Bobby Jindal
GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Office of the Secretary

VIA ELECTRONIC MAIL ONLY

September 30, 2014

Bill Brooks
Associate Regional Administrator
Division of Medicaid & Children's Health
DHHS/Centers for Medicare and Medicaid Services
1301 Young Street, Room #833
Dallas, Texas 75202

Dear Mr. Brooks:

RE: Louisiana Title XIX State Plan
Transmittal No. 14-15

I have reviewed and approved the enclosed Louisiana Title XIX State Plan material.

I recommend this material for adoption and inclusion in the body of the State Plan.

Sincerely,

Kathy H. Kliebert
Secretary

Attachments (1)

KHK/JRK/DAB

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **14-15**

2. STATE: **Louisiana**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 20, 2014

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
1932(a)(4) of Social Security Act

7. FEDERAL BUDGET IMPACT:
a. FFY **2014** **$0**
b. FFY **2015** **$0**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-F, Pages 4, 4a, 5, 7 and 10
Attachment 3.1-F, Page 8 and 8a
Attachment 3.1-F, Page 12

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same (TN 11-21) remove pages 7a and 12a
Same (TN 12-57)
Same (TN 12-65)

10. SUBJECT OF AMENDMENT: **The SPA proposes to make individuals receiving hospice services mandatory participants in BAYOU HEALTH and individuals receiving home and community based waiver services voluntary participants.**

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
The Governor does not review state plan material.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Kathy H. Kliebert

14. TITLE:
Secretary

15. DATE SUBMITTED:
September 30, 2014

16. RETURN TO:
J. Ruth Kennedy, Medicaid Director
State of Louisiana
Department of Health and Hospitals
628 N. 4th Street
PO Box 91030
Baton Rouge, LA 70821-9030

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

FORM HCFA-179 (07-92)

Citation		Condition or Requirement
1932(a)(1)(A) 42 CFR 438.6(c) 42 CFR 438.50(c)(6)	6.	__X__ The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met.
1932(a)(1)(A) 447.362 42 CFR 438.50(c)(6)	7.	N/A The state assures that all applicable requirements of 42 CFR 447.362 for 42 CFR payments under any non-risk contracts will be met.
45 CFR 74.40	8.	__X__ The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.

D. Eligible groups

1932(a)(1)(A)(i) 1. List all eligible groups that will be enrolled on a **mandatory basis.**

- Children (under 19 years of age) including those eligible under Section 1931 poverty-level related groups and optional groups of older children;
- Parents, including those eligible under Section 1931 and optional groups of caretaker relatives;
- CHIP (Title XXI) children enrolled in Medicaid-expansion CHIP (LaCHIP Phase I, II, & III);
- CHIP (Title XXI) unborn option (Phase 4)
- Pregnant Women: Individuals whose basis of eligibility is pregnancy, who are only eligible for pregnancy-related services, and whose eligibility extends 60 days after the end of the pregnancy;
- 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;
- Non-dually eligible Aged, Blind & Disabled Adults age 19 or older (note: dual eligibles are exempt and children are voluntary as noted below).
- Individuals and families who have more income than is allowed for Medicaid eligibility, but who meet the standards for the Regular Medically Needy Program.
- Individuals receiving hospice services who are not otherwise excluded because of their status as a Medicare dual eligible recipient, or a resident of a long-term care facility (nursing facility or intermediate care facility for persons with intellectual disabilities).

2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50.

Use a check mark to affirm if there is **voluntary enrollment** of any of the following mandatory exempt groups.

1932(a)(2)(B)
42 CFR 438(d)(1)

i. ____Recipients who are also eligible for Medicare

If enrollment is voluntary, describe the circumstances of enrollment.
(Example: Recipients who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.)

State: **Louisiana**

Citation		Condition or Requirement
1932(a)(2)(C) 42 CFR 438(d)(2)	ii.	**X** An Indian Health program or urban Indian program operated by a tribe or tribal organization under a contract, grant, cooperative agreement or compact with the Indian Health Service. All enrollees are informed through required member materials that if they are a member of a federally recognized Tribe they may self-identify, provide documentation of Tribal membership, and request disenrollment through the enrollment broker.
1932(a)(2)(A)(i) 42 CFR 438.50(d)(3)(i)	iii.	**X** Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI.
1932(a)(2)(A)(iii) 42 CFR 438.50(d)(3)(ii)	iv.	**N/A** Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.
	v.	**X** Individuals who receive home and community-based waiver services.

