incremental improvements in service to needy families. To this end, grantees were offered training in team-based learning and problem solving, using the model developed by the Institute for Healthcare Improvement of Cambridge, Massachusetts, to enhance medical care quality.

Turning the Supertanker

As the rocky course of Supporting Families illustrates, the job of retooling government administrative systems is neither quick nor easy. Nor is it solely a matter of having sufficient money and technical know-how. Fundamentally, the job requires an attitude shift that establishes children's health and well-being as a priority and then systematically organizes each unit in service of that mission.

Congress twice established the priority—in 1965 with Medicaid and in 1997 with SCHIP. Making that priority a reality has been the harder task, given constraints of budget, law, and the ever-shifting politics of charity in the United States. Public support for health coverage expansions is closely tied to the U.S. economy; polls typically measure strong support for health reform in prosperous times but not during periods of high unemployment, credit stress, and low consumer confidence.

In authorizing Covering Kids, Covering Kids & Families, and Supporting Families after Welfare Reform, the Foundation recognized these constraints but nevertheless sought to stimulate innovation in state administrative practices and capitalize on both SCHIP and the flush national economy of the latter 1990s to improve children's access to timely medical care. The Covering Kids request for proposals identified three goals for Medicaid agencies and their community partners:

- Improve outreach to find children eligible for public health insurance or other coverage
- Simplify the enrollment process
- Improve the coordination of programs so that children are comprehensively evaluated for eligibility and don't miss out on coverage simply because they applied to the wrong program.

The Foundation awarded grants ranging from $500,000 to $1 million to statewide coalitions in all fifty states and the District of Columbia, as well as to 172 coalitions in local communities. It also launched a $26 million communications campaign, beginning in 2000, to increase awareness of Medicaid and SCHIP among eligible families and encourage them to enroll their children. The effort included annual Back-to-School enrollment events and television, radio, and print advertisements to increase the number of people calling a federal hotline (1-877-KIDS-NOW) that connected them with eligibility offices in their states.

Covering Kids & Families, the successor to Covering Kids, continued the communications campaign, repeated the goals and broadened their scope to improve renewal procedures and include eligible adults. The Foundation awarded four-year grants averaging $830,000 to coalitions in all fifty states and the District of Columbia, and these, in turn, distributed half of their money to at least two local grantees, for a total of 173 local projects. In addition to continuing the work begun under Covering Kids, grantees also were asked to make sure that Medicaid and SCHIP patients had access to doctors, clinics, and other health care providers. The Foundation's initiatives weren't the only game in town, since many private organizations and government agencies had been similarly energized by SCHIP's

passage to pursue better coverage for children.

Among specific activities carried out by the states in collaboration with coalitions sponsored by Covering Kids and Covering Kids & Families were development of more appealing and readable program literature and a simplified application process. The latter includes the move by many states to combine Medicaid and SCHIP into a single application. The programs also tried to improve outreach, including decentralized and, in some states, online enrollment options that ease travel burdens on applicants and increase administrative efficiency, and reductions in the number of documents families must provide to prove their eligibility.[4] States have also worked to change the traditional "policing" mindset of staff via incentives that reward successful outreach, enrollment, and retention of health insurance coverage for eligible children.

A closer look at two very different states—New Hampshire and Louisiana—helps to show the many variables in play over the course of Covering Kids, Covering Kids & Families, and Supporting Families after Welfare Reform. Many of these variables—notably, shifting economic forces at the federal, state, and local levels—will continue to influence the process of reform.

New Hampshire

"GREAT HEALTH AND DENTAL BENEFITS FOR YOUR KIDS! LESS WORRY FOR YOU!" screams a headline on the red, white, and blue brochure for New Hampshire's combined Medicaid and SCHIP insurance program, called Healthy Kids. Inside are easy-to-read descriptions of medical and dental benefits, guidelines on how to apply, and eligibility requirements. The text is simply written, using encouraging, positive phrases and short declarative sentences. There's a small section titled "Why Is Health Insurance Important?" that talks about the expense of medical care, the importance of having a regular doctor, and the relationship between a child's health and school performance. Pictures of smiling children at the beach or showing off their new front teeth break up the type. Information phone numbers are listed as well as a Web site with easily downloaded application forms in English and Spanish. The application itself is eight pages, with instructions pegged to a fifth-grade reading level.

These are some of the visible changes in New Hampshire's public insurance programs for children, undertaken through a partnership between the state Department of Health and Human Services and

a community-based nonprofit organization called New Hampshire Healthy Kids. Healthy Kids, in turn, has developed partnerships with Anthem Blue Cross Blue Shield, the state's dominant private insurer; Northeast Delta Dental, a dental insurer; and hospitals, community health centers, physicians' offices, schools, and social service agencies to create a comprehensive health plan for children from low-income families.

The president and chief executive officer of Healthy Kids is Tricia Brooks. Her title reflects the business model New Hampshire has embraced to sell poor families on the benefit of insurance and overcome the stigma associated with government assistance. The approach, combined with eligibility expansions made possible by SCHIP, has contributed to coverage for more than 70,000 New Hampshire youngsters over the last decade, reducing the proportion of uninsured children in the state from 10 to 5 percent.

"We like the business model because we're essentially marketing a product," Brooks said. "Many families qualify for Healthy Kids Gold, which is free up to 185 percent of the federal poverty standard. But we also have a subsidized product called Healthy Kids Silver, which has a low premium and co-pays for families up to 300 percent, and a buy-in program for higher income families (between 300 and 400 percent of federal poverty). So we have to demonstrate the value of our product to our customers, which means our outreach workers have to operate like a sales force. We're counting on them not only to help with enrollment but also to work on building relationships of trust with our families."

How this customer service philosophy manifests itself varies from community to community. In the state capital, Concord, one step was relocating Healthy Kids' headquarters from offices that emphasized employee security to an attractive corporate building that offered a more businesslike ambiance.

"Our previous office had bulletproof glass that separated staff from applicants," Brooks said. "There also wasn't any way you could get to us from the lobby unless you were buzzed in. The message of that office was 'We don't trust you.' And yet that's exactly what we were asking them to do with us."

A very different kind of office awaits prospective families in the hard-up coastal town of Seabrook, an

hour's drive southeast of Healthy Kids' Concord headquarters. Here, clients climb a steep and narrow staircase to reach the cramped local office of SeaCare Health Services, a nonprofit medical access project for uninsured patients that works with Healthy Kids on outreach. If more than one person shows up, as on the day Kim Charland came in with her children, Alexis, fifteen, and Alex, ten, an application assistant named Karen Rowell quite literally has to climb over people in chairs to get around her desk. Yet the rundown nineteenth-century wood-framed building that houses her office, sandwiched between big box stores on commercial Lafayette Road, is a fitting place for Rowell's work. Locally known as the former Seabrook-Sanborn School, it is a fondly regarded landmark where generations of Seabrookers attended first through twelfth grade, including Rowell's father and grandmother.

The Charlands, owners of a small appliance business, typify the dilemma of low-income and some middle-income working families: lack of affordable private health insurance. Yet the Charlands did not think of themselves as people eligible for government aid and waited more than a year to apply for Healthy Kids.

"We had our own insurance ever since the kids were born, but then we had to close one of our stores and we couldn't keep it any longer because it was too expensive, $1,200 a month," Kim Charland said. "I never really thought about it that much—our children are basically healthy—but one day Alexis was practicing cheerleading handstands and fell over. She didn't tell us right away, because she wasn't supposed to be practicing on the driveway; it's concrete. But she didn't look too good when she came in, sort of pale, and when I asked if she was OK, she told me what happened and that she'd gotten the wind knocked out of her. I checked on her a few hours later in her room and she looked really bad and said her side hurt. I took her to the emergency room and the next thing she was in intensive care with a ruptured spleen. She was in there for five days, then home on bed rest with an attendant for one month. The bill was $17,000. Thank goodness we still had our insurace, but they took it away a couple of months later because we couldn't keep up the payments."

The experience, Charland said, left her a "nervous wreck," because she "realized what could happen." One day she confided her fears to Mary MacInness, a school nurse at Seabrook Middle School and one of Rowell's many community contacts. MacInness handed Charland a Healthy Kids brochure, but Charland didn't immediately follow up.

"I never really asked the state for anything, and it was really hard," she said. "We have only two employees at the store and everyone wants health insurance but, geez, we can't give them that—we can't even afford it for ourselves!" Charland's fears of the financial consequences of another random accident like Alexis's overcame her hesitancy, but it was another few months, she said, before she could convince her husband.

Unlike some states where computerized data and Internet links between agencies have reduced duplicative paperwork, New Hampshire's government records remain largely paper-based, with each social welfare agency maintaining its own client files. Applicants for Healthy Kids have a big job assembling birth certificates, Social Security cards, paycheck stubs, tax returns, immunization records, utility bills, and so on. Any irregularity can cause delay. The Charlands' application, for example, was held up because the obstetrician had forgotten to sign Alexis's birth certificate fifteen years before. "I had the original and it had her footprints on it and everything, but they wouldn't accept it without a signature," Charland said. "So my husband had to drive down to Gloucester, Massachusetts, where she was born, and get a verified copy from City Hall."

Rowell helps applicants fill out the forms and assemble required proofs of eligibility. The Charlands were unusually well-organized compared with most of her clients. "It's very rare that our families have their birth certificates," Rowell said. "If they don't, we'll write a letter for them, help them get it notarized, and send it to the town where the child was born. Otherwise they'd just say, 'Oh, forget it, I can't do this.'" Poor reading and writing skills underlie some of the reluctance, program officials say. Other applicants are ashamed and worry about disapproval from friends, relatives, and employers.

Seabrook's relative poverty shows up in student body statistics at Seabrook Elementary and Middle School. Of 900 students in pre-kindergarten through eighth grade, one-third qualify for Healthy Kids, one-third have private insurance, and the rest have no insurance, according to MacInness, the school nurse responsible for elementary-age youngsters. Her colleague, Helen Cataford, who's in charge of the older, middle school students, noted that roughly 40 percent of the students at the school qualify for federally funded free or reduced-cost lunch. Broader economic indicators are consistent; unemployment in Seabrook is more than twice the statewide average.

Such statistical measures of poverty translate medically into long waits at the three local hospital emergency rooms—two in New Hampshire and one just across the border in Massachusetts. There's only one pediatric practice in Seabrook, and those in adjoining towns are crowded, even for patients with insurance. Some uninsured families get around the cost of a doctor or an emergency room visit by sending sick children to school with the instruction to "go down and see Mrs. Mac," according to MacInness. Alternatively, they will take them to the Seabrook fire station, which has paramedics on duty twenty-four hours a day.

MacInness and Cataford have tried in ad-hoc fashion to fill in the health care gaps. For example, MacInness joined the local Lions Club so that she could have an inside track on the international civic group's vaunted free eyeglasses program. She and Cataford also are well known at the local WalMart and Sam's Club outlets because of the retailers' charitable optometric exam and eyeglasses programs. But dealing with disparate charity programs is neither efficient nor reliable, necessitating many phone calls and much time spent coaching parents on how to apply.

"If I have to figure out who to call, where to get the information, wait for the return call, then try to reach the parents—well, I just don't have the time," Cataford said. Moreover, the local WalMart and Sam's Club, which each used to provide thirty free eye exams and glasses annually to children at Seabrook Elementary and Middle School, recently cut their programs, as did the Lions Club. The nurses, therefore, are as grateful for their link to Rowell as she is for their help with Healthy Kids outreach, affirming the win-win business model advocated by CEO Brooks—and the Foundation's strategy of moving public health insurance programs into the mainstream of community life.

Louisiana

Much of New Orleans' once-teeming Lower Ninth ward is a weed lot today, many of its homes swept away by the storm surge that collapsed the levees during Hurricane Katrina in August 2005. Often, the only visible signs of what used to be are rows of cement slab foundations alongside the rubble of what once were streets.

Derrick Edmond, a community health care worker, regularly visits these desolate acres to remind himself of the importance of finding poor children eligible for Louisiana's combined Medicaid and

SCHIP program, called LaCHIP.

