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Act 421 Children's Medicaid Option (TEFRA/Katie Beckett)

Frequently Asked Questions
General Information

1. *What does the Act 421 Children's Medicaid Option do?*

The Act 421 Children's Medicaid Option (Act 421-CMO) provides Medicaid eligibility to children under the age of 19 who have disabilities and meet institutional level-of-care requirements, regardless of parental income and resources.

2. *Why is Act 421-CMO necessary?*

Medicaid is a means-tested program. This means that in order to qualify for Medicaid, an applicant/enrollee's income must be below a certain level set by federal regulations. Usually, when determining if a child is eligible for Medicaid, the Medicaid program must count the income and resources of the child's parent(s).

In many cases, households with higher incomes have access to private health insurance that will cover healthcare costs for children in the household. For children with significant medical needs, this privately available insurance is sometimes not enough to cover the extensive healthcare needs of the child. Act

421-CMO will close the coverage gap between private insurance and Medicaid, while enabling parents to continue working.

3. *What is the goal of Act 421-CMO?*

The goal of Act 421-CMO is to enable children with significant disabilities to avoid long-term institutional care, allowing them to live as independently as possible and in the community with their families.

4. *What is TEFRA? Is 421-CMO a TEFRA program?*

Act 421-CMO is based on the Tax Equity and Fiscal Responsibility Act (TEFRA), which is the federal law that creates this specific option for children with disabilities in Medicaid programs. Act 421-CMO is a traditional TEFRA program. Act 421-CMO has all the features of traditional TEFRA, including eligibility qualifications and the disregard of parental income and resources.

5. *When does the program start?*

Louisiana Medicaid received approval from the Centers for Medicare & Medicaid Services (CMS) to begin implementation of the Act 421-CMO program. The program effective date is January 1, 2022. Applications for enrollment will begin on January 1, 2022.

6. *Will everyone who is eligible be able to get services? Will there be a wait list?*

Applicants that meet the financial and categorical eligibility requirements will be enrolled in the Act 421-CMO program. There will be no waiting list for the Act 421-CMO program.

For more information on the application and enrollment process, please go to Application / Enrollment.

7. *How many people can get services at one time?*

Again, there is no cap on the number of people that can be enrolled in the Act 421-CMO program.

8. *How do I enroll in the Act 421 Children's Medicaid Option program?*

There are four (4) general steps to enrolling in the Act 421-CMO program. They are as follows:

1. Medicaid Application;
2. Level of Care Assessment at your Local Governing Entity;
3. Disability determination; and
4. Enrollment/Service Coverage through a Healthy Louisiana plan.

Please see the section on Application / Enrollment for additional details on each step of the process.

9. *Who do I call if I have more questions?*

You can call Medicaid at 1-800-230-0690, where our Medicaid eligibility staff are available to support you. If the person answering the call is unable to answer your questions, you will be directed to a staff member who works directly with the Act 421-CMO program.

You can also e-mail your questions to 421-CMO@la.gov.

Eligibility – Disability and Level of Care

1. *Who is eligible for Medicaid coverage through Act 421-CMO?*

Children under age 19 with disabilities who meet institutional level-of-care requirements, whose care can be provided safely at home, and whose care costs less at home than it would in an institution and if they meet basic Medicaid requirements (e.g., citizenship and income guidelines). See below for more detail.

2. *How is "disability" defined for this program?*

Act 421-CMO uses the Social Security Administration definition for disability: the child must have a disability that is recognized under the definition of disability utilized in the Supplemental Security Income program of the Social Security Administration, regardless of whether the child is eligible to receive benefits under that program. The Medicaid Eligibility Determination Team (MEDT) will determine disability for individuals who do not have a disability determination from the Social Security Administration.

3. *What does "level-of-care" mean?*

In order to qualify for Act 421-CMO, applicants must show that they meet the medical necessity criteria for facility-based care in an intermediate care facility for individuals with intellectual (ICF/IID) or developmental disabilities (DD), a nursing facility, or a hospital.

Note: In many cases, applicants are not required to show that they are, or have been institutionalized, but still must show that they meet the criteria for institutionalization.

4. *How is level-of-care decided?*

The level-of-care determination is processed through your local governing entity (LGE) [Regional LGE directory]. After it is determined that the applicant is not eligible for any other Medicaid programs, the applicant receives a level of care packet requesting additional information. After returning the completed required documentation to LDH, your LGE will contact you. Different criteria apply for each level of care, as described below.

