§3103. Recipient Participation

A. The following Medicaid recipients shall be mandatory participants in coordinated care networks:

1. mandatory enrollees:

a. children up to 19 years of age who are eligible under §1902 and §1931 of the Social Security Act (hereafter referred to as the Act) as poverty-level related groups and optional groups of older children;

b. parents and caretaker relatives who are eligible under §1902 and §1931 of the Act;

c. Children's Health Insurance Program (CHIP) (title XXI) children enrolled in Medicaid expansion program (LaCHIP Phase I, II, III);

d. CHIP (title XXI) prenatal care option (LaCHIP Phase IV) and children enrolled in the separate, stand-alone CHIP program (LaCHIP Phase V);

e. pregnant women whose basis for eligibility is pregnancy, who are only eligible for pregnancy-related services, and whose eligibility extends until 60 days after the pregnancy ends;

f. non-dually eligible aged, blind, and disabled adults over the age of 19;

g. uninsured women under the age of 65 who have been screened through the Centers for Disease Control National Breast and Cervical Cancer Early Detection Program and identified as being in need of treatment for breast and/or cervical cancer, including pre-cancerous conditions and early stage cancer, and are not otherwise eligible for Medicaid;

h. individuals eligible through the Tuberculosis Infected Individual Program;

i. former foster care children eligible under §1902(a)(10)(A)(i)(IX) and (XVII) of the Act;

j. individuals and families who have more income than is allowed for Medicaid eligibility, but who meet the standards for the Regular Medically Needy Program; or

k. individuals from age 19 to 65 years old at or below 133 percent of the federal poverty level with a 5 percent income disregard as provided in 42 CFR 435.119, hereafter referred to as the new adult group.

B. Mandatory, Voluntary Opt-In Participants

1. Participation in an MCO for the following participants is mandatory for specialized behavioral health, applied behavior analysis (ABA)-based therapy and non-emergency medical transportation (NEMT) services (ambulance and non-ambulance) only, and is voluntary for physical health services:

a. individuals who receive services under the authority of the following 1915(c) home and community-based services waivers; and

i. Adult Day Health Care (ADHC) waiver;

ii. Community Choices Waiver (CCW);

iii. New Opportunities Waiver (NOW);

iv. Children's Choice (CC) waiver;

v. Residential Options Waiver (ROW); and

vi. Supports Waiver (SW);

b. individuals under the age of 21 who are otherwise eligible for Medicaid, and who are listed on the DHH Office for Citizens with Developmental Disabilities' request for services registry. These children are identified as *Chisholm* class members:

i. For purposes of these provisions, *Chisholm* class members shall be defined as those children identified in the *Melanie Chisholm, et al vs. Kathy Kliebert* (or her successor) class action litigation.

C. Mandatory, voluntary opt-in populations may initially elect to receive physical health services through Bayou Health at any time.

D. Mandatory, voluntary opt-in populations who elected to receive physical health services through Bayou Health, but returned to legacy Medicaid for physical health services, may return to Bayou Health for physical health services only during the annual open enrollment period.

E. Mandatory MCO Populations—Specialized Behavioral Health Services and Non-Emergency Ambulance Services Only

1. The following populations are mandatory enrollees in Bayou Health for specialized behavioral health services and non-emergency ambulance services only:

a. individuals residing in nursing facilities; and

b. individuals under the age of 21 residing in intermediate care facilities for persons with intellectual disabilities (ICF/ID).

F. Mandatory MCO Populations—Specialized Behavioral Health and NEMT Services (Ambulance and Non-Ambulance) Only

1. Individuals who receive both Medicare and Medicaid (e.g. Medicaid dual eligibles) are mandatory enrollees in Bayou Health for specialized behavioral health and non-emergency medical transportation services only.

G. The enrollment broker will ensure that all participants are notified at the time of enrollment that they may request dis-enrollment from the MCO at any time for cause.