"I used to ride my bike over here after school to visit friends," Edmond said as he walked through the underbrush. "The hurricane wiped out a whole way of life—you don't even know where the people are now. We've estimated that 66,000 kids lost their Medicaid coverage due to Katrina and the evacuations, and we know some have come back. But you don't necessarily know where they are and which ones came back and who's gone for good, so you have to start all over at the places where you can find them—the schools, the laundromats, Chuck E. Cheese, local -markets."

Edmond works for the nonprofit organization Agenda for Children, which collaborated with the state Department of Health and Hospitals on efforts to improve LaCHIP enrollment. The Foundation's Covering Kids and Covering Kids & Families programs aided ongoing reforms in Louisiana's Medicaid program to double the number of low-income Louisiana children with insurance. Relative to other states, Louisiana also advanced during this period from the nation's fifth highest to the tenth lowest in percentage of uninsured children in families below 200 percent of the federal poverty standard.[5]

The devastating one-two punch of Hurricane Katrina and Hurricane Rita in 2005 killed more than 1,800 people, erased neighborhoods, caused economic losses estimated at more than $80 billion, and upended business as usual throughout Louisiana. In New Orleans, the main source of medical care for the poor, 2,680-bed Charity Hospital, was wrecked and remains closed today. State offices were destroyed, records were lost, and personnel were scattered.

But the disaster also spurred Louisiana's Medicaid agency to turn wreckage into opportunity and leapfrog one of the nation's poorest states into twenty-first-century health systems management.

The Medicaid agency is a division of the Department of Health and Hospitals. It had already been considering ways to make its public insurance programs more appealing when the Foundation's initiatives got under way. In addition to LaCHIP, these include LaMOMS, which covers prenatal, lab, and delivery services for pregnant women, and Take Charge, which covers family planning services. Leading this internal reform effort—and point person on Louisiana's Covering Kids and Covering Kids & Families grants—is LaCHIP Director Ruth Kennedy, who is also deputy director of

Medicaid in Louisiana.

Kennedy did not need to be enlightened about the need for better outreach to overcome enrollment deficits. She knew the problems first hand, having started her career in Louisiana Medicaid as an eligibility worker. It was July 1980, and Kennedy was fresh out of college.

"We were told we were not social workers," she recalled. "There was a toughness to it. You were more like an investigator, and your supervisors valued you for how many cases you closed." This never sat well with Kennedy, and in every new position she looked for ways to improve the agency's relationship with poor families. "The question was how to redirect the energy to keeping people enrolled," she said. "We shouldn't want to close a child who is financially eligible for the program just because of actions of parents who fail to return paperwork."

Participating in Covering Kids and Covering Kids & Families gave her staff access to "tremendous technical assistance," Kennedy said, as well as opportunities at conferences to hear from leading thinkers and to network with counterparts in other states. Program-wide strategies, such as creating a universal application to cover multiple aid programs, also were helpful, as was a communications consultant who helped her agency fine-tune press conference technique and move beyond billboard ads and other static messages to more effectively promote LaCHIP.

But Kennedy's deepest bow acknowledges what the Robert Wood Johnson Foundation did not do: micromanage. The grant requirements and the Southern Institute's direction were loose enough to let states work through the nitty-gritty of reform in their own ways. Said Kennedy: "I was leary of depending on external sources of funding, because it is my experience that when the grants go away, the program goes away. So we were pleased that the leadership fundamentally realized the importance of state CHIP and Medicaid programs as the foundation of outreach."

In contrast to New Hampshire, whose history of collaboration between state and private sector agencies dovetailed neatly with the Foundation's coalition approach, Louisiana largely looked to its state workforce for outreach innovation. Angie Huval's method of chatting up *boudin* in order to forge a link to uninsured families shopping at Guidroz's market was multiplied and revised many times over by eligibility staff members working out of forty-five local Medicaid offices, according to

Kennedy. Structurally, that meant relaxing the administrative hierarchy typical of government agencies.

"The attitude is always that caseworkers have too much to do and therefore are not capable of creative thinking," Kennedy said. "Believe me, my caseworkers have a heavy workload, 1,100 to 1,200 cases each. But we had no money for new outreach people, so I told my eligibility workers to set up a committee and develop an outreach plan. They came up with far more than I ever imagined, and in the ten years we've been working on this, they have never ceased to exceed our expectations."

Among the ideas was better use of the Internet so that eligibility workers could verify income, citizenship, immunization records, and other qualifying criteria electronically. This would make it possible to decentralize outreach operations even further. Instead of merely talking up LaCHIP and passing out promotional literature, eligibility workers could take their laptops to schools, health fairs, and other convenient locales, download applications, and enroll families on the spot.

The idea got support at the highest level of the Health and Hospitals Department. Indeed, Roxane Townsend, then the department's Medicaid medical director and later its chief, had already been exploring the possibility of moving Medicaid operations from paper to virtual, with links to other aid programs to eliminate duplicative effort. For example, families who had already been found eligible for, say, food stamps could be exempted from supplying identical income proofs to LaCHIP. Vital records could verify citizenship. And the quarterly wage information filed by employers with the state Labor Department could be used to back-check income declarations of new applicants.

Conceptual work segued to action in May 2005. Medicaid clerical staff undertook the tedious work of scanning documents into the agency's newly designed electronic database. Kennedy, a skeptic at the time, recalled, "I was not optimistic that we would be able to pull this off, but I didn't have the heart to say anything. We had employees whose sole job was pulling files. It was a staggering amount of work."

The Medicaid pilot project became part of a broader health information technology summit in July 2005. "We had everyone in the room for a day-long event, and it was a really productive meeting with lots of great ideas kicked around," Townsend recalled. Among them were how to link public

databases like Medicaid's with hospital and physician office records so as to begin to address medical care quality in line with emerging federal mandates. "We were supposed to have a follow-up meeting in September," Townsend said. "But, needless to say, we never did. Katrina took care of that."

The New Orleans Medicaid office, located in the low-lying suburb of Metairie, was inundated by ten feet of water. "We had loads of paper files in there, and everything was ruined," Kennedy said. "Even after the water receded, you could barely read them, the mildew was that bad. But we had them all scanned already. Now, we're building replacement offices that don't even have a file room—that's how electronic we are now."

Louisiana today relies for the majority of eligibility proofs on so-called ex-parte review—confirming information through other sources than the applicant. Through electronic links to state and federal databases, eligibility workers can confirm citizenship, household composition, Louisiana residency, children's ages, vaccine records, child support and wage income, and participation in other programs with comparable eligibility standards such as food stamps, federal Supplemental Security Income, and Temporary Assistance for Needy Families (TANF, the program that succeeded welfare in 1996). To speed coverage approval, enrollment and reenrollment standards have been relaxed to accept eligibility workers' "reasonable certainty" that the applicant qualifies. These measures, combined with sleuthlike tracking of families who have changed addresses or phone numbers, reduced the rate of procedural case closures—shorthand for children dropped from coverage because of a paperwork glitch—from 28 percent in 2001 to 1 percent in 2007.

"I'd hoped to get it to 10 percent," Kennedy said. "I never dreamed we'd get it to 1 percent."

Conclusion

Cementing these gains will be the harder challenge. The celebratory mood at Covering Kids & Families' wrap-up gatherings in mid-2007 darkened as SCHIP's reauthorization ran into trouble. Advocates expected easy renewal and expansion of eligibility criteria. Instead, Congress and the administration were at loggerheads, with every bill to expand SCHIP meeting a presidential veto. An intensive lobbying campaign to push for congressional override drew advocates from around the country. Ruth Kennedy flew to Washington in early December to participate in an informational Web cast sponsored by the National Academy for State Health Policy.

Kennedy's role was to narrate a series of slides showing Louisiana's progress under SCHIP, including a reduction in the proportion of uninsured poor children from 31.6 percent to 12.5 percent, and enrollment momentum that by 2007 had built to more than 1,000 new children a month. Kennedy expressed worries that the Bush administration's proposal to hold SCHIP funding to current levels would undermine Louisiana's progress.

"We are very reluctant to make that move to cease and desist outreach because we know how hard it is to get that momentum going," she said.

Yet that is the state of things today. Congress's third override attempt failed in January 2008, in a week that saw the stock market plunge more than four hundred points on fears of global recession. SCHIP was reauthorized—through March 2009—but with funding sufficient only for currently enrolled children.

However painful this political result may be for Medicaid officials and citizen activists who participated in Covering Kids, Covering Kids & Families, and Supporting Families after Welfare Reform, it's neither surprising nor fatal, despite the hot rhetoric of last December's reauthorization fight. Social welfare programs have always had to contend with larger political and economic forces. And just as these forces favored health insurance expansion for children, spawning SCHIP in the late 1990s, so they combined to restrain SCHIP growth a decade later. There's no question that a protracted economic downturn will increase the number of uninsured children from historic lows achieved by states such as Louisiana and New Hampshire. But this is not the sole measure of the last decade's achievement.

The federal government's $48 billion investment in SCHIP and philanthropic contributions through programs like Covering Kids, Covering Kids & Families, and Supporting Families after Welfare Reform have enabled states to put in place a culture favoring enrollment over disqualification. This is a huge social change, and not one easily undone by recession. Ruth Kennedy's personal dismay at the health consequences for children whose parents messed up paperwork has become the social norm. The degree to which states can act to safeguard children fluctuates with their budgets. But the foundation laid by retooling the mission of public health insurance programs to one of proactive

assistance makes it more likely that fiscally driven retrenchments will be transient.

The last decade saw measurable progress in children's access to health care in the United States, partly as a result of better coverage. The proportion of uninsured children dropped from 14 percent to 11.7 percent, the health status of low-income children with chronic conditions improved, and racial and ethnic disparities in access moderated.[6]

Covering Kids, Covering Kids and Families and Supporting Families after Welfare Reform contributed to these gains by helping states and local communities improve outreach and simplify administrative procedures. While cautious about attributing cause and effect numerical results to these strategies because of the many factors influencing enrollment, evaluators said that grantees were overwhelmingly positive in their assessments of the utility of specific program goals, such as coordination of Medicaid and SCHIP applications and simplified enrollment procedures. Covering Kids and Covering Kids & Families grantees also responded favorably to the state and local coalitions approach as a means to build constructive partnerships between government administrators of Medicaid and SCHIP and community organizations with closer ties to eligible families. At the same time, the trio of evaluators of Covering Kids & Families—Mathematica Policy Research, Health Management Associates, and the Urban Institute—noted the discouraging influence of economic downturn on outreach and enrollment, citing the example of the 2001–2003 recession in California. The state cut the budget for statewide media announcements, eliminated its training program for application assistants, and stopped paying for application assistance at schools and community organizations. "These cuts seem to have blunted enrollment growth," wrote Judith Wooldridge of Mathematica in a February 2007 evaluation report.[7]

Table 3.1. Percentage Change in Uninsured Children by State, 1997–1999 and 2004–2006

Uninsured Children	1997–1999* (%)	2004–2006**(%)	% change
Alabama	9.6	4	-5.6
Alaska	8.3	4.9	-3.4
Arizona	19	11.6	-7.4
Arkansas	14.7	6.2	-8.5
California	12.8	8.2	-4.6
Colorado	7.8	9.3	1.5
Connecticut	5.9	3.3	-2.6
Delaware	8.9	6.6	-2.3
D.C.	11.1	5.2	-5.9
Florida	12.2	10.7	-1.5
Georgia	10.7	8.2	-2.5
Hawaii	5	2.2	-2.8
Idaho	13.5	6.3	-7.2
Illinois	8.1	6.4	-1.7
Indiana	7.5	4.8	-2.7
Iowa	5.4	3.4	-2
Kansas	7	4.6	-2.4
Kentucky	9.8	5.8	-4
Louisiana	15.5	7.4	-8.1
Maine	6.3	3.6	-2.7
Maryland	7.1	5.2	-1.9
Massachusetts	4.4	2.8	-1.6
Michigan	5.5	3.3	-2.2
Minnesota	4.4	3.9	-0.5
Mississippi	14.1	10.9	-3.2
Missouri	5.2	5.4	0.2
Montana	12.8	9.5	-3.3
Nebraska	4.6	4.8	0.2
Nevada	14.1	9.5	-4.6

New Hampshire	3.1	2.6	-0.5
New Jersey	6.2	5.3	-0.9
New Mexico	15.9	11.6	-4.3
New York	9	4.8	-4.2
North Carolina	10.2	7.7	-2.5
North Dakota	10.6	6.5	-4.1
Ohio	5.8	4.5	-1.3
Oklahoma	10.6	8.4	-2.2
Oregon	8.5	7.6	-0.9
Pennsylvania	4.5	5.3	0.8
Rhode Island	4.8	3.2	-1.6
South Carolina	12.3	5.7	-6.6
South Dakota	6.1	4.9	-1.2
Tennessee	4.9	5.4	0.5
Texas	17.4	14	-3.4
Utah	6.6	7.4	0.8
Vermont	2.8	2	-0.8
Virginia	7.6	5.3	-2.3
Washington	4.2	3.6	-0.6
West Virginia	8.1	4.8	-3.3
Wisconsin	4.4	3.5	-0.9
Wyoming	8.7	4.2	-4.5

*U.S. Census Bureau, Housing and Household Economic Statistics Division. Low Income Uninsured Children by State, December 7, 2004.

