Contract No.: HHS-100-01-0002
MPR Reference No.: 8782-071

MATHEMATICA
Policy Research, Inc.

# Congressionally Mandated Evaluation of the State Children's Health Insurance Program

## *Site Visit Report: The State of Louisiana's LaCHIP Program*

***February 18, 2002***

***Nancy Fasciano***

Submitted to:

U.S. Department of Health and Human Services
The Office of the Assistant Secretary for Planning and Evaluation
Hubert H. Humphrey Bldg., Rm. 443E
200 Independence Avenue, SW
Washington, DC 20201

Project Officer:
Stephen Finan

Submitted by:

Mathematica Policy Research, Inc.
P.O. Box 2393
Princeton, NJ 08543-2393
(609) 799-3535

and

The Urban Institute
2100 M Street, NW
Washington, DC 20037

Project Director:
Judith Wooldridge

## CONTENTS

**CONTENTS** (*continued)*

## TABLES

## FIGURES

# I. PROGRAM OVERVIEW

Louisiana's Title XXI program, known as "LaCHIP," is a Medicaid expansion program that covers children up to 200 percent of the Federal Poverty Level (FPL). Submitted to the Centers for Medicare and Medicaid Services (CMS, formerly the Health Care Financing Administration) on July 31, 1998, Louisiana's plan was the forty-third approved by the agency. Currently, Louisiana is one of 16 states that have opted to use Title XXI funds solely to expand Medicaid coverage, and one of only 7 states with Title XXI Medicaid expansion programs that did not have Title XIX Section 1115 demonstrations pending or in place in their Medicaid programs prior to implementing SCHIP.

Louisiana phased in SCHIP coverage over a period of about two years (Table 1). On November 1, 1998, the state implemented the first phase of its program, expanding coverage to children ages 6 through 18 with family incomes up to 133 percent of the FPL, the level to which younger children were covered under Title XIX. Given the state's historically low levels of coverage for children born after September 30, 1983, this expansion represented a significant increase in coverage for adolescents. The state subsequently raised the LaCHIP income standard to 150 percent of the FPL on October 1, 1999, and to 200 percent of the FPL on January 1, 2001 (Table 2).

Administered by the Bureau of Health Services Financing in the Office of Management and Finance in the Department of Health and Hospitals (DHH), LaCHIP provides services through a fee-for-service system throughout most of the state. Recently, the Medicaid program announced plans to expand its primary care case management program (PCCM) beyond the 20 rural parishes (counties) in which it now operates and to implement the program statewide by

TABLE 1

SCHIP STATE PLAN AND AMENDMENTS

| | Dates | | | |
|---|---|---|---|---|
| Document | Submitted | Approved | Effective | Description |
| Original Submission | 7/31/98 | 10/20/98 | 11/1/98 | Implemented Medicaid expansion, "LaCHIP," covering children up to age 19 with net family incomes up to 133% of the FPL |
| Amendment 1 | 6/30/99 | 8/27/99 | 10/1/99 | Raised LaCHIP income standard to 150% of the FPL |
| Amendment 2 | 12/18/00 | 6/6/01 | 1/1/01 | Raised LaCHIP income standard to 200% of the FPL |

SOURCE: Centers for Medicare and Medicaid Services (CMS), "Louisiana Title XXI Program Fact Sheet." CMS web site, http://www.hcfa.gov/init/chpafsla.htm.

NOTES: SCHIP=State Children's Health Insurance Program. FPL=federal poverty level.

TABLE 2

MEDICAID AND SCHIP INCOME ELIGIBILITY STANDARDS[a], EXPRESSED AS A PERCENTAGE OF THE FEDERAL POVERTY LEVEL (FPL)

| | Age (in Years) | | | |
|---|---|---|---|---|
| | Up to 1 | 1-5 | 6-17[b] | 17-18[c] |
| Medicaid standards in effect 3/31/97 | Up to 133% | Up to 133% | Up to 100% | Up to 10% |
| SCHIP Medicaid expansion | 133-200% | 133-200% | 100-200% | 10-200% |

SOURCES: Louisiana Department of Health and Hospitals (DHH), *Annual Report of State Children's Health Insurance Plans Under Title XXI of the Social Security Act, 2000*, March 22, 2001. Centers for Medicare and Medicaid Services (CMS), "Eligibility Standards in the 50 States and District of Columbia (01/01/01)." Louisiana DHH, "More Children Now Eligible for Health Insurance," January 9, 2001.

NOTES: SCHIP=State Children's Health Insurance Program (Title XXI).

[a] Income standards are net of deductions for child support, alimony, childcare, and work expenses.

[b] Children born after September 30, 1983, who are more than 5 years of age. The eldest children in this group are now age 17. In November 1998, when LaCHIP was implemented, the age range covered under Title XIX Medicaid up to 100 percent of the FPL was 6-15 years.

[c] Children born on or before September 30, 1983, who are less than 19 years of age. The youngest children in this group are now age 17. In November 1998, when LaCHIP was implemented, the age range covered under Title XIX Medicaid up to 10 percent of the FPL was 15-18.

December 2003. The state also plans to seek CMS approval to extend LaCHIP coverage to low-income parents and pregnant women under a Section 1115 demonstration in Title XXI when state funding becomes available.

As of July 2001, 56,227 children were enrolled in LaCHIP (Kennedy 2001). Enrollment of children in Title XIX Medicaid also increased significantly with the implementation of LaCHIP, and there is widespread agreement that the state has conducted a highly successful marketing campaign and significantly streamlined the application form and process. However, providers, advocates and public health officials reported that access to care, particularly specialty services, has deteriorated because of persistently poor reimbursement and repeated rate cuts in the past few years. Few believe that the expansion of the PCCM program will adequately address these access issues.

This case study is based primarily on a visit to Louisiana conducted June 11-15, 2001, as part of the Congressionally-Mandated Evaluation of the State Children's Health Insurance Program. The visit included interviews with state agency staff, legislators, child health advocates, front-line eligibility workers, health care providers, and staff of organizations involved in outreach and application assistance. (See Appendix A for a list of informants and site visitors.) To gather information about policy development and local implementation of LaCHIP, our time on site was divided between the state capitol (Baton Rouge), New Orleans and several localities in the Thibodaux region.

A seven-parish (county) area in southwestern Louisiana known as the "Cajun Coastline," the Thibodaux region is a primarily rural area with an economy based largely on oil, shipbuilding, and sugarcane.[1] Our visit included interviews in Thibodaux, Franklin, and Houma (the parish

[1] The seven parishes are Assumption, Lafourche, St. Charles, St. James, St. John, St. Mary and Terrebonne.

seats of LaFourche, St. Mary, and Terrebonne parishes, respectively). Houma is the largest of the three towns, with a population of about 30,000, compared with Thibodaux's 14,000, and Franklin's 9,000. Lafourche Parish has the highest concentration of Cajuns (over one-third of the population), and St. Mary the lowest. St. Mary is the most westerly and poorest of the three parishes (Louisiana Department of Economic Development 1998).

Together, the seven bayou parishes account for about 9 percent of both the state population and LaCHIP enrollees, while Orleans Parish, which includes the city of New Orleans, accounts for about 11 percent of the state population and 12 percent of LaCHIP enrollees (Kennedy 2001).

## II. BACKGROUND AND HISTORY OF SCHIP POLICY

The passage of the federal SCHIP legislation touched off a struggle between DHH and the Department of Insurance for control of the state's Title XXI program, a struggle waged—and eventually won by DHH—in meetings of the LaCHIP task force from the fall of 1997 to the spring of 1998. Established by executive order of the governor at the urging of DHH administrators, the LaCHIP task force was chaired by state Senator Donald Hines, M.D., a family practice physician, and included several other legislators as well as representatives of DHH, the Department of Insurance, the governor's office and the Louisiana State University (LSU) Medical Center. A subcommittee of health care providers, advocates, and state agency staff was formed to address outreach and enrollment issues.

DHH representatives to the task force believe that by persuading the governor to establish the task force to develop recommendations to the legislature, it averted the "free-for-all" in legislative committees that might otherwise have ensued. Advocates and state agency staff alike credit Senator Hines with promoting a deliberative, inclusive process that allowed advocates, insurers, providers and state staff to weigh in on various aspects of program design.

The key issue was the fundamental structure of the program. DHH wanted to use Title XXI funds to expand Medicaid coverage, while the Department of Insurance wanted to establish a separate child health program that it would oversee. The task force eventually recommended a phased combination of the two, starting with a relatively small Medicaid expansion (to 133 percent of the FPL), followed by a further Medicaid expansion (to 150 percent of the FPL), culminating with the establishment of a separate child health program that would cover children with family incomes from 150 to 200 percent of the FPL and include cost sharing. The legislation establishing the program gave DHH the lead and called for the agency to establish an

interagency agreement with the Department of Insurance to manage the third phase of the program. However, by the time the legislature was ready to authorize this final phase, the Medicaid program had "proved itself," in the words of the state Maternal and Child Health (MCH) director, and the Department of Insurance had lost interest in setting up a separate child health program. Thus, the final expansion was implemented under Medicaid.

Task force participants generally agreed that the state opted to begin and eventually continue with a Medicaid expansion for two primary reasons: (1) the operational structure for the program was already in place, thereby permitting a more rapid and less costly start-up than would have been possible with a separate child health program; and (2) the Medicaid benefit package was considered more appropriate than the packages offered by most private insurance plans. One task force participant stated that the ability to cover children of state employees under a Medicaid expansion (which would not have been allowed under a separate program) was also a key factor because of the high cost and low take-up rates for dependent coverage in the state employee plan, but other participants either did not mention this or stated that it was only a secondary consideration.

Little or no concern was expressed during the policy debates about the possibility of a Medicaid expansion carrying a stigma. Respondents agreed that perceptions of the Medicaid program were less negative in Louisiana than in many other states, because Medicaid coverage is so common (one-half of the births in the state are covered by Medicaid [National Center for Health Statistics 1998]) and because the state had made changes years earlier that had effectively destigmatized the program.

In 1988, the state legislature, seeking a more manageable organizational structure, ordered that the state agency that housed both DHH and the Department of Social Services (DSS) be split in two. Initially, DSS retained responsibility for determining eligibility for Medicaid, as well as

food stamps and cash assistance, but in 1992, responsibility for Medicaid eligibility determination shifted to DHH, which was already managing service delivery and financing. In addition to setting up parish offices to determine Medicaid eligibility, DHH established a network of Medicaid Application Centers (MACs) at health care facilities and community-based organizations to eliminate the need for applicants to go to the parish offices to apply for coverage. DHH staff at both the state and parish level contend that the split from DSS and the separation of Medicaid from cash assistance promoted a more positive attitude toward Medicaid on the part of both staff and eligibles. One caseworker in a local parish office stated that before the split, "staff looked for ways to deny coverage, [now] we look for all the reasons someone might be eligible."

Perceptions of the Medicaid program were not entirely positive, however. One criticism leveled at DHH during the task force meetings was that the agency had failed to enroll one-third of the children who were eligible for Title XIX coverage. A commitment by DHH to work with advocates to streamline the state's cumbersome Medicaid application form and enrollment process helped assuage this concern.

A larger issue was the mushrooming Medicaid budget. DHH staff reported that many legislators were wary of expanding the entitlement program because Medicaid costs had frequently exceeded projections. Moreover, "they were afraid that this was another program where the federal government would get the states hooked and then cut their feet out from under them," in the words of one hospital administrator. Enormous cuts in federal disproportionate share hospital (DSH) payments to the state two years earlier fueled this anxiety. (Between 1995 and 1996, combined state and federal DSH spending in Louisiana was slashed from $1.2 million to about $662 billion [Fagnani and Tolbert 1999].)

