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State/Territory Name: Louisiana

State Plan Amendment (SPA) #: 18-0015

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Dallas Regional Office
1301 Young Street, Suite 833
Dallas, Texas 75202

CENTERS FOR MEDICARE & MEDICAID SERVICES
CONSORTIUM FOR MEDICAID & CHILDREN'S HEALTH OPERATIONS

DIVISION OF MEDICAID & CHILDREN'S HEALTH - REGION VI

December 20, 2018

Our Reference: SPA LA 18-0015

Ms. Jen Steele, State Medicaid Director
Department of Health
628 North 4th St.
Post Office Box 91030
Baton Rouge, LA 70821-9030

Attention: Karen Barnes

Dear Ms. Steele:

The Centers for Medicare & Medicaid Services has reviewed the State's proposed amendment to the Louisiana State Plan Amendment (SPA) submitted under Transmittal Number 18-0015 dated September 24, 2018. This state plan amendment provides that the state is assessing drug copays to managed care enrollees and that cost sharing rules comply with federal cost sharing rules which went into effect January 1, 2014. With this SPA, the state has elected to update the cost sharing pages to the new Medicaid Model Data Lab (MMDL) format.

Sections 1916 (A)(a)(2)(B), 1916 (A)(b)(1)(B)(ii), and 1916(A)(b)(2)(A), as implemented through 42 CFR §447.56 (f), limits the amount of cost sharing and premiums that a beneficiary may incur up to a 5 percent of family income aggregate limit. When a beneficiary reaches the limit, the state is required to notify the beneficiary and the beneficiary is no longer subject to cost sharing for the remainder of the tracking period, either on a monthly basis or a quarterly basis. Currently, the state's information systems lack the functionality to automate this tracking requirement, thus limiting cost sharing to the 5% aggregate cap. During discussions, the state indicated that as a long term care solution, the state will build functionality into its systems so that cost sharing is not charged at the point of service when individuals hit the 5% household income aggregate cap. The state anticipates this system build to integrate the tracking functionality will be complete by January 2020. In the interim, the state has elected to tier copays so that individuals with income between $0-800 per month will be charged $0 drug copays for one year beginning January 1, 2019 until the state has built the functionality to track electronically. This policy minimizes the risk that lower income individuals will pay any out of pocket expenses that would place the person over the aggregate limit.

As part of the agreement to implement this tiered copay, the state agreed to notify providers and beneficiaries of the new copay amounts that will be in effect through 2019 until the state has built

the functionality to track electronically. The state will notify providers via the provider newsletter and the provider-specific website. The pharmacies will be paid in full at the point of service through the NCPDP system for individuals with income less than or equal to $800/month, and no copay will be assessed against these beneficiaries during the mitigation period. The state will also notify beneficiaries on the state's Medicaid website and ensure that a paper notice will be posted at the point-of-service.

Based on the information submitted, we have approved the amendment for incorporation into the official Louisiana State Plan with an effective date change of August 31, 2018. A copy of the CMS-179 and approved plan pages are enclosed with this letter.

If you have any questions, please contact Cheryl Rupley at (214) 767-6278 or by email at Cheryl.Rupley@cms.hhs.gov.

Sincerely,

[redacted]

Bill Brooks
Associate Regional Administrator

Medicaid Premiums and Cost Sharing: Summary Page (CMS 179)

State/Territory name: **Louisiana**

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

LA-18-0015

Proposed Effective Date

08/31/2018 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

1916, 1916A, 42 CFR 447.50 through 447.57 (excluding 447.55)

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2019	$ 3514765.00
Second Year	2020	$ 3246856.00

Subject of Amendment

The SPA proposes to amend the Medicaid State Plan provisions governing managed care to make technical changes to incorporate cost sharing requirements for managed care enrollees in order to align these provisions with those currently in place for the collection of co-payments for covered prescription drugs under the Medicaid fee-for-service delivery model. The technical changes in this SPA will also align these provision with the State's current administrative rules and operational practices governing cost sharing and managed care for physical and behavioral health.

Governor's Office Review

- ○ **Governor's office reported no comment**
- ○ **Comments of Governor's office received**
  Describe:
- ○ **No reply received within 45 days of submittal**
- ◉ **Other, as specified**
  Describe:
  The Governor does not review State Plan material.