**U.S. Census Bureau. Current Population Survey, 2005, 2006, and 2007 Annual Social and Economic Supplements, 2008.

In an evaluation survey of sixty-five state officials representing Covering Kids & Families activities in forty-six states, sixty-one of the respondents said the programs had influenced state policies and procedures and that half of them would not have occurred without the programs.[8] Procedural reforms in Medicaid and SCHIP promoted by the Robert Wood Johnson Foundation's initiatives included the following:

- Elimination in virtually all states of the requirement of face-to-face interviews for enrollment or renewal
- Elimination in most states of the asset test for eligibility
- A combined Medicaid and SCHIP application adopted by thirty-three states
- Coverage for children under age nineteen expanded to at least 200 percent of federal poverty in forty-one states
- Most states also have simplified program documents and literature to make their Medicaid and SCHIP programs more visible and accessible. Covering Kids & Families played a role by sponsoring workshops, bringing in design experts, and commissioning a guidebook, *The Health Literacy Style Manual,* which describes how to design brochures, create appealing logos, simplify prose, select easy-to-read typeface, and convert intimidating documents into friendly invitations.

Sexy? Hardly. But in the survey of state officials by the evaluators of Covering Kids & Families, the majority credited this sort of technical assistance with helping them fine-tune enrollment and retention processes, coordinate benefits, invigorate outreach, and improve policy. Moreover, the respondents characterized nearly two-thirds of these changes as permanent.[9]

That in itself speaks to the attitude shift at the heart of Covering Kids, Covering Kids & Families, and Supporting Families after Welfare Reform. *Permanent* is not a word you hear often from state officials; the culture of government work tends to discourage predictions beyond the current political administration. The greatest expression of this bolder outlook in Medicaid and SCHIP is found among the outreach workers that New Hampshire's Tricia Brooks called her "sales force" and Louisiana's Ruth Kennedy described as "my incredibly dedicated eligibility staff." No longer deskbound, this mostly young workforce seems to thrive on the freedom to innovate, pinched budgets notwithstanding.

No money for consultants? That didn't stop New Hampshire's April Purinton from making friends

with a computer savvy co-worker so that she could program Microsoft Access to track her applicants. Nor did it keep Trene Jenkins from buttonholing strangers in New Orleans' public libraries to ask for feedback on the ease of using LaCHIP's online application, which went live at the end of 2007.

As for Angie Huval, it's hard to imagine a bureaucracy capable of holding her back. The young woman who washed out of her first career as a prison guard because she was too chatty with the inmates is having the time of her life promoting LaCHIP.

"It's not that I don't take my work seriously," Huval said. "It really kills me if my supervisor finds one of my families that I didn't track down first. But I was just a watchdog in that guard job. This one lets me be a compassionate being."

Notes

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Maximizing Enrollment in Louisiana: Results from a Diagnostic Assessment of the State's Enrollment and Retention Systems for Kids

Prepublication Copy

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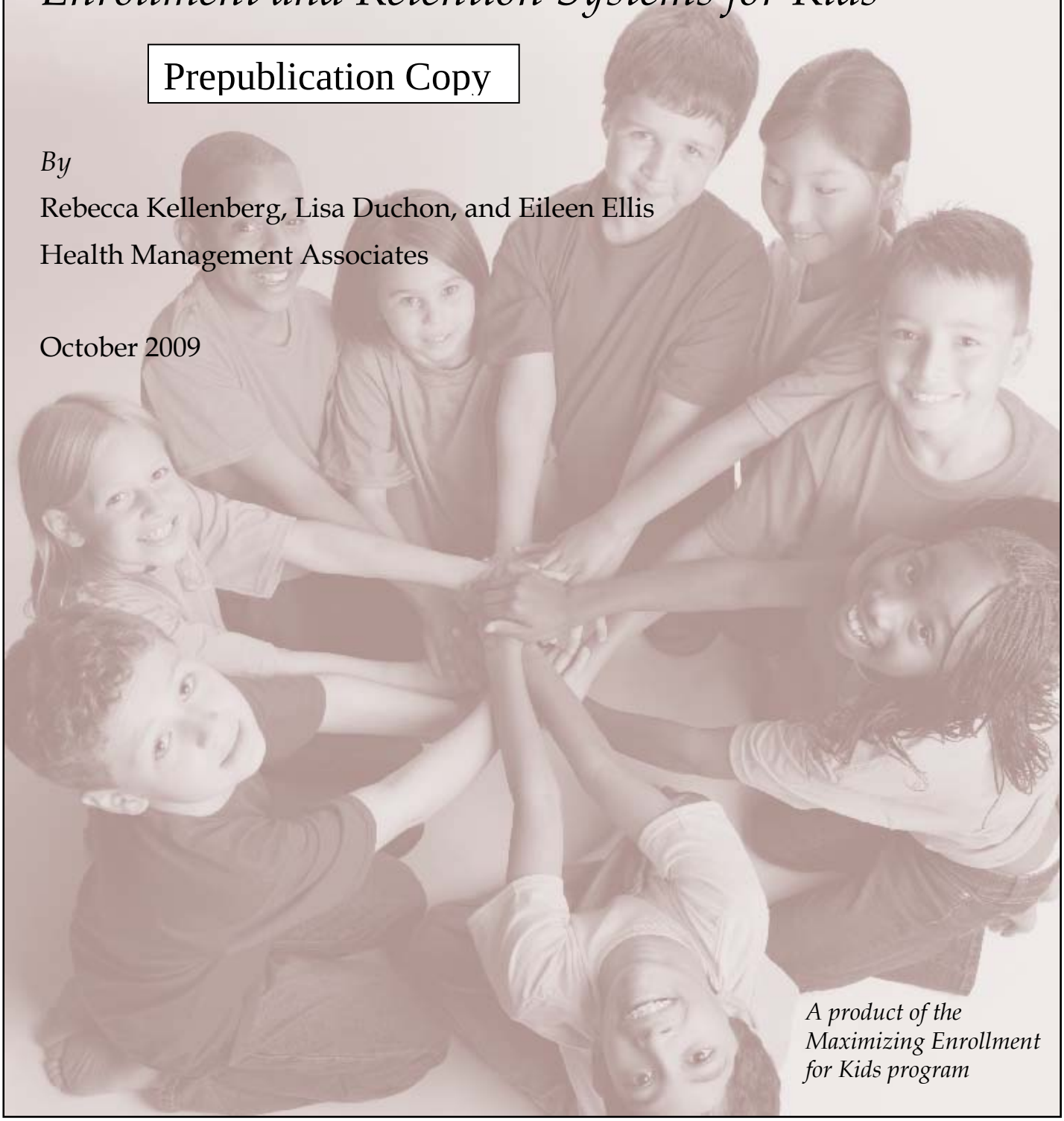

A product of the Maximizing Enrollment for Kids program

This report is a product of the Maximizing Enrollment for Kids program, a $15 million initiative of the Robert Wood Johnson Foundation (RWJF) to increase enrollment and retention of children who are eligible for public health coverage programs like Medicaid and the Children's Health Insurance Program (CHIP) but not enrolled. Under the direction of the National Academy for State Health Policy (NASHP), which serves as the national program office, Maximizing Enrollment for Kids aims to help states improve their systems, policies and procedures to increase the proportion of eligible children enrolled and retained in these programs.

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Executive Summary

In February 2009, Louisiana was selected as one of eight grantees of the Robert Wood Johnson Foundation's (RWJF) Maximizing Enrollment for Kids Program, with the goal of helping states to improve the enrollment and retention of eligible children in Medicaid and the Children's Health Insurance Program (CHIP). In the first year, the National Academy for State Health Policy (NASHP), which is serving as the National Program Office on behalf of the RWJF, collaborated with Health Management Associates (HMA) to conduct a baseline assessment of each state's systems, policies, and processes for enrolling and retaining children in coverage. The assessment of each state included reviewing state's reports and policies, conducting onsite interviews with stakeholders and administrators in children's health insurance programs, and reviewing published research about the impact of policies on coverage. This report synthesizes the information gathered, distilling the state's current strengths, challenges, and opportunities for improvements in Louisiana's enrollment and retention of eligible children.

Findings

Despite recent natural disasters and a Southern-state demography known for high rates of uninsured, 95 percent of Louisiana children have health insurance.[1] Louisiana's LaCHIP program (a combination Medicaid and CHIP program) has become a national model of innovation in eligibility operations and policy and for long-term investments in technological solutions.

Based on a review of materials provided by Louisiana, information gathered through site visit interviews, and best practices across the states, the following themes emerged as significant for Louisiana:

- *Louisiana has leveraged both technological and policy solutions to create customer-oriented, simplified enrollment and renewal processes*. Louisiana's Department of Health and Hospitals (DHH) implemented a collection of technologies to support the eligibility determination process including an electronic case record (ECR) and the Medicaid Eligibility Determination System (MEDS).
    - The ECR has improved processes by:
        - Allowing workers to move eligibility determination out of the office to where eligible children live,
        - Allowing managers to redistribute workload, and
        - Assuring process integrity by mitigating lost applications and case records.
    - MEDS supports eligibility by:
        - Matching applicant information in the Food Stamps program (recently renamed by the U.S. Department of Agriculture as Supplemental Nutrition Assistance Program, or SNAP) and other data sources to remove documentation burden on families, and

[1] 2007 data from the Louisiana Health Insurance Survey, a 10,000 household survey conducted by Louisiana State University.

    - Facilitating implementation of numerous simplification policies such as the 97 percent "reasonable certainty" policy for verifying reported income and administrative and ex parte renewals, which places the burden on workers, rather than families, to prove eligibility. As a result, most cases can be handled faster and with fewer families dropping out of the process, compared to results before these policy changes were in place.

- *An integrated culture of and sustained commitment to continuous quality improvement has helped Louisiana repeatedly simplify the steps families and workers follow in enrolling and renewing coverage*. Developed and refined over a 10 year period, LaCHIP staff applies management science principles to identify potential eligibility simplification processes and then conducts small-scale testing and rigorous analysis before adopting policies and disseminating practices that improve operational efficiencies while maintaining acceptable accuracy rates. Employees are encouraged to participate in the identification of areas in need of further improvement.
- *Louisiana has made children's health insurance programs and their management seamless, reducing complexity for families and aligning workers under a single set of goals.* All children eligible for public insurance, whether Medicaid or CHIP, apply through a single application process branded as LaCHIP. Eligibility workers then place eligible children in the appropriate program. All eligibility workers are state employees who report directly to DHH, which has facilitated the agency's ability to hold workers accountable through management reporting of quality metrics, such as procedural denial and closure rates. Managers evaluate and reward staff based on performance measures that support its mission of enrolling and retaining all children eligible for LaCHIP.
- *Consistent bipartisan commitment to covering children has been a contributing factor in supporting Louisiana's Department of Health and Human Services (DHH) eligibility innovations over the years*. Both the administration and legislature are supportive of children's insurance coverage and LaCHIP, giving DHH administrators wide flexibility in program operations. There have been no roll-backs in eligibility since LaCHIP was implemented.