Respondents unanimously agreed that the phased-in approach to expanding coverage was critical to the legislature's approval of LaCHIP. The plan was for the program to expand each year if appropriations were made, which allowed the legislature to control how quickly the program grew. According to one lobbyist, DHH "built trust in the legislature by accurately predicting what would happen in each phase." The use of enrollment projections from a single source that proved highly accurate helped bolster the agency's credibility.

# III. OUTREACH

## A. INTRODUCTION

In its outreach for LaCHIP, DHH sought to forge a new identity for the Medicaid program and empower field staff in the nine regional DHH offices to experiment with new promotional strategies. At the state level, the Medicaid program has worked closely with its sister organization in DHH, the Office of Public Health, which holds the state's Covering Kids grant from the Robert Wood Johnson Foundation. The Medicaid program has also partnered with the Department of Social Services to promote LaCHIP to food stamp recipients and with the Office of Public Health to reach WIC participants. At the local level, DHH offices have partnered with schools, health care providers, fast food restaurants, faith-based organizations, and other community-based groups.

Louisiana has spent relatively little on outreach. In fiscal year 2000, for example, the state devoted about $128,000, or less than half of one percent of total program expenditures, to outreach. (Total administration costs amounted to less than 7 percent of expenditures in 2000 [DHH 2000].) However, spending is expected to increase, as DHH has authorized overtime pay for field staff who do outreach after normal working hours.

## B. STATEWIDE MEDIA EFFORTS

The "LaCHIP" name has been an important part of the state's strategy to promote Title XXI coverage. To reinforce the new program identity, the state has produced and distributed (in partnership with Covering Kids) an array of colorful promotional materials, including posters, brochures, mugs, and post-it notes.

Key components of state-level outreach include:

- ***Broad Distribution of Applications.*** The LaCHIP application was designed to be both a data collection form and a marketing tool. Instead of a simple legal-size sheet, the state created a tri-fold application/brochure that can be easily displayed in a "take-one" plastic holder placed on a countertop or mounted on a wall. To date, DHH has distributed well over a million applications through the efforts of Medicaid field staff, Covering Kids, and other organizational partners.

- ***Hotline.*** Like most states, Louisiana established a toll-free number to field inquiries about its Title XXI program. Families who want an application can leave their name and address on the automated system operated by the central processing office in Baton Rouge. Since October 1998, over 40,000 callers have requested applications.

- ***School Outreach***. The state's largest single outreach effort is its back-to-school campaign, conducted in partnership with Covering Kids, the state Department of Education and the National School Lunch Program. Launched in 1999 and expanded in 2000, the back-to-school campaign delivered to every schoolchild in the state a LaCHIP flyer along with the application for the Free/Reduced-Price School Lunch Program. (Some 860,000 flyers were distributed in 2000.) DHH and Covering Kids also collaborated on outreach to school principals, developing a PowerPoint presentation and other materials that principals can use to promote LaCHIP at Parent-Teacher Association meetings and other gatherings. This year, DHH and Covering Kids partnered with Wal-Mart stores to distribute flyers and other promotional items to back-to-school shoppers.

- ***Radio Advertising***. In the second year of the program, the state spent $25,000 on radio advertising for LaCHIP. Another $30,000 is budgeted for this year. The Covering Kids national office also selected New Orleans as one of two media sites for a six-week radio advertising campaign in March and April 2001.

- ***Media Events***. DHH has obtained free media coverage by holding LaCHIP "launch meetings" featuring key public officials.

The state has targeted special outreach efforts to particular groups. For example, DHH used a portion of its Federal TANF outreach funds and worked with DSS to target a mailing to food stamp recipients who were not enrolled in Medicaid. The state also created special posters and brochures for placement in DSS offices statewide.

In addition to spearheading the back-to-school campaign, the statewide Covering Kids initiative has produced local television advertising and conducted extensive outreach to day care centers. The Covering Kids grantee, the Office of Public Health, also collaborated with the

Medicaid program to inform WIC and Medicaid eligibles about income verification requirements (WIC started requiring income verification at the time LaCHIP was implemented); public health administrators also included information about LaCHIP in WIC staff training. The two Covering Kids pilot projects have formed broad-based coalitions to promote LaCHIP. Both projects have distributed information through schools, faith-based organizations, childcare providers, and other grassroots organizations. The Orleans Parish project, operated by Agenda for Children, has also recruited medical school students to help families complete applications at enrollment events, made cold calls and presentations to employers to interest them in making information about LaCHIP available to their employees, and persuaded chain stores (Kmart, Wal-Mart and Rite Aid) to post materials and/or participate in enrollment events.

Promotional messages vary slightly depending on the source and target audience, but the gist of most LaCHIP promotions is, "free health care for kids." Posters and flyers in the DSS offices pitched LaCHIP by emphasizing the delinking of health coverage from TANF: "On welfare? Off welfare? It doesn't matter – your kids can still get health insurance at no cost." The flyer distributed with school lunch applications underscored that the program serves working families ("Working families may be able to get no cost health coverage through LaCHIP"). The Covering Kids radio campaign spoke to the anxieties of families with limited disposable income ("You don't have to make a choice between buying groceries and taking your child to the doctor"). DHH staff noted that the promotional messages developed by the national Covering Kids office had to be tailored for Louisiana by removing the reference to "low-income" families, as families in Louisiana with incomes up to 200 percent of the FPL do not necessarily consider themselves low income. Staff also mentioned the importance of conveying that LaCHIP serves adolescents as well as younger children and said that the Louisiana Covering Kids initiative had

sought to make the program more attractive to junior high and high school students by developing a flyer that features photos of teens.

## C. COMMUNITY-BASED EFFORTS

Louisiana has relied heavily on its regional and parish offices and on community-based groups to publicize LaCHIP—an approach state staff call "bubble-up outreach." Although prompted in part by limited state funding and lack of political support for outreach, delegation to regional office staff was also seen as an effective way to encourage creative localized strategies and promote "ownership" of the program among field staff. The state initiated this strategy with intensive internal marketing ("inreach") to field staff about the importance of health insurance and why families may incorrectly assume their children are not eligible for LaCHIP. The state DHH office then directed the nine regional offices to develop outreach plans structured to meet regional needs. One of the few state requirements was that the regional offices stage launch meetings to kick off their campaigns and generate support from community-based organizations and other stakeholders. Some 120,000 applications were distributed at these launch meetings.

To support regional efforts, the state has provided promotional items, PowerPoint presentations, media training, scripts for public service announcements, draft press releases, and information about outreach efforts in other states (drawn from state SCHIP plans and the Internet). Best practices are shared among the regions through e-mails, monthly reports, and meetings of the regional coordinators.

Outreach strategies used in the nine regions include distribution of applications at school fairs and health fairs; outstationing of additional Medicaid staff at hospitals; placement of articles and editorials in local newspapers; distribution of applications during toy drives; contacts with employers; and appearances by Medicaid staff on local TV and radio programs. As noted, the regional offices have also garnered support from a broad range of local organizations. For

example, the Thibodaux regional office has an active partnership with Catholic Social Services, which has spread the word about LaCHIP through its food banks, money management classes, emergency assistance program, day care center, foster grandparent program, and diocesan publications.

The state DHH office has also awarded a few small grants to community-based organizations to conduct intensive outreach in selected areas with low enrollment. For example, DHH funded outreach workers in St. Landry Parish to go door to door helping families apply for Medicaid and LaCHIP.

## D. IMPLEMENTATION EXPERIENCES AND LESSONS LEARNED

By all accounts, Louisiana's outreach efforts have been highly successful. The state estimated in 2000 that about 160,000 children were uninsured and eligible for either Title XIX or Title XXI coverage (DHH 2000).[2] As of July 2001, 56,227 children were enrolled in LaCHIP. Another 81,884 children had been added to the Title XIX Medicaid rolls, bringing the total number of children enrolled in Title XIX Medicaid to 397,155. Application assistors and advocates agreed that the state has succeeded in creating a new identity for children's Medicaid coverage. As one advocate put it, "The perception is that LaCHIP is different than Medicaid….People know that LaCHIP is a government program, but the name doesn't have any negative connotation."

DHH and Covering Kids staff reported that the single most effective outreach effort has been the back-to-school campaign. A graph of the number of applications received each month since the program's inception shows sharp peaks in August and September of 1999 and 2000, the

[2] The estimate of the same population (number of uninsured children with family incomes below 200 percent of the FPL) that was used by the U.S. Department of Health and Human Services to determine the state's 1998 allotment was 194,000 (*Federal Register* 2000).

months in which LaCHIP flyers went home with free lunch applications. Calls to the hotline jumped almost 600 percent between July and August of both years. Media campaigns were also associated with significant, but smaller, spikes in enrollment. (In addition to tracking the numbers of calls and applications received, the state asks callers and applicants where they heard about LaCHIP.)

Although state-level efforts have had the most obvious impact on enrollment, state Medicaid and Covering Kids staff emphasized the importance of local involvement. The Medicaid Deputy Administrator said she believes the most important lesson the state has learned is that "if something needs to be done, give the task to local staff." Encouraging field staff to take ownership of outreach efforts for LaCHIP has promoted commitment and enthusiasm for the program and inspired creative initiatives tailored to individual communities. Covering Kids staff stressed the need to combine "macro and micro" outreach efforts: "The macro efforts, such as media, bring in the big numbers, while the micro—more one-on-one efforts, the involvement of CBOs and so forth—reach the people who are most at risk and hardest to reach." The associate director of Catholic Social Services concurred regarding the importance of CBOs and one-on-one contact: "People are more open to listening to us because we ask them questions before giving them brochures. There's a high level of trust. They understand that we're giving them this information because we think they need it."

Community-based organizations and parish Medicaid offices have also identified ineffective strategies. Activities that produced disappointing results include distributing applications through booths or tables at health fairs, parish festivals, or at parent-teacher nights; including applications as inserts in local newspapers; and asking large employers to make materials available to employees. For example, respondents said that few people stopped at booths or tables to pick up information about LaCHIP, either because they were embarrassed to show an

interest in public insurance or because they were focused on other things at the time (such as talking with their children's teachers).

# IV. ENROLLMENT AND RETENTION

## A. POLICY DEVELOPMENT

Streamlining the application form and process for children was a high priority for both the LaCHIP task force and the legislature. The legislation authorizing the first phase of LaCHIP called for DHH to create a steamlined application process for both LaCHIP and CHAMP, Louisiana's poverty-related Title XIX coverage for children, by "significantly" shortening the application form, implementing 12-month continuous eligibility, developing a mail-in application process, and making information about applying for LaCHIP available at such locations as health care facilities, schools, community centers, churches, and grocery stores. (South Carolina's outreach and enrollment strategy served as a model.) Charged with shortening the application, the task force's outreach and enrollment subcommittee whittled down the 18-page form to one legal-size page (front and back). The state already had about 300 certified Medicaid Application Centers (MACs) in place statewide to provide information about the program and help families complete applications. To implement the mail-in application process called for by the legislature, DHH established a single processing unit in Baton Rouge, reasoning that centralization would facilitate monitoring and administration.

## B. ENROLLMENT PROCESSES

Like all state Medicaid programs, LaCHIP provides up to three months of retroactive eligibility for enrollees who incurred medical costs before they applied for coverage (Table 3). The state has not adopted presumptive eligibility for children but, as noted, grants 12 months of continuous eligibility from the date of application. The state uses net income standards, allowing deductions for child support, alimony, childcare, and work expenses. The asset test for children in the poverty-level groups was dropped in the early 1990s.

