SECTION 1115 DEMONSTRATION PROPOSAL FOR ACT 421 CHILDREN'S MEDICAID OPTION

LOUISIANA DEPARTMENT OF HEALTH

Contents

Instructions: This template is meant to assist states that are developing an application for a new section 1115 demonstration project; submission of the information provided in this template or the attachments does not guarantee approval of a state's demonstration request. CMS will work with states to identify any additional information necessary to consider demonstration requests. Use of this guide/format is not required; it is a tool that states can use at their option. It was designed to help states ensure the application contains the required elements as provided for under 42 CFR 431.412, as well as promote an efficient review process. It can also be used by states as a template for their application; states can add narrative responses to the information requested in the sections below that are applicable to the state's particular application, and complete the charts and checkboxes provided. We will continue to improve this guide based on input from states and expect to have an online section 1115 demonstration application available for us in the future.

Please submit applications electronically to 1115DemoRequests@cms.hhs.gov and mail hard copies to:

Ms. Victoria Wachino
Centers for Medicare &Medicaid Services
Children and Adults Health Programs Group
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244

Section I – Program Description

This section should contain information describing the goals and objectives of the Demonstration, as well as the hypothesis that the Demonstration will test. In accordance with 42 CFR 431.412(a)(i), (v), and (vii), the information identified in this section must be included in a state's application in order to be determined complete. Specifically, this section should: (1) provide a summary of the proposed Demonstration program, and how it will further the objectives of title XIX and/or title XXI of the Social Security Act (the Act); (2) include the rationale for the Demonstration; (3) describe the hypotheses that will be tested/evaluated during the Demonstration's approval period and the plan by which the State will use to test them; (4) describe where the Demonstration will operate; (5) include the proposed timeframe for the Demonstration; and (6) describe whether the Demonstration will affect and/or modify other components of the State's current Medicaid and CHIP programs outside of eligibility, benefits, cost sharing or delivery systems.

(1) Summary of and (2) Rationale for the Proposed Demonstration Program

The goal of this demonstration is to support children with complex medical needs in living at home by allowing access to Medicaid state plan services, regardless of parental income. The objective of the demonstration is to provide Medicaid services to as many children as possible within the legislatively appropriated budget for that purpose.

Louisiana proposes to establish a program to implement Act 421 enacted by the Louisiana Legislature in 2019. The program is titled the Act 421 Children's Medicaid Option ("421-CMO"). The Demonstration extends Medicaid eligibility to children covered by § 1902(e)(3) of the Social Security Act, i.e., children age 18 and younger who meet institutional level of care (Nursing Facility, Hospital, Intermediate Care Facility for Individuals with Intellectual/Developmental Disabilities) and are in families with income that is too high to qualify for Medicaid, who could become Medicaid eligible if receiving extended care in an institutional setting. The Demonstration option allows these children with disabilities to become Medicaid eligible based on their own income and resources in order to receive medical services in less-costly home-settings instead of an institution. The 1115 authority is to be used to provide coverage to eligible children but with a condition of coverage that families maintain pre-existing private health insurance (obtained through employment or the private insurance market) unless the family demonstrates that obtaining or maintaining private insurance would create a financial hardship for the family. Because the Demonstration covers a new eligibility group, the State proposes to cap enrollment under the Demonstration at the number of children who can be served based on annual legislative appropriation. The State further proposes to require enrollment of all participants in managed care in order to control costs and enhance budget predictability. These measures will allow the State to assess the needs of the population and control costs without jeopardizing allocated funding for existing optional Medicaid programs.

All Medicaid title XIX requirements as expressed in law, regulation and policy statement not expressly waived or identified as not applicable in these approval documents shall apply to this Demonstration. Louisiana's authority to deviate from Medicaid requirements is limited to the specific authorities described in the enclosed approval documents and to the purpose(s) indicated.

Glossary:
Below is a glossary of commonly used terms in this application that may clarify some of the provisions and processes.

- Register/Registry/Registration – Process by which a child seeking entry into the Act 421 Children's Medicaid Option can sign up. The list of children seeking coverage under the Act 421 Children's Medicaid Option.
- Offer – An offer is made to a child on the registry when a slot in the Act 421 Children's Medicaid Option becomes available. After the offer is made, clinical and programmatic eligibility are determined for the Medicaid program per the parameters of this Demonstration.
- Apply/Application – The Medicaid eligibility application that determines programmatic eligibility such as meeting age requirements, citizenship, financial requirements, and coinsurance requirements. It will also be where the applicant chooses a health plan. The application process does not occur until after a waiver offer is made.
- Enroll – After Medicaid eligibility is certified, the child is enrolled into Medicaid and a health and dental plan. Enrollment is the process whereby the child is actually linked to services through Medicaid coverage.

- Prioritization – A process whereby a child can be qualified to be fast-tracked or prioritized to receive a waiver offer among all registrants.
- Clinical Eligibility – Determination of disability in order to meet federal Medicaid requirements and ensure children in Demonstration meet level of care for institutionalization.
- Programmatic Eligibility – Medicaid eligibility requirements regarding age, citizenship, financial requirements, co-insurance requirements.

(3) Hypotheses

Describe the hypotheses that will be tested/evaluated and the plan by which the State will use to test them.

This Demonstration will test hypotheses under two broad categories: (1) increased access to and quality of care for enrollees; and (2) cost containment and program sustainability.