The assessment identified some challenges in the current program policies and procedures:

- *Remaining pockets of uninsured children throughout the state will require targeted strategies to find and enroll*. Engaging the families of remaining uninsured children will involve partnerships with neighborhood and community leaders connected to specific populations, such as children who are living with kin without legal guardian status, teens who drop out of high school, Vietnamese and Hispanic families, and children released from the Office of Juvenile Justice.
- *Interagency collaborations are in their early stages, and may not progress without leadership and/or funding*. DHH has identified outreach, enrollment, and data matching opportunities but is making slow progress due to conflicting priorities.

Even with its very notable successes, Louisiana still has opportunities for improvement in policies and processes that will increase the number of eligible children enrolled and retained in Medicaid and LaCHIP. The following strategies may have the greatest payoff:

- Tailor outreach and application assistance to hard-to-reach populations, which include children between ages six and 19, predominately African American and Hispanic children, children living with kin who are not legal guardians, and high school drop-outs.

- Increase the number of eligible children who apply for LaCHIP by working in targeted communities to identify children who are eligible but not enrolled.
- Direct community outreach and marketing efforts to more fully utilize available resources.
- Continue to strengthen and reinforce its customer-oriented organizational culture.
- Consider using Charity Hospitals and other providers to perform Presumptive Eligibility (PE) Determinations once the PE policy is in place.

Introduction

As many as five million children in the United States may be eligible for but not enrolled in Medicaid or CHIP programs in their state and a third are estimated to have been covered in the last two years. Maximizing Enrollment for Kids, a national program of the Robert Wood Johnson Foundation (RWJF), aims to address these problems by helping states improve the identification, enrollment and retention of eligible children. Directed by the National Academy for State Health Policy (NASHP), Maximizing Enrollment for Kids is a $15 million initiative that RWJF launched in June 2008. In support of enrollment and retention goals, the initiative also aims to establish and promote best practices among states.

To achieve these goals, the program includes:

- A standardized diagnostic assessment of participating states' enrollment and retention systems, policies and procedures;
- Individualized technical assistance to help states develop and implement plans to increase enrollment and retention of eligible children, consistent with the findings of the assessment, and to measure their progress; and
- Participation in peer-to-peer exchange to share information regarding challenges and discuss solutions and effective strategies with other states.

Through a competitive application process, eight states were selected to receive four-year grants of up to $1 million to participate in the program: Alabama, Illinois, Louisiana, Massachusetts, New York, Virginia, and Wisconsin. This paper reports on the diagnostic assessment of Louisiana.

The economic and political environment at the time of this assessment (March - June 2009) provides important context for understanding the status of children's health insurance programs and the opportunities emphasized in this report. During the development of the assessment protocol in late 2008 and throughout the spring of 2009, the United States was in a deep recession with high unemployment leading to a greater demand for public health insurance coverage. State budgets were greatly depressed, two-thirds of states were facing budget shortfalls, and the outlook was for worse shortfalls for about the next three years. There was an enormous tension in most states about how to maintain access to insurance and still balance the budget.

In early 2009, Congress passed the American Recovery and Reinvestment Act (ARRA) to help buffer the impact of the recession on individuals and states. Medicaid relief for 2009 was included, contingent upon states not reducing Medicaid eligibility levels from 2008 levels. About the same time, Congress passed the Children's Health Insurance Program Reauthorization Act (CHIPRA), a law continuing the Children's Health Insurance Program (CHIP). It expanded funding to states that meet enrollment and retention performance incentives. The tension of the recession and the opportunities to obtain new funding for simplifications and expansions serve as a backdrop for state assessments.

Methodology

NASHP has partnered with Health Management Associates (HMA) to complete the Diagnostic Assessment phase of the program. In consultation with NASHP, HMA designed and administered a set of data collection and interview protocols to complete an assessment of the strengths, weaknesses and potential opportunities associated with each participating state's enrollment and retention systems, policies and procedures and external environment.

The diagnostic assessment centers on six areas:

- Enrollment and Renewal Simplification and Retention Policies
- Coordination between Medicaid and CHIP and Other State Agencies
- Analytic Capacity for Program Management and Decision-making
- Client-centered Organizational Culture
- Non-governmental Partnerships and Outreach
- State Leadership

In March 2009, information was collected from each state in advance of onsite interviews. Each state provided annual or progress reports on Medicaid and CHIP; trend data on program enrollment and disenrollment, and the number of uninsured children; policy and procedure manuals related to enrollment and renewal; process flow charts for enrollment and renewal; interagency agreements that would affect enrollment and renewal, such as with a sister agency that conducts intake interviews; and contracts with third party vendors who handle enrollment, retention, or a call center.

Each state was then asked to fill out a 20-page questionnaire that requested states to describe key components of its enrollment and renewal practices and outcomes. The questionnaire addressed the six themes identified above.

Based on the findings from the pre-site visit materials and questionnaire, an interview guide was developed to be used during a two day site visit in each state. During the visit to each state, interviews included state program staff as well as people outside the program whose views would help identify current strengths of the program and new opportunities to cover and retain more children. The type of people interviewed included: the Governor's health policy director, state legislators or staff of the legislative health care committees, policy advocates, organizations that work directly with families in completing applications, officials from sister agencies or bureaus, such as public health, and health plans involved in enrollment and retention. The names of interviewees in Louisiana are listed in Appendix 1.

The findings in this report are based on information collected from the state, a recent review of the literature,[2] and experience from our work in numerous states, to distill the opportunities states

[2] Victoria Wachino and Alice M. Weiss, "Maximizing Kids' Enrollment in Medicaid and SCHIP: What Works in Reaching, Enrolling and Retaining Eligible Children," National Academy for State Health Policy for Robert Wood Johnson Foundation, February 2009. Accessible at: www.nashp.org/files/Max_Enroll_Report_FINAL.pdf.

have to improve enrollment and retention of children in coverage. While many opportunities were identified, this report highlights those we thought would have the greatest impact on children's coverage and be administratively and politically feasible.

Findings across all eight states' assessments will be published in a separate report.

About Louisiana's Health Insurance Programs for Children

The latest federal statistics estimate Louisiana's uninsured rate for children to be 12 percent.[3] However, according to a recent state survey, just 5.4 percent of Louisiana children are uninsured,[4] and about 80 percent of these children are currently eligible for public insurance through LaCHIP, Louisiana's joint Medicaid and CHIP program.[5] Eligible but uninsured children are disproportionately between the ages of six and 19, and are African-American or Hispanic (see Appendix 2, for detailed information on the demographics of the uninsured).[6]

While the program is publicly known under one name, Medicaid and CHIP do operate under different rules within DHH. Louisiana Medicaid eligibility follows the mandatory levels, with coverage for children ages zero to five up to 133 percent of the Federal Poverty Level (FPL) and children ages six to 18 up to 100 percent FPL. Children with incomes over the Medicaid limit and up to 200 percent FPL are covered through LaCHIP, a Medicaid expansion CHIP program. Louisiana's CHIP program status changed from a Medicaid expansion to combination program with the implementation of a separate state program for the unborn in June 2007. In June 2008, the LaCHIP Affordable Plan, a separate state CHIP program was implemented. Children with net income above 200 percent FPL and gross income at or below 250 percent FPL may enroll in coverage through the LaCHIP Affordable Plan.

Eighty-six percent of publicly insured children are enrolled in Medicaid and 14 percent are enrolled in CHIP (either LaCHIP or LaCHIP Affordable Plan). The Medicaid program, with 551,608 children enrolled, has grown steadily over the past five years. The LaCHIP program has also experienced consistent growth and covers an additional 126,195 children, which includes 2,483 children enrolled through the LaCHIP Affordable Plan[7] and 1,492 expectant mothers enrolled in the prenatal plan.[8] Table 1 in Appendix 2 summarizes children's enrollment from 2003 to 2007.

The state experienced a significant increase in children's enrollment in the months immediately following Hurricane Katrina in August of 2005.[9] From August 2005 to December 2006, children in the most severely affected parishes were automatically reenrolled in LaCHIP or Medicaid thereby artificially inflating enrollment numbers. Over that same period, the state engaged in intensive outreach efforts which increased enrollment significantly. Enrollment numbers declined somewhat in January 2007 after the state conducted renewals on those children in the devastated areas for the first time since the storm. In recent months, however, the state has surpassed pre-Katrina enrollment numbers. These enrollment gains have been sustained in large part by the proactive retention strategies the state has adopted, which are described below.

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[3] KFF State Health Facts, 2007-2008, CPS analysis.

[4] Data from 2007 Louisiana Health Insurance Survey, a 10,000 household survey conducted by Louisiana State University. http://www.lpb.org/programs/criticalcondition/LHIS_DHH_Dec_2007.pdf

[5] The CPS estimates 14.5% of children are uninsured in Louisiana. This survey is known to have some limitations in smaller states and with people not identifying public insurance when asked about current coverage. New York, which also reports this incongruity in CPS data, adjusts the uninsured count downward to address underreporting of Medicaid enrollment.

[6] 2007 Louisiana State University health insurance survey.

[7] An additional 6,500 children are expected to be eligible for this expansion.

[8] July 2009 enrollment report from J. Ruth Kennedy.

[9] LaCHIP and LaCHIP Medicaid enrollment increased by over 12,000 children in the six months immediately following Hurricane Katrina. Source: DHH MaxEnroll Initiative Grant Application

Louisiana operates a Health Insurance Premium Payment Program under Section 1066 of the Social Security Act. Called LaHIPP, the program reimburses the employee share of employer-based health insurance in cases where a worker or at least one member of a worker's household is enrolled in Medicaid or LaCHIP. In the most recent fiscal year, the LaHIPP program had 743 cases, which included 2,491 recipients and 964 beneficiaries. The cost to the state for this program was $7,591,456.

Recent Initiatives to Expand Insurance Coverage

In the fall of 2007 Louisiana implemented an online application. The online application, along with an aggressive outreach campaign which included numerous enrollment events and activities with community partnerships throughout the state, helped Louisiana enroll an additional 11,000 children from January to June of 2008.[10] Additionally, in 2007, the legislature authorized the implementation of presumptive eligibility (PE) for children in both Medicaid and CHIP. However, Louisiana has encountered administrative and operational issues that need to be addressed before full implementation can occur.

Applying for and Renewing Coverage

Families can apply for children's coverage on the Internet or by completing a paper application. Approximately 15 percent of Medicaid and LaCHIP applications are submitted online by clients, with another 15 percent being electronically submitted from certified Medicaid Application Centers. All paper applications and associated documentation are scanned into the electronic case record system. Caseworkers can accept and fully process applications out in the field with the use of technology, including laptop computers, remote wireless access to eligibility systems, and portable scanners. Workers check multiple data sources to verify applicant information, including income and citizenship, and will call employers and applicants to proactively follow up on missing information.

LaCHIP and Medicaid have leveraged operational and policy innovations to achieve high retention rates. The state has tried to remove the burden of renewal from families by doing as much as they can before they contact the family. The least burdensome renewal method for families is administrative (a system-generated renewal), followed by exparte, telephone, internet, and finally regular paper renewals. DHH uses an algorithm based on characteristics of each case, stored in the mainframe eligibility system, to determine the most appropriate method of renewal. This approach, combined with an eligibility workforce that is held accountable for renewal rates, has resulted in a 99 percent retention rate among eligible children.

Leadership and Political Context

As the single state agency administering Medicaid and CHIP, the Department of Health and Hospitals (DHH) is responsible for all policy and operational aspects of Medicaid and LaCHIP, including eligibility. Eligibility workers in local DHH offices, who are state employees, conduct eligibility determinations for both programs as well as for LaCHIP Affordable Plan. With line-level

[10] Louisiana Department of Health and Hospitals News Release, June 5, 2008.

authority over the local eligibility staff, the Deputy Medicaid Director/CHIP Director has the ability to direct and monitor eligibility functions. The Department of Social Services (DSS) is responsible for administering other social welfare programs such as cash assistance, Food Stamps and child care assistance.

In Louisiana both Democratic and Republican administrations have actively supported providing health coverage to all children. With one of the nation's highest child poverty rates (28 percent) and multiple hurricane-related crises, the state has faced significant challenges in its efforts to find and enroll eligible but uninsured children. However, the Governor and Legislature support outreach and enrollment efforts in both the Medicaid and LaCHIP programs. The equal support for both programs is notable, and in contrast to many other states where Medicaid enjoys less support than CHIP.

