



State of Louisiana
Louisiana Department of Health
Office of the Secretary

March 7, 2025

James G. Scott, Director
Division of Program Operations
Medicaid & CHIP Operations Group
601 East 12th Street, Room 0300
Kansas City, Missouri 64106-2898

RE: Louisiana Title XXI State Plan
Transmittal No. 25-0003

Dear Mr. Scott:

The purpose of this SPA is to eliminate the premium lock-out period and provide assurance that, in accordance with 42 CFR 457.1130(a)(3), beneficiaries are provided with an opportunity for an impartial review to address disenrollment from the program.

I have reviewed and approved the enclosed Louisiana Title XXI State Plan material and recommend it for adoption and inclusion in the body of the State Plan.

Tribal notification around this State Plan action was issued to the Tribes on January 28, 2025, with the comment period ending on February 27, 2025. No comments were received in response to the notice.

Should you have any questions or concerns regarding this matter, please contact Marjorie Jenkins at (225) 342-3881 or via email at Marjorie.Jenkins@la.gov.

Sincerely,

A handwritten signature in cursive script that reads "Michael Harrington".

Michael Harrington, MBA, MA
Secretary

Attachments (2)

RLA:KS:KC

Amendment 30

LA SPA TN 22-0001

CHIP - American Rescue Plan (ARP) Act Coverage

The purpose of this SPA is to demonstrate compliance with the American Rescue Plan Act provisions that require states to cover treatment (including treatment of a condition that may seriously complicate COVID-19 treatment), testing, and vaccinations for COVID-19 without cost sharing in CHIP.

Effective date: March 11, 2021

Amendment 31

LA SPA TN 23-0042

CHIP – Mandatory Coverage of Age-Appropriate Vaccines

The purpose of this SPA is, in accordance with section 11405 of the Inflation Reduction Act, to cover-age appropriate vaccines approved by the U.S. Food and Drug Administration (FDA) and administered in accordance with recommendations of the Advisory Committee on Immunization Practices (ACIP), and their administration, without cost sharing.

Effective date: October 1, 2023

Implementation date: October 1, 2023

Amendment 32

LA SPA TN 24-0005

CHIP – Continuous Eligibility

The purpose of this SPA is to comply with section 5112 of the Consolidated Appropriations Act (CAA) 2023, which requires states to provide continuous eligibility to children in the Children’s Health Insurance Program (CHIP).

Effective Date: January 1, 2024

Implementation date: January 1, 2024

Amendment 33

LA SPA TN 25-0003

CHIP – Premium

The purpose of this SPA is to eliminate the premium lock-out period and provide assurance that, in accordance with 42 CFR 457.1130(a)(3), beneficiaries are provided with an opportunity for an impartial review to address disenrollment from the program.

Effective Date: January 1, 2025

Implementation date: January 1, 2025

1.4- TC

Tribal Consultation (Section 2107(e)(1)(C)) Describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved.

On January 28, 2025, notification of the State’s intent to seek approval from CMS to demonstrate compliance with 42 CFR 457.1130(a)(3) by providing assurance that beneficiaries are provided with an opportunity for an impartial review to address disenrollment from the program and to eliminate the premium lock-out period was submitted to the Louisiana Tribes.

TN 25-0003 Approval Date: _____ **Effective Date:** January 1, 2025

In the event of a state or federally declared disaster or public health emergency, the State may modify the tribal consultation process by shortening the number of days before submission of the SPA and/or conducting consultation after submission of the SPA. The duration of the provisions may not exceed the duration of the state or federal disaster period.

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Section 8. Cost-Sharing and Payment

Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan, and continue on to Section 9.

8.1. Is cost-sharing imposed on any of the children covered under the plan? (42 CFR 457.505) Indicate if this also applies for pregnant women. (CHIPRA #2, SHO # 09-006, issued May 11, 2009)

8.1.1. Yes, **with the exception of unborn children covered in LaCHIP Phase IV.**
In the event of a FEMA or governor-declared disaster and at the State's discretion, the State may waive cost sharing for families living in FEMA or governor-declared disaster areas at the time of a disaster event.

8.1.2. No, skip to question 8.8.

8.1.1-PW Yes

8.1.2-PW No, skip to question 8.8.

Guidance: It is important to note that for families below 150 percent of poverty, the same limitations on cost sharing that are under the Medicaid program apply. (These cost-sharing limitations have been set forth in Section 1916 of the Social Security Act, as implemented by regulations at 42 CFR 447.50 - 447.59). For families with incomes of 150 percent of poverty and above, cost sharing for all children in the family cannot exceed 5 percent of a family's income per year. Include a statement that no cost sharing will be charged for pregnancy-related services. (CHIPRA #2, SHO # 09-006, issued May 11, 2009) (Section 2103(e)(1)(A)) (42 CFR 457.505(a), 457.510(b) and (c), 457.515(a) and (c)).