TABLE 3

MEDICAID/SCHIP ELIGIBILITY POLICIES

| Policy | Medicaid[a]/SCHIP Program |
|---|---|
| Retroactive eligibility | Yes, 3 months |
| Presumptive eligibility | No |
| Continuous eligibility | Yes, 12 months |
| Asset test | No |
| U.S. citizenship requirement | Yes (or qualified alien) |

SOURCE: Centers for Medicare and Medicaid Services (CMS), "Application and Enrollment Simplification Profiles: Medicaid for Children and SCHIP."

NOTE: SCHIP=State Children's Health Insurance Program (Title XXI).

[a]Children's coverage groups.

The one-page "LaCHIP" application, available in English and Spanish, can be used to determine eligibility for LaCHIP or CHAMP.[3] A longer form, the "1-G," is used to determine eligibility for TANF-related (Section 1931) and medically needy Medicaid coverage.

In July 2000, DHH relaxed its verification requirements for both LaCHIP and CHAMP (Table 4). In addition to requesting only one month of income verification instead of two, the state stopped requesting verification of age, household composition, state residency, and social security number. The state also adopted a policy of allowing caseworkers to approve LaCHIP applications without verification as long as the caseworker can conclude with "reasonable certainty" that family income is within the program limits—for example, by checking Department of Labor databases.[4]

[3] Although the application form is used for both LaCHIP and CHAMP, we will refer to it throughout this report as the "LaCHIP" application, as it is labeled.

[4] At the time of our visit, families applying for either 1931 or medically needy coverage were required to meet an asset test and supply considerably more documentation than LaCHIP applicants. In July 2001, DHH announced that the asset test will be dropped for all TANF-related programs effective October 1, 2001, and that until that time, verification of resources for TANF-related cases will no longer be required.

TABLE 4

APPLICATION AND REDETERMINATION FORMS,
REQUIREMENTS AND PROCEDURES

| Characteristic | Medicaid[a]/SCHIP |
|---|---|
| **APPLICATION** | |
| **Form** | |
| Joint Form | NA |
| Length | 1 legal-size page (front and back) |
| Languages | 2 (English and Spanish) |
| **Verification Requirements** | |
| Age | No |
| Income | Yes |
| Deductions | Yes |
| Assets | NA |
| State Residency | No |
| Immigration Status | No, required only of qualified aliens |
| Social Security Number | No |
| **Enrollment Procedures** | |
| Mail-in Application | Yes |
| Phone Application | No |
| Internet Application | No; form is available on the Internet |
| Hotline | Yes |
| Outstationing | Yes |
| Community-Based Enrollment | Yes |
| **REDETERMINATION** | |
| Same Form As Application | No (Slightly simplified form) |
| Pre-Printed Form | No |
| Mail-In Retermination | Yes |
| Income Verification Required | Yes |
| Other Verification Required | No |

SOURCE: Centers for Medicare and Medicaid Services (CMS), "Application and Enrollment Simplification Profiles: Medicaid for Children and SCHIP."

NOTE: SCHIP=State Children's Health Insurance Program (Title XXI). NA=Not applicable.

[a] Children's programs.

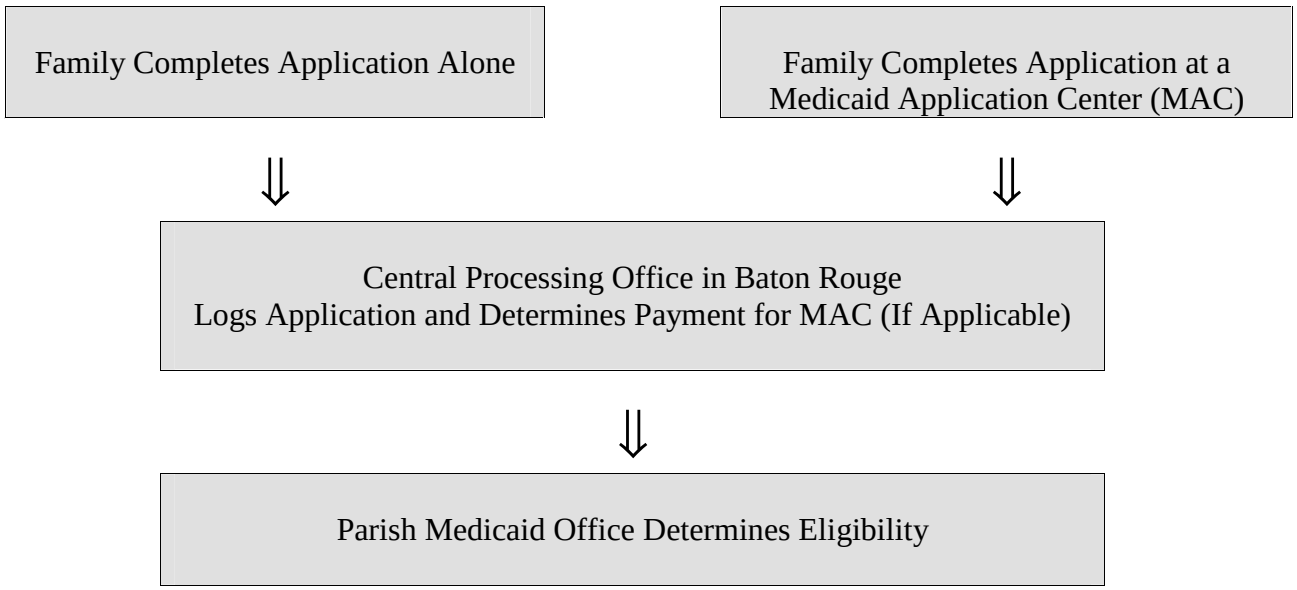
All LaCHIP applications must be mailed to the central processing office (Figure 1). Until April 2001, when the volume became overwhelming, all LaCHIP applications were processed at this office. Although the central office is still the receiving point for all LaCHIP applications, staff now send all applications to the parish Medicaid units for eligibility determination. The parish Medicaid offices also receive eligibility information from their sister DSS offices. Whenever a TANF case is certified, closed or rejected, the applicant/client data are electronically relayed to the Medicaid office to make an eligibility determination.

About 20 percent of the applications received by the central office come from MACs. The rest are sent directly by applicants; few families go to the parish Medicaid offices to apply. Organizations certified by the state as MACs include hospitals, Federally Qualified Health Centers (FQHCs), pharmacies, home health providers, transportation agencies, public housing agencies, faith-based organizations, Head Start centers, and community-based organizations, such as Councils on Aging. Executives of these organizations must complete application management training that covers such issues as record keeping and confidentiality; staff who will assist families with LaCHIP applications must complete a three-day training that covers eligibility requirements. (Unlike outstationed eligibility workers, MAC staff cannot determine eligibility.)

The procedures followed by the MAC staff we interviewed were fairly consistent. Depending on the type of site, families may be referred to the MAC by hospital or clinic admissions staff, a parish Medicaid office or a public health unit, or may self-refer, having seen information about the MAC in an ad, the yellow pages or the list of MACs in their application packet. MAC staff generally provide assistance by appointment and tell families at the time of scheduling what to bring with them. Some application assistors we interviewed regularly tell people to bring all the documentation required for the 1-G application, because they do not know

FIGURE 1

LACHIP/CHAMP APPLICATION AND ELIGIBILITY DETERMINATION PROCESS[a]




[a]The LaCHIP application is used for both LaCHIP and CHAMP (poverty-related Title XIX coverage).

in advance what kind of coverage the family may be eligible for. Assistors use a checklist provided by DHH to determine which application form to complete. The LaCHIP application is used only if parents indicate they do not want coverage for themselves. (Several respondents reported that some families ask to apply for LaCHIP because they have heard the name, but actually want coverage for the entire family and therefore must complete the longer 1-G form.) MACs are reimbursed $14 for every completed LaCHIP application that includes the appropriate verification (whether or not the application is approved.) Acceptable income verification includes pay stubs for the previous month or a wage form completed by the applicant's employer. If a family does not provide the required verification within 10 days, the MAC will generally submit the application without it.

The central processing office currently receives about 1000 applications per week. Each application is logged in and those submitted by MACs are checked for completeness. Then all applications are routed to the parish Medicaid offices and assigned to individual caseworkers for eligibility determination. If an application is incomplete, the case worker will attempt to contact the family or obtain the missing information from other sources, such as the state's Food Stamp Program database. Once a determination is made (within an average of 24 days from the date of application [DHH 2001a]), a notice that names the assigned caseworker is sent to the family.

## C. REDETERMINATION PROCESSES

In May 2001, DHH debuted a new LaCHIP renewal form. The form closely resembles the LaCHIP application but is shorter and requests information about household members only insofar as they have changed (members who have joined or left the household since the last application or renewal). In addition to completing the form, enrollees are required to provide verification of current income.

Sixty days before the case closure date, the Medicaid eligibility system generates a "scroll" that lists by caseworker the names of children who are due for renewal. Caseworkers in the parish offices then mail each family on their list a renewal letter and form. If the form is not returned to the central processing office (and then to the parish office) by the date specified, the caseworker sends a notice to alert the family that the case will be closed in 10 days. If the family still does not respond, the caseworker attempts a telephone contact. The case is held open until the third to the last working day of the month in which it is due to be closed.

In July 2001, DHH announced that families who are receiving food stamps will not be required to complete a renewal form and that caseworkers will instead complete an *ex parte* renewal based on information in the food stamp system.

## D. IMPLEMENTATION EXPERIENCES AND LESSONS LEARNED

As noted, enrollment of children in LaCHIP and Title XIX Medicaid has met state targets for phased-in enrollment increases, with a net increase of 138,111 children by the end of 2000 (Table 5). Simplification of the application form and process are widely perceived as key to the state's success in enrolling children. Application assistors consistently described the simplified LaCHIP form as "user friendly" and estimated that it takes about 15 minutes to complete, compared with about 45 minutes for the 1-G form. DHH staff reported that since the easing of verification requirements in July 2000, application approval rates have risen from about 50 percent to about 80 percent. Income verification remains a barrier, however. About one-quarter of the applications received by the central processing office are incomplete, the vast majority because of missing income verification.

Opinions differed somewhat about the importance of MAC assistance for LaCHIP. One regional administrator said he sees little difference in the applications completed by assistors and those completed by applicants, and assistors said that families are more likely to need help with the 1-G form than with the LaCHIP form. However, staff at the regional processing center indicated that applications submitted by MACs were more likely to be complete than those submitted directly by families. In addition, one health department administrator said that the "one-on-one" with families is important because it offers an opportunity to provide information about preventive care and program requirements, and several assistors reported that many families simply want someone to look over the form before they send it in. As noted, the procedures followed by MAC assistors were generally consistent. But the challenge of keeping a decentralized workforce informed about policy changes was evident in the misconception on the part of several of the assistors we interviewed that the three-month waiting period, eliminated in January 2001, was still in effect. (See discussion in Chapter V.)

TABLE 5

ENROLLMENT TRENDS

| Enrollment Measure | 1998 | 1999 | 2000 | July 2001[a] |
|---|---|---|---|---|
| Number ever enrolled in year | — | 21,580 | 49,995 | NA |
| Number enrolled at year end (point in time) | 3,741 | 26,649 | 42,304 | 56,227 |
| Percent change in point-in-time enrollment | — | +612% | +59% | +33% |

SOURCE: Centers for Medicare and Medicaid Services (CMS), "State Children's Health Insurance Program (SCHIP) Aggregate Enrollment Statistics for the 50 States and the District of Columbia for Federal Fiscal Years (FFY) 2000 and 1999"; Vernon K. Smith, "CHIP Program Enrollment: June 2000," Kaiser Commission on Medicaid and the Uninsured, January 2001.

[a]Most recent enrollment data available.