H. Participation Exclusion

1. The following Medicaid and/or CHIP recipients are excluded from participation in an MCO and cannot voluntarily enroll in an MCO. Individuals who:

a. reside in an ICF/ID (adults);

b. are partial dual eligibles;

c. receive services through the Program for All-Inclusive Care for the Elderly (PACE);

d. have a limited period of eligibility and participate in either the Spend-Down Medically Needy Program or the Emergency Services Only program;

e. receive services through the Take Charge Plus program; or

f. are enrolled in the Louisiana Health Insurance Premium Payment (LaHIPP) Program.

EXCEPTION: This exclusion does not apply to LaHIPP enrollees eligible to receive behavioral health services only through the managed care organizations.

I. The department reserves the right to institute a medical exemption process for certain medically high risk recipients that may warrant the direct care and supervision of a non-primary care specialist on a case by case basis.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:1573 (June 2011), amended LR 40:310 (February 2014), LR 40:1096 (June 2014), LR 40:2258 (November 2014), LR 41:929 (May 2015), LR 41:2363 (November 2015), LR 42:754 (May 2016), amended by the Department of Health, Bureau of Health Services Financing, LR 42:1522 (September 2016), LR 43:663 (April 2017), LR 43:1553 (August 2017), LR 44:1253 (July 2018).

Subpart 9. Act 421 Children's Medicaid Option

Chapter 81. General Provisions

§8101. Purpose

A. The purpose of the Act 421 Children's Medicaid Option (421-CMO) program is to provide Medicaid State Plan services to children with disabilities who meet the eligibility criteria set forth in this Subpart, despite parental or household income that would otherwise exclude them from Medicaid eligibility.

B. The Department of Health (LDH) has expenditure authority under section 1115 of the Social Security Act (Act) to claim as medical assistance the costs of services provided under a risk contract to eligible individuals. Through this section 1115 demonstration, the State is allowed to permit Medicaid managed care organizations (MCOs) to provide Medicaid State Plan services to children with disabilities regardless of their parents' and/or household income. LDH shall, subject to the approval of the Centers for Medicare and Medicaid Services (CMS), institute a program to provide health care services via the State's Medicaid program for the population contemplated under Section 134 of the Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248), subject to additional terms and conditions set forth in this Subpart.

C. 421-CMO enrollees are eligible for all medically necessary Medicaid State Plan services.

D. The number of enrollees in the 421-CMO program is contingent upon the amount appropriated by the Louisiana legislature annually for that purpose.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:977.21-977.25, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing and the Office for

Citizens with Developmental Disabilities, LR 46:1676 (December 2020), repromulgated LR 47:43 (January 2021).

§8103. Effective Date and Administration

A. Services provided under the 421-CMO program shall begin upon approval of expenditure authority under section 1115 of the Act by CMS.

B. Upon approval by CMS, enrollment and start of services will commence at the beginning of the first calendar quarter after conclusion of the initial registration period.

C. The 421-CMO program shall be administered as a section 1115 demonstration waiver under the authority of LDH, in collaboration with the Healthy Louisiana MCOs.

D. The 421-CMO program is a demonstration waiver that will span five years. LDH may request approval for an extension of this section 1115 demonstration from CMS prior to the expiration date.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:977.21-977.25, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 46:1677 (December 2020), repromulgated LR 47:43 (January 2021).

§8105. Enrollee Qualifications and Admissions Criteria

A. In order to qualify for the 421-CMO program, an individual must meet both programmatic eligibility and clinical eligibility criteria as set forth in this Subpart.

B. Programmatic eligibility. In order to be programmatically eligible for the 421-CMO program, an individual must meet all of the following criteria:

1. Is 18 years of age or younger (under 19 years of age).

2. Is a U.S. Citizen or qualified alien.

3. Is a Louisiana resident.

4. Has or has applied for a Social Security Number.

5. Has countable resources of $2,000 or less (parental/household resources not considered).

6. Has care needs that can be safely met at home at a lower cost than the cost of services provided in an institutional setting.