(1) The Act 421 Children's Medicaid Option will improve access to high-quality, person-centered services that produce positive health outcomes for individuals by:

- Ensuring that Demonstration enrollees have coverage of needed health services, including Medicaid wrap services that would help prevent institutionalization and are not available or not available to the extent needed under participants' private health insurance plans. The State will require participants to carry private health insurance, unless a hardship exception applies. The State will test this hypothesis by measuring the utilization of Medicaid-covered services not commonly covered by private health insurance to the extent needed by Demonstration participants.
- Examining the effect on health outcomes resulting from the designation of this population as a special healthcare needs group, such that recipients receive case management and enhanced care coordination through their managed care plan. The State will test this hypothesis by measuring utilization of inpatient hospital, emergency department, nursing home, and ICF/IID services by Demonstration participants as compared to a baseline utilization established in year one of the Demonstration

(2) The Act 421 Children's Medicaid Option will contain costs in order to create a sustainable program that enhances overall access to Medicaid services by:

- Ensuring cost of care provided under the demonstration will be more cost-effective than equivalent care provided in an institutional setting. The State will evaluate this hypothesis by comparing managed care per-member, per-month expenditures against average cost of care in institutional settings.
- Ensuring enrollment is limited to the number of children who can be served by the amount annually appropriated by the Louisiana Legislature for this purpose, thereby ensuring existing optional programs under Louisiana Medicaid remain fully funded. The State will evaluate this hypothesis by assessing (a) the number of participants enrolled in the

Demonstration; (b) the number of people on the Demonstration registry; (c) funding available to the Demonstration.

- Requiring families to maintain pre-existing coverage in privately available health insurance, in order to maximize third-party liability for healthcare needs of enrollees and thereby reduce primary Medicaid coverage costs and provide access to a greater number of participants, unless a hardship exception is granted. The State will evaluate this hypothesis by assessing the cost of services provided under the demonstration with Medicaid acting as secondary payer against the cost of those same services, assuming no third-party liability existed.
- Implementing a hardship exception to the private insurance requirement, to ensure that the requirement does not create a barrier to healthcare access. The State will evaluate this hypothesis by tracking the extent to which the hardship exception is applied for and granted.
- Offering families the option of enrollment into Louisiana's Health Insurance Premium Program (LaHIPP), if eligible, to ensure cost burdens associated with maintaining private insurance are minimized as much as possible. The State will evaluate this hypothesis by tracking the hypothetical annual costs to participant families associated with maintaining private insurance, absent enrollment in LaHIPP.

(4) Statewideness

Describe where the Demonstration will operate.

This Demonstration will operate statewide.

(5) Proposed Timeframe

The proposed timeframe for this Demonstration has an effective date of January 1, 2021, and an end date of December 31, 2025. It is preferable that the effective date start at the beginning of the quarter on January 1, 2021 since this will provide a more efficient process for data collection and annual reporting and align with annual/biannual rate-setting cycles for managed care

(6) Effect on Other State programs

Describe whether the Demonstration will affect and/or modify other components of the State's current Medicaid and CHIP programs outside of eligibility, benefits, cost sharing or delivery systems.

This Demonstration will not affect and/or modify other components of the State's current Medicaid and CHIP programs outside of eligibility, cost sharing, benefits, or delivery systems.

Section II – Demonstration Eligibility

This section should include information on the populations that will participate in the Demonstration, including income level. In accordance with 42 CFR 431.412(a)(ii), the information identified in this section must be included in a state's application in order to be determined complete.

(1) Chart

Include a chart identifying any populations whose eligibility will be affected by the Demonstration. Please refer to Medicaid Eligibility Groups: List of Medicaid Eligibility Groups when describing Medicaid State Plan populations and for an expansion eligibility group, please provide the state name for the groups that is sufficiently descriptive to explain the groups to the public.

Optional Categorically Needy

Eligibility Group Name	Social Security Act and CFR Citations	Income Level
Qualified Disabled Children under 19	1902(e)(3)	300% of Federal Poverty Level; $2,000 asset limitation.

(2) Standards and Methodologies

Describe the standards and methodologies the state will use to determine eligibility for any populations whose eligibility is changed under the Demonstration.

Louisiana does not currently allow for eligibility of this population under 1902(e)(3) of the Social Security Act, so all affected individuals will be newly eligible. In order to be eligible under this Demonstration, a child shall meet programmatic and clinical eligibility criteria as follows:

(a) Programmatic Eligibility. The participant:

1) Is 18 years of age or younger;
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 an annual gross income of no more than three times the current SSI Standard Payment Amount (parental income not considered);
6) Has countable assets of $2,000 or less (parental assets not considered);
7) Has care needs that can be safely met at home for a cost lower than the cost of services provided in an institutional setting;
8) Is covered by privately acquired health insurance, unless a hardship exception is applied for and granted by the State (see Section II.6.3)
9) Is not eligible for Medicaid or CHIP coverage through any other eligibility pathway or program.

(b) Clinical Eligibility. The participant:

1) Has a medically determinable physical or mental impairment (or combination of impairments); and (1) the impairment(s) results in marked and severe functional limitations; and (2) the impairment(s) has lasted or is expected to last for at least one year or to result in death.

   Under the Louisiana Medicaid State Plan, when an individual applies for Medicaid based on disability but does not have a disability determination from the Social Security Administration, disability is determined through a specific process that meets the requirements of 42 C.F.R. § 435.541. In order to streamline processes, avoid duplication, and therefore improve access to the program, the State will use the level-of-care clinical eligibility determination as described in paragraph (2) below to meet the requirements of § 435.541:

2) Meets the medical necessity requirement, assessed on an annual basis, for institutional placement in a hospital, a skilled nursing facility, or an intermediate care facility for individuals with intellectual disabilities (ICF/IID), as assessed according to standards and procedures established by the Louisiana Department of Health, as outlined below:
   a. **ICF/IID.** In order to qualify under the ICF/IID level-of-care, a child must meet criteria LDH currently employs to screen individuals for a developmental disability and to determine ICF/IID level-of-care for its 1915(c) waivers. Specifically, a child must:
      i. Obtain a Statement of Approval (SOA) from LDH's Office for Citizens with Developmental Disabilities (OCDD) under the procedures outlined in Appendix A (Louisiana DD Eligibility Determination Rule and Policy Manual), attesting that the child has a developmental disability as defined in 45 C.F.R. § 435.541; and
      ii. Be determined to meet level of care for an ICF/IID using the Form 90-L Attached as Appendix B (Form 90-L) and signed by a physician.