(a) **Intermediate Care Facility.** In order to qualify under ICF level of care, an applicant must first obtain a statement of approval (SOA) from the Office for Citizens with Developmental Disabilities (OCDD), showing that they have a developmental disability. The applicant's physician will need to complete a Form 90-L to attest that the applicant meets ICF level of care.

(b) **Nursing Facility.** In order to qualify under nursing facility level of care, a registered nurse, in accordance with LDH's assessment protocol, must assess an applicant. Each local governing entity (LGE) will use a nurse to perform assessments via record review and interviews with relevant people. The assessment must show:

- The need for skilled nursing and/or therapeutic interventions on a regular and sustained basis**; and**
- Substantial functional limitations as compared to age appropriate levels.

(c) **Hospital.** In order to qualify under hospital level of care, a registered nurse, in accordance with LDH's assessment protocol, must assess an applicant. Each LGE will use a nurse to perform assessments via record review and interviews with relevant people. The assessment must show:

- Frequent medical care that requires the use of equipment to prevent life-threatening situations, with skilled medical care required more than once during each 24-hour period;
- Skilled medical interventions that are expected to last at least six months; and
- An overall health condition that is unstable, presenting constant potential for complications or rapid deterioration, such that the child requires monitoring in order to detect unstable or life threatening condition and respond with appropriate care.

5. *Do I pick the level of care for my child? Who decides what level of care is used?*

If an applicant has already been determined to have a developmental disability, the applicant will have a Statement of Approval (SOA) from an LGE. These applicants will be assessed under the level-of-care for an Intermediate Care Facility for Individuals with Developmental Disabilities (ICF/IID).

If an applicant does not have a Statement of Approval, the applicant will be assessed under Hospital level-of-care first, and then Nursing Facility level of care if necessary. The applicant may demonstrate eligibility under either level of care.

Medicaid services and benefits are identical across all three levels of care.

6. *How do I schedule a level-of-care assessment?*

Assessments are performed by your regional LGE office. Louisiana Department of Health's (LDH) website provides a list of LGEs as well as the contact information for each region at Regional LGE directory.

In order to receive an assessment, applicants must first apply for Medicaid and meet the requirements for Act 421-CMO. The level of care assessments are not conducted unless an application for Medicaid is received and basic requirements are met. After applying for Medicaid, you will receive documents to complete and return to LDH. When the required documents are returned to LDH, the LGE will contact you to schedule your child's assessment.

The level of care assessment is conducted annually. Your LGE will contact you when it is time to conduct the annual reassessment.

See the section on Application / Enrollment below for more information on this process.

Eligibility – Basic Medicaid

1. *How does an applicant qualify for Medicaid?*

In addition to disability, level of care, and age requirements, a child applying for 421-CMO must meet basic Medicaid eligibility criteria that apply to all enrollees. The child must:

- Be a U.S. citizen or qualified non-citizen.

- Be a Louisiana resident.
- Have or has previously applied for a Social Security Number.
- Meet the income and resource limits.

2. *Does any of the parents' income or assets (resources) count in determining eligibility?*

No. However, since an Act 421-CMO enrollee cannot be otherwise eligible for any other Medicaid program, LDH will need information on family income and resources to ensure that the applicant is not first eligible for a different Medicaid program before enrolling them into Act 421-CMO.

3. *Are there income and asset (resource) limits for the applicant (child)?*

Yes. The applicant (i.e., the child) can have no more than $2,000 in assets (resources) and income no more than three (3) times the Federal Benefit Rate (FBR), which is the individual Special Income Limit (SIL).

4. *Will LDH collect any information about parents' income and assets (resources)?*

Yes. LDH will collect information on the household's income and assets (resources), which includes the income and assets of the applicant.

5. *Why does LDH require information about parent income and assets (resources) if it's only the applicant's income and resources that counts?*

LDH needs to collect household financial information to check for other Medicaid eligibility first before enrolling in Act 421-CMO.

6. *What if I am losing Medicaid, can my child still get Act 421-CMO?*

It depends on the reason you are losing Medicaid. If you are losing Medicaid because you make too much money to qualify, your child may still be able to get Medicaid coverage through the Act 421-CMO program. You would have to establish eligibility for the child (disability, level of care, etc.).

Eligibility – Private Health Insurance

1. *Will I be required to keep health insurance? Doesn't Act 421-CMO provide health coverage for my child?*

While you are not required to keep private health insurance, having coverage allows LDH to keep the costs of the Act 421-CMO program down because the private insurer provides primary coverage, and Medicaid only pays for services that private insurance will not.

2. *What if I don't have insurance coverage?*

You are not required to obtain new insurance for the enrollee.