7. Maintains pre-existing private health insurance for major medical coverage, either through employer sponsored insurance, the federal marketplace, or other independently purchased commercial health insurance, unless a hardship exception is applied for and granted by LDH.

a. LDH will employ a look-back period of one 180 days to determine pre-existing private health insurance.

b. Lock-out period. If LDH determines that a family or responsible adult has discontinued pre-existing private health insurance, either during the look-back period or at any time during the enrollee's enrollment in the 421-CMO program, LDH will impose a lock-out.

c. During the lock-out period, the enrollee will be unable to receive services, but will retain his or her enrollment in the 421-CMO program.

d. The lock-out period will end when the enrollee demonstrates new or former pre-existing private health insurance has been re-instated.

e. The lock-out period will extend up to 180 days from discontinuation of pre-existing private health insurance or 421-CMO program offer, whichever date is later.

f. At the conclusion of the 180-day lock-out period, if the enrollee has not re-instated the pre-existing private health insurance, the enrollee will be terminated from the 421-CMO program.

g. If terminated, the individual can re-register for the 421-CMO program and be placed on the 421-CMO registry as a new applicant.

h. Hardship Exception. The enrollee can apply for a hardship exception at any time, including during a lock-out period.

i. A hardship exists when:

(a). private health insurance premiums and any additional deductibles and co-payments or out of pocket healthcare costs for the individual obtaining coverage equal or exceed 5 percent of the household income;

(b). unemployment resulting in loss of employer-sponsored private insurance for the child; or

(c). an exemption period of 90 days for transition to new employment, after which the enrollee must resume private health insurance.

ii. LDH's grant of a hardship exception will end the lock-out period.

8. Is not otherwise eligible for Medicaid or CHIP.

C. Clinical eligibility. In order to be clinically eligible for the 421-CMO program, an individual must meet all of the following criteria:

1. Has a disability, defined as a medically determinable physical or mental impairment (or combination of impairments) that:

a. results in marked and severe functional limitations; and

b. has lasted or is expected to last for at least one year or to result in death.

2. Meets the medical necessity requirement, assessed on an annual basis, for institutional placement in an intermediate care facility for individuals with intellectual disabilities (ICF/IID), a nursing facility, or a hospital.

a. An individual meets ICF/IID level of care when he/she:

i. has obtained a statement of approval from the Office for Citizens with Developmental Disabilities,

confirming that he has a developmental disability as defined in R.S. 28:451.2; and

ii. meets the requirements for active treatment of a developmental disability under the supervision of a qualified developmental disability professional, as prescribed on Form 90-L.

b. An individual meets nursing facility level of care when he demonstrates the following, assessed in accordance with the Act 421 Children's Medicaid Option Assessment Tool:

i. the need for skilled nursing and/or therapeutic interventions on a regular and sustained basis; and

ii. substantial functional limitations as compared to same age peer group in two of the following areas: learning, communication, self-care, mobility, social competency, money management (for children 18 and older), work, and meal preparation.

c. An individual meets hospital level of care when he demonstrates the following, assessed in accordance with the Act 421 Children's Medicaid Option Assessment Tool:

i. frequent and complex medical care that requires the use of equipment to prevent life-threatening situations, with skilled medical care required multiple times during each 24-hour period;

ii. complex skilled medical interventions that are expected to persist for at least six months; and

iii. overall health condition that is highly unstable and presents constant potential for complications or rapid deterioration, with the result that the child requires continuous assessment by professional nurses, parents, or other properly instructed individuals, in order to detect unstable and life-threatening condition and respond promptly with appropriate care.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:977.21-977.25, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 46:1677 (December 2020), repromulgated LR 47:43 (January 2021).