   b. **Nursing Facility.** In order to qualify under Nursing Facility level-of-care, a child must demonstrate the following, as assessed by a registered nurse using clinical records and interviews with appropriate parties:
      i. The need for skilled nursing / therapeutic interventions, that must be required on a specified basis (daily or weekly, depending on the intervention) for a period of up to six months, including:
         1. IV Access;
         2. Tracheostomy care;
         3. Oxygen;
         4. Total Parenteral Nutrition;
         5. Tube feedings;
         6. Dialysis;
         7. Specified respiratory treatments, not including inhalers or nebulizers;

8. Intensive daily wound or special skin care interventions;
9. Specified bowel or ostomy care;
10. Urinary catheter;
11. Physical, occupational, or speech therapy multiple times per week; **AND**

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

c. Hospital. In order to qualify under hospital level-of-care, the child must require the following, as assessed by a registered nurse using clinical records and interviews with appropriate parties:

i. Frequent and Complex Medical Care that requires the use of equipment to prevent life-threating situations, with skilled medical care required multiple times during each 24-hour period and involving:

1. Tracheostomy care
2. Ventilator Care
3. IV Access
4. Oxygen
5. Total parenteral nutrition
6. Rehabilitation for brain injury or coma (minimum of 15 hours per week)
7. Dialysis; **AND**

ii. The child's complex skilled medical interventions are expected to persist for at least six months; and

iii. The child's overall health condition must be highly unstable and present the 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.

3) Enrollment Limitations

Specify any enrollment limits that apply for expansion populations under the Demonstration.

For the purpose of this Demonstration, the number of recipients will be limited to the number of children that can be served under an amount appropriated for this purpose by the Louisiana legislature.

The State will not impose limitations on its Medicaid expansion population through this program. By definition, children eligible for the 421 CMO are not otherwise eligible for Medicaid or CHIP, and are under the age limitation for the expansion adult group.

Enrollment under this Demonstration will be limited to the number of children who can be served according to the amount appropriated by the Louisiana Legislature through its annual budgetary process. The State projects the Demonstration will serve up to 2,540 recipients at a given time, based on an assumed annualized budget of $27.2 million as appropriated by the Louisiana Legislature. The Demonstration budget and corresponding number of recipients, are subject to annual legislative appropriation. Allocation of initial offers, including prioritization based on medical need, and organization of a program registry are described below in Section V.

4) Projected Number of Recipients

The State projects the Demonstration will serve up to 2,540 recipients at a given time, based on an assumed annual budget of $27.2 million as appropriated by the Louisiana Legislature. The Demonstration budget and corresponding number of recipients, are subject to annual legislative appropriation.

5) Post-Eligibility Treatment of income

Describe how the Demonstration will address post-eligibility treatment of income, if applicable. Indicate whether the Demonstration will utilize spousal impoverishment rules under section 1924, or will utilize regular post-eligibility rules under 42 CFR 435.726 (SSI State and section 1634) or under 42 CFR 435.735 (209b State).

Not applicable.

6) Eligibility Procedural Changes

Describe any changes in eligibility procedures the state will use for populations under the Demonstration, including any eligibility simplifications that require 1115 authority (such as continuous eligibility or express lane eligibility for adults or express lane eligibility for children after 2013).

In order to demonstrate eligibility for 421 CMO, an individual must qualify on the basis of programmatic requirements for Medicaid eligibility listed in Section II.2.a above (e.g., citizenship, residence), and in addition must meet clinical eligibility requirements, showing:

(1) He or she requires hospital, nursing facility, or ICF/IID level-of-care, as determined in accordance with the following standards:

- a. **ICF/IID.** In order to qualify under the ICF/IID level-of-care, a child must meet criteria LDH currently employs to screen individuals for a developmental disability and to determine ICF/IID level-of-care for its 1915(c) waivers. Specifically, a child must:
  - i. Obtain a Statement of Approval (SOA) from LDH's Office for Citizens with Developmental Disabilities (OCDD) under the procedures outlined in Appendix A (Louisiana DD Eligibility Determination Rule and Policy Manual),

attesting that the child has a developmental disability as defined in 45 C.F.R. § 435.541; and

ii. Be determined to meet level of care for an ICF/IID using the Form 90-L Attached as Appendix B (Form 90-L) and signed by a physician.

b. **Nursing Facility.** In order to qualify under Nursing Facility level-of-care, a child must demonstrate the following, as assessed by a registered nurse using clinical records and interviews with appropriate parties:

i. The need for skilled nursing / therapeutic interventions, that must be required on a specified basis (daily or weekly, depending on the intervention) for a period of up to six months, including:

1. IV Access;
2. Tracheostomy care;
3. Oxygen;
4. Total Parenteral Nutrition;
5. Tube feedings;
6. Dialysis;
7. Specified respiratory treatments, not including inhalers or nebulizers;
8. Intensive daily wound or special skin care interventions;
9. Specified bowel or ostomy care;
10. Urinary catheter; or
11. Physical, occupational, or speech therapy multiple times per week; **AND**

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

c. Hospital. In order to qualify under hospital level-of-care, the child must require the following, as assessed by a registered nurse using clinical records and interviews with appropriate parties:

i. Frequent and Complex Medical Care that requires the use of equipment to prevent life-threating situations, with skilled medical care required multiple times during each 24-hour period and involving:

1. Tracheostomy care;
2. Ventilator care;
3. IV access;

4. Oxygen;
5. Total Parenteral Nutrition;
6. Rehabilitation for brain injury or coma (minimum 15 hours per week); or
7. Dialysis; **AND**

ii. The child's complex skilled medical interventions are expected to persist for at least six months; and

iii. The child's overall health condition must be highly unstable and present the 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.

(2) He or she has a disability, defined as medically determinable physical or mental impairment (or combination of impairments); and the impairment(s) results in marked and severe functional limitations; and the impairment(s) has lasted or is expected to last for at least one year or to result in death. For this Demonstration, the level-of-care determinations and other existing processes described elicit sufficient information regarding disability such that an individual who meets annual level-of-care requirements (see part (1) of this Section) would meet the disability standard. In order to streamline processes and therefore access to the program, the State will use the level-of-care determination as described in part (1) to meet the requirements of § 435.541.

