To navigate directly to a specific section of the FAQs, select the hyperlink below:

Act 421 Children's Medicaid Option

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.

2. *Why is Act 421 CMO necessary?*

Medicaid is a means-tested program. This means that in order to qualify for Medicaid, a member'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 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. But 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 ***not*** a traditional TEFRA program. Louisiana does not have a traditional TEFRA program. Act 421 CMO has many features of traditional TEFRA, including eligibility qualifications and the disregard of parental income, but Act 421 CMO has additional features that will be explored throughout this document.

LDH is implementing Act 421 CMO, rather than traditional TEFRA, in order to maximize available funding allowing it to serve as many children as possible and create a sustainable program.

5. *When does the program start?*

Program registration will begin upon receipt of federal approval of the program. The program is still under review by the Centers for Medicare & Medicaid Services (CMS). CMS approval is needed to start Medicaid services.

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

There could be a wait list for Act 421 CMO services. Because Act 421 CMO is a brand new program, LDH is not sure yet how many children across Louisiana will be interested and will meet the eligibility qualifications for the program. For this reason, LDH is creating a "Request for Services" Registry (the "Registry") for this program. The possibility of a wait list depends on how many people register and how many people Medicaid can afford to provide services for.

For more information on the Registry and the registration process, please go to Registration/ Priority Requests / Application / Enrollment.

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

Again, because the program is completely new, LDH cannot say with certainty how many enrollees the program will support. Our initial estimates project that just under 3,000 children will be able to receive services from Act 421 CMO under the initial funding for the program. The number of enrollees is tied to the legislative appropriation for this specific program, which will be set annually during the regular Louisiana legislative session.

8. *How long will the wait list be? How long will someone on the wait list have to wait for services?*

LDH estimates that approximately 3,500 children in Louisiana would be eligible for Act 421 CMO. This number is a projection based on enrollment in or registries for other programs, but we will not know the size of the population until the program starts.

It is also not clear at this time how frequently enrollees will move through the program, so it is unclear how long wait times may be. When more information is obtained after the start of the program, LDH will update the public information regarding the size of the registry and the average amount of time a person spends on the Registry before a service "offer to apply" is made.

9. *How will the Registry be organized? How is it decided who receives an offer?*

Please see the section on Registration/ Priority Requests / Application / Enrollment.

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

There are five general steps to enrolling in the Act 421 CMO program. They are listed as follows:

1. Registration & Priority Requests
2. Act 421 Service Offer
3. Medicaid Application
4. Level of Care Assessment at your Local Governing Entity
5. Enrollment/Service Coverage through a Healthy Louisiana plan

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

11. *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 question 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 medically determinable physical or mental impairment that results in marked and severe limitations and has lasted or is expected to last at least one year, or to result in death.

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 or developmental disabilities (ICF), 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]. Your LGE will contact you after you have accepted your Act 421 service offer that is mailed to 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, an applicant must be assessed by a registered nurse in accordance with LDH's assessment protocol. 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.
- Substantial functional limitations as compared to age appropriate levels.

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

- Frequent and complex medical care that requires the use of equipment to prevent life-threatening situations, with skilled medical care required multiple times during each 24-hour period;
- Complex skilled medical interventions that are expected to last at least six months; and
- An overall health condition that is highly unstable and presents constant potential for complications or rapid deterioration, such that the child requires continuous assessment 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 from an LGE. These applicants will be assessed under the level-of-care for an Intermediate Care Facility for Individuals with Developmental Disabilities.

If an applicant does not have a Statement of Approval, the applicant will be assessed under Hospital level-of-care first, 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 at your regional LGE office. Louisiana Department of Health's website provides a list of LGEs as well as the contact information for each region at Office for Citizens with Developmental Disabilities directory.

In order to receive an assessment, applicants must first register through the Act 421 CMO portal. Level of care assessments are not conducted until an Act 421 service offer is mailed to and accepted by the applicant. The level of care assessment is conducted annually. Your LGE will contact you when it is time to conduct the annual re-assessment.

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

Eligibility – Basic Medicaid

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

In addition to disability and level of care, 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

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

No. However, since an Act 421 CMO enrollee cannot be otherwise eligible for any other Medicaid program, Medicaid will need information on family income 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 limits for the applicant (child)?*

Yes. The applicant (i.e., the child) can have no more than $2,000 in assets.

4. *Will LDH collect any information about parents' income?*

Yes. LDH will also collect information on the household income of the applicant.

