09-306 Bureau of Health Services Financing
Medical Vendor Payments

Vision
We envision a future where the people of Louisiana are healthier through accessible, quality and comprehensive health care services with emphasis on efficiency and cost effectiveness in community-based settings.

Mission
Our mission is to respond to the health needs of Louisiana's citizens by developing, implementing, and enforcing administrative and programmatic policy with respect to eligibility, licensure, reimbursement and monitoring of health care services, in concurrence with federal and state laws and regulations.

Philosophy
Our philosophy is to administer the Medicaid program in an equitable manner, while continuing to seek ways of providing effective and innovative customer service.

Executive Summary
The direction of health care on both the national and state level has been toward more cost-effective, comprehensive, accessible, community-based, and individualized services. Louisiana has taken steps to shift from overall higher-cost institutional to lower cost preventive, primary and home and community-based long-term care. It has expanded Medicaid eligibility through the LaCHIP program and other initiatives. Louisiana completed statewide expansion of the primary care case management program, CommunityCARE, which provides access to a medical home for more than 75% of the Medicaid population. Medicaid now focuses on the quality of care provided to our population. To accomplish this, the Bureau uses the Health Plan Employer Data and Information Set (HEDIS) tools currently deployed by more than 90 percent of America's health plans measuring performance on important care and service dimensions. Additionally, we enhance healthcare access, quality and efficiency with pay for performance initiatives. As technology moves medical care forward, Medicaid providers must utilize electronic tools to streamline work processes resulting in increased program operation efficiencies and to provide improved delivery of healthcare services. In the event of another national disaster, the Medicaid provider community must be prepared by having implemented tools facilitating continuity of operations regardless of the patient's geographical location.

Strategic Links

Vision 2020: Vision 2020 is directly linked to Medical Vendor Administration as follows:

Goal Three: *To achieve a standard of living among the top ten states in America.*
Objective 3.3: T*o ensure quality healthcare for every Louisiana citizen.*
Objective 3.4: *To improve the quality of life of Louisiana's children.*

Children's Cabinet: In general child/adolescent services identified in this budget unit are indirectly linked to the Children's Cabinet via the Children's Budget. The Children's Budget reflects funding and expenditures for a broad range of Medicaid services for children under 21 years of age. The specific links to the recommended funding priorities for the Children's Cabinet are as follows:

Healthy People 2010: Linkage to Healthy People 2010 is through

Goal 1: *Improve access to comprehensive, high-quality health care services.*

- *1-1 Increase the proportion of persons with health insurance.*
- *1-4 Increase the proportion of persons who have a specific source of ongoing care.*
- *1-5 Increase the proportion of persons with a usual primary care provider.*

Human Resource Policies Beneficial to Women and Families: This agency supports Act 1078 by insuring the provision of healthcare services to women and families. The Bureau of Health Services Financing is committed to providing health and medical services for the prevention of disease for the citizens of Louisiana, particularly those individuals who are indigent and uninsured, persons with mental illness, persons with developmental disabilities and those with addictive disorders.

Goal I

To improve health outcomes by emphasizing primary care and reducing the number of uninsured persons in Louisiana.

Goal II

To expand existing and develop additional community-based services as an alternative to institutional care.

Goal III

To ensure cost effectiveness in the delivery of healthcare services by using efficient management practices and maximizing revenue opportunities.

Goal IV

To assure the integrity and accountability of the health care delivery system in an effort to promote the health and safety of Louisiana citizens.

Goal V

To implement measures that will constrain the growth in Medicaid expenditures while improving services and to secure alternative sources of funding for healthcare in Louisiana.

Program A: Payments to Private Providers
and
Program B: Payments to Public Providers

Programs A and B are being combined for planning purposes. In terms of services rendered, the programs and their goals, objectives and indicators are identical. Payments for services rendered are made to either public or private providers and will be reported along those lines. It should be noted, however, that control over the amount of monies going to public versus private entities is affected by the service recipient's choice of providers.

Programs A & B Mission

The mission of Payments to Private/Public Providers is to administer the Medicaid Program to ensure operations are in accordance with federal and state statutes regarding medically necessary services to eligible recipients.

Programs A & B Goals

I. To provide cost effective and medically appropriate pharmaceutical services.
II. To improve health outcomes by emphasizing primary and preventive care.

Objective I: To reduce the rate of growth of expenditures for drugs in the DHH Pharmacy Benefits Management Program by maintaining the prior authorization program (PA) with updates to the preferred drug list (PDL) and obtaining supplemental rebates from drug manufacturers resulting in significant cost avoidance for the program through June 30, 2013.

Strategies:

1.1 Encourage providers to utilize the prior authorization program and preferred drug list when clinically appropriate.
1.2 Obtain supplemental rebates from drug manufacturers

Performance Indicators:

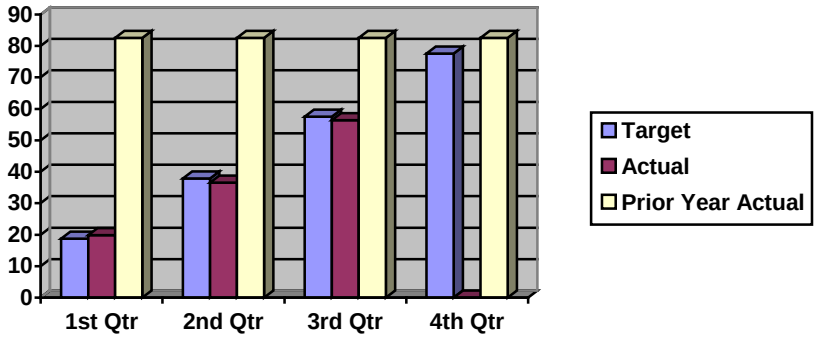
- Amount of cost avoidance (in millions)

General Performance Indicator

- Number of classes of therapeutic drugs established

Amount of cost avoidance avoidance (in millions), based on Provider Synergies Quarterly Pharmacy Reports FY 06-07

This graph measures cost avoidance resulting from the implementation of the Pharmacy PA and PDL and State Supplemental Rebates process.