§8107. Admission Denial or Discharge Criteria

A. Individuals shall be denied admission to or discharged from 421-CMO program if any of the following criteria is met:

1. the individual does not meet the programmatic eligibility requirements for the 421-CMO program;

2. the individual does not meet the clinical eligibility requirements for the 421-CMO program;

3. the individual is incarcerated or placed under the jurisdiction of penal authorities, courts or state juvenile justice authorities;

4. the individual resides in another state or has a change of residence to another state;

5. the individual or responsible adult fails to cooperate in the eligibility determination/re-determination process; or

6. the 421-CMO enrollee is admitted to an ICF/IID, nursing facility, or hospital with the intent to not return to 421-CMO services;

a. the enrollee is deemed to intend to return to 421-CMO services when documentation is received from the treating physician that the admission is temporary and shall not exceed ninety (90) days;

b. the enrollee will be discharged from 421-CMO on the ninety-first (91st) day after admission if the enrollee is still in the ICF/IID, nursing facility, or hospital.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:977.21-977.25, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 46:1678 (December 2020), repromulgated LR 47:44 (January 2021).

§8109. Allocation of Act 421 Children's Medicaid Option Opportunities

A. The Act 421 Children's Medicaid Option request for services registry, hereafter referred to as the 421-CMO registry, shall be used to identify persons who meet ICF/IID, nursing facility, or hospital level of care who are waiting for a 421-CMO program slot. Individuals who are found eligible and who request 421-CMO program services will be added to the 421-CMO registry. Funded 421-CMO program slots will be offered in accordance with this Subpart.

B. Initial Registration

1. There will be an initial registration period lasting one month, during which time registration will occur in two pathways:

a. Online registration forms will be taken from individuals who are not currently on the intellectual/developmental disabilities (I/DD) request for services registry or otherwise enrolled in Medicaid.

b. Children 18 years of age and under (under 19) who are on the I/DD request for services registry and are not currently enrolled in Medicaid or CHIP will be automatically registered for participation.

i. Individuals receiving automatic placement on the 421-CMO registry will receive a preprinted mailed form explaining the 421-CMO program and that they are automatically registered. The form will provide them with the opportunity to opt out of participation, and if they do not opt out, attest to prioritization needs per the process set forth in this Subpart.

2. LDH will create a numerically ordered 421-CMO registry based on individuals that registered during the initial registration period, placing them in random order.

3. Individuals registered during the initial registration period will receive 421-CMO program offers according to the prioritization process established in this Subpart first.

Once priority offers are complete, 421-CMO program offers will then be made in numeric order of the 421-CMO registry.

4. Individuals who do not receive 421-CMO program offers will remain on the 421-CMO registry in the numeric order assigned, with a protected registry date corresponding to the close of the initial registration period.

C. Ongoing Registration. After the initial registration period and slot allocation, subsequent registrants for the 421-CMO program will be assigned a 421-CMO registry date based on the date on which they register and will receive an offer on a first-come, first-served basis unless otherwise prioritized as provided for in this Subpart. 421-CMO program offers will be made upon availability.

D. Prioritization

1. In order to ensure individuals with the most urgent needs receive services, LDH will prioritize 421-CMO program offers to individuals who meet either of the following criteria:

a. The individual has been institutionalized in an ICF/IID, nursing facility, or hospital for 30 of the preceding 90 days. Institutional days do not have to be consecutive.

b. On three or more separate occasions in the preceding 90 days, the individual has been admitted to an ICF/IID, nursing facility, or hospital and remained institutionalized for at least 24 hours.

2. An individual newly registering for 421-CMO program during ongoing registration may request and, if the individual qualifies, receive prioritization in order to receive the next available 421-CMO program offer. In addition, at any time an individual currently on the 421-CMO registry may request and, if the individual qualifies, receive prioritization.