3. *What is LaHIPP? How do I qualify for LaHIPP?*

LaHIPP is the Louisiana Health Insurance Premium Payment program. In some cases, it is less expensive for Medicaid to pay private insurance premiums, other out-of-pocket costs, and any wrap costs (healthcare costs that your insurance does not cover) than it is to cover all of the healthcare costs of the Medicaid enrollee. In these cases, Medicaid will pay the cost of your insurance premiums for you and the enrollee (your child), and additionally cover the enrollee's co-pays, deductibles, and costs your insurance would not otherwise cover.

Act 421-CMO enrollees that qualify for LaHIPP will receive their coverage through Legacy Medicaid, which is fee-for-service.

4. *How will LDH know whether or not my child has insurance?*

By law, Medicaid is the payer of last resort and is required to search for existing health insurance coverage for all enrollees, regardless of program or eligibility group. LDH will search for existing coverage applicable to enrollees at regular intervals; however, it is the responsibility of the enrollee/parent/guardian/representative payee to report any health insurance coverage that a Medicaid applicant or enrollee has through private health insurance. Contact Health Management Systems (HMS) at 1-877-204-1324 to report private health insurance coverage or anytime there is a change in coverage.

5. *How do I apply for LaHIPP?*

To apply for LaHIPP, download a LaHIPP application here and complete it. **After** you complete the application, submit to LDH in one of the following ways:

Email: La.HIPP@la.gov

Fax: 1-855-618-5486

Mail: LDH
ATTN: LaHIPP
P.O. Box 91030
Baton Rouge, LA 70821-0930

Application / Enrollment

In this document, the terms "apply" and "enroll," mean different things.

Apply: To go through the Medicaid eligibility determination processes for Act 421-CMO. Applications involve demonstrating eligibility for all aspects of the program discussed in the Eligibility FAQs including medical/disability certification and basic Medicaid eligibility. The person applying for Act 421-CMO is the **applicant**.

Enroll: To accept Medicaid benefits with a Healthy Louisiana plan (in managed care). Enrollment happens after the individual has been determined eligible for Act 421-CMO. An **enrollee** is the person receiving services under Act 421-CMO.

There are four (4) general steps to enrolling in the Act 421-CMO program as follows:

1. Medicaid Application;
2. Level of Care Assessment at your Local Governing Entity;
3. Disability Determination; and
4. Enrollment/Service Coverage through a Healthy Louisiana plan.

Medicaid Application

1. *I would like to apply for the Act 421-CMO program. What should I do?*

Beginning on January 1, 2022, you should apply for Medicaid on behalf of the child (the Act 421-CMO applicant) through our online self-service portal: OLA. Applications received prior to January 1 will not be considered for Act 421-CMO. See section Eligibility – Basic Medicaid for more information on these standards. In order to be considered for Act 421-CMO, you must check yes to the question that asks if the applicant has a physical, mental, or emotional health condition that causes limitations in activities (disability).

2. *What happens after I complete a Medicaid application?*

You will receive a letter along with documents needed for your child (the Act 421-CMO applicant) to be assessed for level of care eligibility by your local governing entity (LGE). If the applicant has a Statement of Approval (SOA) from OCDD, the level of care is established via Form 90L. Have the applicant's physician complete the Form 90L and return the form to LDH according to the instructions in the letter that you receive. You will also need to complete the Child's Medical and Social Interview form. Additionally, to establish level of care and/or disability, it will be necessary to obtain medical records. If you would like LDH to assist in obtaining medical records, you will need to sign the Authorization to Release or Obtain Health Information for Eligibility in Program Enrollment Form authorizing LDH to obtain these records on your behalf.

If the applicant does not have a Statement of Approval, the applicant will be assessed under the **Nursing Facility** or **Hospital** level of care criteria. You will also need to complete the *Health Assessment Record Form* and a Child's Medical and Social Interview form. Additionally, to establish level of care and/or disability, it will be necessary to obtain medical records. If you would like LDH to assist in obtaining medical records, you will need to sign the Authorization to Release or Obtain Health Information for Eligibility in Program Enrollment Form authorizing LDH to obtain these records on your behalf.

The level-of-care assessment is for medical certification only. Services and benefits are identical across all three levels of care.

In addition to meeting the level of care criteria, individuals must be determined to have a disability that is recognized under the definition of disability utilized in the Supplemental Security Income program of the Social Security Administration (SSA), regardless of whether the child is eligible to receive benefits

under that program. Individuals that do not have an SSA determination will need Louisiana Medicaid to review medical records and render a disability determination. Your family may need to provide additional medical records or authorize LDH to request the records on your behalf.