Objective II: To encourage all Medicaid enrollees to obtain appropriate preventive and primary care in order to improve their overall health and quality of life as shown by well-visits and asthma measures through June 30, 2013.

Strategies:

2.1 Provide support and education to providers about the advantages of preventive care for their patients.

2.2 Provide education to all Medicaid enrollees about the advantages of preventive care in preventing disease.

Performance Indicators:

- Percentage of children that have at least six well-visits within the first 15 months of life
- Percentage of adults aged 20-44 years that have at least one preventive care visit per year
- Percentage of Medicaid enrollees, aged 5-56 years old identified as having persistent asthma who were appropriately prescribed asthma medication.

Program C: Medicare Buy-Ins and Supplements

Program C Mission

The mission of Medicare Buy-Ins and Supplements is to allow states to enroll certain groups of needy people in the supplemental medical insurance program and pay their premiums. The Medicare Buy-Ins and Supplements Program may permit the State, as part of its total assistance plan, to provide medical insurance protection to designated categories of needy individuals who are eligible for Medicaid and also meet the Medicare eligibility requirements. It has the effect of transferring some medical costs for

this population from the Title XIX Medicaid program, which is partially State financed, to the Title XVIII program, which is financed by the Federal government. Federal matching money is available through the Medicaid program to assist the States with the premium payments for certain buy-in enrollees.

Program C Goal

To avoid additional Medicaid cost by utilizing Buy-In (premiums) for Medicare and Medicaid eligibles.

Objective I: To save the State of Louisiana a minimum of $300 million by purchasing Medicare premiums for elderly, indigent citizens, rather than reimbursing the total cost of their health care each year through June 30, 2013.

Strategies:

1.1 To identify persons eligible for buy-in.
1.2 To pay Medicare premiums for eligibles

Performance Indicators:

- Buy-in Expenditures (Part A)
- Total number of recipients (Part A)
- Buy-in expenditures (Part B)
- Total number of recipients (Part B)
- Total number of Buy-in eligibles (Parts A & B)
- Total savings (cost of care less premium costs for Medicare benefits)

Objective II: To enroll people into the Louisiana Health Insurance Premium Payment (LaHIPP) program by reimbursing for employee sponsored insurance (ESI) for those that are working with a Medicaid eligible person in the home and is determined to be cost effective through June 30, 2013.

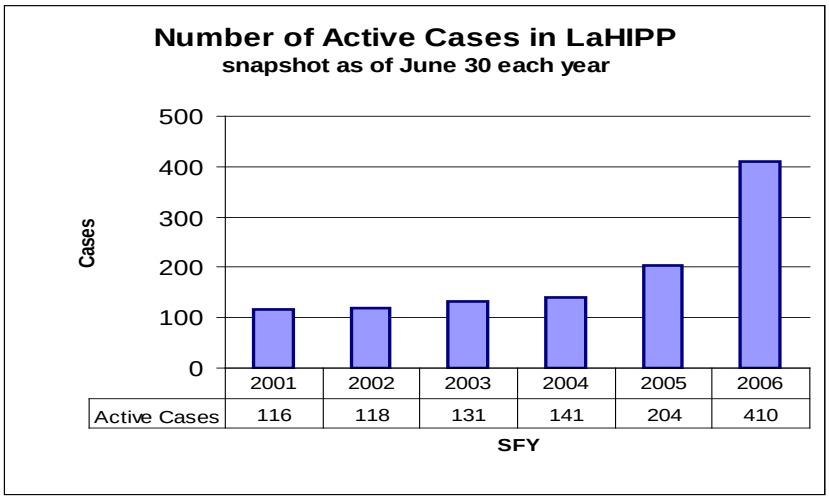
Strategies:

2.1 To identify persons eligible for buy-in.
2.2 To assist with premiums for ESI for those who are eligible.
2.3 To educate providers about LaHIPP

Performance Indicators

- Number of cases added in LaHIPP

This indicator measures number of cases added in LaHIPP.



Data Source: Checkwrite information for the LaHIPP Recipients Prior to 2005 the information was from the GHIP system thereafter the LaHIPP system.

Program D: Uncompensated Care Cost

Program D Mission

The purpose of the Uncompensated Care Costs program is to encourage hospitals and providers to serve uninsured and indigent clients. As a result, the client's quality and access to medical care is improved. Louisiana's disproportionate share hospital cap allotment provides federal funding to cover a portion of qualifying hospitals' costs of treating uninsured and Medicaid patients. If this funding was not available, hospitals' cost of treating uninsured would have to be financed by State General Fund.

Program D Goal

To encourage hospitals and other providers to provide access to medical care for the uninsured and to reduce reliance on the State General Fund to cover these costs.

Objective I: To encourage hospitals and other providers to provide access to medical care for the uninsured and reduce the reliance on the State General Fund by collecting disproportionate share (DHS) payments through June 30, 2013.

Strategies:

1.1 To utilize Disproportionate Share Payments (DSH).

Performance Indicators

- Total DSH funds collected in millions

- Total federal funds collected in millions
- Total State Match in millions
- Public Disproportionate Share (DSH) in millions
- Amount of federal funds collected in millions (public only)
- State Match in millions (public only)

General Performance Indicator

- Number of state facilities in DSH
- Number of private facilities in DSH

Total federal funds collected in millions FY 06-07

This indicator measures payments made during the state fiscal year to all hospitals that qualify for Medicaid disproportionate share payments.