(3) The individual's family maintains pre-existing privately available health insurance coverage, unless the family can show so doing would create financial hardship. A look back period of six months will apply for determining pre-existing coverage.

a. Lock-out Period. If the State determines that a family or responsible adult has discontinued privately available health insurance, either during the six-month look back period or at any time during the participant's enrollment, the State will impose a lock-out. During the lock-out period, the participant will be unable to receive benefits or services, but will retain his or her status as a Demonstration participant. The lock-out will end when the participant demonstrates health insurance has been re-instated. The lock-out period will extend up to six months from discontinuation of insurance or Demonstration offer, whichever date is later. At the conclusion of six months, if the participant has not re-acquired health insurance, the participant will be dis-enrolled from the Demonstration. At the participant's request, he or she may re-register for participation and be placed on the Demonstration registry as a new applicant.

At any time during the lock-out period, the participant may apply for a financial hardship exception to the insurance requirement. The State's grant of a financial hardship exception will end the lock-out period.

b. "Financial hardship" is defined, for the purposes of this Demonstration, as:
   i. Health insurance premiums for the child and responsible adult obtaining coverage, and any additional deductibles and co-payments, that would equal or exceed 5% of the household's modified adjusted gross income;
   ii. Unemployment resulting in loss of employer-sponsored private insurance; or
   iii. Period of 90-days for transition to new employment

(4) The income of the individual is no more than 300% of federal poverty level and the individual's assets have a value of no more than $2,000; parental income and assets are not counted.

7) Eligibility Changes regarding Transitioning

If applicable, describe any eligibility changes that the state is seeking to undertake for the purposes of transitioning Medicaid or CHIP eligibility standards to the methodologies or standards applicable in 2014 (such as financial methodologies for determining eligibility based on modified adjusted gross income), or in light of other changes in 2014.

Not applicable.

Section III-Demonstration Benefits and Cost Sharing Requirements

This section should include information on the benefits provided under the Demonstration as well as any cost sharing requirements. In accordance with 42 CFR 431.412(a)(ii), the information identified in this section must be included in a state's application in order to be determined complete.

1) Benefits

Indicate whether the benefits provided under the Demonstration differ from those provided under the Medicaid and/or CHIP State Plan: Yes/No (if no, skip questions 3-7)

No. The benefits provided under this Demonstration will not differ from those provided under the Medicaid and CHIP State Plan.

2) Cost Sharing Requirements

Indicate whether the cost sharing requirements under the Demonstration differ from those provided under the Medicaid and/or CHIP State Plan: Yes/No (if no, skip questions 8-11)

Yes, please see question #9 in this section.

3) Proposed Changes

If changes are proposed, or different benefit packages will apply to different eligibility groups affected by the Demonstration, please include a chart specifying the benefit package that each eligibility group will receive under the Demonstration (see example chart provided).

Not applicable

4) Benchmark-Equivalent Coverage

If electing benchmark-equivalent coverage for a population, please indicate which standard is being used:

☐ Federal Employees Health Benefit Package
☐ State Employee Coverage
☐ Commercial Health Maintenance Organization
☐ Secretary Approved

Not applicable

5) Benefits that Differ from Medicaid or CHIP State Plan

In addition to the Benefit Specifications and Qualifications form: Benefit Specifications and Provider Qualifications Form, please complete the following chart if the Demonstration will provide benefits that differ from the Medicaid or CHIP State Plan.

Not applicable as demonstration will provide benefits that align with Medicaid and CHIP State Plan.

6) Provision of Long Term Services and Supports

☐ Yes (if yes, please check the services that are being offered)
☐ No

In addition, please complete the: Long Term Services and Supports Form, and the: Long Term Services Benefit Specifications and Provider Qualifications Form.

Not applicable (see question 2 of this Section).

7) Premium Assistance for Employer Sponsored Coverage

☐ Yes (If yes, please address the questions below)
☐ No (if no, please skip this question)

a) Describe whether the state currently operates a premium assistance program and under which authority, and whether the state is modifying its existing program or creating a new program.
b) Include the minimum employer contribution amount.
c) Describe whether the Demonstration will provide wrap-around benefits and cost-sharing.
d) Indicate how the cost-effectiveness test will be met.

Question not applicable (see question 2 of this Section).

8) Premium Amounts

If different from the State Plan, provide the premium amounts by eligibility group and income level.

Not applicable.

9) Copayments, Coinsurance and/or Deductibles

(a) Include a table if the Demonstration will require copayments, coinsurance and/or deductibles that differ from the Medicaid State Plan (see example table).

Recipients participating in this demonstration will be required to maintain existing private or employer-sponsored health insurance coverage, unless the family can show that doing so would create financial hardship. A look back period of six months will apply for determining pre-existing coverage.

The State will impose a lock-out period on participants in cases where a family or responsible adult has discontinued privately available health insurance, either during the six-month look back period or at any time during the participant's enrollment. During the lock-out period, the participant will be unable to receive benefits or services, but will retain his or her status as a Demonstration participant. The lock-out will end when the participant demonstrates health insurance has been re-instated. The lock-out period will extend up to six months from discontinuation of insurance or Demonstration offer, whichever date is later. At the conclusion of six months, if the participant has not re-acquired health insurance, the participant will be dis-enrolled from the Demonstration. At the participant's request, he or she may re-register for participation and be placed on the Demonstration registry as a new applicant.

At any time during the lock-out period, the participant may apply for a financial hardship exception to the insurance requirement. The State's grant of a financial hardship exception will end the lock-out period. "Financial hardship" is defined, for the purposes of this Demonstration, as: (1) health insurance premiums for the child and responsible adult obtaining coverage, and any additional deductibles and co-payments, that would equal or exceed 5% of the family's modified adjusted gross income; (2) unemployment resulting in loss of employer-sponsored private insurance; or (3) a period of 90-days for transition to new employment

(b) If the state is proposing to impose cost sharing in the nature of deductions, copayments or similar charges beyond what is permitted under the law, the state should also address in its application, in accordance with section 1916(f) of the Act, that its waiver request:

a) will test a unique and previously untested use of copayments;
b) is limited to a period of not more than two years;
c) will provide benefits to recipients of medical assistance which can be reasonably be expected to be equivalent to the risks to the recipients;
d) is based on a reasonable hypothesis which the demonstration is designed to test in a methodologically sound manner, including the use of control groups of similar recipients of medical assistance in the area;
e) is voluntary, or makes provision for assumption of liability for preventable damage to the health of recipients of medical assistance resulting from involuntary participation. –

Not applicable.