Priorities Identified by the Grantee

In the grant application, Louisiana identified the following priorities to support the state's goal of increasing the percentage of eligible children enrolled in LaCHIP and Medicaid to 98 percent by January 2013, which will be considered along with opportunities identified in this report, as the State works with NASHP to plan the use of grant funds:

- Implement full Presumptive Eligibility (PE) for both LaCHIP and Medicaid by: identifying qualified entities to be involved in the development of the program; designing educational and communications campaigns to counter previous participants' negative experiences with PE for pregnant women in the 1990s; making necessary systems changes; and developing a required State Plan Amendment with all implementation details included;
- Implement express lane eligibility with Food Stamps data;
- Develop electronic data interfaces with the state income tax agency, schools, providers, child care assistance, Food Stamps, and the Workforce Commission to facilitate enrollment; and
- Reassess the existing LaCHIP and Medicaid application and enrollment process to further simplify and reduce rejection rates of new LaCHIP and Medicaid applications.

Findings from the Diagnostic Assessment

1. Enrollment and Renewal Processes and Policies

CURRENT APPROACH TO ENROLLMENT

Louisiana has a single application for Medicaid, LaCHIP and LaCHIP Affordable Plan. Using the online application, families can also apply for LaMOMs (the Medicaid program for pregnant women), and several other programs for disabled adults and Medicare beneficiaries. Louisiana has simplified its income documentation requirements for clients by providing eligibility workers resources to check a number of third party data sources, and by calling an employer before asking applicants to submit a paycheck stub.

REASONABLE CERTAINTY POLICY

Since 2000, eligibility workers follow a "reasonable certainty" policy that is defined as 97 percent or greater certainty. This policy allows workers to use their judgment in determining whether the income reported appears to be within range of what they are able to verify using third party sources. DHH implemented this policy after extensive quality improvement tests demonstrated that the "reasonable certainty" policy showed comparable accuracy rates and improved administrative efficiencies as compared to requiring full documentation.

The Department has adopted a client-centered orientation that includes shifting the burden of proof of eligibility from parents to the local DHH eligibility worker. This approach is embedded in the following practices:

- An application is ready to be processed whether it arrives complete or incomplete.
- Staff proactively retrieve information from other sources including Food Stamps or employers rather than waiting for parents to comply with documentation requests. Additionally, staff uses other online data sources to find new contact information for recently moved families.

ELECTRONIC CASE RECORD SYSTEM FACILITATES ENROLLMENT PROCESS

When an application is received by mail, it is scanned into the electronic case record system. Online applications and scanned applications are entered into MEDS, the eligibility determination system, by central or local office administrative staff. On a daily basis, workers select applications to process from the statewide electronic listing of new applications. This electronic format allows any worker to access and process an application and ensures no two workers are working the same application at one time.[11]

Program officials have made electronic case records and performance measurement and reporting high priorities for supporting both management and caseworker decision-making. The

[11] Most applications are selected by parish region to maximize local knowledge, but this is not required.

systems approach to quality improvement emphasizes measurement and accountability across regions, parishes and at the individual level. Early efforts in the division's transformation focused on reducing processing times for eligibility determination of applications and renewals. The division generates monthly "production" reports on processing times with comparisons at the region, parish and caseworker level.

Workers' proactive efforts to fill in missing information have had significant results. In March 2009, six percent of Medicaid applications and just under two percent of LaCHIP applications were denied for failure to submit essential information. Average application processing timeframes are three days for pregnant women and eight calendar days for children. Caseworkers, on average, manage approximately 220 cases each month, with approximately 560 eligibility workers employed statewide.

CURRENT APPROACH TO RENEWAL AND RETENTION

With a totally paperless eligibility case record system, DHH has a "virtual file room" of every Medicaid and LaCHIP case in the state, to which all eligibility employees have online access. This level of data accessibility is a key component to DHH's noteworthy successes in managing worker caseloads and improving productivity through team rather than individual assignments. Anyone on the team—whether an eligibility worker or members of the centralized Customer Service Unit which answers calls from clients—can work on a case (e.g., take or return a client's phone call) because each has access to the same information.[12] Additionally, the state has found the process to be an efficient way to spread workloads evenly.

ADMINISTRATIVE AND EX PARTE RENEWALS

In Louisiana only 5.4 percent of Medicaid and 10.4 percent of LaCHIP case reviews require the member to submit a signed renewal form in order to renew their eligibility. Correspondingly, case workers perform the remaining 94.6 percent of Medicaid and 89.6 percent of LaCHIP renewals using either:

- The ex parte renewal process, which involves verification of information using Food Stamp case information, state tax information or The Work Number (33 percent of Medicaid and 32.6 percent of LaCHIP);
- The administrative renewal process, which involves notices to children and families at very low risk of failing to meet eligibility requirements at renewal, requesting that they report changes in income or household composition (44.1 percent of Medicaid and 3.7 percent of LaCHIP);
- Telephone renewals, which involves an incoming call or outbound call in which factors subject to change are reviewed (15 percent of Medicaid and 37.3 percent of LaCHIP); and
- Web-based renewal, which represents 4 percent of LaCHIP cases.

[12] All caseworkers are state employees and are bound by all state and federally mandated confidentiality rules regarding the use and sharing of personal health information.

Members are more often required to submit information for a LaCHIP renewal than for a Medicaid renewal because children participating in LaCHIP are from higher income families and therefore are less likely to be found in other state databases such as Food Stamps.

DHH has developed criteria to determine which cases are appropriate for ex parte renewal or administrative renewal. Decision criteria are programmed into MEDS, and ex parte or administrative renewals are used whenever possible.

Specific cases are eligible for administrative renewals if they meet certain eligibility criteria such as: cases where the child's relationship to the applicant is not parent/child, for example, when the child is the applicant's grandchild, niece or nephew or other relative; cases where the parent has Retirement, Survivors Disability Insurance (RSDI) income; cases where a single parent has stable unearned income, such as child support or alimony; and/or cases where there has been no change in eligibility in the last three years and net income is less than or equal to $500.

If a child's case does not qualify for administrative renewal, and he or she has an open Food Stamps (FS) case in the FS eligibility system, the case is eligible for ex parte renewal. On a monthly basis, all children's health insurance files that are due for renewal are matched against the DSS-maintained FS eligibility system. Information from open cases is entered by Medicaid caseworkers into the Medicaid eligibility determination system, MEDS. To process the ex parte renewal, a worker first reviews information in the FS eligibility system to update any contact information in MEDS, then does data entry to calculate the LaCHIP or Medicaid budget based on FS income and household information, determines eligibility, and sends the approval notice.

If the information in the FS system cannot be used to determine eligibility because the Food Stamps case is closed or the FS information is out of date, a case is considered for renewal involving contact. If changes are reported, the case reverts to a regular renewal process. Otherwise, the eligibility is extended and the electronic case record is annotated to show completion of renewal without ever having been handled by an eligibility worker.

PHONE RENEWALS AND OFF-CYCLE RENEWALS

When neither ex parte nor administrative renewals are possible, DHH uses a regular renewal process to conduct a redetermination of eligibility. Notices are mailed to the family with response required by phone or mail. The majority of these renewals are conducted by phone without the need for a signed renewal form.

In a series of process improvement tests using the Plan-Do-Study-Act (PSDA) method,[1] eligibility employees from a variety of offices (staff size, geography, etc.) compared the efficiency (taking the least time and effort by employee and customer) of two different methods of completing a telephone renewal. The first method began with a worker mailing a letter asking the customer to call at their convenience to renew. When the customer called, the worker asked for pertinent information, including verifications if needed. The second method began with an attempt to contact the customer by phone. If the worker was able to make customer contact by phone, an interview was completed by phone, and a letter was mailed to the customer only as a follow up if

[1] The Plan Do Study Act Method is a process improvement model originally developed by Walter A. Shewhart, and is widely taught as a method of process improvement. See for example, the Institute for Health Care Improvement (www.ihi.org).

the worker requested verifications. The worker mailed a letter asking the customer to call to renew only if the customer could not be contacted by phone first. Test data showed that in many cases (generally geographic areas where customers tend to move less) attempting phone contact first was more efficient. As a result, many offices abandoned the practice of first contact attempt by mail, and instead made the first contact attempt by phone standard practice. Those offices that found that attempting first contact by phone was less efficient (generally urban areas, especially those affected by recent hurricanes, where customer mobility is high) continued the practice of first contact attempt by mail. As noted earlier, phone renewals account for 15 percent of all Medicaid and 37 percent of all LaCHIP renewals, and renewals completed by mail account for just 6 percent of Medicaid renewals and 11 percent of CHIP renewals.

Staff use a variety of sources to identify a current home or work phone number for the parent of the child. After three unsuccessful phone attempts, a renewal notice is mailed. Workers will enclose a self-addressed envelope to ensure any required documentation gets mailed back to their local office. If the worker is able to reach the parent by phone and no changes are reported or changes fall within the 97 percent reasonable certainty threshold of what the worker is able to independently verify with other data sources, the case is renewed and no additional follow up is necessary.

DHH also performs off-cycle renewals; any time a client makes contact with the agency, the caseworker is to consider it an opportunity to update case information and renew coverage.

PERFORMANCE EVALUATED ON LOWERING PROCEDURAL CLOSURE RATES

DHH staff cites several factors that have contributed to the success of these simplified renewal policies. Workers are evaluated (often with results posted at the local offices) based on their rates of success in lowering the number of cases closed for procedural reasons. Louisiana's rate of closures due to procedural reasons dropped from 22 percent in 2001 to just less than one percent in 2009. According to DHH, the proportion of children who retained eligibility at renewal increased from 72 percent to 92 percent between June 2001 and April 2005. The proportion of enrollees who lost coverage due to failure to return forms also fell from 17 percent to one percent,[13] resulting in an overall retention rate of 99 percent for eligible children. Another unique factor contributing to the success of simplified renewals is the DHH policy that closing a case requires supervisory approval. This holds staff accountable for completing all possible checks.

NEW INITIATIVES

EXPRESS LANE ELIGIBILITY

DHH senior staff are implementing Express Lane Eligibility (ELE) per CHIPRA 2009 guidelines. The DHH vision is to create an ELE process where every child who applies for Food Stamps can

[13] Victoria Wachino, Alice M. Weiss. "Maximizing Kids' Enrollment in Medicaid and SCHIP: What Works in Reaching, Enrolling and Retaining Eligible Children" (Washington D.C. National Academy for State Health Policy, 2009)

be automatically considered for Medicaid eligibility without further actions by parents. To do this, they are working with the Department of Social Services (DSS) to include "opt out" language in the Food Stamps application and renewal forms. They are also considering a process of mailing a card with a phone number and directions for parents to "call to activate," similar to a credit card process. This call-in step would assist DHH in assuring an accurate eligibility determination process as well as get the parents' attention that coverage has been provided for their child(ren). The process will require substantial system changes for both the Food Stamps and Medicaid eligibility systems.

OTHER APPLICATION STREAMLINING EFFORTS

With the focus to date largely on renewal processes to improve retention rates, DHH officials acknowledged the need to put a greater emphasis on the application process and reduce denials of eligible children. To this end, DHH officials are developing new system capabilities to pull out denial reason codes and are planning to hire eligibility retirees to look at rejection data.

STRENGTHS

A number of policies and practices in Louisiana appear to contribute to the successful enrollment and retention of children in Medicaid and LaCHIP.[14] LaCHIP program leadership actively seeks ways to push the envelope of simplifying enrollment and renewal.

- *Use of process improvement methods to continuously improve program function.* Process improvement efforts have resulted in numerous operational and policy changes to simplify the application process. For example, officials discontinued presumptive eligibility for Pregnant Women as a result of reducing application processing timeframes to three calendar days, making the need for presumptive eligibility obsolete. Another recent process improvement that originated at a local DHH office allows the local charity hospital to "right fax" applications directly to an eligibility worker's email instead of mailing them.