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

There is limited funding available for Act 421 CMO. In order to ensure program offers are made only to children who need them, LDH needs to make sure the child is not eligible for Medicaid in some other way. In order to do this, we need 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 first register, and then after an Act 421 CMO service offer is made, establish eligibility for the child (disability, level of care, etc.). If you register outside the Initial Registration Period (see Registration below) you will have access to services in the order your registration is received. You may also submit a priority request (see Priority Requests below).

Eligibility – Private Health Insurance

1. *What is the Act 421 CMO private health insurance requirement?*

Families will be required to maintain any pre-existing private, major medical health insurance already in place for the applicant prior to enrolling in Act 421 CMO. This includes employer-sponsored insurance or if purchased through an insurance exchange. However, LDH will grant good cause hardship exceptions for this requirement for families that meet the criteria (see *#8 below* in this section).

2. *Why will I be required to keep health insurance? Doesn't Act 421 CMO provide health coverage for my child?*

Requiring private health insurance 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. Keeping costs down allows LDH to provide coverage to more children.

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

Act 421 CMO requires you to keep **pre-existing** insurance. You are not required to obtain new insurance for the enrollee if they were not already covered prior to enrollment in the Act 421 CMO program.

To ensure fairness and maximize funding for services, LDH will conduct a 6-month look-back, prior to the start of the Act 421 CMO enrollment, to determine whether coverage was dropped prior to application. This means that if you have dropped private insurance coverage of the Act 421 CMO enrollee in the 6 months prior to Act 421 CMO enrollment, you will be deemed out of compliance with this requirement.

4. *What happens if I dropped insurance coverage within 6 months before applying for Act 421 CMO?*

If you drop your private, major medical insurance coverage of the Act 421 CMO enrollee within 6 months prior to their Act 421 CMO application, you will have the opportunity to first request a good cause hardship exception to the private insurance requirement. This form will be mailed to you and you

will have ten days to respond. If you do not respond, or do not meet the good-cause hardship criteria, the Act 421 CMO enrollee will go into a 6-month lockout period. This means that during that time, the enrollee will not receive Medicaid coverage of any healthcare services. Enrollees in lockout keep their "slot" during the lockout period, and do not have to re-apply if the parent/guardian takes the necessary steps to keep the child enrolled.

5. *What happens if I drop insurance coverage while my child is enrolled in Act 421 CMO?*

If you drop private, major medical insurance coverage of the Act 421 CMO enrollee during their enrollment, you will have the opportunity to first request a good cause hardship exception to the private insurance requirement. This form will be mailed to you and you will have 10 days to respond. If you do not respond, or do not meet the good cause hardship criteria, the Act 421 CMO enrollee will go into a 6-month lockout period. During that time, the enrollee will not receive Medicaid coverage of any healthcare services. Enrollees in lockout keep their "slot" during the lockout period, and do not have to re-apply if the parent/guardian takes the necessary steps to keep the child enrolled.

6. *What is lockout? How do I get my child out of lockout?*

Lockout is the penalty assessed when a family ends private, major medical insurance coverage of an Act 421 CMO enrollee, either within 6 months prior to the enrollee's application or at any time during enrollment in the Act 421 CMO program.

During lockout, Medicaid will not pay for healthcare services rendered to the child.

If you re-insure the Act 421 CMO enrollee with major medical coverage at any point during the 6-month lockout period, Medicaid coverage will resume.

7. *What happens if I don't re-insure my child and my 6-month lockout expires?*

If you do not re-insure the Act 421-CMO enrollee into private major medical coverage and you have not requested and met the criteria for a good cause hardship exception, the lockout period will end six months from its start date. At this point, the enrollee will be deemed ineligible for Medicaid coverage and a termination letter will be sent. You may re-register for the program, but you will not retain your original spot on the Registry and will be required to go through the eligibility determination process again.

8. *Are there any exceptions to the private insurance requirement? What if my insurance is too expensive? What if I can't keep private insurance or re-insure my child during the lockout?*

In some cases, LDH may determine that a family is entitled to a good cause exception to the private insurance requirement. Families that can show that the insurance requirement results in hardship to the family may be exempt from the insurance requirement by showing one of the following conditions:

- Divorce
- Death of parent

- Change in employment (reduction in hours, loss of employment, new employment that does not provide coverage, break in coverage due to job transition) resulting in loss of dependent coverage
- Child's premium exceeds 5% of household income
- COBRA expired
- Family coverage premiums exceed 9.5% of household income
- Parent determined eligible for advance payment of premium tax credit for enrollment in a qualified health plan through the Exchange because existing insurance determined unaffordable in accordance with federal regulation
- Other (example: parent or child's health & safety at risk, grandfathered annual maximum limit under ACA)

9. *How do I apply for a good cause hardship exception? How do I get the form? Where do I send it in?*

You may contact Medicaid Eligibility at 1-800-230-0690 and ask for information on applying for a good cause hardship exception. Medicaid eligibility staff will send you a form to complete. You will need to provide supporting documentation demonstrating that you meet one of the criteria listed above.