10) Cost Sharing Exemptions
Indicate if there are any exemptions from the proposed cost sharing.

A family that can demonstrate that maintaining private or employer-sponsored health insurance would create financial hardship is not required to maintain such insurance coverage. "Financial hardship" is defined, for the purposes of this Demonstration as:

i. Health insurance premiums for the child and responsible adult obtaining coverage, and any additional deductibles and co-payments, that would equal or exceed 5% of the household modified adjusted gross income;
ii. Unemployment resulting in loss of employer-sponsored private insurance; or

iii. Period of 90-days for transition to new employment.

Section IV-Delivery System and Payment Rates for Services

This section should include information on the means by which benefits will be provided to Demonstration participants. In accordance with 42 CFR 431.412(a)(ii), a description of the proposed healthcare delivery system must be included in a state's application in order to be determined complete.

1) Delivery System

Indicate whether the delivery system used to provide benefits to Demonstration participants will differ from the Medicaid and/or CHIP State Plan:

☑ Yes

☐ No (if no, please skip questions 2-7 and the applicable payment rate questions)

2) Delivery System Reforms

Describe the delivery system reforms that will occur as a result of the Demonstration, and if applicable, how they will support the broader goals for improving quality and value in the health care system. Specifically, include information on the proposed Demonstration's expected impact on quality, access, cost of care and potential to improve the health status of the populations covered by the Demonstration. Also include information on which populations and geographic areas will be affected by the reforms.

All participants in the Demonstration will be required to enroll in managed care for all services provided under the State Plan, including Demonstration participants in the Louisiana Health Insurance Premium Program (LaHIPP) and Chisholm class members. State projections, using capitated rates set by actuaries and examination of past usage in fee-for-service by similar eligibility groups, indicate that use of managed care will cost less to provide the same range of services. Rate capitation additionally allows greater budgetary predictability, which is important to ensuring coverage of the new eligibility group remains fully funded without negatively impacting funds for existing optional services or programs.

The entire Demonstration eligibility group, in all geographic regions of the State, will be enrolled in managed care.

3) Delivery System

Indicate the delivery system that will be used in the Demonstration by checking one or more of the following boxes:

☑ Managed Care
- ☑ Managed Care Organization (MCO)
- ☐ Prepaid Inpatient Health Plans (PIHP)
- ☑ Prepaid Ambulatory Health Plans (PAHP)

☐ Fee-for-service (including Integrated Care Models)

☐ Primary Care Case Management (PCCM)

☐ Health Homes

☐ Other (please describe)

4) Multiple Delivery Systems

If multiple delivery systems will be used, please include a table that depicts the delivery system that will be utilized in the Demonstration for each eligibility group that participates in the Demonstration (an example is provided). Please also include the appropriate authority if the Demonstration will use a delivery system (or is currently seeking one) that is currently authorized under the State Plan, section 1915(a) option, section 1915(b) or section 1932 option:

Eligibility Group	**Delivery System**	**Authority**
Qualified Disabled Children under 19	Managed Care – MCO: all services available under State Plan excluding dental	Section 1932(a) state plan authority
Qualified Disabled Children under 19	Managed Care – PAHP: dental services	Section 1915(b)

5) If Managed Care Delivery System

If the Demonstration will utilize a managed care delivery system:

a) Indicate whether enrollment will be voluntary or mandatory. If mandatory, is the state proposing to exempt and/or exclude populations?

Mandatory enrollment in managed care will be required. No excluded populations are contemplated in the Demonstration.

b) Indicate whether managed care will be statewide, or will operate in specific areas of the state.

Managed care will operate statewide.

c) Indicate whether there will be a phased-in rollout of managed care (if managed care is not currently in operation or in specific geographic areas of the state.

Not applicable.

d) Describe how the state will assure choice of MCOs, access to care and provider network adequacy.

LDH will leverage its existing managed care reporting requirements to assure choice of MCOs/PAHPs, access to care and provider network adequacy for those enrolled under this Demonstration. Applicants have a choice of health plan upon enrollment. If they do not choose one, they are auto-assigned and then allowed a 90-day period to change plans. Additionally, members are given an annual open enrollment period. LDH has entered into contract with an enrollment broker to ensure individuals enrolling into MCOs/PAHPs have choice and are educated on and assisted with selecting the most appropriate MCO/PAHP based on healthcare needs, and monitors compliance with these requirements through reporting by the enrollment broker. LDH additionally monitors access to care and provider network adequacy through its existing managed care reporting. MCOs submit network adequacy reports to LDH on a quarterly basis, inclusive of counts of available network providers by provider type. LDH will be including certain provisions and

protections for Demonstration participants in the managed care contracts. The contract will designate 421-CMO participants as part of the Special Healthcare Needs group with enhanced case management and care coordination. LDH will ensure that appropriate expertise is hired on managed care staff for working with this population. LDH will also continue to work stakeholders on identified needs to reduce administrative burden and access to existing providers through managed care.

e) Describe how the managed care providers will be selected/procured.
The state will use its existing managed care providers under its current Healthy LA and Dental Benefit Programs.

6) Service Exclusion

Indicate whether any services will not be included under the proposed delivery system and the rationale for the exclusion.

There will be no State Plan services excluded under the proposed delivery system in this Demonstration

7) Self-Direction

If the Demonstration will provide personal care and/or long term services and supports, please indicate whether self-direction opportunities are available under the Demonstration. If yes, please describe the opportunities that will be available, and also provide additional information with respect to the person-centered services in the Demonstration and any financial management services that will be provided under the Demonstration.