See FAQs under Eligibility – Level of Care for more information on the eligibility criteria and assessment process.

If the applicant meets eligibility criteria for the Level of Care, Disability criteria, *and* Medicaid, the applicant will be enrolled in Act 421-CMO.

3. *Does my eligibility expire?*

Eligibility for Act-421 CMO must be renewed annually per federal requirements. You will receive notice when it is time for the level of care re-assessment, disability redetermination and your Medicaid renewal. If you have questions about the renewal timeline, contact your LGE or Medicaid at 1-800-230-0690.

Enrollment

Managed Care / Services / Benefits

1. Is managed care the same thing as Medicaid?

Yes. Medicaid services sometimes are provided through Managed Care Organizations (MCOs), also known as "Healthy Louisiana" plans. Medicaid beneficiaries who enroll with an MCO for coverage receive the same services and benefits as they would under traditional or legacy Medicaid, sometimes referred to as fee-for-service (FFS).

2. Do I have to enroll in managed care?

Act 421-CMO enrollees must enroll in managed care with a Healthy Louisiana plan with the exception of children dually eligible in Medicare and those who are approved for LaHIPP.

3. Does the level of care assessment change the kind of benefits my child can get?

No. The level of care assessment provides medical certification only. Services and benefits are identical across all three levels of care.

4. Do I get to pick my Healthy Louisiana plan/MCO?

Yes. You can select your Healthy Louisiana plan (or MCO) on your Medicaid application. If you do not select a plan, one will be selected for you. To learn out more about MCOs, so that you can make your choice, visit Healthy Louisiana's webpage: healthy.la.gov/choose.

5. How do I decide which managed care plan to choose?

To find out more about the Healthy Louisiana plans/MCOs, so that you can make your choice, you can visit their webpage: healthy.la.gov/choose.

6. Do I get to keep my doctor?

Yes, as long as your doctor is willing to become a Medicaid provider and contracts with your Healthy Louisiana plan. MCOs are required to offer provider contracts to any in-state provider you wish to keep.

7. How do I find out if my doctor is in my managed care network?

You can search for your provider on Healthy Louisiana's provider database, or you may call your managed care plan.

In addition, MCOs are required to offer provider contracts to any in state existing provider you wish to keep.

8. Can I switch to fee-for-service or legacy Medicaid?

No. Managed care enrollment is mandatory for Act 421-CMO enrollees. Only individuals approved for LaHIPP or Medicare eligible can be in fee-for-service.

9. If I have Act 421-CMO coverage, but it is still not enough, can I get a waiver?

If you have been determined eligible for OCDD services and need a SUN assessment or reassessment, then contact your LGE. If you have not applied for services through OCDD and think you may have a developmental disability, contact your LGE to apply for services.

10. How do I request prior authorization for a service I need?

Your provider should contact your Healthy Louisiana plan/MCO to request prior authorization and supply the necessary information.

11. Will I have out-of-pocket expenses?

You will need to pay any insurance premiums associated with any private medical coverage the Act 421-CMO enrollee may have, as well as co-pays and deductibles associated with that coverage. Medicaid will pay for services if you have reached service limits or if the service is one that your insurance does not cover.

If you qualify for and enroll in LaHIPP, you will pay your first month's premium. Medicaid will reimburse you and pay your premiums moving forward, as well as any co-pays, deductibles, and costs that your private insurance does not cover.

For more information on LaHIPP, see section above.

12. I got an OCDD waiver offer. What do I do?

Make sure that you have completed the full application process for the waiver and supply any requested information. When the enrollee is enrolled in the new OCDD waiver, Act 421-CMO enrollment will terminate.

Local Governing Entities (LGEs)

1. What is an LGE?

Local Governing Entities are regional districts and authorities that are collaborating with LDH to perform the level of care assessments for Act 421-CMO.

2. Who is my LGE?

LGEs are listed on the Regional LGE directory If you are not sure which region you are in, click on the individual LGE to see which parishes each region covers.

3. How do I contact an LGE?

LGEs and contact information are listed on the Regional LGE directory

Appeals and Grievances

Many decisions regarding access to services under Act 421-CMO can be appealed if you are not satisfied with the decision. These include but are not limited to: determination that an applicant does not meet level of care standards, denial of Medicaid eligibility, or denial of prior authorization.

The method of appeal will depend on what decision was made and who made it. Please refer to the letter you received for instructions on how to appeal.