10. *What happens if I qualify for a good cause hardship exception?*

If you meet hardship or good cause criteria, you do not have to maintain private insurance coverage of the Act 421 CMO enrollee. You may be eligible for participation in the Louisiana Health Insurance Premium Payment (LaHIPP) program to assist you with your private insurance premiums. See more on LaHIPP below.

11. *If I qualify for a hardship exception, do I need to tell LDH or can I just drop the insurance coverage?*

You should contact LDH and apply for a good cause hardship exception prior to dropping coverage. If you have already dropped coverage and LDH determines that you do not meet hardship, the enrollee will be placed into lockout.

In addition, if you do qualify for a good cause hardship exception, it may be possible to enroll in LaHIPP to help with your private insurance premiums and out of pocket costs. In some cases, LaHIPP may cover costs of insuring not only the Medicaid enrollee, but you or your spouse or partner as well. See more on LaHIPP below.

12. *My child has been placed in lockout. I would like to resume coverage of my child but I can't get insurance coverage through my employer until open enrollment, and the 6-month lockout will expire before then. What should I do?*

Because your child has lost Medicaid coverage, you should be able to enroll for private coverage through the health exchange marketplace, regardless of when this event occurs. Marketplace policies are frequently expensive, but if the price of coverage is too high, you may qualify for one of the cost-

based hardship exceptions (see (8) above). If the health exchange marketplace insurance is not available to you, contact us at 1-800-230-0690.

13. 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.

In order to be eligible for LaHIPP, Act 421 CMO enrollees must first demonstrate that they qualify for a good cause hardship exception to the private insurance requirement.

Act 421 CMO enrollees that qualify for LaHIPP will still receive their coverage with a Healthy Louisiana plan in managed care.

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

Medicaid will search for existing coverage applicable to enrollees at regular intervals. (Medicaid is by law the payer of last resort, and is therefore required to search for existing coverage for all enrollees, regardless of program or eligibility group)

15. *How do I apply for LaHIPP?*

Because Act 421 CMO enrollees must demonstrate that they qualify for hardship exception to the private insurance requirement in order to be eligible for LaHIPP, you should first contact Medicaid to apply for a good cause hardship exception. Once the hardship exception is approved, you will be referred to LaHIPP.

16. *I have been told that I meet good cause or qualify for a hardship exception. I was asked to apply for LaHIPP. Do I have to apply for LaHIPP?*

No. LaHIPP participation is completely voluntary. However, it may be to your benefit to do so. In some cases, LaHIPP is able to cover some costs associated with your insurance, in addition to your child's.

If you prefer not to apply for or enroll in LaHIPP you do not have to, and if you have been determined to meet the good cause or hardship criteria, you do not have to maintain insurance coverage over the Act 421 CMO enrollee.

Registration / Priority Requests / Application / Enrollment

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

Register: To inform LDH that you are interested in Act 421 CMO services for your child. Once you register, you will be placed on the Act 421 CMO **Request for Services Registry**.

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 five general steps to enrolling in the Act 421 CMO program as follows:

1. Registration & Priority Requests
2. Act 421 Service Offer
3. Medicaid Application
4. Level of Care Assessment at your Local Governing Entity
5. Enrollment/Service Coverage through a Healthy Louisiana plan

Registration

1. *When will registration begin?*

Registration will begin upon approval from the Centers for Medicare & Medicaid Services (CMS). The Initial Registration Period will last one month. Communications will be published to notify stakeholders and the public before the registration period begins. Please be on the lookout for a press release from the Department, or check for regular updates on our Act 421 webpage at www.ldh.la.gov/act421 where all announcements will be posted.

2. *How long after registration will services begin?*

This is still to be determined. LDH cannot begin processing applications until we have received approval for this program from CMS, the federal agency that oversees Medicaid programs. As soon as we are able, we will begin the process of making Act 421 service offers to apply.

4. *What is the Initial Registration Period?*

The Initial Registration Period is a month-long period during which families may register a child for Act 421 CMO coverage. It will be the first opportunity for families to register.

5. *How and where do I go to register?*

Go to www.ldh.la.gov/Act421 and complete the registration form. You will receive confirmation of your registration.