☐ Yes
☑ No

8) Deviation from State Plan Payment Rates

If fee-for-service payment will be made for any services, specify any deviation from State Plan provider payment rates. If the services are not otherwise covered under the State Plan, please specify the rate methodology.

Fee-for-service payments will not be made for any services.

9) Managed Care Capitation

If payment is being made through managed care entities on a capitated basis, specify the methodology for setting capitation rates, and any deviations from the payment and contracting requirements under 42 CFR Part 438.

Managed care capitation payments will be set consistent with the Medicaid managed care regulations and contracting requirements. Capitation rates will be actuarially sound and submitted to CMS for review and approval.

10) Quality-Based Supplemental Payments

If quality-based supplemental payments are being made to any providers or class of providers, please describe the methodologies, including the quality markers that will be measured and the data that will be collected.

Quality-based supplemental payments will not be made to any providers or class of providers as part of this Demonstration.

Section V-Implementation of Demonstration

This section should include the anticipated implementation date, as well as the approach that the state will use to implement the Demonstration.

1) Implementation Schedule

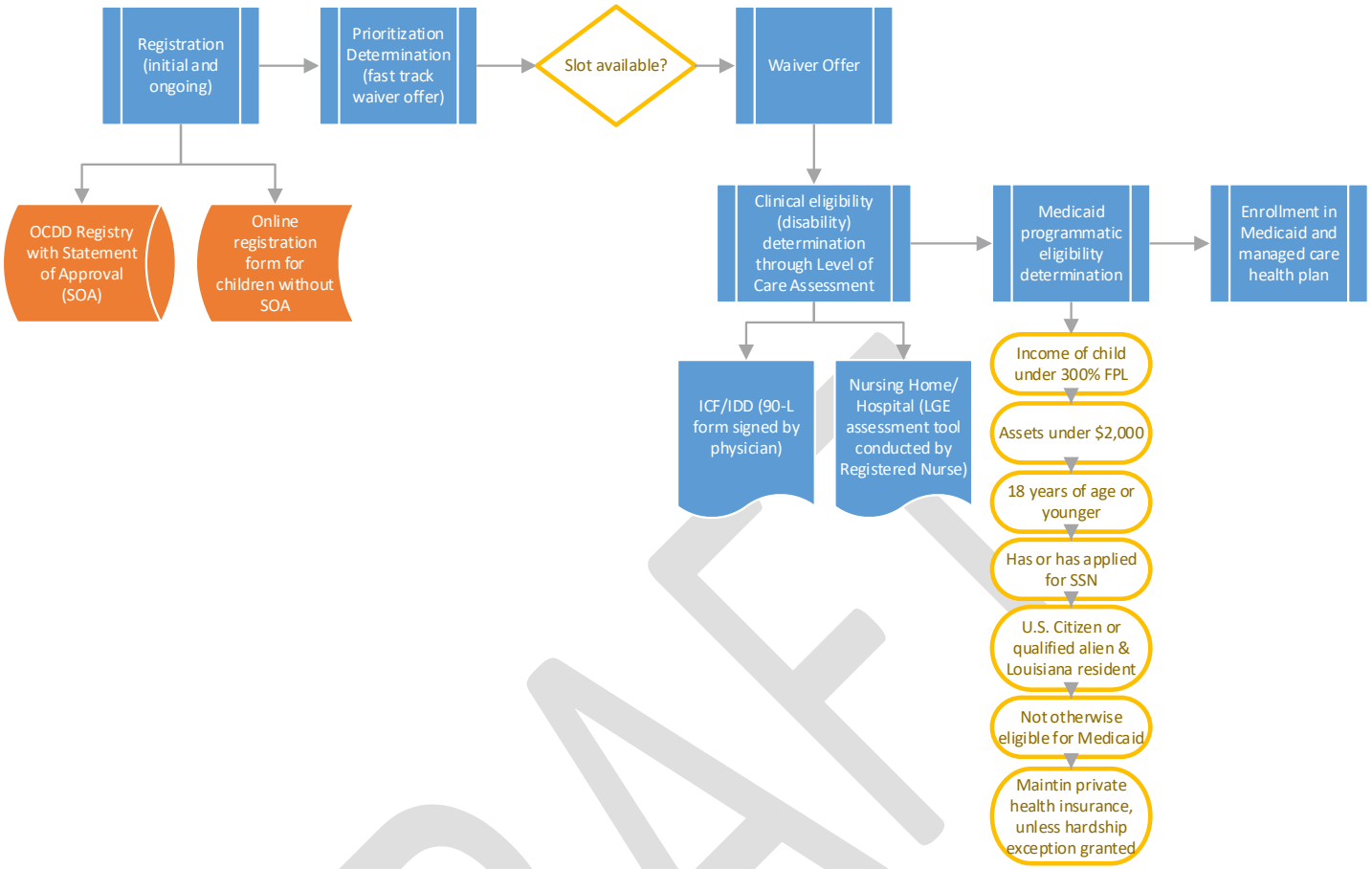
Describe the implementation schedule. If implementation is a phase-in approach, please specify the phases, including starting and completion dates by major component/milestone.

The State is requesting an implementation date of 1/1/2021. The State's goal is for the effective and implementation dates to coincide with the beginning of the calendar year and quarter to better coordinate quarterly and annual reporting and to align with the state's historical annual and biannual rate-setting cycles. In the alternative, the state requests approval for an effective date at the start of a new quarter.

2) Notification/Enrollment of Participants

Describe how potential Demonstration participants will be notified/enrolled into the Demonstration.

Please see below work flow of program notification, registration and enrollment along with detailed descript of each step of the process.