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge by age and income (if applicable) and the service for which the charge is imposed or time period for the charge, as appropriate. (Section 2103(e)(1)(A)) (42 CFR 457.505(a), 457.510(b) and (c), 457.515(a) and (c))

8.2.1. Premiums:
\$50 per month per family where family income is above 212 percent of the federal poverty level (FPL), but no greater than 250 percent of the FPL.

In the event of a FEMA or governor-declared disaster and at the State's discretion, the State may waive or delay collection of premiums at initial application or renewal for families living in FEMA or governor-declared disaster areas at the time of a disaster event. If the State elects to delay collection of premiums, eligible individuals will be enrolled prior to payment of the premium.

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8.2.2. Deductibles:

8.2.3. Coinsurance or copayments:

8.2.4. Other:

8.2-DS **Supplemental Dental** (CHIPRA # 7, SHO # #09-012 issued October 7, 2009) For children enrolled in the dental-only supplemental coverage, describe the amount of cost-sharing, specifying any sliding scale based on income. Also describe how the State will track that the cost sharing does not exceed 5 percent of gross family income. The 5 percent of income calculation shall include all cost-sharing for health insurance and dental insurance. (Section 2103(e)(1)(A)) (42 CFR 457.505(a), 457.510(b), and (c), 457.515(a) and (c), and 457.560(a)) Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, 6.2-DS, and 9.10 when electing this option.

8.2.1-DS Premiums:

8.2.2-DS Deductibles:

8.2.3-DS Coinsurance or copayments:

8.2.4-DS Other:

8.3. Describe how the public will be notified, including the public schedule, of this cost sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. (Section 2103(e)(1)(A)) (42 CFR 457.505(b))

The cost sharing information is explained to potential enrollees through the application, which includes a chart of income eligibility and premium payment amounts. This information is also prominently displayed on the LaCHIP website. If changes are necessary to the cost sharing requirements, all current enrollees are notified by letter of the changes and the effective dates. Public hearings are held to allow the public to comment on any proposed changes to cost sharing.

Guidance: The State should be able to demonstrate upon request its rationale and justification regarding these assurances. This section also addresses limitations on payments for certain expenditures and requirements for maintenance of effort.

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8.4. The State assures that it has made the following findings with respect to the cost sharing in its plan: (Section 2103(e))

- 8.4.1. Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B)) (42 CFR 457.530)
- 8.4.2. No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2)) (42 CFR 457.520)
- 8.4.3. No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. (Section 2103(e)(1)(A)) (42 CFR 457.515(f))

8.4.1- MHPAEA There is no separate accumulation of cumulative financial requirements, as defined in 42 CFR 457.496(a), for mental health and substance abuse disorder benefits compared to medical/surgical benefits. (42 CFR 457.496(d)(3)(iii))

8.4.2- MHPAEA If applicable, any different levels of financial requirements that are applied to different tiers of prescription drugs are determined based on reasonable factors, regardless of whether a drug is generally prescribed for medical/surgical benefits or mental health/substance use disorder benefits. (42 CFR 457.496(d)(3)(ii)(A))

8.4.3- MHPAEA Cost sharing applied to benefits provided under the State child health plan will remain capped at five percent of the beneficiary's income as required by 42 CFR 457.560 (42 CFR 457.496(d)(3)(i)(D)).

8.4.4- MHPAEA Does the State apply financial requirements to any mental health or substance use disorder benefits? If yes, specify the classification(s) of benefits in which the State applies financial requirements on any mental health or substance use disorder benefits.

- Yes (Specify: Pharmacy co-payments)
 No

Guidance: For the purposes of parity, financial requirements include deductibles, copayments, coinsurance, and out of pocket maximums; premiums are excluded from the definition. If the State does not apply financial requirements on any mental health or substance use disorder benefits, the State meets parity requirements for financial requirements. If the State does apply financial requirements to mental health or substance use disorder benefits, the State must conduct a parity analysis. Please continue below.

Please ensure that changes made to financial requirements under the State child health plan as a result of the parity analysis are also made in Section 8.2.

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8.4.5- MHPAEA Does the State apply any type of financial requirements on any medical/surgical benefits?

- Yes
 No

Guidance: If the State does not apply financial requirements on any medical/surgical benefits, the State may not impose financial requirements on mental health or substance use disorder benefits.

8.4.6- MHPAEA Within each classification of benefits in which the State applies a type of financial requirement on any mental health or substance use disorder benefits, the State must determine the portion of medical and surgical benefits in the class which are subject to the limitation.

- The State assures it has applied a reasonable methodology to determine the dollar amounts used in the ratio described above (Section 6.2.5.2-MHPAEA) for each classification or within which the State applies financial requirements to mental health or substance use disorder benefits. (42 CFR 457.496(d)(3)(i)(E))

Guidance: Please include the State’s methodology and results of the parity analysis as an attachment to the State child health plan.