There was wide agreement that MACs are not fully compensated for the time involved in helping families complete applications, particularly the 1-G. DHH staff said that the $14 payment was not intended to be a "lucrative incentive," but to cover about half of the administrative cost involved. The MAC staff we interviewed indicated that their organizations are committed to helping families get Medicaid benefits, but the Medicaid manager in the Thibodaux region reported that some organizations have dropped their MAC certification since DHH increased the burden on MACs (by requiring them to collect verification for the LaCHIP form) without increasing their compensation.

Retention has proved considerably more challenging than enrollment. Retention issues came to the fore in the fall of 1999, when many children who enrolled in Title XIX Medicaid or LaCHIP when LaCHIP was implemented failed to complete the renewal process. (Enrollment of children in Title XIX Medicaid actually dipped as a result.) Since that time, DHH has streamlined the renewal form, extended the period in which it can be returned, begun requiring caseworkers to attempt to contact families who haven't returned their forms, and created new codes to track reasons for case closures. Tracking data show that 42 percent of the 2,642

LaCHIP enrollees who were up for renewal in June 2001 lost coverage. Although most of these cases were closed because the child no longer met the eligibility criteria for the program (e.g., the family's income exceeded the threshold or the child obtained insurance or turned 19), two-fifths of the closures (41 percent) were due to families failing to return the redetermination form or provide income verification. Another 2 percent were returned by the post office as undeliverable. (A survey conducted by the Terrebonne parish Medicaid office suggests that some families do not return the form because their children are no longer eligible. For example, 16 percent of the 40 families contacted said they had gotten other insurance.)

Several people we spoke with suggested that renewal rates have been low partly because the notion of "re-enrolling" was foreign to many families initially. In addition, some suggested that the ease of application and the availability of retroactive coverage may work against renewal. Said one physician, "People get lazy. They know they can get a new card in two weeks, and there's no consequence to not renewing."

This spring, DHH charged the regional Medicaid offices to develop and test new strategies for improving renewal rates. Some of the methods regions will test this fall include: attempting to verify income using administrative databases; completing a renewal form if one is not returned and sending it to the family for signature; sending additional reminders about renewal at various stages of the process (for example, with the approval notice, before the renewal form/notice is sent, and/or when the renewal form is not returned); using special stamps on the envelopes containing renewal forms (noting that it's flu season, for example, or simply stating "renewal forms enclosed").

# V. CROWD OUT

## A. POLICY DEVELOPMENT

Until January 1, 2001, the state denied coverage to applicants who had voluntarily terminated private coverage within the past three months. DHH staff said the three-month waiting period was implemented because CMS required crowd-out prevention measures and the legislature also wanted some sort of provision to prevent crowd out. However, a lobbyist for the MCH coalition recalled that because so many people in the state were uninsured, crowd out was never a major concern and "you couldn't find three legislators who knew what crowd out was." The state eliminated the waiting period after CMS issued new guidance stating that eligibility-related substitution provisions such as periods of uninsurance were inconsistent with the entitlement nature of Medicaid.

## B. PROGRAM CHARACTERISTICS

The state now denies coverage to children who have private insurance at the time they apply. The application form still asks not only whether applicants currently have insurance that covers doctor and hospital visits, but whether anyone has lost coverage in the past three months and why. The state is using this information to monitor whether crowd-out is occurring.

## C. IMPLEMENTATION EXPERIENCES AND LESSONS LEARNED

The extent to which crowd out is occurring is uncertain, but respondents generally believe that it is not uncommon for families with private dependent coverage to drop it to qualify for LaCHIP. According to one DHH administrator, "Crowd out is happening like crazy here. People are dropping coverage right and left." The number of families who are in a position to drop coverage is lower in Louisiana than elsewhere in the country, however, as Louisiana's children have a higher rate of uninsurance and a lower rate of employer-based coverage than

children in the U.S. as a whole [Employee Benefit Research Institute 2000].) Eligibility staff in the Baton Rouge parish office reported that 15 to 20 percent of LaCHIP applicants have other insurance at the time they apply. An assistor at Children's Hospital said that among the families she has helped, as many as one in five who had coverage has dropped it to apply for LaCHIP. Assistors who knew that the state had eliminated the waiting period generally indicated that the number of families who have dropped coverage has risen since the policy changed.

The state has no data to confirm that crowd-out is occurring, in part because application data do not necessarily reveal whether families dropped coverage before they applied. While the three-month waiting period was in place, fewer than one percent of applicants were denied LaCHIP coverage because they had private coverage during the waiting period; these applications were reviewed after CMS issued its new policy. Currently, 3 to 5 percent of applicants report on their application that they currently have other insurance; this accounts for 18 to 21 percent of all denials. Application assistors indicated that many families who are denied coverage because they have other coverage simply drop the coverage and reapply.

For many families, the decision to drop private coverage is a calculated risk, said one advocate, and is likely to depend on children's health status. Application assistors generally said that when they learn a family has other coverage they say nothing and simply send the application to DHH to make the determination; the letter from DHH informs the family that their application has been denied because the children have other coverage. Some assistors said that they have actively discouraged families from dropping their coverage by explaining that if their children are denied LaCHIP, they may not be covered for pre-existing conditions under their next private policy. Almost all of the people we interviewed were quick to point out that dependent coverage is prohibitively expensive for many families (for example, the employee share of the family coverage premium for the state employee plan is $575 per month, or about 20

percent of the gross income of a family of four at 200 percent of the FPL). Under the circumstances, said one Medicaid caseworker, “crowd out is not a bad thing.”

# VI. BENEFITS

## A. POLICY DEVELOPMENT

The comprehensive benefit package offered by Medicaid was a key reason that children's health advocates and health care providers supported a Medicaid expansion. Although some members of the LaCHIP task force expressed concern that the Medicaid benefit package was too rich, the ultimate consensus was that the benefits offered by benchmark plans were lacking, particularly in terms of services for children with special health care needs. Some of the packages reviewed by the task force did not even cover preventive care.

## B. BENEFIT PACKAGE CHARACTERISTICS

The Louisiana Medicaid program actually offers fewer optional benefits than any state but Delaware (DHH 2001b), but as required by federal law, children enrolled in Medicaid have access to the full scope of mandatory and optional Medicaid benefits under the state's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, known as "KidMed." Moreover, children can be exempted on the basis of medical necessity from the state limits that apply to many services (such as the limitation of physician visits to 12 per year). Louisiana also has generous prescription drug coverage and at the time of our visit, was the only state with a statute requiring an open formulary. (Act 395 of the 2001 legislature revised the Medicaid pharmacy program to permit the state to require prior authorization of certain drugs as well as other pharmacy management programs.) The only services not covered under LaCHIP are over-the-counter medications, residential substance abuse treatment, developmental assessments, hospice care, and habilitative services.

## C. IMPLEMENTATION EXPERIENCES AND LESSONS LEARNED

The LaCHIP benefit package is uniformly viewed as extremely generous relative to private insurance, particularly in terms of drug coverage and EPSDT benefits. One physician described KidMed as "the gold standard for screenings every child should get," and another praised the periodicity schedule for the program, noting that sending providers a monthly list of children who are due for services helps ensure that enrollees receive appropriate preventive care. Two physicians commented that the KidMed package may be overgenerous, covering some screens more frequently than may be medically necessary.

The lone complaints about the benefit package focused on coverage for inpatient and mental health care. Staff of Children's Hospital in New Orleans commented that the Medicaid program "severely curtails" length of stay for inpatient care, which is problematic for children with injuries that require extensive rehabilitation. Several providers said that the state effectively limits coverage of mental health care by excluding services provided by mid-level mental health professionals in some settings and allowing psychiatrists to bill only under general office visit codes instead of the specialty codes used by other states. As a result, psychiatrists are reimbursed at the same rates as primary care providers and must justify every bill with a lengthy explanation of services performed (DeSantis 2001).

# VII. SERVICE DELIVERY AND PAYMENT ARRANGEMENTS

## A. POLICY DEVELOPMENT

Concerns about health care access for Medicaid recipients surfaced during the policy debates surrounding the development of LaCHIP. Provider shortages are endemic in Louisiana, particularly in rural areas. At the time LaCHIP was under development, the state ranked worst in the nation in access to primary care, with 24 percent of the population residing in primary care provider shortage areas, compared with 10 percent nationwide (DHH 2000b).[5] Lacking a primary care provider, many people seek care in hospital emergency rooms. In 1998, the number of emergency outpatient visits to community hospitals was 517 per 1000 population, compared with 351 nationwide (DHH 2000b). Concerns that primary care access was even worse for Medicaid recipients than for other state residents prompted legislators to include in the LaCHIP legislation a 10 percent increase in reimbursement for three key procedure codes (office visits).

## B. SERVICE DELIVERY SYSTEM

Unlike most states, Louisiana still operates its Medicaid program largely as a fee-for-service program. Although the state implemented a PCCM program, CommunityCARE, in 1992, by mid-2000, the program was operating in just 20 of 64 parishes and serving only 6 percent of the state's Medicaid recipients (DHH 2000b). (Meanwhile, 56 percent of Medicaid recipients nationwide were enrolled in managed care, the vast majority in risk-based programs [CMS 2000].) The state recently announced its timetable for expanding CommunityCARE beyond the rural counties on the Arkansas and Texas borders, beginning with the Lake Charles region in the

[5] In 1999, the most recent year for which data are available, the state ranked second worst, with 23 percent of the population residing in primary care provider shortage areas (Health Manpower Shortage Areas), compared with 9 percent nationwide. (DHH 2001d).

southwestern area of the state in August 2001, adding another region every three months thereafter and concluding with the Shreveport-Monroe regions in December 2003. In 2000, 142 providers, employing a total of 238 physicians, (most of the primary care providers in the 20 parishes, according to state staff) were participating in CommunityCARE (DHH 2000b). The state also plans to implement a voluntary HMO program in New Orleans.

Since 1991, the state has contracted with Birch and Davis, a private firm headquartered in Maryland, to manage the KidMed program. The firm's responsibilities include enrolling, certifying, and training KidMed providers; scheduling and tracking medical appointments; monitoring quality of care; and conducting outreach. In 1994, the contract was expanded to include administration of CommunityCARE (Birch and Davis 2001). The state is currently seeking a disease management contractor to aid primary care providers (PCPs) with case management.

Providers serving children in the Medicaid program include state (charity) hospitals, small rural and community hospitals, community health centers (CHCs), public health units, and private primary and specialty care physician practices.

- ***State Hospitals.*** A unique aspect of the Louisiana health care system, and one that speaks to residents' longstanding reliance on the state for health care, is the state hospital system (formerly known as the charity hospital system). Run by the state from early eighteenth century until 1997 when operations were assumed by LSU Health Care Services Division, the system consists of 10 facilities scattered across the state, including two in the regions we visited: the Medical Center of Louisiana (Charity Hospital) in New Orleans and the Leonard J. Chabert Medical Center in Houma (Terrebonne Parish). Total state funding for the hospitals this year was $794 million (House Fiscal Division 2001). Consistent with their historic mission, the hospitals are "operated primarily for the medical care of the uninsured and medically indigent residents of the state" and offer care on a sliding fee scale.
- ***Community Hospitals.*** Louisiana also has small community hospitals located in all but eight parishes. Concerns that the financial pressures on some small rural hospitals might force these facilities to close their doors prompted the state to provide grants over the past few years to fund a variety of projects, including the purchase of updated equipment and physician coverage for emergency rooms (DHH 2001d).

