DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

Medicaid and CHIP Operations Group

June 18, 2024

Kimberly Sullivan
Medicaid Executive Director
State of Louisiana
Department of Health
628 N. 4th Street
P.O. Box 91030
Baton Rouge, LA 70821-9030

Re: Louisiana State Plan Amendment (SPA) 24-0001

Dear Medicaid Executive Director Sullivan:

The Centers for Medicare & Medicaid Services (CMS) has completed our review of the proposed amendment submitted under transmittal number (TN) 24-0001. This plan amendment has a requested effective date of January 20, 2024 and was submitted in order to adopt provisions governing incurred medical and remedial care expenses in the determination of financial eligibility for the Medical Assistance Program in order to deduct expenses incurred for necessary medical and remedial care, subject to the reasonable limits, from the individual's income when calculating patient liability to an institution and to limit the time institutions have to report these expenses.

Before we can continue processing this amendment, we need additional or clarifying information.

General Comments/Questions

1) The state has requested to impose as a reasonable limit a disallowance of deductions "for payment of a medical or dental service plan that has not been approved by the Louisiana Department of Insurance in accordance with the Louisiana Insurance Code" (item 2.b.). Under section 1902(r)(1)(A)(i) of the Social Security Act (the Act) and 42 CFR § 435.725(c)(4)(i), states must include in the post-eligibility treatment of income (PETI) calculation health insurance premiums, deductibles, or coinsurance charges that are not subject to payment by a third party. Please clarify whether this limitation would apply only to policies that have been formally denied approval by the Louisiana Department of Insurance, or includes policies that are under review by, or have not yet been submitted to, the Louisiana Department of Insurance.

2) The state has requested to impose as a reasonable limit a disallowance of deductions "for medical or remedial care expenses that were incurred during a period when the individual is not subject to patient liability" (item 5). Under section 1902(r)(1)(A)(ii) of the Act and 42 CFR § 435.725(c)(4)(ii), incurred expenses for necessary medical or remedial care recognized under State law but not covered under the State's Medicaid plan that is not subject to third party payment must be deducted in the PETI calculation. CMS interprets "not covered under the State's

Medicaid plan" to include (but not be limited to) medical or remedial services a recipient receives prior to attaining Medicaid eligibility which are included in the state plan but for which the state Medicaid agency does not pay; e.g., medical services an individual received during the three months preceding their Medicaid application ("retro period"), which are otherwise covered under the state Medicaid plan but for which the state agency does not pay because the individual did not meet all eligibility requirements during their retro period. The statute and regulation allow states to impose optional "reasonable limits" on incurred medical or remedial expenses, subject to CMS' approval. CMS has approved as a reasonable limit the disallowance of expenses incurred before an individual's retro period. However, the state's request to broadly disallow all incurred expenses received when an individual is not subject to patient liability would include circumstances in which an individual receives services, such as nursing facility (NF) services, during their retro period and does not receive coverage for the NF services due to the individual not meeting all Medicaid eligibility requirements during the retro period. As such, this is not a reasonable limit. Please revise the request to describe a reasonable limit or remove this language from the SPA submission.

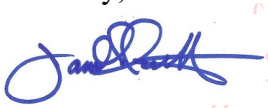
We are requesting this additional/clarifying information under provisions of section 1915(f) of the Social Security Act (added by PL 97-35). This has the effect of stopping the 90-day clock for CMS to take action on the material, which would have expired on June 24, 2024. A new 90-day clock will not begin until we receive your response to this request.

In accordance with our guidelines to all State Medicaid directors dated January 2, 2001, and subsequently reiterated in the August 16, 2018 Center for Medicaid and CHIP Services Informational Bulletin, if a response to a formal request for additional information from CMS is not received from the state within 90 days of issuance, CMS will initiate disapproval of the SPA or waiver action. In addition, because this amendment was submitted after January 2, 2001 and is effective after January 1, 2001, please be advised that we will defer federal financial participation (FFP) for state payments made in accordance with this amendment until it is approved. Upon approval, FFP will be available for the period beginning with the effective date through the date of approval.

We ask that you respond to this RAI via the OneMAC portal at http://onemac.cms.gov.

If you have any questions, please contact Tobias Griffin at 214-767-4425 or via email at Tobias.Griffin@cms.hhs.gov.

Sincerely,



James G. Scott, Director
Division of Program Operations

cc: Nikki Lemmon, Acting Branch Manager
Karen Barnes, LA Department of Health