Note: Voluntary enrollment is allowed under the CCN Program.

Citation	Condition or Requirement
	Louisiana does not cover these optional groups.
1932(a)(2)(A)(v) 42 CFR 438.50(3)(iii)	**X** Children under the age of 19 years who are in foster care or other out-of- home placement.
1932(a)(2)(A)(iv) 42 CFR 438.50(3)(iv)	**X** Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.
1932(a)(2)(A)(ii) 42 CFR 438.50 (3)(v)	**X** Children under the age of 19 years who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the state in terms of either program participation or special health care needs.

E. Identification of Mandatory Exempt Groups

1932(a)(2)
42 CFR 438.50(d)

1. Describe how the state defines children who receive services that are funded under section 501(a)(1)(D) of title V. *(Examples: children receiving services at a specific clinic or enrolled in a particular program.)*

   The State defines the above referenced children as those children receiving services at a Children's Special Health Services (CSHS) clinic Operated by the Louisiana Department of Public Health.

1932(a)(2)
42 CFR 438.50(d)

2. Place a check mark to affirm if the state's definition of title V children is determined by:

   X i. program participation (**receipt of services at a CSHS clinic**),
   ____ ii. special health care needs, or
   ____ iii. both

1932(a)(2)
42 CFR 438.50(d)

3. Place a check mark to affirm if the scope of these title V services is received through a family-centered, community-based, and coordinated care system.

   X i. yes
   ____ ii. no

State: **Louisiana**

Citation		Condition or Requirement
1932(a)(2) 42 CFR 438.50(d)	6.	Describe how the state identifies the following groups who are exempt from mandatory enrollment into managed care: *(Examples: usage of aid codes in the eligibility system, self- identification).* The following Medicaid and/or CHIP recipients are excluded from participation in a CCN and cannot voluntarily enroll in a CCN. Individuals who: • are both Medicaid and Medicare recipients (identified by Medicare Indicator in the MMIS recipient file); • reside in a long-term care facility (nursing facility or intermediate care facility for persons with intellectual disabilities); • receive services through the Program of All-Inclusive Care for the Elderly (PACE); • have a limited period of eligibility such as eligibility through the Spend-down Medically Needy Program or Emergency Services Only; • are participants in the Take Charge Family Planning Waiver Program; • are eligible through the Tuberculosis Infected Individual Program; or • are enrolled in the Louisiana Health Insurance Premium Payment (LaHIPP) Program.
42 CFR 438.50	F.	List other eligible groups (not previously mentioned) who will be exempt (excluded) from mandatory enrollment. • **Individuals under the age of 21 otherwise eligible for Medicaid who are listed on the New Opportunities Waiver (NOW) Request for Services Registry, also known as Chisholm Class Members;** • **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.**

State: **Louisiana**

Citation	Condition or Requirement

42 CFR 438.50 G. List all other eligible groups who will be permitted to enroll on a voluntary basis
N/A

H. Enrollment process.

1932(a)(4)
42 CFR 438.50

1. Definitions

i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience, or through contact with the recipient.

ii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.

1932(a)(4)
42 CFR 438.50

2. State process for enrollment by default.

Describe how the state's default enrollment process will preserve:

i. the existing provider-recipient relationship (as defined in H.1.i).

As part of the financial Medicaid and LaCHIP application process, applicants may be given the option to indicate their preferred choice of CCN and PCP. If the choice of CCN and PCP is not indicated on the new enrollee file transmitted by DHH to the Enrollment Broker, the Enrollment Broker shall contact the enrollee to request their choice of CCN and PCP. The Enrollment Broker shall encourage the continuation of any existing satisfactory provider/patient relationship with their current PCP who is in a CCN.

Enrollment Broker staff will be available by telephone to assist program enrollees. Program enrollees will be offered multilingual enrollment materials or materials in alternative formats, large print, and/or Braille when needed. The enrollment broker shall assist the Medicaid enrollee with the selection of a CCN that meets the enrollee's needs by explaining in a non-biased manner the criteria that may be considered when selecting a CCN.

If no CCN choice is made, the enrollment broker will utilize available information about relationships with existing PCPs in the assignment process.