Signature of State Agency Official

Submitted By:	**Karen Barnes**
Last Revision Date:	**Dec 17, 2018**
Submit Date:	**Dec 14, 2018**

Medicaid Premiums and Cost Sharing

State Name: Louisiana

OMB Control Number: 0938-1148

Transmittal Number: LA - 18 - 0015

Cost Sharing Requirements G1

1916
1916A
42 CFR 447.50 through 447.57 (excluding 447.55)

The state charges cost sharing (deductibles, co-insurance or co-payments) to individuals covered under Medicaid. Yes

☑ The state assures that it administers cost sharing in accordance with sections 1916 and 1916A of the Social Security Act and 42 CFR 447.50 through 447.57.

General Provisions

☑ The cost sharing amounts established by the state for services are always less than the amount the agency pays for the service.

■ No provider may deny services to an eligible individual on account of the individual's inability to pay cost sharing, except as elected by the state in accordance with 42 CFR 447.52(e)(1).

■ The process used by the state to inform providers whether cost sharing for a specific item or service may be imposed on a beneficiary and whether the provider may require the beneficiary to pay the cost sharing charge, as a condition for receiving the item or service, is (check all that apply):

☒ The state includes an indicator in the Medicaid Management Information System (MMIS)

☐ The state includes an indicator in the Eligibility and Enrollment System

☒ The state includes an indicator in the Eligibility Verification System

☐ The state includes an indicator on the Medicaid card, which the beneficiary presents to the provider

☒ Other process

Description:

The State's provider manual lists all costs and copayments.

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■ Contracts with managed care organizations (MCOs) provide that any cost-sharing charges the MCO imposes on Medicaid enrollees are in accordance with the cost sharing specified in the state plan and the requirements set forth in 42 CFR 447.50 through 447.57.

Cost Sharing for Non-Emergency Services Provided in a Hospital Emergency Department

The state imposes cost sharing for non-emergency services provided in a hospital emergency department. No

Cost Sharing for Drugs

The state charges cost sharing for drugs. Yes

The state has established differential cost sharing for preferred and non-preferred drugs. No

☒ All drugs will be considered preferred drugs.

Beneficiary and Public Notice Requirements

☑ Consistent with 42 CFR 447.57, the state makes available a public schedule describing current cost sharing requirements in a manner that ensures that affected applicants, beneficiaries and providers are likely to have access to the notice. Prior to submitting a SPA which establishes or substantially modifies existing cost sharing amounts or policies, the state provides the public with advance notice of the SPA, specifying the amount of cost sharing and who is subject to the charges, and provides reasonable opportunity for stakeholder comment. Documentation demonstrating that the notice requirements have been met are submitted with the SPA. The state also provides opportunity for additional public notice if cost sharing is substantially modified during the SPA approval process.

Other Relevant Information

The State's provider manual lists all costs and copayments.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20160722

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Medicaid Premiums and Cost Sharing

State Name: Louisiana

OMB Control Number: 0938-1148

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Cost Sharing Amounts - Categorically Needy Individuals G2a

1916
1916A
42 CFR 447.52 through 54

The state charges cost sharing to all categorically needy (Mandatory Coverage and Options for Coverage) individuals. Yes

Services or Items with the Same Cost Sharing Amount for All Incomes

Add	Service or Item	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	Prescription Drugs $10.00 or less	0.50	$	Prescription		Remove
Add	Prescription Drugs $10.01 - $25.00	1.00	$	Prescription		Remove
Add	Prescription Drugs $25.01 - $50.00	2.00	$	Prescription		Remove
Add	Prescription Drugs $50.01 or more	3.00	$	Prescription		Remove

Services or Items with Cost Sharing Amounts that Vary by Income

Service or Item: Prescription Drugs

Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

Add	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add		$800	0.00	$	Prescription	Through December 31, 2019, beneficiaries with a monthly income between $0 and $800, are not charged a copayment.	Remove

Add Service or Item

Cost Sharing for Non-preferred Drugs Charged to Otherwise Exempt Individuals

If the state charges cost sharing for non-preferred drugs (entered above), answer the following question:

The state charges cost sharing for non-preferred drugs to otherwise exempt individuals. No

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Medicaid Premiums and Cost Sharing

Cost Sharing for Non-emergency Services Provided in the Hospital Emergency Department Charged to Otherwise Exempt Individuals

If the state charges cost sharing for non-emergency services provided in the hospital emergency department (entered above), answer the following question:

The state charges cost sharing for non-emergency services provided in the hospital emergency department to otherwise exempt individuals.	No

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20181119

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Medicaid Premiums and Cost Sharing

State Name: Louisiana

OMB Control Number: 0938-1148

Transmittal Number: LA - 18 - 0015

Cost Sharing Amounts - Medically Needy Individuals	G2b
1916 1916A 42 CFR 447.52 through 54	
The state charges cost sharing to all medically needy individuals.	Yes
The cost sharing charged to medically needy individuals is the same as that charged to categorically needy individuals.	Yes