- ***Community Health Centers.*** The state has 12 Federally Qualified Health Centers (FQHCs), facilities supported by federal grants under the U.S. Public Health Service Act, as well as other CHCs that receive no "330" funding (NACHC 2001). Though a critical component of the health care delivery system for low-income people in the state, FQHCs appear to play a smaller role in Louisiana than in other states, serving about 8 percent of the state population with incomes below 200 percent of the FPL, compared with 23 percent nationwide. Per capita federal funding for this population is also lower in Louisiana than in the U.S. as a whole (about $7 versus $14). According to an official at the National Association of Community Health Centers, this disparity is due to "a lack of political and community leadership in the state to aggressively pursue available federal funding."

- ***Parish Health Units.*** Until now, parish health units have been an important part of the Medicaid delivery system, even though they provide a limited array of personal health services (immunizations, family planning, prenatal care, child health screenings, nutrition counseling, and infectious disease testing and monitoring) and cannot serve as primary care providers. One change in the health care system that promises to have significant ramifications for the Medicaid population is the state's ambitious effort to reorganize the parish health system. Like many states before it, Louisiana has begun to reduce its direct service capacity and to focus on other public health roles. In July 2000, DHH announced the closing of 25 of its 109 parish health units (OPH 2001). The following month, the agency launched an effort to partially privatize other units, as part of an effort to convert the units to primary care centers. Since the announcement of its Primary Care Enhancement Plan (PEP) in August 2000, the state has contracted with primary care providers, including FQHCs, physician practices, and hospital clinics, to take over parish facilities and assume responsibility for the services previously provided by the health units and provide primary care.

- ***Private Primary and Specialty Care Physician Practices.*** LaCHIP enrollees are also served by private physicians. Although the state has not published Medicaid participation rates for primary or specialty care physicians in either its SCHIP or Medicaid annual reports to CMS, a survey by the American Academy of Pediatrics (AAP) found that the percentage of AAP fellows who were participating in Medicaid/SCHIP in 2000 was slightly higher in Louisiana than in the U.S. as a whole (92 percent versus 89 percent). Louisiana also has about the same number of pediatricians per 10,000 population as the rest of the nation (AAP 2001). However, reports from providers and public health officials in the New Orleans and Thibodaux regions, as well as data from the Health Resources and Services Administration, suggest that these participation figures do not provide a complete picture of access to care for LaCHIP enrollees, as discussed in section D.

## C. PAYMENT ARRANGEMENTS

The state reimburses almost all providers on a fee-for-service basis. CommunityCARE PCPs receive an additional $3 per member per month management fee. Currently, the state pays

$36 for an interim established patient visit (the most common charge). Providers are reimbursed for only one service per patient per day. KidMed screenings (initial or periodic) by a nurse or physician are reimbursed at $51.

Reimbursement levels have seesawed over the past several years, in response to state budget pressures and concerns about access. As noted, the state legislature raised reimbursement rates for three primary care procedure codes in 1998, as part of the legislation authorizing LaCHIP. But in the previous three years, the state had twice enacted rate cuts, including a 40 percent reduction in PCCM fees, from $5 to $3, in 1996. (The reduction in the PCCM fee was reportedly implemented to bring the fee in line with those in most other states with PCCM programs.) In February of 2000, the state again sliced provider reimbursement, enacting a 7 percent across-the-board cut to close an anticipated $126 million hole in the DHH budget. Two rural hospitals and a chain of nursing homes immediately filed suit. In May, an appeals court cleared the way for the rate reductions, but in July, at the start of the new fiscal year, the state reversed most of the rate cuts and, in an effort to boost provider participation, raised fees for six evaluation/management codes. (For example, the rate for an interim established patient visit was raised from $27 to $36.) The legislature approved another rate increase for three primary care codes in summer 2001.

The state plans to convert to prospective payment for all FQHCs by the end of this year. One FQHC we visited stated that the clinic is currently reimbursed about $69 for an interim core visit. The prospective rates will be based on the FQHCs' 1999-2000 cost reports and adjusted annually based on the Medicare Economic Index.

## D. IMPLEMENTATION EXPERIENCES AND LESSONS LEARNED

Providers unanimously agreed that reimbursement for most services is too low and that access has deteriorated, particularly in rural areas. For safety-net providers, though, LaCHIP has

proved a boon, as the Medicaid expansion has provided coverage to children who previously lacked insurance and were unable to pay for services they received.

Providers cited sharp differences in rates paid by Medicaid and private insurers for a variety of basic services. According to Senator Hines, rates for the three codes the state plans to increase are now set at $30 to $39, or about 60 to 70 percent of the rates paid by private insurers. "No matter what you charge, Medicaid pays $30," said another physician, who noted that for a complex office visit, a private insurer pays five times as much. The payment gap is equally wide for specialty services. For example, staff at Children's Hospital in New Orleans reported that Medicaid pays about 11 percent of charges for outpatient surgical services, while private insurance pays 55 to 65 percent. Reimbursement for both primary and specialty care is further constrained by the state's policy of limiting payment to one service per day per child. Said one FQHC administrator, "The premise is, the more you do, the less you're paid." Reimbursement for inpatient care and KidMed screenings is perceived to be better and, indeed, a state public health official described KidMed as "a money-maker for private physicians."

Providers reported higher administrative costs associated with Medicaid than with private insurance. No-show rates tend to be high, the paperwork burden is considerable for KidMed screenings, and some outpatient service providers said they have to "chase the dollars" to ensure reimbursement. The state Office of Public Health, for example, reported that half of the Medicaid claims submitted by public health units are denied on first submission and 25 to 30 percent are never paid. (In contrast, another provider stated that denial rates are worse for private insurance.)

Data from the AAP member survey support these findings. Compared with their counterparts nationwide, Louisiana pediatricians were 35 percent more likely to cite low

reimbursement as a very important reason to limit participation in Medicaid and between 57 and 67 percent more likely to cite missed appointments and lack of patient compliance.

Timeliness of payment does not appear to be an issue for most providers. However, one FQHC administrator said that the state primary care association is on the verge of suing DHH for failure to pay cost settlements on time. (DHH reported in February 2002 that all cost settlements currently payable had been paid.) FQHCs also fear a drop in reimbursement when the prospective payment system for FQHCs takes effect next year, and some are demanding reviews of the 1999-2000 cost reports on which rates will be based, contending that the state auditor erroneously disallowed some reported costs.

Perceptions of access to primary care for the LaCHIP population vary, and little hard data exist. But providers, advocates, and state agency staff agreed that some private physicians dropped out of the Medicaid program after the rate cuts in 2000 and did not rejoin when the cuts were reversed. DHH officials contend that net physician participation is higher than before the rate cuts and asserted that the state does "not have a problem providing primary care." Other observers outside the state's major metropolitan areas disagreed. A Medicaid administrator in the rural Thibodaux region stated that some families in the area do not re-enroll in LaCHIP because they have trouble finding providers and end up going to the charity hospital as they did before they had coverage. Whether physicians accept Medicaid may depend on whether they have other options, said one FQHC administrator: "Docs [in very rural St. Mary parish] don't have a flourishing market of private-pay patients to support their practices, so they are more open to Medicaid. Things may be different in Thibodaux, given the industry there." Indeed, the sole pediatric practice in Thibodaux that accepts Medicaid stopped taking new Medicaid patients shortly before our visit. Despite a long history of serving the Medicaid population, this practice finally succumbed to financial pressure and closed its doors to new Medicaid patients in order to

contain its losses. A survey of primary care providers in four New Orleans-area parishes by an intern in the Office of Public Health found that the proportion of those that had filed a Medicaid claim in the past year who were accepting new patients ranged from 10 to 37 percent. DHH is in the process of conducting a similar analysis statewide.

Physician participation in KidMed is reportedly good because of the relatively high reimbursement for EPSDT screens. However, some practices that do screenings do not provide follow-up or acute care. DHH staff hope that expansion of the PCCM program will improve both access and continuity of care by bringing more primary care physicians into the program and providing Medicaid enrollees with a medical home. A public health administrator in the Thibodaux region reported that CommunityCARE has had a "tremendous impact" on access in the one parish in the region in which it has been implemented (St. Charles). Overall, physician participation has been good to date, but DHH staff acknowledged that recruitment will be more difficult in less rural areas and suggested that the state may need to increase fees or create a savings pool to attract physicians in metropolitan areas.

Access to specialty care is widely viewed as more problematic. Although access is good for some specialties in some areas (notably New Orleans), LaCHIP enrollees in more rural areas may have to travel long distances for some specialty services. Shortages vary from area to area. For example, one pediatrician in Houma cited referrals for orthopedics as particularly difficult and said that if a child with Medicaid coverage goes to the emergency room at the local hospital with a broken bone, "the ER physicians will put on a splint and send the child to [the charity hospital] or to the child's physician." However, this physician reported that access to dental care was reasonably good in Terrebonne parish, while a study in neighboring St. Mary parish found dental care in short supply for Medicaid recipients there. State agency staff said they have not heard of problems with access to dental care, but in its 2000 annual report, the state

acknowledged that dental screening rates were very low for all children enrolled in Medicaid. Providers agreed that access to mental health care was very poor ("atrocious," in the view of one physician).

DHH has done little analysis to date of utilization by LaCHIP enrollees, other than to compare utilization rates for LaCHIP enrollees with those of other eligibility groups (CHAMP and SSI children). These comparisons found fairly similar use rates for many preventive services (DHH 2000a) and lower hospital admission rates and ER use (DHH 2001e) by LaCHIP enrollees than CHAMP enrollees. The state plans to identify areas for improvement this year.

## VIII. COST SHARING

As a Medicaid expansion, LaCHIP requires no consumer cost sharing. The option to impose premiums on families with incomes above 150 percent of the FPL was reportedly one of the main reasons the Department of Insurance argued for a separate child health program, and as noted, the LaCHIP task force initially recommended that children in the 150-200 percent FPL income range be covered under a separate program that included cost sharing. However, when the time came for the legislature to authorize the third phase of the program, there was "surprisingly little discussion of cost sharing," according to Senator Hines. DHH Secretary David Hood said that legislators may have feared that requiring premiums would discourage enrollment, since families with incomes below 200 percent of the FPL who lack insurance can obtain free care from the state charity hospital system. DHH staff and a lobbyist for the state MCH coalition predicted that the state might consider cost sharing if the income threshold for LaCHIP were raised above 200 percent of the FPL.

## IX. PROGRAM WAIVERS

On June 27, 2001, Governor Foster signed legislation (Act 1027) authorizing DHH to seek approval from CMS to cover parents with family incomes up to 100 percent of the FPL and pregnant women with family incomes between 185 and 200 percent of the FPL under a Section 1115 demonstration in Title XXI. This expansion of LaCHIP is contingent not only upon CMS approval but on legislative appropriation of the state match or approval to use other Medicaid funds (such as DSH payments). DHH has requested for state fiscal year 2002 a total of about $30 million to cover an estimated 115,000 parents and 5,000 pregnant women.

Senator Hines, author of the Senate bill (SB781), and DHH Secretary David Hood offered three reasons for expanding coverage for parents and pregnant women: (1) studies have shown that parents are more likely to seek appropriate care for their children if they themselves are covered, (2) the provision of preventive and prenatal care to adults is likely to reduce preventable disabilities and thereby reduce future program costs, and (3) expansion of LaCHIP will allow the state to access more of its federal allotment. The state also explored the possibility of instituting a premium assistance program, but according to DHH staff, opted against it because many employers do not offer dependent coverage and because administration would be complicated by the lack of large employers in the state.