1. **Notification**. Notice providing a description of the program and a month-long enrollment period, with instructions on how registration can be completed on-line, in person, or over the phone will be provided in the following formats:
    a. Through a press release produced by LDH and circulated to major newspapers;
    b. Social media postings on the LDH Facebook, Twitter and Instagram pages;
    c. Through publication and resources with the Special Needs and Parent Support Services of La, LLC (SNAPSS) contractor;
    d. Publication on LDH's main website and the specific webpage devoted to the program;
    e. Email distribution to stakeholders who have expressed prior interest in the 421 CMO program;
    f. Notice to legislators for their constituencies; and
    g. Email distribution to public and private organizations that advocate for children's services and services for people with disabilities in Louisiana, including Louisiana's Developmental Disabilities Council, and Parent Training & Information Centers.
2. **Initial Registration**. LDH will have an Initial Registration Period lasting one month, during which time registration will occur in two pathways:

a. Online applications will be taken from interested parties that are not currently on the developmental disabilities request for services registry. During the Initial Registration Period, LDH will collect information pertinent to the Prioritization process described in paragraph (4) below.
b. Children who have already been determined by LDH to have a developmental disability in accordance with the process described in Appendix A but who are not currently eligible for Medicaid services will be automatically registered for participation. They will receive a preprinted mailed form explaining the Demonstration 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 described in paragraph (4) below.
c. At the conclusion of the Initial Registration Period, LDH will randomize the registered applicants to create a numerically ordered Registry of applicants.
d. Children registered in the Initial Registration Period will receive Demonstration offers according to the Prioritization described in paragraph (4) below, and then according to numeric order on the Registry.
e. All children who do not receive Demonstration offers will remain on the Registry in the numeric order assigned, with a Registry date corresponding to the close of the Initial Registration Period. In other words, all children entering the Demonstration during the initial registration period will receive the same Registry date.

3. **Ongoing Registration**. After the Initial Registration Period and slot allocation, subsequent registrants for the program will be assigned a Registry date/number on a first-come, first-served basis. Demonstration offers will be made upon availability.
4. **Prioritization.** LDH anticipates that more children will be eligible for the 421 CMO than can be served by the projected legislative appropriation. In order to ensure children with the most urgent needs receive services, the State will prioritize Demonstration offers to children who:
    a. Have been institutionalized in an ICF/IID, nursing facility, or hospital for 30 of the preceding 90 days at time of registration; in-facility days do not have to be consecutive.
    OR
    b. On three (3) or more separate occasions in the preceding 90 days, have been admitted to an institution or hospital and remained in-facility for at least 24 hours.
    c. Following the Initial Registration Period, a new applicant may apply for and, if eligible, receive prioritization in order to receive the next available Demonstration offer. In addition, any person on the Registry may apply for and, if eligible, receive prioritization at any time.
    d. The State anticipates all children registered during the Initial Registration Period who are eligible for Prioritization will receive Demonstration offers.

e. **Prioritization after the Initial Registration Period**: For children not receiving an offer during the Initial Registration Period and remaining on registry or that subsequently enter the demonstration, prioritization will be considered valid for a period of 6 months from the date that prioritization is approved while waiting for a Demonstration offer. At the expiration of 6 months, if no Demonstration offer has been made, the individual loses Prioritization but retains his or her original Registry date for purposes of receiving a Demonstration offer.
    i. If an individual's Prioritization period has expired with no Demonstration offer available during that time period, he or she may apply for and, if eligible, receive a new Prioritization date. There is no limit on the number of times an individual may receive Prioritization prior to receiving a Demonstration offer.
    ii. If more than one registrant has received Prioritization at one time, the next available Demonstration offer will be made to the registrant with an earlier Prioritization date.

f. Once enrolled in the 421 CMO, participants will have to demonstrate annually that they meet level-of-care requirements, but will not be required to demonstrate ongoing need for Prioritization. Prioritization is only a tool for fast-tracking initial entry into the Demonstration for families with a higher urgency of need.

5. **Eligibility and Enrollment**. Upon extension of a Demonstration offer to a registrant, the registrant will need to establish programmatic and clinical eligibility by showing he or she meets all eligibility criteria (see Section II.2) for the Demonstration. When eligibility is confirmed, the registrant will be enrolled in the program and with a health and dental plan.

3) MCO Contracting

If applicable, describe how the state will contract with managed care organizations to provide Demonstration benefits, including whether the state needs to conduct a procurement action.

The existing Healthy Louisiana and Dental Benefit Program contracts and rate certifications on file with CMS will be amended to include this population.

Section VI-Demonstration Financing and Budget Neutrality

This section should include a narrative of how the Demonstration will be financed as well as the expenditure data that accompanies this application. The State must include 5 years of historical data, as well as projections on member month enrollment. In accordance with 42 CFR 431.412(a)(iii) and (iv), historical and projected expenditures as well as projected enrollment for the proposed demonstration project must be included in a state's application in order to be determined complete. The additional information requested will be needed before the application can be acted upon.

Please complete the Demonstration financing and budget neutrality forms, respectively, and include with the narrative discussion. The Demonstration Financing Form includes a set of standard financing questions

typically raised in new section 1115 demonstrations; not all will be applicable to every demonstration application. The Budget Neutrality Form and spreadsheet includes a set of questions with respect to historical expenditure data as well as projected Demonstration expenditures.
Enrollment under this Demonstration will be limited to the number of children who can be served according to the amount appropriated by the Louisiana Legislature through its annual budgetary processes. Any changes to future appropriations will require the State to increase/decrease the number served accordingly.

Section VII-List of Proposed Waivers and Expenditure Authorities

This section should include a preliminary list of waivers and expenditures authorities related to title XIX and XXI authority that the State believes it will need to operate its Demonstration. In accordance with 42 CFR 431.412(a)(vi), this section must be included in a state's application in order to be determined complete. Specifically, this section should:

(1) Provide a list of proposed waivers and expenditure authorities; and
(2) Describe why the state is requesting the waiver or expenditure authority, and how it will be used.

(1) List of proposed waivers and expenditure authorities

Under the authority of section 1115(a) (2) of the Social Security Act (the Act), expenditures made by Louisiana for the items identified below, that are not otherwise included as expenditures under section 1903 of the Act, shall, for the period of the proposed demonstration waiver, be regarded as expenditures under the State's title XIX plan.

The following expenditure authority shall enable Louisiana to operate the Act 421 Children's Medicaid Option section 1115 demonstration waiver.

Demonstration Waiver Population: Expenditures for services provided to children age 18 and under, who require an institutional level of care, and would otherwise be Medicaid-eligible under a TEFRA state plan option.