  The Department has created an infrastructure for promoting process improvements called WorkSmart! Led by the Deputy Medicaid Director of Eligibility/LaCHIP, WorkSmart! is a process improvement initiative that incorporates management science principles from the Toyota Production System, the PDSA approach, the Southern Institute on Children and Families' Process Improvement Collaborative, and Continuous Quality Improvement processes. Built into the WorkSmart! infrastructure is an Eligibility Process Improvement Manager who coordinates process improvement activities among regional managers, parish supervisors and staff—all of whom are state employees. Incremental changes are implemented as ideas are generated anywhere within the Division, tested on a small scale and results are measured from baseline. Eligibility staff at the state and local levels were well-versed in WorkSmart! techniques, as observed during the site visit.

[14] While the strategies listed here appear to promote coverage and enhance enrollment and renewal, the impact of these strategies has not been systematically evaluated. Additional strategies that were not forthcoming in the assessment may also contribute to successful enrollment and renewal.

- *Staff flexibility.* The Department's adoption of a 97 percent reasonable certainty standard for processing applications and renewals greatly streamlines the application and renewal process for families and serves as a powerful decision-making tool for caseworkers.
- *Technology solutions.* DHH has made significant investments in technological solutions to simplify the eligibility process. DHH has leveraged the mainframe Medicaid/CHIP eligibility system (MEDS) and electronic case record (ECR) system to:
    - Create a team-approach to processing eligibility of cases;
    - Ensure equal distribution of caseloads across workforce;
    - Perform automatic renewal criteria determinations and conduct interfaces with Food Stamps and other data sources to complete eligibility functions that would otherwise require significant manual caseworker time;
    - Handle real-time application processing, eligibility determinations, account updates and renewals anytime and anywhere in the field;
    - Free up caseworkers to perform in a more customer-oriented manner and shift the burden of proof of eligibility from parents to DHH.
    - Allow caseworkers to submit applications via laptop computers from the field, as can staff from contract Application Centers.
- *Positive brand recognition.* The state has simplified its marketing and outreach efforts by marketing all of its public health insurance programs for children under the LaCHIP brand, which has helped make LaCHIP a well-known and popular program. Distinctions among Medicaid and Medicaid expansion CHIP, and separate CHIP programs are largely invisible to Louisiana families.

CHALLENGES

The following program challenges may hinder enrollment and retention, and require closer examination.

- *Phone Assistance.* The Call Center is not as user friendly as DHH staff would like it to be. While parents can call and renew over the phone, DHH staff reported that the system is somewhat difficult to navigate and could be improved.
- *Risk of reintroducing welfare stigma*. Interfacing with DSS may challenge LaCHIP and Medicaid information systems, as well as risk re-creating a connection between health insurance and welfare, which the agency has done so well to break.[15] Stigma associated with the Food Stamps and TANF programs will need to be addressed to ensure the remarkable progress made toward eliminating welfare model-type barriers is not lost.

[15] Legislative interest in merging DSS and DHH back together has the potential to improve coordination, but could also negatively affect the progress DHH has made to make the organizational culture more customer-oriented.

- *Risk of gaming*. Transparency of performance, while contributing to high retention rates in LaCHIP, has raised concerns that staff may be "gaming the system" in their coding of closures. State officials expressed a need to explore this further.

2. Coordination Among State Agencies

CURRENT APPROACH

Many customers receive medical assistance from DHH and other public services administered by DSS. Since the two departments have separate local offices, coordination requires deliberate efforts. DHH and DSS have shared goals of making the application and renewal process for public services as streamlined and administratively efficient as possible. Officials from both departments described several service integration efforts underway, including initiatives to identify DSS customers that qualify for Medicaid or LaCHIP. DHH is working to identify data sources from other government agencies that can be leveraged to identify eligible, uninsured children for outreach, verify eligibility for applications, and include in the ELE process. Officials are working to develop data interfaces with the local school districts to obtain free and reduced school lunch income information, Department of Revenue for income tax data, and Workforce Development Commission for health insurance status reported on unemployment benefits.

DHH also coordinates with the Department of Education to identify and enroll eligible children in the school system. Legislation was passed in 2005 to require schools to report data on children enrolled in the Free & Reduced lunch programs to DHH on children who are uninsured and potentially eligible for LaCHIP. However, due to the paper-based nature of this type of information, school reporting rates have been low to date.

State officials cite one of the nation's highest school dropout rates as another reason most schools cannot provide reliable information on eligible uninsured children. However, certain school based health centers have had significant success assisting eligible children to enroll in LaCHIP and Medicaid.

Individual departments have pledged support for programming changes proposed by DHH that would support data exchanges and application modifications to facilitate enrollment of eligible children. Efforts include adding "opt out" boxes on applications for Food Stamps or child care assistance, which if not checked, would authorize DSS to share application data with DHH for the purposes of identifying uninsured children eligible health coverage. A similar approach is possible for other need-based assistance programs and possibly unemployment benefit applications.

NEW INITIATIVES

In 2008, legislation referred to as "Neighborhood Place" was passed to improve inter-agency coordination of children and family services. Based on a model in operation in Kentucky, Louisiana is developing team-based community sites with a single intake and assessment process for multiple programs. A few parishes, through local school leadership, have begun development of a Neighborhood Place initiative. The first site opened in June 2009. The

legislation's impact has been limited because implementation relies entirely on local and community leadership.

STRENGTHS

- *Coordination is a priority*. Senior officials have a vision to maximize enrollment of eligible children by expanding the potential for a family's interaction or connection with any state (or local) agency, or provider, to be an opportunity to enroll or presumptively enroll an eligible child in LaCHIP, and at the very least, provide an application. The following agencies or institutions offer this potential:
  - Department of Social Service (DSS) offices for Food Stamps, child care assistance, and other needs-based programs;
  - DHH Office of Public Health for WIC, and family planning services;
  - Schools, both public and private;
  - Office of Juvenile Justice;
  - Unemployment offices; and
  - Hospital emergency rooms.

CHALLENGES

- *Differing priorities between agencies limit expenditure of resources to address coverage*. DHH and DSS plans for improved systems integration, particularly those that extend to the Workforce Commission (Department of Labor) and Department of Revenue, may not be feasible. Leadership, and/or funding, could help overcome barriers. In addition, the lack of coordination among state agencies and a lack of funding to support agencies directly will continue to be a barrier to widespread implementation of the Neighborhood Place service integration delivery model. Technical assistance to negotiate data-sharing agreements between DHH and other agencies, as requested by Medicaid Division officials, could help, to a degree.
- *Need for greater legislative support*. The legislature supports health insurance coverage for children via LaCHIP and Medicaid. However, this support is not as strong for food stamps, cash assistance or publicly sponsored insurance coverage for parents. DHH will need to consider how to ensure that the progress made toward eliminating "welfare model" barriers in Medicaid is not eroded by increased integration and coordination between DHH and DSS.
- *Information system priorities*. Prior to welfare reform de-linking efforts, the DHH and DSS agencies were a single state agency. As a remnant of this history, the DSS mainframe hosts DHH's legacy eligibility system. This requires close coordination between the two agencies to prioritize systems changes.

3. Analytic Capacity for Program Management and Decision-Making

CURRENT APPROACH

Program officials have used electronic case records and performance measurement to support both management and caseworker decision-making. The eligibility determination system (MEDS) is stored on a mainframe housed within DSS. The DHH eligibility systems staff has modified the system to enable management to draw out the data elements necessary to analyze operational performance and program outcomes. The division generates monthly "production" reports on processing times with comparisons at the region, parish and caseworker level. As described earlier, the statewide average processing time for an application is 8 calendar days from date of receipt.

More recently, emphasis has been on retention of eligible children, for which the Department developed metrics for measuring the percentage of procedural closures at renewal. In some offices, individual performance on procedural closures is publicly displayed on office bulletin boards. Statewide, one percent of renewals are denied for procedural reasons.

Electronic case records, use of third party data systems, access to the Food Stamps eligibility system and online resources provide information tools to caseworkers to pro-actively complete application and renewal processes quickly and support caseworker judgment and decision-making.

NEW INITIATIVES

DSS and DHH plan to develop a unique identifier for all families involved in all public programs so they can better track families through their systems and provide program interfaces where possible, as well as improve the state's ability to measure its performance on health and other outcomes. DSS recently engaged a consultant to conduct an analysis of what was called "natural technology partnerships" to identify where system interfaces could most easily be made.

State officials wish to increase their focus on applications rejected for procedural reasons. In March 2009, six percent of Medicaid applications and two percent of LaCHIP applications were rejected for procedural reasons. The Medicaid Eligibility Quality Control (QC) Section reviews monthly samples of applications and renewals including rejections to study accuracy rates of both approvals and rejections.

STRENGTHS

- *Use of data for program management.* The DHH staff appears to have and use an extensive set of analysis and reporting tools for management decision-making. This analytic capacity has been useful in identifying and mitigating renewal closures for procedural reasons and guiding the priorities of their quality improvement agenda. As mentioned in Section 1, DHH is turning its focus from renewals to applications and plans to use detailed denial reason code reports to identify further opportunities for improvement.

- *Staff flexibility.* DHH staff members are allowed some discretion in applying eligibility rules based on the totality of the information available to them.

CHALLENGES

- *Inconsistency in eligibility determinations.* While local parish eligibility staff has been trained to use its professional judgment in making income eligibility determinations, there is a lack of uniformity in training for new staff in utilizing the full potential of resources available. A review of training practices at the parish level may be helpful to identify opportunities for improvement.

4. Client-Centered Organizational Culture

CURRENT APPROACH

Transformation of Medicaid's organizational culture to a client-centered orientation has occurred over more than a 10 year period, and continues. For example, the WorkSmart! Initiative has evolved to give staff at all levels more opportunities and incentives to be actively involved in process improvement. Staff receives office and program-wide recognition and also tangible rewards when successful in reducing processing times without sacrificing quality. An example is the potential to work from home in some situations. DHH officials said this effort has provided a strong incentive for performance improvement. For 2008 there were seven areas in which statewide eligibility process improvement aims were set and measured. (See Appendix III.)

As a result of eligibility processes being more efficient, staff resources have been freed up to conduct outreach and application assistance in the community. DHH senior staff stated that part of the overall process improvement efforts is to identify variation in the operational processes and eliminate the waste associated with it by creating standardization. At the same time, they strive to strike a balance between flexibility and total standardization. They want to encourage innovation and know this only happens through experimentation.

STRENGTHS

- *Commitment to assisting families.* Local parish eligibility staff has been trained to use professional judgment in determining eligibility on the basis of income. One worker said, "As long as we can justify what it is, if it's close, we don't push for a check stub." Workers also discussed being proactive by calling employers, calling applicants if they haven't heard back on a documentation request within ten days, using an employer wage database vendor called The Work Number, and doing "whatever it takes" to assist families with the application process.
- *Aggressive tracking of information by staff.* Eligibility staff has been reoriented to be proactive rather than reactive in its approach to verification and follow up on missing information. For example, workers have been trained to conduct intensive research to follow up on outdated addresses. When a family is not located at the address or phone on file, workers look up the name on anywho.com, white pages/yellow pages, Food Stamps case file, applications from previous electronic case record logs and any other potential source to track the family down.
- *Building enrollment success into worker incentives.* DHH has built a strong culture promoting enrollment as goal, rather than keeping ineligibles out. This is illustrated by the practice of evaluating and incentivizing performance based on ability to enroll and retain eligible children, allowing work at home for top performers, and paying overtime to caseworkers who want to conduct outreach activities on evenings and weekends.
- *Align caseload management strategy with program goals.* DHH management has used the electronic case record system to strategically apply resources where needed in

support of the goal of moving caseload assignments away from individuals and toward a team approach for accountability.

CHALLENGES

- *Local variability*. State officials indicated that not every parish has reached the level of performance expectations and embraced the internal marketing the division has conducted to educate staff on "the complicated lives of clients" and "Maslow's hierarchy of needs" which may make families living in crisis situations to consider Medicaid renewals a very low priority. State officials also reported that 17 years after the split from DSS[16] there are still some employees with the mentality to over-investigate cases, ask for unnecessary documentation, and act reluctantly in taking extra steps to research missing information on non-responsive enrollees.