## X. FINANCING

Louisiana implemented its title XXI program in the waning months of federal fiscal year (FFY) 1998 and by the end of FFY 1999 had spent just 10 percent of its 1998 allotment (Table 6). Spending more than doubled the following year, rising from about $10.4 million to $25.2 million, after the state expanded eligibility to 200 percent of the FPL. By the end of the three-year-period of availability, Louisiana had spent 35 percent of its 1998 allotment. At 79.37 percent, Louisiana's enhanced federal matching rate is the eighth highest in the nation. Since 1999, state general funds have replaced foundation grants and school board funds as sources of the state share (along with state appropriations).

Respondents believe there is broad legislative support for continued LaCHIP funding. "It's hard for the legislature not to want to invest twenty cents on the dollar," said one advocate. The administration's support for the Medicaid expansion is more questionable, as Governor Foster has made improvements in public education his highest priority. "Oil money" has helped protect the health care budget to date, said Senator Hines, and the recent state legislation to expand LaCHIP to low-income parents and pregnant women suggests that the program is likely to continue.

TABLE 6

SCHIP ALLOTMENTS AND EXPENDITURES, IN MILLIONS, 1998-2000

| FFY | Federal Allotment | Expenditures | Expenditures as Percentage of Allotment for Year | Percentage of Year's Allotment Spent by End of FFY 2000 | Redistributed Amount |
|---|---|---|---|---|---|
| 1998 | $101.7 | — | — | 35% | |
| 1999 | $101.3 | $10.4 | 10% | 0% | |
| 2000 | $91.1 | $25.3 | 28% | 0% | NA |

SOURCE: Centers for Medicare and Medicaid Services (CMS), Memo from Center for Medicaid and State Operations to State, January 25, 2000; Federal Register Notice, May 24, 2000; Kenney et al., "Three Years into SCHIP: What States Are and Are Not Spending." Urban Institute: September 2000.

NOTE: SCHIP=State Children's Health Insurance Program (Title XXI); FFY=federal fiscal year; NA=Not applicable.

## XI. LESSONS LEARNED

By almost all accounts, Louisiana has done an excellent job of enrolling children in LaCHIP, but has done less well retaining children and addressing growing concerns about access to care. Although the data needed to assess the extent of the access problem are lacking, there is broad agreement that repeated rate cuts have driven some providers out of the Medicaid market.

Other key findings from the site visit include the following:

- ***A primary reason the state implemented a Medicaid expansion under Title XXI was the perceived efficiency of building upon an existing infrastructure.*** LaCHIP task force participants agreed that the potential for a more rapid, low-cost start-up than would have been possible with a new separate child health program was a key factor in the state's choice of a Medicaid expansion

- ***A gradual, staged expansion of coverage helped relieve legislators' qualms about expanding an entitlement program.*** The plan to phase in expansions of LaCHIP only with legislative approval allowed legislators to maintain control of program growth and reportedly assuaged their fears of spiraling costs.

- ***Louisiana was able to "re-invent" Medicaid with relative ease because it had disassociated the program from welfare years earlier.*** The complete separation of DHH from the Department of Social Services and the establishment of application centers in a variety of community-based organizations facilitated efforts to erase the welfare stamp from Medicaid and present the Title XXI expansion as an insurance program for working families.

- ***A new name helped forge a new identity for the Medicaid program.*** "LaCHIP says insurance," said one advocate. That perception of LaCHIP has spilled over onto other forms of Medicaid coverage. People tend to think of all Medicaid coverage for children as "LaCHIP" now, and although the approval notices sent to families specify the type(s) of coverage for which children have been approved, the cards do not.

- ***Outreach through schools has proved highly effective in Louisiana.*** The largest increases in LaCHIP enrollment coincided with the back-to-school campaigns that delivered LaCHIP flyers with applications for the school lunch program to every schoolchild in the state.

- ***Building support for LaCHIP among field staff has provided Louisiana with an effective mechanism for grassroots outreach.*** Louisiana has conducted a successful, low-cost outreach campaign by giving field staff "ownership" of local outreach efforts, promoting collaboration with local stakeholders, and providing the tools staff need to market the program in their communities. A highly collaborative relationship with the state Covering Kids program also helped DHH stretch its outreach dollars.

- ***Simplification of the application form and process has contributed significantly to enrollment growth.*** Enrollment of children in Title XIX Medicaid rose appreciably with the implementation of LaCHIP and the debut of the simplified mail-in application. Application approval rates also rose when the state reduced verification requirements for LaCHIP and CHAMP in July 2000.

- ***Income verification requirements constitute a substantial barrier.*** Although the state has removed many barriers to enrollment, the requirement that families provide proof of the prior month's income remains a stumbling block for a significant proportion of families. Close to one-quarter of the applications received by the central processing office are missing income verification.

- ***Even with a streamlined application form and limited verification requirements, application assistance is still critical for at least a subset of the target population.*** Although most families who apply for coverage using the LaCHIP application are able to complete the form themselves, advocates and assistors agreed that some parents, particularly those with low literacy levels, may need help to complete the application correctly.

- ***Retention may be particularly challenging if application is easy.*** Several respondents suggested that the ease of application may work against retention. Caseworkers and application assistors reported that a substantial number of families let their coverage lapse and then reapply.

- ***Reports from the field suggest that some crowd out is occurring in Louisiana, but the cost of private dependent coverage may make this almost inevitable.*** There was widespread agreement that some families have dropped private insurance coverage to qualify for LaCHIP. But respondents also reported that few employers subsidize much, if any, of the cost of dependent coverage, making premiums prohibitively expensive for many families. Some states have taken the cost issue into consideration in their crowd-out policies—for example, by allowing families to drop coverage within the waiting period if their employer assumes less than a certain percentage of the cost.

- ***Like most states, Louisiana has focused on outreach and enrollment rather than access and quality of care during the first years of program operation.*** The state has only recently begun to collect the data needed to assess access to care. Although DHH can tally the number of "active" Medicaid providers (those that filed a claim within a specified period of time) by parish, the agency has little information about the proportion accepting new patients or the number of slots available. Information about specialty care access appears to be even scantier. And although DHH has established baseline measures for certain performance indicators, the agency has not yet set benchmarks for these measures. The state recognizes that access, in particular, may be inadequate and is poised to address the problem.

- ***Fluctuations in reimbursement levels may have hurt provider participation more than chronically low rates.*** "Trust" was a word frequently mentioned in discussions of provider relations. Many respondents said that physicians "lost trust" in DHH when rates were cut, and remain wary despite recent rate increases. Speaking of the reduction in PCCM fees, one DHH staff member acknowledged, "Physicians felt that

DHH violated its contract with them." DHH is now confronting the consequences of these cuts as it seeks to expand the PCCM program. Said one physician, "Doctors are afraid they're going to get lured into CommunityCARE and then have to take reimbursement cuts." Agency flip-flops about dental fees and coverage have reportedly had a similar impact on dentists.

- ***The availability of charity care made cost-sharing a less viable option for LaCHIP.*** With the state hospital system, "the state has created a mindset of free care," said one FQHC administrator. With such a mindset, families are likely to be unwilling to pay premiums for health care coverage.

## REFERENCES


American Academy of Pediatrics (AAP). "Pediatrician Participation in Medicaid/SCHIP: Survey of Fellows of the American Academy of Pediatrics, 2000." AAP: 2001

Birch & Davis. "KIDMED Responsible for Louisiana's High Ranking in Children's Health." Birch & Davis: 2001. http://www.birchdavis.com/nkidmed.htm

Centers for Medicare and Medicaid Services (CMS), "Eligibility Standards in the 50 States and District of Columbia (01/01/01)" (unpublished document). CMS: 2001.

Centers for Medicare and Medicaid Services (CMS) "Medicaid Managed Care State Enrollment as of June 30, 2000." http://www.hcfa.gov/medicaid/omc2000.htm

DeSantis, John. "Need or greed? Psychiatrists shun Louisiana Medicaid's low pay." *Houma Today*, May 3, 2001.

Employee Benefit Research Institute (EBRI). "Sources of Health Insurance and Characteristics of the Uninsured, West South Central Sites, 1998." Washington, DC: EBRI, July 2000. http://www.ebri.org/facts/0700fact2.htm.

Fagnani, Lynne and Jennifer Tolbert. "The Dependence of Safety Net Hospitals and Health Systems on the Medicare and Medicaid Disproportionate Share Hospital Payment Programs." The Commonwealth Fund, November 1999. http://www.cmwf.org/programs/minority/

Kennedy, Ruth. Personal communication, August 15, 2001.

Louisiana Department of Economic Development. *Parish Profiles, 1998.* http://leap.ulm.edu/PPROF98/

Louisiana Department of Health and Hospitals (DHH), *Annual Report of State Children's Health Insurance Plans Under Title XXI of the Social Security Act, 2000*, March 22, 2001.

Louisiana Department of Health and Hospitals (DHH), "More Children Now Eligible for Health Insurance," January 9, 2001. http://www.dhh.state.la.us/NEWS/LaCHIP200.htm.

Louisiana Department of Health and Hospitals (DHH). "Medicaid Spending Reduction Issues: Interview with DHH Secretary Hood." DHH: 2001 http://www.dhh.state.la.us/NEWS/BUDGET.htm.

Louisiana Department of Health and Hospitals (DHH). "DHH Expands CommunityCARE Statewide." DHH: July 20, 2001. http://www.dhh.state.la.us/NEWS/CommCAREExpands.htm

Louisiana House Fiscal Division. "2001-2002 State Budget Fast Facts and Budget Summary: Health and Social Services." House Fiscal Division: July 2001. http://house.legis.state.la.us/housefiscal/2001FastFacts/health.htm

Louisiana State Senate. "Final 2001 Regular Session Legislative Highlights," July 20, 2001. http://senate.legis.state.la.us/SessionInfo/2001/RS/Highlights/Default.htm

National Association of Community Health Centers (NACHC). "Community Health Center Facts : Louisiana" NACHC: 2001 http://www.nachc.com/state_affairs/frame/state_data.htm

National Center for Health Statistics. "Current Estimates from the National Health Interview Survey, 1995. Atlanta, GA: Centers for Disease Control and Prevention, October 30, 1998. http://www.ihaonline.org/la_hc_facts.html.

Office of Public Health, Louisiana Department of Health and Hospitals. *2001 Louisiana Health Report Card: Louisiana State Health Care System.* DHH: March 23, 2001. http://www.dhh.state.la.us/OPH/pub.htm

Office of Public Health, Louisiana Department of Health and Hospitals. "DHH Announces Streamlining Plan." DHH: July 28, 2000. http://www.dhh.state.la.us/NEWS/streamline.htm.