PRA Disclosure Statement

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Medicaid Premiums and Cost Sharing

State Name: Louisiana

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Cost Sharing Amounts - Targeting	G2c
1916 1916A 42 CFR 447.52 through 54	
The state targets cost sharing to a specific group or groups of individuals.	No

PRA Disclosure Statement

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Medicaid Premiums and Cost Sharing

State Name: Louisiana

OMB Control Number: 0938-1148

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Cost Sharing Limitations G3

42 CFR 447.56
1916
1916A

☑ The state administers cost sharing in accordance with the limitations described at 42 CFR 447.56, and 1916(a)(2) and (j) and 1916A(b) of the Social Security Act, as follows:

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Exemptions

Groups of Individuals - Mandatory Exemptions

The state may not impose cost sharing upon the following groups of individuals:

- ■ Individuals ages 1 and older, and under age 18 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118).
- ■ Infants under age 1 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118), whose income does not exceed the higher of:
  - ■ 133% FPL; and
  - ■ If applicable, the percent FPL described in section 1902(l)(2)(A)(iv) of the Act, up to 185 percent.
- ■ Disabled or blind individuals under age 18 eligible for the following eligibility groups:
  - ■ SSI Beneficiaries (42 CFR 435.120).
  - ■ Blind and Disabled Individuals in 209(b) States (42 CFR 435.121).
  - ■ Individuals Receiving Mandatory State Supplements (42 CFR 435.130).
- ■ Children for whom child welfare services are made available under Part B of title IV of the Act on the basis of being a child in foster care and individuals receiving benefits under Part E of that title, without regard to age.
- ■ Disabled children eligible for Medicaid under the Family Opportunity Act (1902(a)(10)(A)(ii)(XIX) and 1902(cc) of the Act).
- ■ Pregnant women, during pregnancy and through the postpartum period which begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends, except for cost sharing for services specified in the state plan as not pregnancy-related.
- ■ Any individual whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs.
- ■ An individual receiving hospice care, as defined in section 1905(o) of the Act.
- ■ Indians who are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services.
- ■ Individuals who are receiving Medicaid because of the state's election to extend coverage to the Certain Individuals Needing Treatment for Breast or Cervical Cancer eligibility group (42 CFR 435.213).

Groups of Individuals - Optional Exemptions

The state may elect to exempt the following groups of individuals from cost sharing:

The state elects to exempt individuals under age 19, 20 or 21, or any reasonable category of individuals 18 years of age or over. Yes

Indicate below the age of the exemption:

- ○ Under age 19
- ○ Under age 20
- ◉ Under age 21
- ○ Other reasonable category

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The state elects to exempt individuals whose medical assistance for services furnished in a home and community-based setting is reduced by amounts reflecting available income other than required for personal needs. Yes

Services - Mandatory Exemptions

The state may not impose cost sharing for the following services:

- ■ Emergency services as defined at section 1932(b)(2) of the Act and 42 CFR 438.114(a).
- ■ Family planning services and supplies described in section 1905(a)(4)(C) of the Act, including contraceptives and pharmaceuticals for which the state claims or could claim federal match at the enhanced rate under section 1903(a)(5) of the Act for family planning services and supplies.
- ■ Preventive services, at a minimum the services specified at 42 CFR 457.520, provided to children under 18 years of age regardless of family income, which reflect the well-baby and well child care and immunizations in the Bright Futures guidelines issued by the American Academy of Pediatrics.
- ■ Pregnancy-related services, including those defined at 42 CFR 440.210(a)(2) and 440.250(p), and counseling and drugs for cessation of tobacco use. All services provided to pregnant women will be considered pregnancy-related, except those services specificially identified in the state plan as not being related to pregnancy.
- ■ Provider-preventable services as defined in 42 CFR 447.26(b).