Title XIX Requirements Being Waived

All requirements of the Medicaid program expressed in law, regulation, or policy statement, except those expressly identified below, shall apply to the Act 421 Children's Medicaid Option demonstration waiver project beginning the date of the approval of the demonstration request.

- **Cost Sharing, Section 1902(a)(14) Insofar as it incorporates Section 1916**
    - The State proposes to require families of eligible children maintain employer-sponsored or other privately available health insurance, except that no such requirement will apply where the cost of providing such insurance (responsible adult's premium, child's premium, child's co-pay, and child's deductibles) do not exceed 5% of the modified adjusted gross income of the household.
- **Enrollment Limitation**

- The State proposes to limit enrollment to the number of participants who can be served under an amount annually appropriated by the Louisiana legislature for the Demonstration.

- **Mandated Enrollment in Managed Care**
  - The State proposes to enroll all participants in the Demonstration in managed care for all services provided under the State Plan.

(2) Reason for Waiver or Expenditure Authority

The goal of this demonstration is to support children with complex medical needs in living at home by allowing access to Medicaid state plan services, regardless of parental income, and avoiding institutionalization. Louisiana requests the waiver authorities in order to (1) maximize the cost-effectiveness of the program, ensuring sustainability and allowing as many recipients as possible to be served; and (2) ensure existing optional programs and services offered under Louisiana's State Plan remain funded and are not adversely impacted by the addition of a new eligibility group.

Please refer to the list of title XIX and XXI waivers and expenditure authorities: List of Frequently Requested Waivers and Expenditure Authorities that the state can reference to help complete this section. CMS will work with the State during review process to determine the appropriate waivers and expenditures needed to ensure proper administration of the Demonstration.

Section VIII-Public Notice

This section should include information on how the state solicited public comment during the development of the application in accordance with the requirements under 42 CFR 431.408. For specific information regarding the provision of state public notice and comment process, please click on the following links to view the section 1115 Transparency Final Rule and corresponding State Health Official Letter.

Please include the following elements as provided for in 42 CFR 431.408 when developing this section:

1) Start and end dates of the state's public comment period.

The public comment period will extend July 10 to August 10, 2020.

2) Certification that the state provided public notice of the application, along with a link to the state's web site and a notice in the state's Administrative Record or newspaper of widest circulation 30 days prior to submitting the application to CMS.

The State certifies that it has complied with the requirements as listed above.

3) Certification that the state convened at least 2 public hearings, of which one hearing included teleconferencing and/or web capacity, 20 days prior to submitting the application to CMS, including dates and a brief description of the hearings conducted.

4) Certification that the state used an electronic mailing list or similar mechanism to notify the public.

5) Comments received by the state during the 30-day public notice period.

6) Summary of the state's responses to submitted comments, and whether or how the state incorporated them into the final application.

7) Certification that the state conducted tribal consultation in accordance with the consultation process outlined in the state's approved Medicaid State Plan, or at least 60 days prior to submitting this Demonstration application if the Demonstration has or would have a direct effect on Indians, tribes, or Indian health programs, or on urban Indian health organizations, including dates and method of consultation.

In addition to the measures noted above, the State communicated extensively with stakeholders throughout the development of the program. Activities included:

- November 21, 2019: Public meeting with stakeholders to present outlines of a new TEFRA-like program. The meeting was publicized through existing stakeholder networks, and included distribution to:
    - Statewide Developmental Disabilities Council
    - Regional (covering the entire state) parent resource centers / Parent Training and Information Centers
    - Existing stakeholder group for the Office of Citizens with Developmental Disabilities
    - Statewide Early Intervention advisory group

  At this meeting, the State solicited volunteers for a stakeholder work group which met several times during the planning phase of this Demonstration:

    - January 10, 2020: Stakeholder work group meeting (in-person and virtual)
    - January 30, 2020: Stakeholder work group meeting (in-person and virtual)
        - Temporary suspension of work due to COVID-19
    - June 12, 2020: Stakeholder work group meeting (virtual)
    - June 22, 2020: Stakeholder work group meeting (virtual)
    - June 29, 2020: Stakeholder work group meeting (virtual)

Act 421 Stakeholder Work Group

The Act 421 CMO stakeholder work group is comprised of sixteen (16) volunteers; members are parent and professional advocates. The State has communicated with Stakeholders regarding every major aspect of the 421 program. Specifically, the State has discussed the following issues and aspects of program design with the stakeholder work group:

- Estimated size of the eligible population.
- Estimated costs associated with services: discussion included State uncertainty as to costs prior to the launch of a new eligibility group, desire to minimize impacts to existing programs.
    - Stakeholders were asked about and expressed clear opposition to the Department's exploration of cuts to other optional programs and services that currently exist in Louisiana Medicaid.

- Possible vehicles for extending coverage to this new eligibility group (i.e., state plan amendment, 1915(c) waiver, 1115 demonstration waiver).
- Possible cost-sharing options, including the requirement of maintaining private health insurance included in the program.
- Initial and ongoing registry / offer allocations.
- Prioritization: stakeholders requested need-based prioritization and contributed extensively to the design of the prioritization process.
- Use of the managed care delivery system and the possible impacts on program cost.
- Level-of-care assessments.
- The need for ongoing, post-implementation stakeholder engagement, to ensure established processes and systems are meeting the needs of the population.

Stakeholder meetings will continue up to and beyond implementation to ensure the State continues to receive information and perspectives from affected families.

If this application is an emergency application in which public health emergency or a natural disaster has been declared, the State may be exempt from public comment and tribal consultation requirements as outlined in 42 CFR 431.416(g). If this situation is applicable, please explain the basis for the proposed emergency classification and public comment/tribal consultation exemption.

Not applicable.

Section IX-Demonstration Administration

Please provide the contact information for the state's point of contact for the Demonstration application.

Name and Title: Brian Bennett/Medicaid Program Support and Waivers Section Chief
Telephone Number: (225) 342-9846
Email Address: Brian.Bennett@la.gov