# APPENDIX A

# SITE VISITORS AND KEY INFORMANTS

Louisiana Site Visit

June 11-15, 2001

## Site Visitors

*Mathematica Policy Research, Inc.*
Ruchika Bajaj
Nancy Fasciano

*The Urban Institute*
Ian Hill

*U.S. Department of Health and Human Services, Office of the Secretary for Planning and Evaluation*
Adelle Simmons

## Key Informants: Baton Rouge

*Louisiana Department of Health and Hospitals (DHH), Medicaid division*
David Hood, DHH Secretary
Ruth Kennedy, Deputy Director, Medicaid Larry
J. Hebert, Former Medical Director, DHH
Carolyn Maggio, Former Director, Division of Research and Development
Helene Robinson, Director, Division of Research and Development
Ben Bearden, Medicaid Director
John W. Fralick, Field Operations Director Lynn
Rayburn, Program Manager, Eligibility Donna
Dedon, Program Manager, Eligibility Darlene
Hughes, Program Manager, Eligibility Rhett
Decoteau, Program Specialist, Child/Family Eligibility
Joan Carmouche, Medicaid Eligibility System
Johnnie Fitzgerald, Medicaid Eligibility Field Operations
Bruce Gomez, Operations

*Louisiana Department of Social Services* Julie Howard, Division Director of Financial Assistance

*Louisiana DHH, Central Processing Office*
Dexter Campbell, Manager
Mary Washington, Eligibility Supervisor
Janelle Sparks, Medicaid Analyst

*East Baton Rouge Parish Medicaid Office*
Amy Evans
Robin Foster-Langford

*MCH Coalition*
Sandra Adams, Executive Director

*Louisiana Health Care Campaign*
Margaret Pereboom

*Louisiana State Senate*
Senator Donald E. Hines

## Key Informants: Thibodaux Region (Thibodaux, Franklin and Houma)

*Medicaid Regional Office*
Norris Barrilleaux, Regional Manager

*Lafourche Parish Medicaid Office*

*Agenda for Children*
Dianna Constant, CRR Thibodaux Region III Coordinator

*Lafourche Community Housing*
Debra Legaux

*Assumption Parish Council on Aging*
Shirley Lee, Office Clerk

*Louisiana DHH, Office of Public Health, Region III*
Fred Duplechin, Regional Administrator

*Children's Clinic of Thibodaux (Private Pediatric Practice)*
Dr. Sheila Pitre
Susie Richard, KidMed Coordinator

*Teche Action Clinic (Franklin)*
Carla Pellerin, Exec Director
Debra Lacose, RN, KidMed coordinator
Beverly Wilson, Medicaid Manager
Roderick Campbell, Chief Financial Officer
Dr. Bustilla, Pediatrician
Anita Miller, Billing Clerk

*Chabert Medical Center (State Charity Hospital)*
Daniel Trahan, Hospital Administrator
Ketti Braux, Chief Financial Officer
Sandra Jaensonne, Administrative Manager
Susie Steward, Registrar for LaCHIP
Debra Umbehagen, DHH Medicaid Worker,
Pauline Abear, Manager
Dr. Adela Dupont, pediatrician

*Private Pediatric Practice (Houma)*
Dr. Aruna Sangisetty

*Catholic Social Services (Houma)*
Germaine Jackson, Associate Director for Social Services

Key Informants: New Orleans

*Louisiana DHH, Office of Public Health*
Joan Wightkin, Maternal and Child Health Director
Nancy Gathright, State Project Director for Covering Kids
Inca Gomez
Ed Tierney and Finance Division staff

*Children's Hospital*
Eileen (Rusty) Gasser, Director of Social Services
Joyce Baugere, Medicaid Enroller
Wilson Williams, Vice President of Operations
Greg Feirn, Head of Accounting Department
Rick Guevara, Vice President of Legal Affairs
A. Joanne Gates, MD, Associate Medical Director

*Medicaid Regional Office*
Florence Wicker, Regional Manager

*New Orleans Health Department*
Donna Malus, Director of Nursing Services
Jacquelyn Johnson, Medicaid Caseworker II,
Monna Mathieu, Special Administration Services Coordinator
Patricia Hutton, Medicaid Supervisor

*EXCELth*
Mike Andry, Executive Director
Mary Crooks, Clinic Administrator, New Orleans East, Carolton Clinic

*Agenda for Children, Covering Kids Project*
Sharon Pomeroy
Louanne Francis

# APPENDIX B

# APPLICATION AND RENEWAL FORMS

# Louisiana's Medicaid Program

## Pre-Application Clearance

| | | |
|---|---|---|
| Name: | | Today's Date: |
| | Please answer the following questions about yourself and all persons who five with you. | |
| 1. | Is anyone blind? | ❑ Yes ❑ No |
| 2. | Is anyone age 65 or older? | ❑ Yes ❑ No |
| 3. | Is anyone disabled or incapacitated? | ❑ Yes ❑ No |
| 4. | Is anyone pregnant? | ❑ Yes ❑ No |
| 5. | Is anyone under age 19? | ❑ Yes ❑ No |
| 6. | Is anyone eligible for Medicare Part A (Hospital) Insurance? | ❑ Yes ❑ No |
| 7. | Is anyone eligible for Medicare Part B (Physician Services) Insurance? | ❑ Yes ❑ No |
| 8. | Is anyone a resident of or planning to enter a nursing facility, medical institution or Waiver program? | ❑ Yes ❑ No |

A) If you have answered YES to **any** question, you may be eligible for Medicaid. If you wish to pursue a Medicaid application for anyone who is not under age 19, please check (√) this block (a), provide the information below and sign this form.

B) If you have answered YES only to question 5, you are entitled to complete a simplified application form for LaCHIP, which provides Medicaid only to persons under age 19. If you wish to pursue a LaCHIP application, please check (√) this block (❑), complete the information below and sign this form.

C) If you wish to apply for FITAP cash or Refugee assistance, you must contact your local Office of Family Support. If you wish to apply for SSI cash benefits, you must contact the Social Security office nearest to your home.

Mailing Address: _____ Parish:

_____

Signature: Telephone #
( )

BHSF Form 2(CH)
Revised 05/01
II

# LaCHIP

Louisiana's Children's Health Insurance Program

Renewal Due: _____
C5LD/WKR: _____

# Renewal Form

**If you need help filling out this form or have questions about LaCHIP, call us toll free at 1+877+252-2447**

What language do you speak best? ❑ English ❑ Spanish ❑ Vietnamese ❑ Other (specify) _____
What language do you write best? ❑ English ❑ Spanish ❑ Vietnamese ❑ Other (specify) _____

**"We can provide an interpreter at no cost to you, if you do not speak English"**

This form is used to continue getting health coverage for children under age 19. If you want health coverage for anyone else in the household who is older than 18, mark (X) this box ( ❑ ). We will send you information about applying for other health coverage and tell you what you need to do to protect your application date. Please complete EVERY item on this form. If an item does not apply to you or your family, write "does not apply". If an answer to any question is none or 0, write "none". IF MORE SPACE IS NEEDED, USE A SEPARATE SHEET.

1. Tell us who YOU are and where YOU get your mail:

Name of person completing form _____

Mailing Address _____ City_____State ___Zip Code _____

Home Address _____ City_____State ___Zip Code _____

Parish_____Home Phone # (___)_____Daytime Phone # (__)_____ ___

2. Have there been any changes in the family members living in your home since your last application or renewal? ❑ No ❑ Yes (If No, GO TO Question 3 on the back.)

If **Yes,** tell us about the **New** family members who have moved into your home.

Step-parent income will not be counted in determining eligibility for step-children. You DO NOT have to give Social Security numbers for NEW family members who ARE NOT applying for coverage. Children , if eligible, will still get coverage even if you do not give us this information. If you do give us Social Security numbers, they will ONLY be used to verify income.

| Name – First, Middle Initial, Last (IF applying for LaCHIP, mark (x) the ❑) | Social Security Number | Date of Birth | | | U.S. Citizen Y/N | Sex M/F | Race (1) | Relation to you (husband, son, etc.) |
|---|---|---|---|---|---|---|---|---|
| | | Month | Day | Year | | | | |
| ❑ | | | | | | | | |
| ❑ | | | | | | | | |
| ❑ | | | | | | | | |

(1) Race information DOES NOT have to be given. If you choose to do so, use the following codes: A = Asian; B : Black; H = Hispanic; I : American Indian; W = White.

Give us the name of any family members who have moved **OUT** of your home since your last application or renewal._____

3. Does anyone applying for or getting Medicaid now have private health insurance that covers doctor and hospital visits? ❑ Yes ❑ No If Yes, give us the following information:

| Insurance Company Nome Address & Phone # | Group/ Policy # | Monthly cost | Person(s) covered | Policy covers: | | |
|---|---|---|---|---|---|---|
| | | | | Hospital Maternity | Doctor Drugs | Ambulance Dental |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

4. Does anyone work? ❑ Yes ❑ No (For each fob. send copies of all pay check stubs or other proof of earnings for last month .) Is anyone self -employed? ❑ Yes ❑ No (If Yes send copies of the most recent federal tax form with all schedule attachments, OR other proof if you do not have tax forms.) Tell us below about EACH full-time job, part-time job, or business. Show income before any deductions, NOT take-home pay.

| A. Give us the Name, Address & Phone # of the company or person your work for **OR** B. Self-Employment Information | Name of the person working | Amount paid per hour | Number of hours worked/week | How often do you get paid? |
|---|---|---|---|---|
| | | | | |
| | | | | |

5. Does anyone pay for child care (or care for a disabled adult) so that person can work or get training? ❑ Yes ❑ No If Yes, give us the following information.

(To get a deduction, send proof of the payments.)

| Care giver's Name, Address & Phone # | Name of person who pays for core | Who gets this care? | How much do you pay? | How often? |
|---|---|---|---|---|
| | | | $ | |

6. Does anyone get ANY other money, like the kinds listed below? ❑ Yes ❑ No If Yes, give us the following information. (Circle the kind of income source and send proof of this income.)

| Income Source | Source Name, Address & Phone # | Who gets this money? | How much? | How often? |
|---|---|---|---|---|
| Social Security/SSI | | | $ | |
| Child | | | $ | |
| Other (please be specific) | | | $ | |

7. Does anyone pay child support or alimony to someone outside of your home? ❑ Yes ❑ No

(To get a deduction send proof of how much, how often and the name and relationship of the person to whom payments are made )

If you are deaf or have hearing problems, you may call the TTY number toll free at +800+220-5404

Signature of Applicant (Parent) or Authorized Representative

Date

(◀TEAR-OFF THE APPLICATION HERE BEFORE MAILING KEEP THIS PAGE FOR YOURSELF)

## What do I do next?

After you have filled out the form, tear it off and MAIL or FAX it to:

LaCHIP Processing Office
P. O. Box 91278
Baton Rouge, LA 70821-9278
FAX 1+877+523-2987 (LA FAX US)

You can also bring, mail or fax this form to any local Medicaid office or to a Medicaid Application Center.

## What will happen to my application?

We will make a decision and you will be notified within 45 days (with some exceptions) after we get your application.

Coverage can start as early as 3 months **before** the month we get your application. **DON'T WAIT**

**Get** the form to **US** as soon as you can.

(◀TEAR-OFF THE APPLICATION HERE BEFORE MAILING KEEP THIS PAGE FOR YOURSELF)

## Can I be paid back for - medical services I already received?

You may be eligible to be paid back for medical services received up to 3 months prior to your application if:

- you are eligible for the date the service was received, and
- you used a Medicaid provider, and
- the service is covered by the Medicaid program

## Where can I call for help?

If you need help to complete this form or to get any of the needed proof, please call us toll-free at 1+877+252-2447 (2LaCHIP).

If you are deaf or hard of hearing, you may call the TTY number at 1+800+220-5404.

You may also call us if you have any questions or need more information about this or any other Medicaid program.

**HELP US share information about this program - if you don't use this form, please pass it on to someone who can.**

## What are my rights?

If you think the decision we make is unfair, incorrect or is made too late, you may ask for a Fair Hearing by:

- calling the LaCHIP office at 1+877+252-2447 (2LaCHIP),
- calling or writing to your local Medicaid office, AND/OR
- writing directly to
  LA DHH Bureau of
  Appeals P. O. Box 4183
  Baton Rouge, LA 70821-4183

LaCHIP is an equal opportunity program. We can't treat you differently because of your race, color, sex, age, disability, religion, nationality, or political belief If you think we have:

- call the U.S. DHHS Regional Office for Civil Rights in Dallas, TX at 1+800+368-1019,
- call or write to your local Medicaid office, AND/OR
- write directly to
  LA Department of Health & Hospitals
  P O. Box 1349
  Baton Rouge, LA 70821-1349

The public document was published at a total cost of $53,426 four hundred thousand (400,000) copies of this public document were published on this first printing at a cost of $53,426.11. This document was published for Louisiana's Department of Health and Hospitals Office of Management & Finance, P.O. Box 91030, Baton Rouge, LA 70821 9030 by LSU Graphic Services, 3555 River Road, Baton Rouge, LA 70830 8201 to advise applicants recipients and other individuals of LaCHIP coverage available through the Medicaid Program as required by 42 CFR 435 905 (a X1) and Act 128 of the 1228 1st Extraordinary Session of the Louisiana Legislature. This material was printed in accordance with the standard for printing by state agencies established pursuant to R S 43 31

BHSF Form 1-CH Cover
Rev. 01/01

# Application for

# LaCHIP

Louisiana's Children's Health Insurance Program

# Total Health Care for Louisiana Children

**1+877+252-2447 (2LaCHIP)**

# Louisiana Children's Health Insurance Program

Louisiana provides health benefits for eligible children from birth up to age 19 using special income amounts and fewer requirements than other Medicaid programs.