Enforceability of Exemptions

The procedures for implementing and enforcing the exemptions from cost sharing contained in 42 CFR 447.56 are (check all that apply):

- ■ To identify that American Indians/Alaskan Natives (AI/AN) are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services in accordance with 42 CFR 447.56(a)(1)(x), the state uses the following procedures:
  - ☒ The state accepts self-attestation
  - ☐ The state runs periodic claims reviews
  - ☐ The state obtains an Active or Previous User Letter or other Indian Health Services (IHS) document
  - ☒ The Eligibility and Enrollment and MMIS systems flag exempt recipients

☐ Other procedure

Additional description of procedures used is provided below (optional):

☒ To identify all other individuals exempt from cost sharing, the state uses the following procedures (check all that apply):

☒ The MMIS system flags recipients who are exempt

☒ The Eligibility and Enrollment System flags recipients who are exempt

☐ The Medicaid card indicates if beneficiary is exempt

☒ The Eligibility Verification System notifies providers when a beneficiary is exempt

☐ Other procedure

Additional description of procedures used is provided below (optional):

Payments to Providers

☑ The state reduces the payment it makes to a provider by the amount of a beneficiary's cost sharing obligation, regardless of whether the provider has collected the payment or waived the cost sharing, except as provided under 42 CFR 447.56(c).

Payments to Managed Care Organizations

The state contracts with one or more managed care organizations to deliver services under Medicaid. Yes

☑ The state calculates its payments to managed care organizations to include cost sharing established under the state plan for beneficiaries not exempt from cost sharing, regardless of whether the organization imposes the cost sharing on its recipient members or the cost sharing is collected.

Aggregate Limits

☑ Medicaid premiums and cost sharing incurred by all individuals in the Medicaid household do not exceed an aggregate limit of 5 percent of the family's income applied on a quarterly or monthly basis.

☒ The percentage of family income used for the aggregate limit is:

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- (●) 5%
- ( ) 4%
- ( ) 3%
- ( ) 2%
- ( ) 1%
- ( ) Other: [ ] %

☑ The state calculates family income for the purpose of the aggregate limit on the following basis:

- ( ) Quarterly
- (●) Monthly

The state has a process to track each family's incurred premiums and cost sharing through a mechanism that does not rely on beneficiary documentation. **No**

Explain why the state's premium and cost sharing rules do not place beneficiaries at risk of reaching the aggregate family limit:

To comply with the tracking requirement, the State conducted an analysis of its Medicaid beneficiaries to determine who might be at risk of exceeding the five percent aggregate cap. The State used this data to alter cost sharing policies to effectuate policies that would limit the risk of individuals exceeding the aggregate cap. Using state fiscal year 2018 (SFY18) data, the State determined that out of 1,634,418 Medicaid beneficiaries, that 158,138 beneficiaries who exceeded the five percent aggregate cap, incurred copayments during this period. Applying parameters on the data to reflect a tiered copay structure, the State established an income tier of $0-$800 per month, whereas beneficiaries are subject to $0 drug copays and an income tier of greater than $800 per month, whereas a copay would apply. Tiering by income, the State determined that 158,138 beneficiaries who previously exceeded the five percent aggregate cap would fall within the $0 drug copay income band, leaving approximately zero individuals who previously exceeded the five percent aggregate cap, subject to any cost sharing. In the event that any beneficiary's cost sharing exceeds his/her five percent aggregate cap, the State will have a process in place to reimburse these beneficiaries. Beneficiaries who are not exempt from copayment or that do not fall within the $0-$800 monthly household income tier, would still be subject to established copayments.

The state has a documented appeals process for families that believe they have incurred premiums or cost sharing over the aggregate limit for the current monthly or quarterly cap period. **Yes**

Describe the appeals process used:

MCOs are contractually required to operate a grievance and appeal process. If MCO members are not satisfied with the outcome of the MCO appeal process, they may file an appeal with the State. Individuals enrolled in fee-for-service (FFS) may file an appeal directly with the State.

☑ Describe the process used to reimburse beneficiaries and/or providers if the family is identified as paying over the aggregate limit for the month/quarter:

The State will provide information to beneficiaries about copayments, the five percent aggregate family limit, and how to contact the State if they perceive that the five percent aggregate family limit has been exceeded, via its website at www.medicaid.la.gov, until January 1, 2020, when the State will operationalize individual, system-generated notices. The State has implemented a tiered copayment structure through December 31, 2019, that significantly narrows the risk for individuals to exceed the aggregate family limit. Effective January 1, 2020, the State will implement a Point of Sale edit that will calculate the five percent aggregate limit, flag individuals as exempt/non-exempt and turn off cost sharing when the five percent aggregate family limit has been met, eliminate all of the risk for individual to exceed the aggregate family

limit.

☑ Describe the process for beneficiaries to request a reassessment of their family aggregate limit if they have a change in circumstances or if they are being terminated for failure to pay a premium:

The beneficiary notifies the State of a change in circumstance and their family aggregate limit is reevaluated based on the information provided.

The state imposes additional aggregate limits, consistent with 42 CFR 447.56(f)(5). No

PRA Disclosure Statement

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