Medicaid potential enrollees who are eligible for CCN, excluding those whose Medicaid eligibility is predicated upon determination of pregnancy, will have thirty (30) calendar days from the postmark date that an enrollment form is sent to them by the Enrollment Broker to select a CCN. Pregnant recipients with Medicaid eligibility limited to prenatal, delivery, and post-partum services will immediately be automatically assigned to a CCN by the enrollment broker. All members of a family unit will be encouraged to select the same CCN.

With the implementation of the CCNs in a geographic service area, enrollees will be given the chance to choose a CCN. Enrollees have 90 days from the initial date of enrollment into a CCN in which they may change the CCN for any reason. If the enrollee does not request disenrollment from the CCN within 90 days, the enrollee will be locked-in to the CCN for up to 12 months, or until their next open enrollment period unless they are disenrolled for cause.

State: **Louisiana**

Citation	Condition or Requirement

ii. the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii).

All CCNs will contract with providers who have traditionally served Medicaid recipients and will be available for choice and default assignment. Preexisting relationships are a factor in the auto-assignment algorithm.

Recipients who fail to choose a CCN shall be automatically assigned to a CCN by the enrollment broker and the CCN shall be responsible to assign the member to a PCP if a PCP is not selected at the time of enrollment into the CCN.

Recipients of home and community-based services shall be exempt from automatic assignment to a CCN.

Citation	Condition or Requirement

v. Describe the default assignment algorithm used for auto-assignment. *(Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)*

Mandatory CCN participants that fail to select a CCN and voluntary participants that do not exercise their option not to participate in the CCN program within the minimum 30 day window, with the exception of recipients of home and community-based services, shall be auto-assigned to a CCN.

Potential enrollees are auto-assigned based on the State's algorithm taking into consideration:

- **The member's previous CCN;**
- **Inclusion in the CCN provider network of the member's historic provider as identified by Medicaid claims history;**
- **If the provider with which the member has a historic provider relationship contracts with more than one CCN, the member will be assigned to a CCN with which the provider contracts, on a round robin basis;**
- **If the provider with which the family member has a current or historic provider relationship contracts with more than one CCN, the member will be assigned to a CCN with which that provider contracts, on a round robin basis;**
- **If neither the member nor a family member has a current or historic provider relationship, the member will be auto-assigned to a CCN with one or more PCPs accepting new patients in the member's parish of residence, on a round robin basis subject to CCN capacity; and**
- **Beginning in October 2014, the CCN's quality measures will be factored into the algorithm for automatic assignment.**

vi. Describe how the state will monitor any changes in the rate of default assignment. *(Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker)*

The State will use regular reports generated by the enrollment broker to monitor CCN choice rates, auto-assignments, and disenrollments.

1932(a)(4)
42 CFR 438.50

I. State assurances on the enrollment process

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

1. **X** The state assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.

State: **Louisiana**

Citation	Condition or Requirement

1932(a)(5)(D)
1905(t)

L. List all services that are excluded for each model (MCO & PCCM)

The following services are excluded from coverage under the CCN-P Model:

- **Dental;**
- **ICF/DD Services*;**
- **Personal Care Services;**
- **Nursing Facility Services*;**
- **Individualized Education Plan (IEP) Services provided by a school district and billed through the intermediate school district, or school-based services funded with certified public expenditures (these services are not provided by OPH certified school-based health clinics);**
- **Specialized Behavioral Health;**
- **Targeted Case Management Services including Nurse Family Partnership; and**
- **Services provided through DHH's Early-Steps Program (Individuals with Disabilities Education Act (IDEA) Part C Program Services)**

***Individuals receiving these services are excluded from enrollment or will be disenrolled from the CCN-P.**

Medicaid state plan covered services other than primary care case management services are covered and reimbursed outside of the CCN through the Medicaid fee-for-service payment system or other managed care programs. The CCN-S is responsible for authorizing all State plan covered service, except:

- **Services provided through DHH's Early Step Services (IDEA Part C Program Services)**
- **Dental Services**
- **Personal Care Services (EPSDT and LT-PCS)**
- **Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) Services***
- **Non-Emergency Transportation**
- **School-based Individualized Education Plan (IEP) Services provided by a school district and billed through the intermediate school district**
- **Nursing Facility Services***
- **Specialized Behavioral Health Services**
- **Targeted Case Management**
- **Durable Medical Equipment and certain supplies**
- **Prosthetics and orthotics**

***Individuals receiving these services are excluded from enrollment or will be disenrolled from the CCN-S.**