## What services are covered?

Doctor visits
Hospital care
Dental care
Vision care
Hearing care Lab
Lab work & tests
Immunizations (shots)
Prescription medicines
Medical equipment & supplies
Medically necessary transportation
Speech At language therapy
Physical therapy
Occupational therapy
Mental health clinic services
Psychological tests & therapy
Appointment scheduling assistance

## What are the income amounts for children?

Your children may be eligible if your total family income, before any deductions, is below the amounts in this chart.

| Number in family | Income Amounts through March 31, 2001 | |
|---|---|---|
| | Weekly Income | Monthly Income |
| 1 | $322 | $1,392 |
| 2 | $433 | $1,875 |
| 3 | $545 | $2,359 |
| 4 | $656 | $2,842 |
| 5 | $768 | $3,325 |
| 6 | $879 | $3,809 |
| 7 | $991 | $4,292 |
| 8 | $1102 | $4,775 |
| More Than 8 | For each extra person, add $484 to the monthly amount for 8 people | |

**Even if your income is more than these amounts, your children may still qualify.** You can receive deductions from your total income for:

Earned Income (up to $90 for each working person)
Childcare Payments (up to $90 deduction)
Child Support Received (up to $50 deduction)
Child Support Payments to someone outside the home

## What information will you need to give us?

**For ANYONE who needs LaCHIP, we will need:**

Social Security number for anyone who is applying for coverage

Alien registration card or Immigration papers for anyone who is applying for coverage

**We will ALSO need:**

Proof of your total family income
Health insurance cards or benefit letters
Proof of expected date of delivery for anyone who is pregnant
Proof of child support payments made to someone out of your home*
Receipts for the care of a child or disabled adult*

*Verification needed only if you wont to get a deduction

We can provide an interpreter at no cost to you if you do not speak English.

Si usted no habla Ingles, le proveemos los servicios de un traductor sin costa alguno.

## It's Easy To Apply

(1) Fill out the form.

(2) Collect the information we need.

(3) Get the form and information to us as soon as possible.

Send COPIES of as many of the needed items as you can when you send in your application but DO NOT wait to send in this form.

If you need help filling out the form or getting the needed items, we may be able to help you Just give us a call.

Children can keep their health coverage for one full year regardless of changes in income or other household circumstances. There are no enrollment fees, no premiums, no co payments, and no deductibles.

Revised 01/01
II

# LaCHIP

Louisiana's Children's Health Insurance Program

What language do you prefer? ❑ English ❑ Spanish ❑ Vietnamese ❑ Other (specify)
cQue idioma prefiere usted? ❑ Espanol ❑ Inglés ❑ Otro (especifloue)_____

"We cart provide an interpreter at no cost to you if you do not speak English"
"Si usted no habla Inglés, le proveemos los servicios de un traductor sin costo aiguno"

This LaCHIP application is to get health benefits for children under age 19. be not aPply for anyone who **already gets** Medicaid. If **you want** Medicaid for **anyone else, older than 18**, in **the household**, mark (X) this box (❑). **We** will send you information **about applying** for other Medicaid **coverage** and tell you what you **need to do** to protect your application date. **Please complete EVERY** item on this form. If an item does not apply to you or your family, write 'does not apply'. If an answer to any question is none or 0, write 'none'. IF MORE SPACE 1S NEEDED, USE A SEPARATE SHEET.

1. Tell us who YOU are, where YOU live, and where YOU get your mail:

Name of person completing form_____
Mailing address _____City _____ State_____ Zip code _____
Home address _____ City _____ State _____Zip code_____
Parish _____Home phone # ( _____ Daytime phone #(___)_____

2. Tell us about the children living in the home who need health coverage. Please include all brothers and sisters under age 19.

| Name - First, Middle Initial, Last (If applying for coverage. Mark (X) the (❑)) | Social Security number | Date of Birth | | | **Sex** M/F | US Citizen Y/N | Race (1) | Relation to **you** (son, daughter) |
|---|---|---|---|---|---|---|---|---|
| ❑ | | | | | | | | |
| ❑ | | | | | | | | |
| ❑ | | | | | | | | |
| ❑ | | | | | | | | |
| ❑ | | | | | | | | |

--Race Information DOES NOT nave to be given. If you choose to do so, use the following codes: A = Asian. B = Black:
H = Hispanic: I = American Indian: W = White

3. Tell us about the child(ren)'s parent(s), caregiver(s) or step-parent(s) who live in the home. Step-parent income will not be counted in determining eligibility for step-children.

You **DO NOT** have to give Social Security numbers if you ARE NOT applying for yourself. Children, if eligible, will still get coverage even if you do not give us this information. If you do give us Social Security number(s), they will ONLY be used to verify income.

| Name - First, Middle Initial, Last | Social Security number | Date of Birth | | | **Sex** M/F | US Citizen Y/N | Race (1) | Relation to Child(ren) (Mom , Dad, Step-parent) |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| | | | | | | | | |

4. Is anyone pregnant **AND** applying for health coverage? ❑ Yes ❑ No If **Yes**, give us the following information. (Send proof of the expected date of delivery, such as a doctors statement.)

Name:_____ Expected Date of Delivery _____

5. Is everyone applying for health coverage a Louisiana resident? ❑ Yes ❑ No If **No**, tell us who wants Medicaid, and is NOT a Louisiana resident. _____

6. Has anyone applying now ever received Medicaid in Louisiana? ❑ Yes ❑ No
If **Yes**, do we need to replace plastic Medicaid cards for anyone who is applying now? ❑ Yes ❑ No
If **Yes**, for whom?

7. Does anyone applying for Medicaid now have private health insurance that covers doctor and hospital visits? ❑ Yes ❑ No Has anyone lost health insurance coverage in the past three months? ❑ Yes ❑ No If **Yes** to either question, give us the following information.

| Insurance Company Name, Address & Phone # | Group/ Policy # | Monthly Cost | Person(s) Covered | Policy covers | | |
|---|---|---|---|---|---|---|
| | | | | Hospital | Doctor | Ambulance |
| | | | | Maternity | Drugs | Dental |
| | | | | | | |
| | | | | | | |
| | | | | | | |

If anyone applying for Medicaid has lost health insurance coverage in the past 3 months, tell us why.

8. Does anyone applying need coverage for medical care or services received during the last 3 months? ❑ Yes ❑ If **Yes**, for which months?_____

(If **Yes** also send proof of the income shown in items 9 and 11 and payments shown in items 10 and 12 for the months you listed here, if you want to receive a deduction.)

9. Does anyone work? ❑ Yes ❑ No (For each job send copies of all pay check stubs or other proof of earnings for last month.) Is anyone self -employed? ❑ Yes ❑ No (Send conies of the most recent federal tax form with all schedule attachments OR other proof you do not have tax forms) Tell us below about EACH full-time job, part-time job, or business. Show income before any deductions - NOT take-home pay.

| A. Give us the **name**, address and phone # of the **company** or person **you** wore for OR B. **Self-Employment** Inform Lion | Name of the person working | Amount paid per hour | Number of hours worked/week | How often do you get paid? |
|---|---|---|---|---|
| | | $ | | |
| | | $ | | |

10. Does anyone pay for child care (or care for a disabled adult) so that person can work or get training?

❑Yes ❑ No If **Yes**, give us the following information. (To get a deduction send proof of the payments)

| Caregivers Name Address & Phone # | Name of the person who pays for care | Who gets this care? | How much do you pay | How often? |
|---|---|---|---|---|
| | | | | |

11. Does anyone get ANY other money, like the kinds listed below? ❑ Yes ❑ No If **Yes**, give us the following information. Circle the kind of income source and send proof of this income. You DO NOT have to send proof or Social Security SSI income.

| Income source | Source Name Address 6 Phone St | Who gets this money? | How much? | How often? |
|---|---|---|---|---|
| Social Security/SS1 | | | $ | |
| Child Support/Alimony | | | $ | |
| Other (please be specific) | | | $ | |

12. Does anyone pay child support or alimony to someone outside of your home? ❑ Yes ❑ No (To get a deduction send proof or how much how often and they name and relationship of the person to whom payments are made)

13. Is a parent of any child who needs LaCHIP **not** living in your home? ❑ Yes ❑ No If **Yes**, do you want Medicaid to make a referral to Child Support Enforcement for **medical support** for any child who is applying ? ❑ Yes ❑ No

14. Where did you get this application form?

_____

How did you hear about LaCHIP? ❑ Newspaper ❑ TV ❑ Radio ❑ Friend/Relative
❑ School ❑ Headstart Program ❑ Daycare ❑ Hospital/Clinic ❑ Doctor ❑ WIC ❑ KIDMED
❑ Welfare Office ❑ Medicaid Eligibility Office ❑ Other _____

(This information will be used by Louisiana Medicaid for research and statistical purposes ONLY)

**Rights and Responsibilities**

- I declare that everyone wno is applying for health insurance is a U.S. citizen or is In this country legally.
- The information I give on this form is true and correct to the best of my knowledge. I realize if I knowingly give information that isn't true OR if I knowingly withhold information and my child(ren) get health benefits for which they are not eligible, I can be lawfully punished for fraud and I may have to re-pay Medicaid for any medical bills which are paid incorrectly.
- I understand that the information I give about our situation will be checked. I agree to help do that and to let Medicaid get needed Information from government agencies, employers, medical providers and other sources.
- I know that our Social Security numbers will only be used to get information from other government agencies to prove eligibility.
- I f Medicaid/LaCHIP pays for health care for me or my child(ren), I give permission for Medicaid to collect payments from anyone who is supposed to pay for that care and to share medical information on my child(ren) with any insurance company to get the medical bills Paid.
- I agree to tell Medicaid within 10 days of the following changes: 1) I f anyone receiving health coverage moves out of state. 2) Changes where we live or get our mail: and 3) Changes in other health insurance coverage.
- I can ask for a Fair Hearing if I think the decision made on my case is unfair, incorrect or made too late.
- Medicaid can't discriminate because of race, color, sex, age, disability, religion, nationality or political belief. I f I think they have, I can call the U.S. DHHS Regional Office for Civil Rights in Dallas. TX at 1800368-1019 or write to Louisiana's Department of Health & Hospitals, Human Resources at P. O. Box 1349 Baton Rouge, LA 70821-1349.
- Information about WIC, KIDMED and other Medicaid services will be sent to me if we are eligible for Medicaid.

_____ _____
Signature of Applicant (Parent) or Authorized Representative Date

_____ _____
Signature of Agency or AC Representative, if applicable Date

**Please MAIL this form as soon as possible to:**
**LaCHIP Processing Office**
**P.O. Box 91278**
**Baton Rouge, LA 70821-9278**
**FAX 1.877.523-2987 (LA FAX US)**

**If you are deaf or have hearing problems, you may call the TTY number, 1.800.220-5404 (toll free).**