5. Non-Governmental Partnerships and Outreach

CURRENT APPROACH

Louisiana continued to support the Covering Kids and Families coalition and leadership after the grants from this initiative ended. DHH contracts with 11 community-based organizations that conduct outreach and enrollment functions across the state. These organizations use their established relationships with ethnic groups, religious organizations and other social safety net resources to connect with families and encourage enrollment into health coverage programs. DHH leverages relationships with community health centers, Charity Hospitals, and other health care providers to house eligibility workers, conduct outreach events, and promote program eligibility in places where families with uninsured children typically seek care.

DHH has had varying levels of success in partnering with local school districts to conduct outreach and enrollment. A 2005 legislative mandate requiring schools to transmit Free and Reduced Lunch Program (FRLP) data to DHH provides potential for increased coordination in serving families with eligible but uninsured children. The Department of Education supports the efforts of schools to transmit FRLP data to DHH, but it does not have specifically authorized funding or authority over local school districts to fully facilitate the process. A stronger example of partnerships with schools is emerging through the expansion of the Neighborhood Place Initiative, described in more detail in Section 2.

As processing times for applications and renewals have decreased, staff has had more opportunities to participate in community outreach during work hours. Staff also may take paid over-time and volunteer to participate in community-based outreach activities such as parades, health fairs, road races, back to school campaigns, and outreach coordinated with local churches.

Advocates are largely supportive of the DHH's enrollment efforts at the state and local level but see a need to expand the role of community-based organizations in neighborhoods where

[16] Formerly known as OFT (Food Stamp/TANF Agency)

pockets of uninsured children may reside. An estimated 50,000 LaCHIP-eligible children remain uninsured. Barriers to enrollment include:

- Low literacy rates among native residents and immigrant families;
- Distrust of government among poorly educated and immigrant families;
- Stigma associated with government "welfare" programs, particularly among higher income families that may have eligible children due to recent unemployment;
- Lack of awareness or misperceptions about eligibility (e.g., belief that a child who drops out of school is ineligible for coverage);
- Perceptions that health care services will always be available from charity hospitals, even without health insurance coverage;
- Lack of broad-band Internet access and isolation in rural areas;
- High teen school drop-out rates; and
- High rate of kinship arrangements in which a relative has physical but not legal custody of children.

STRENGTHS

- *Louisiana has demonstrated a great deal of activism around enrolling and retaining kids I coverage.* Schools distribute LaCHIP applications with Free and Reduced Lunch Program (FRLP) applications and information can be shared with the LaCHIP program unless parents decline this option. Officials find these efforts have contributed to expanded enrollment of children, particularly in concert with "Back-to-School" coverage initiatives. The ongoing work with and continued funding of the 11 members of the covering Kids and Families (CKF) coalition builds stronger community relations and maintains goodwill awareness of LaCHIP. Despite a challenging budget environment, the state continues a robust and proactive outreach campaign, including television and radio ads, floats in local parades, and continued investment in promotional materials. Lastly, outreach workers with connections to their community are used.

CHALLENGES

- *Limited evidence about the benefits of diffuse marketing efforts.* Louisiana may have support for generalized marketing, but they may want to redirect funds to efforts that more closely target the eligible but uninsured.
- *Few advocates engaged in coverage.* Despite DHH leadership's encouragement of a broader number of children's health care advocates, statewide, only a few individuals provide significant input to DHH and the legislature. This lack of advocacy presence may limit opportunities for communication exchanges between officials and advocates that could facilitate both positive and negative feedback on program policies and practices.

- *Few local supporters.* The local parish office staff said they struggle with certain areas of the community that are opposed to hosting outreach events. As unemployment rates rise, these higher income areas most likely are where many newly eligible children live. Finding outreach opportunities in these communities presents unique challenges.
- *Linkages with the Free and Reduced Lunch Program are unfunded*. Recent legislation requiring (public) schools to release information on the health insurance eligibility status of Free and Reduced Lunch Program (FRLP) applicants did not provide financial support to set up or maintain this exchange of information. Therefore, school districts view it as an "unfunded mandate" that will require a dedicated source of funding to fully implement. Local communities participate at their own discretion.
- *Children being raised by non-parents are hard to reach.* A large number of Louisiana children live with individuals who are not their legal guardians. About 10 percent of all children in Louisiana live in households headed by grandparents, many of whom are not their legal guardian. Targeted outreach and communication strategies are needed to identify and enroll eligible children in these families.

6. State Leadership

CURRENT APPROACH

Both the administration and legislature are supportive of children's insurance coverage and LaCHIP. There have been no roll-backs in eligibility since LaCHIP was implemented. While statewide budget cuts are being considered in the current legislative session, the state would be more likely to cut provider payment rates rather than reduce eligibility.

The administration and legislature generally do not seek to influence program policies and practices, but also do not set the agenda. For example, coordination among departments occurs mainly at the agency level, rather than being directed from the Governor's Office. The Children's Cabinet, comprised of state agency leaders is the only leadership forum supported by the Governor's office on children's issues. However, it is not an influential body according to several sources.

Strong leadership within the Medicaid Division is a driving force behind the gains made in simplifying enrollment and renewal in the LaCHIP programs. Medicaid division officials have considerable influence over legislative proposals affecting their program and benefit from the bipartisan legislative support of LaCHIP. The Division reports a set of quarterly performance measures to the legislature, and is proactive in reporting progress to the Governor's office.

STRENGTHS

- *Leadership commitment to coverage.* The LaCHIP programs benefit from strong and sustained support from leadership in both the legislature and the Governor's office. It seems to be universally acknowledged that children's health insurance is important and should not be cut, even in an economically challenging environment.

CHALLENGES

- *Influence of potential leadership group is limited.* The Children's Cabinet, which is comprised of state officials whose agencies touch the lives of children, has limited policy influence. There may be potential for this group to facilitate progress on inter-agency coordination such as the Neighborhood Place initiative.

Opportunities

Based on our understanding of Louisiana's current practices, systems, and partnerships, we have identified the following opportunities to help the State realize its goal of maximizing enrollment of eligible children. Recommendations emphasize community outreach and marketing that targets specific populations, and improving inter-agency coordination.

Tailor outreach and application assistance to hard-to-reach populations, which include children between ages six and 19, predominately African American and Hispanic children, children living with kin who are not legal guardians, and high school drop-outs. Multiple contacts through a variety of means may be needed to enroll some children. Application assistance and follow up could be provided through:

1. Expanded participation of community-based organizations and providers in assisting families with the application process.
2. Full adoption of Presumptive Eligibility, such as through health care providers or in tandem with an Express Lane Eligibility policy.
3. Improved coordination with court appointed special advocates to proactively identify children involved in the juvenile justice system who are in need of health coverage.
4. Coordination with Area Agencies on Aging s for outreach to guardians of children.
5. Third party data matching, such as with Food Stamps, tax data, WIC, or other public programs.

Direct community outreach and marketing efforts to fully utilize available resources.

1. Adding a dedicated DHH or DOE staff person to facilitate the school district's involvement in identifying eligible but uninsured children;
2. More community-based (non-governmental) face-to-face outreach that provides opportunities for private, online application assistance;
3. Application/change reporting "kiosks" placed in hospitals, post-offices, other community settings that offer applicants private, online access to enrollment, eligibility information or a way to make contact with the Division; and
4. Reinstating the practice of LaCHIP officials visiting local school PTA meetings.

5. Consider using Louisiana's MaxEnroll funds to help DHH and DOE (and possibly carefully targeted school districts) develop strategies for overcoming barriers that prevent most schools from being able to share FRLP data with DHH.

Continue to build on customer-oriented organizational culture. Division staff and community-based outreach workers acknowledged additional opportunities to expand the client-centered organizational culture throughout the division by:

1. Standardizing performance review criteria across parishes and regions to include expectations about enrollment and retention could reduce variability in performance across regions.
2. Increasing monitoring activities of application approval rates could be useful for identifying weaknesses by parish or region.
3. Giving greater attention to perceptions among applicants that caseworkers are disrespectful and not receptive to service complaints or do not offer appropriate avenues for addressing or resolving complaints.
4. Improving call-center operations to make them more consumer-friendly.

Consider using Charity Hospitals and other providers to perform Presumptive Eligibility Determinations once the PE policy is fully in place.

Increase the number of eligible children who apply for LaCHIP and Medicaid by working in targeted communities to identify children who are eligible but not enrolled.

1. Conduct surveys and focus groups to identify characteristics of remaining eligible but uninsured children.
2. Encourage schools to participate in the legislatively mandated sharing of NSLP data by funding a staff person to serve as a liaison between DHH and DOE or local school districts.

Appendix I

Diagnostic Assessment Interview Participants

Name/Title	Organization
Ruth Kennedy, Medicaid Deputy Director, LaCHIP Director	Department of Health and Hospitals (DHH)
Kyle Viator, LaCHIP Director of Operations/Medicaid Eligibility Supports Section Chief	DHH
Don Gregory, Acting Medicaid Deputy Director	DHH
Diane Batts, Eligibility Systems Chief	DHH
Darlene Hughes, Eligibility Policy Chief	DHH
Bill Perkins, Eligibility Special Services Section Chief	DHH
John Fralick, Administrator, Region VI Eligibility Field Operations	DHH
Cynthia Walls, Regional CKF Coordinator	Family Road of Greater Baton Rouge
Sandra Adams, Executive Director	Louisiana Chapter of American Academy of Pediatrics
Berkley Durbin, Executive Director	Louisiana Maternal & Child Health Coalition
Margorie Jenkins, Medicaid Analyst Supervisor	E. Baton Rouge Parish Medicaid Office
Joan Wightkin, Program Director	DHH Office of Public Health Maternal & Child Health Bureau
Donna Nola-Ganey, Assistant Superintendent, Office of School and Community Support	Louisiana Department of Education
Suzy Sonnier, Deputy Secretary	Louisiana Department of Social Services

Appendix II

Data on Children's Coverage

Table 1. 5-year Enrollment Trends for Children

	Number of Children				
	2003	2004	2005	2006	2007
Medicaid or Medicaid/CHIP Enrollees					
Total	583,758	586,383	643,060	650,171	683,542
New	24,311	26,826	21,486	18,570	18,940
Disenrolled	27,815	33,689	15,687	34,560	14,783
CHIP Enrollees					
Total	104,908	105,580	146,347	142,389	154,286
New	16,304	7,616	9,635	8,720	11,142
Disenrolled	16,444	8,360	4,590	9,120	6,500
Retention Rates*					
Medicaid & CHIP	4.18	4.60	3.74	9.49	1.07

SOURCE: CHIP Statistical Enrollment Data at end of each Federal Fiscal Year.

Definitions:

Total=number ever enrolled year; New=Unduplicated number new enrollees; Disenrolled= Unduplicated number disenrollees; Please note that the CHIP numbers for 2007 also include Phase IV unborn enrollees.

Retention Rates: This is the average for the state fiscal year and represents percentage of procedural closures at renewal. This is one of the Performance Measures reported quarterly to the legislature.

In looking at retention, we measure what we can control, which is procedural closures at renewal This is the percentage of children due for renewal who are closed for a procedural reason rather than the percentage of closures at renewal for a procedural reason (which would be higher).

Table 2. 5-Year Uninsured Trends for Children

Uninsured Children	2003	2004	2005	2006	2007
All uninsured children	143,173	n/a	97,403	n/a	64,355
Eligible but not enrolled	83,669	n/a	72,429	n/a	50,918

SOURCE: 2003, 2005, and 2007 Louisiana Health Insurance Surveys (LHIS).

All uninsured children=Uninsured estimates for children (under 19); Eligible but not enrolled= Uninsured

Estimates for children (under 19) eligible for Medicaid/LaCHIP.

Table 3. Characteristics of Children by Insurance Status and Eligibility for Public Programs

	Number of Children				
Year: 2007	**Total Children**	**Total Insured**	**Total Uninsured**	**Uninsured, Eligible for Public Program** (200%)**	**Enrolled in Public Coverage**
Age					
0-5	372,656	355,280	17,376	12,772	189,876
6-18*	824,157	777,178	46,979	36,449	357,234
Race/Ethnicity					
African Am./Black	425,927	398,004	27,923	23,462	279,322
White, Non-Hispanic	666,786	636,535	30,251	20,467	216,752
Hispanic	11,269	10,076	1,193	1,008	6,540
Asian	5,280	5,080	199	42	2,796
Other	87,551	82,762	4,789	4,243	41,700
Poverty***					
0-100% FPL	344,580	324,958	19,622	19,622	267,805
101%-200% FPL	319,848	299,634	20,214	20,214	196,896
201%-300%tFPL	215,968	200,932	15,036	9,216	N/A
> 300% FPL	316,417	306,935	9,482	169	N/A
TOTAL	1,196,813	1,132,458	64,355	49,221	547,110

SOURCE: Appendix EE: 2007 LHIS

*Eligible age limit is up to the 19th birthday

**Public coverage does not include children covered by Medicare or Military coverage through their parents

***Poverty definition based on household income

Appendix III

WorkSmart!