3. Prioritization will be considered valid for a period of 180 days from the date that prioritization is approved while waiting for a 421-CMO program offer. At the expiration of the 180 days, if no 421-CMO program offer has been made, the individual loses prioritization but retains his or her original protected registry date for purposes of receiving a 421-CMO program offer.

a. If an individual's priority period has expired with no 421-CMO program offer available during that time period, he or she may request to requalify for prioritization.

i. If the individual qualifies without a break in the two priority periods (they are consecutive), he/she shall retain the original prioritization date.

ii. If the individual qualifies with a break in the priority periods, he/she shall receive a new prioritization date.

b. There is no limit on the number of times an individual may qualify for prioritization prior to receiving a 421-CMO program offer.

c. If more than one individual has received prioritization at one time, the next available 421-CMO program offer will be made to the individual with the earliest prioritization date.

4. Once enrolled in the 421-CMO program, enrollees will not be required to demonstrate ongoing need for prioritization. Prioritization is only a method of fast-tracking initial entry into the 421-CMO program for families with the highest urgency of need.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:977.21-977.25, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 46:1678 (December 2020), repromulgated LR 47:44 (January 2021).

§8111. Eligibility and Enrollment

A. Upon extension of a 421-CMO program offer to an individual, the individual will need to establish programmatic and clinical eligibility by showing he or she meets all eligibility criteria. When eligibility is determined, the individual will be enrolled in the 421-CMO program and with a health and dental plan of their choice.

B. Louisiana Health Insurance Premium Payment Program (LaHIPP)

1. Enrollees in the 421-CMO program shall be enrolled in LaHIPP when cost-effective health plans are available through the individual's employer or a responsible party's employer-based health plan or other health insurance if the individual is enrolled or eligible for such a health plan.

2. All requirements and coverage through the LaHIPP program shall follow the provisions set forth in LAC 50:III.2311 except that 421-CMO program enrollees enrolled in LaHIPP shall receive their Medicaid benefits through managed care.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:977.21-977.25, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 46:1679 (December 2020), repromulgated LR 47:45 (January 2021).

Chapter 83. Services

§8301. Covered Services

A. The coverage of 421-CMO services under the scope of this demonstration are all services offered under the Louisiana Medicaid State Plan.

B. All 421-CMO services must be medically necessary. The medical necessity for services shall be determined by a licensed professional or physician who is acting within the scope of his/her professional license and applicable state law.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:977.21-977.25, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing and the Office for

Citizens with Developmental Disabilities, LR 46:1679 (December 2020), repromulgated LR 47:46 (January 2021).

§8303. Service Delivery

A. Louisiana's Act 421 Children's Medicaid Option delivery system is based on an integrated managed care model for physical and behavioral health services. Under this demonstration, Healthy Louisiana will continue to operate as approved in Section 1932(a) state plan authority for managed care and concurrent 1915(b) demonstration.

B. Enrollees in the 421-CMO program shall be mandatorily enrolled in Healthy Louisiana and in a dental benefits prepaid ambulatory health plan. They shall have the opportunity to choose a health and dental plan upon application. If they do not choose a plan, one will be automatically assigned to them upon enrollment per the current methodology outlined in the Medicaid State Plan.

C. Enrollees shall be designated as a special health care needs group, entitling recipients to receive case management and enhanced care coordination through their managed care plan.

D. All of the covered services under the 421-CMO program shall be delivered in accordance with the Medicaid State Plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:977.21-977.25, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 46:1679 (December 2020), repromulgated LR 47:46 (January 2021).

Chapter 85. Reimbursement

§8501. Reimbursement Methodology

A. For 421-CMO program enrollees, LDH or its fiscal intermediary shall make monthly capitation payments to the managed care organizations (MCOs) and dental benefits prepaid ambulatory health plans for the provision of all covered services. The capitation rates paid to the MCOs and dental benefits prepaid ambulatory health plans shall be actuarially sound rates, and the MCOs and dental benefits prepaid ambulatory health plans will determine the rates paid to its contracted providers. No payment shall be less than the minimum Medicaid fee-for-service fee schedule on file.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:977.21-977.25, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 46:1680 (December 2020), repromulgated LR 47:46 (January 2021).