8.4.7- MHPAEA For each type of financial requirement applied to any mental health or substance use disorder benefits within a given classification, does the State apply the same type of financial requirement to at least two-thirds (“substantially all”) of all the medical/surgical benefits within the same classification? (42 CFR 457.496(d)(3)(i)(A))

- Yes
 No

Guidance: If the State does not apply a type of financial requirement to substantially all medical/surgical benefits in a given classification of benefits, the State may not impose financial requirements on mental health or substance use disorder benefits in that classification. (42 CFR 457.496(d)(3)(i)(A))

8.4.8- MHPAEA For each type of financial requirement applied to substantially all medical/surgical benefits in a classification, the State must determine the predominant level (as defined in 42 CFR 457.496(d)(3)(i)(B)) of that type which is applied to medical/surgical benefits in the classification. For each type of financial requirement applied to substantially all medical/surgical benefits in a classification, the State assures:

- The same reasonable methodology applied in determining the dollar amounts used in determining whether substantially all medical/surgical benefits within a classification are subject to a type of financial requirement also is applied in determining the dollar amounts used to determine the predominant level of a type of

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financial requirement applied to medical/surgical benefits within a classification. (42 CFR 457.496(d)(3)(i)(E))

The level of each type of financial requirement applied by the State to mental health or substance use disorder benefits in any classification is no more restrictive than the predominant level of that type which is applied by the State to medical/surgical benefits within the same classification. (42 CFR 457.496(d)(2)(i))

Guidance: If there is no single level of a type of financial requirement that exceeds the one-half threshold, the State may combine levels within a type of financial requirement such that the combined levels are applied to at least half of all medical/surgical benefits within a classification; the predominant level is the least restrictive level of the levels combined to meet the one-half threshold. (42 CFR 457.496(d)(3)(i)(B)(2))

- 8.5. Describe how the state will ensure that the annual aggregate cost sharing for a family does not exceed five percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the state for overpayment by an enrollee: (Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))

Because there will no longer be co-pays, the maximum amount that a family would pay for coverage is \$600 per year for premiums. This amount does not exceed five percent of 200 percent FPL.

- 8.6 Describe the procedures the state will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost sharing. (Section 2103(b)(3)(D)) (42CFR 457.535)

All Louisiana Medicaid and SCHIP applications request ethnicity information on each applicant. No cost sharing is imposed on those children who are verified to be a member of a federally recognized tribe. The applicant's statement on the application form is sufficient to exempt the child from any cost-sharing obligations.

- 8.7 Please provide a description of the consequences for an enrollee or applicant who does not pay a charge. (42CFR 457.570 and 457.505(c))

Applicants will not be enrolled in LaCHIP Phase V until they pay for the first month's premium. They will not receive access to benefits and will subsequently be notified that their eligibility is ending due to failure to pay. Premiums are due by the tenth of each month. If payment is not received by the tenth of the month a notice is generated notifying the responsible party that coverage will be terminated if payment is not received by the twenty-first of the month. Non-payment of premium results in disenrollment effective 60 days after the due date.

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In the event of a FEMA or governor-declared disaster and at the State's discretion, the State may waive or delay collection of premiums in accordance with Sections 8.1.1 and 8.2.1.

8.7.1 Please provide an assurance that the following disenrollment protections are being applied:

- State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. (42CFR 457.570(a))
- The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. (42CFR 457.570(b))
- In the instance mentioned above, that the State will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. (42CFR 457.570(b))
- The State provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42CFR 457.570(c))

8.8 The State assures that it has made the following findings with respect to the payment aspects of its plan: (Section 2103(e))

- 8.8.1. No Federal funds will be used toward state matching requirements. (Section 2105(c)(4)) (42CFR 457.220)
- 8.8.2. No cost sharing (including premiums, deductibles, copays, coinsurance and all other types) will be used toward state matching requirements. (Section 2105(c)(5) (42CFR 457.224) (Previously 8.4.5)
- 8.8.3. No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. (Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))
- 8.8.4. Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1)) (42CFR 457.622(b)(5))
- 8.8.5. No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105(c)(7)(B)) (42CFR 457.475)
- 8.8.6. No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). (Section 2105(c)(7)(A)) (42CFR 457.475)



CHIP Eligibility

State Name:

OMB Control Number: 0938-1148

Transmittal Number: LA - 25 - 0003

Separate Child Health Insurance Program Non-Financial Eligibility - Non-Payment of Premiums		CS21
42 CFR 457.570		
Non-Payment of Premiums		
Does the state impose premiums or enrollment fees?	<input type="text" value="Yes"/>	
Can non-payment of premiums or enrollment fees result in loss of CHIP eligibility?	<input type="text" value="Yes"/>	
Does the state have a premium lock out period?	<input type="text" value="No"/>	
<input checked="" type="checkbox"/> The state assures that it provides enrollees with an opportunity for an impartial review to address disenrollment from the program in accordance with section 457.1130(a)(3).		

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 50 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.

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