The 2008 *WorkSmart!* Awards competition recognized outstanding achievements in 7 areas where statewide eligibility process improvement aims were set. These areas were:

1. Maintain gains
    a. Reductions in processing times for several types of applications
    b. Reductions in procedural closures
2. Improve in new areas
    a. Increase public use of online application and renewal tools
    b. Reduce processing times for applications requiring an MEDT decision
3. Spread improvement
4. Reduce variation
5. Food Stamps Outreach
6. Green Government
7. Work@Home

To be considered for an award, employees had to enter as a group (the awards focused on joint effort or teamwork) and explain why their group should be recognized and rewarded for its efforts toward accomplishment of one or more of the aims outlined above. Using a standard format, entries were required to: identify group members by name, title, office and unit; state the aim(s) the group sought to accomplish; state the strategies used to reach the aim(s); include PDSAs, Regional Manager reports, process improvement board contents; describe the respective roles/contributions of group members (how each supported the whole); and describe the outcome in terms of the problems addressed and improvements made from the point of view of the employee, supervisor/manager, customer, and agency.

The evaluation committee members assessed whether actual PDSA processes were followed.

Success within *WorkSmart!* and other process improvement initiatives in Louisiana is recognized in a variety of ways.

Georgetown University Health Policy Institute
Center for Children and Families
Georgetown UNIVERSITY

The Louisiana Experience:
Successful Steps to Improve Retention in Medicaid and SCHIP

In 2008, less than 1% of children enrolled in Louisiana's LaCHIP program lost coverage at renewal due to procedural or administrative reasons…

Over the past decade, the Louisiana Department of Health and Hospitals has taken a series of progressive and innovative steps to reduce the number of children who lose Medicaid or CHIP (known as LaCHIP) coverage at renewal for reasons not related to eligibility. In 2008, less than 1% of children enrolled in Louisiana's LaCHIP program lost coverage due to procedural or administrative reasons compared to other states where as many as half of enrolled children lose coverage at renewal.[1] Thus, Louisiana's experience serves as a model for retention policy and process improvements.

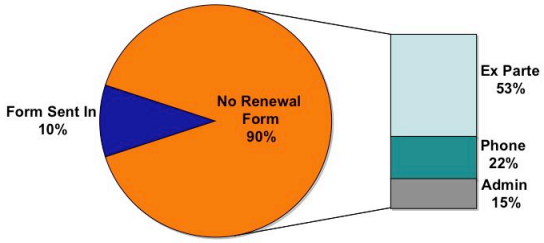
Improving retention is important from two perspectives. First, it is impossible to reach coverage goals unless retention problems are solved: as many as 40% of uninsured eligible children were enrolled in Medicaid and CHIP in the previous year.[2] Enrollment gains achieved through aggressive outreach and improved application procedures quickly disappear if eligible children lose coverage at renewal. Second, while many children who lose coverage at renewal eventually re-enroll, it is more administratively efficient and cost-effective to renew a child's eligibility than to terminate coverage and then process a new application. More importantly, continuous coverage ensures children an ongoing source of care, contributes to better quality care and avoids delayed and thus costlier care often delivered in hospital emergency rooms.[3]

The Louisiana experience demonstrates that it is possible to eliminate virtually all procedural closings at renewals. Here's what Louisiana has done to achieve these results.

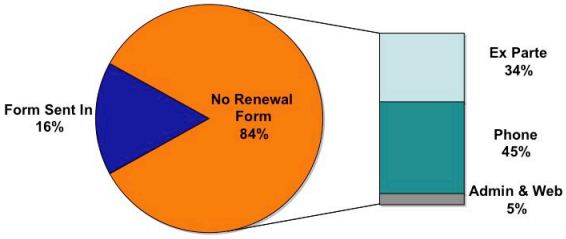
Large Majority of Children Renew without a Renewal Form

What is perhaps most notable about Louisiana's efforts is that only 10% of Medicaid cases and 16% of CHIP cases are renewed through the typical submission of a renewal form. This is possible because while federal rules require an annual review of eligibility, they do not require a renewal form or signature. In Louisiana, the vast majority of children – 90% of Medicaid children and 84% of CHIP children – are renewed without renewal forms, as described below. Note that each of these strategies have evolved over time, through testing and refinement, to make certain they are effective in promoting enrollment goals while assuring program integrity.

Medicaid Enrollment Procedures



SCHIP Enrollment Procedures



Administrative Renewals

Louisiana's process starts with administrative renewal of cases that are highly unlikely to have a change in circumstances affecting eligibility, including specific categories of eligibility such as long-term care. Other cases that are administratively renewed must meet defined criteria such as when the child's caretaker is someone whose income is not counted (e.g., a grandparent or guardian); there is a single parent with stable unearned income (usually child support); all household income is from social security; or the household monthly income is less than $500 and there has been no change in eligibility in the past three years. On average, 15% of Medicaid cases are automatically renewed through system processes requiring no intervention by agency staff. These cases are sent a notice of renewal that requires a response only if there has been a change in circumstances.

Ex Parte Reviews

Cases that cannot be administratively renewed are assigned to eligibility caseworkers who first conduct an ex parte review as required in Medicaid by federal law and detailed in guidance issued in a State Medicaid Director's letter on April 7, 2000.[4] Ex parte reviews (action by one party without involvement by the other) of ongoing eligibility rely on information already available to the state Medicaid or CHIP agency. Louisiana workers, like those in most states, have ready access to Food Stamp and TANF records, wage and unemployment information, and eligibility and payment data from the Social Security Administration for individuals receiving social security or supplemental security income. In addition, Louisiana accesses "The Work Number," a private automated service that verifies employment and income (a data source most useful for large employers). Ex parte reviews help states avoid unnecessary and repetitive requests for information from families that can add to state administrative burdens while making it difficult for individuals and families to retain coverage.

More than half of Louisiana Medicaid cases and one third of CHIP cases are renewed through ex parte review, meaning that the eligibility worker is able to verify ongoing eligibility by checking these databases and sources of information. In these cases, the worker simply sends out a notice to the household informing them that their coverage has been renewed.

Follow-up by Phone

When an eligibility worker can verify some but not all of the information needed to process a renewal through the ex parte process, they will follow up by phone to ask the individual to provide whatever additional information is needed. In early efforts, when workers did not have current phone numbers for many of the households they have aggressively sought out those numbers. This has become less of an issue since most families now rely on cell phones and tend to keep the same numbers even if they have moved.

Rolling or Off-Cycle Renewals

Another strategy that Louisiana employs to promote renewals that do not require mailing and returning forms is to allow rolling or off-cycle renewals online or when the family is otherwise in contact with the agency. This means that families do not have to wait until the renewal is due to provide updated information that confirms ongoing eligibility and starts a new renewal period. By providing this option, the state provides opportunities for families who have reason to visit the program website or talk with program staff to renew coverage at any time.

Renewal Mailings Encourage Families to Renew by Phone or Online

Returned mail for families due for renewal has been a longstanding bottleneck in state renewal processes. In Louisiana, this problem is significantly diminished considering that renewal reminders are mailed only to Medicaid and SCHIP families who have not been renewed administratively, through ex parte review, or off-cycle before the renewal date. By testing and tracking different strategies, Louisiana discovered that it was more effective to send a friendly letter (rather than a renewal form) requesting the family to renew by phone or online. By phone, families can talk directly with an eligibility worker during business hours or access a 24/7 automated voice response (AVR) system to provide needed information. Information taken over the phone or submitted online is verified using administrative means. Louisiana has adopted a policy that income only needs to be verified through documentation if the reported income cannot be verified through databases and the reported income is below 25 percent of the upper income eligibility limit.

Almost half of CHIP families (45%) and nearly a quarter of Medicaid families (22%) complete the renewal process over the phone. Louisiana reports that families are extremely enthusiastic about the ability to renew by phone. Eligibility caseworkers also believe that the eligibility decision is more accurate based on a telephone interview with no renewal form versus a signed form where there is no direct contact with the parent or caretaker.

Aggressive Follow-up on Outstanding Renewals

Louisiana conducts aggressive follow-up when cases have not been renewed through the efforts noted above. In particular, the state takes considerable steps to find families who could not be located at the address or phone number on file. Efforts to contact these families include using information from other computer systems, schools, and medical providers. Online searches and phone calls are required and must be documented by eligibility workers and front-line supervisors. While this requires an investment of staff time, the agency has found that overall the time spent is less than that required to close and then reopen a case.

Closures Require Supervisory Review

Before a case can be closed at renewal, a supervisor works with the eligibility worker to review the actions that have been taken to conduct an ex parte review and connect with the family. Together they brainstorm and attempt other ways to locate and reach the family. A minimum of three documented calls to connect with the family is required before closure and often many more are made. Documented notes on attempts to the reach the family must support the closure decision. Significantly, each eligibility office and parish (similar to counties in other states) reports its renewal data monthly. Statewide goals are developed and each office and parish is accountable for achieving those goals.

Policy Changes

Louisiana implemented these policy changes along the way to ensure retention of eligible children at renewal:

- Signed form not required to review eligibility
- Eligibility can be renewed anytime (rolling or off-cycle renewal)
- Not necessary to send a renewal form prior to closure (friendly reminders have proven more effective)
- Reasonable certainty verification standard, meaning that eligibility workers renew cases if, based on all of the information gathered, there is a "reasonable certainty" that the individual/family is eligible
- Income verification not required unless declared income is within 25% of income limit and cannot be verified through databases available to the department

Elements of Success

State officials attribute their success to creating a greater sense of purpose among eligibility caseworkers. Staff members are educated about the barriers families face in getting and staying enrolled and about the importance of health coverage not only to the child but also to the state and society at large. Over time the state has shifted expectations of eligibility caseworkers from passive to pro-active with a focus on the outcome as it affects children. Eligibility staff are encouraged and recognized for suggesting ways to streamline the work, eliminate waste, expedite the process, and improve customer service, all with the end goal of ensuring that no eligible child slips through the cracks. New ideas are tested on a small scale to see if they are effective and should be adopted on a larger scale.

Louisiana's retention improvement efforts have contributed to "green government." By going largely paperless, there is a huge efficiency gained in no longer opening and sorting mail, distributing it to workers and ultimately filing it. Administrative costs are lowered through reduced printing, postage, and staff time. Even states with electronic eligibility case records, which are a great foundation for building a paperless system, gain efficiency by eliminating the need to open and scan mail and documents into the electronic file.

Louisiana's experience demonstrates that focused, continuous, yet incremental change is important and that tracking, reporting, and sharing retention data is critical to measuring the impact of each change.[5] State officials contend that theirs is not a static process; that it continues to evolve as they find better ways of achieving results. Lessons learned highlight that retention improvement is a continual process with significant potential for enhanced outcomes and greater efficiencies.

Endnotes

[1] J. Costich and S. Slavova, "Churning: SCHIP Coverage Discontinuity and Its Consequences," University of Kentucky (presentation, AcademyHealth, San Diego, CA, June 8, 2004).

[2] B. Sommers, "Why Millions of Children Eligible for Medicaid and SCHIP are Uninsured: Poor Retention Versus Poor Take-Up," *Health Affairs* 26(5): w560-w567 (July 26, 2007).

[3] L. Summer and C. Mann, "Instability of Public Health Insurance Coverage for Children and Their Families: Causes, Consequences, and Remedies," Commonwealth Fund (June 2006).

[4] Letter from Centers for Medicare and Medicaid Services to State Medicaid Directors, (April 7, 2000).

[5] T. Brooks, "Data Reporting to Assess Enrollment and Retention in Medicaid and SCHIP," Center for Children and Families (January 2009).

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