Online registration is the fastest and easiest way to register. However, if you are unable to register online, you may download a paper registration form from www.ldh.la.gov/Act421 to print and mail in. Alternatively, you may go to your LGE and request the paper form. The paper form has the mailing address for where it should be returned.

6. *My child is on the OCDD Registry. Do I also have to register for Act 421 CMO?*

Anyone who is registered for OCDD services can also register for Act 421 CMO services.

A child who is on the DD Registry will not have to affirmatively register for Act 421 CMO. LDH will automatically register any child in Act 421 CMO who (1) has an OCDD Statement of Approval and (2) is not currently eligible for Medicaid. LDH will mail a letter and allow the families to opt out of Act 421 CMO registration if you do not wish to be on the Registry.

7. *What happens after the Initial Registration Period? How will LDH decide who is allowed to apply and who will be on the Registry?*

After the Initial Registration Period ends, LDH will assemble the list of registrants, including anyone who was automatically registered by virtue of having a Statement of Approval from OCDD. The entire list of registrants will be randomized for fairness and assigned numbers. Act 421 service offers to apply will be made first to registrants who qualify based on approved priority requests (see Priority Requests below) and then according to numeric order on the randomized Registry list.

After the conclusion of the Initial Registration Period, Registry placements will be assigned in the order they are received. When Act 421 CMO services become available, an Act 421 service offer to apply will be sent to (1) a prioritized registrant (see Priority Requests below) or (2) if no prioritized registrant, the next person in order on the Registry.

8. *Can you tell me, step-by-step, what will happen after I register?*

There are five general steps to enrolling in the Act 421 CMO program as follows:

1. Registration & Priority Requests
2. Act 421 Service Offer
3. Medicaid Application
4. Level of Care Assessment at your Local Governing Entity
5. Enrollment/Service Coverage through a Healthy Louisiana plan

9. Where am I on the wait list?

Call Medicaid at 1-800-230-0690 and you will be directed to an Act 421 CMO staff member who can answer your question.

10. How do I move on the waitlist?

Act 421 service offers are made as they become available. If you do not receive an offer to apply when the Act 421 CMO program opens, offers will be made as program enrollees move out the program (for example, by reaching age 19 or obtaining other Medicaid coverage). Act 421 service offers will be made in numeric order from the Registry, unless a registrant has an approved priority request.

If you believe your child may be eligible for a priority request, you can submit a Priority Request Form so that you have the earliest possible access to an Act 421 service offer. See Priority Request section below.

Priority Requests

1. *What are priority requests? How does it work*?

Because some people will have to wait for services until an Act 421 services offer becomes available, LDH has created a process to provide quickest access to services to the most medically needy registrants. This process, which we call "prioritization" allows someone on the registry to become eligible for the next available Act 421 CMO offer to apply.

Prioritization is available to registrants who have:

- Been institutionalized in an ICF/IID, nursing facility, or hospital for 30 of the prior 90 days at time of the submitted priority request (in-facility days do not have to be consecutive); OR
- On three (3) or more separate occasions in the prior 90 days, been admitted to an institution or hospital and remained in-facility for at least 24 hours.

Registrants who have an approved priority request will have access to the next available Act 421 service offers.

2. How do I submit a priority request?

You will be able to submit a Priority Request Form electronically by visiting the Act 421 webpage at any time. You can also download the paper form from the portal where it is linked and email/mail it to the address provided on the form. Alternatively, you can request a paper Priority Request Form from your LGE.

3. Do prioritized registrants get access to services immediately?

Not necessarily. If all Act 421 CMO slots are currently in use, the priority registrant will wait until a service offer is available, and then be required to apply.

4. Does a priority request determination last indefinitely?

No. Approved priority requests last for a period of 6 months.

5. What happens if six months pass and a slot has not become available?

If at the end of 6 months no Act 421 service offer has become available, the priority request will expire. The registrant may submit a new Priority Request Form based on the 3 months preceding the new request. There is no limitation on the number of priority requests you can submit.

6. What happens if more than one person is prioritized at the same time?

Priority Requests are date and time stamped. The next available Act 421 service offer will go to the person with the earliest approved priority request submission date and time.

7. What is the status of my priority request?

Please call Medicaid at 1-800-230-0690. They will connect you with Act 421 CMO program staff who can give you more information on your request.

8. When do I apply for prioritization?

At registration or any time prior to receiving an Act 421 service offer to submit request.

9. If my priority request is approved, do I still have to apply for Act 421 CMO?

Yes. The standards for program eligibility are different from those for priority requests. You/the applicant will need to complete a full Medicaid eligibility application and level of care assessment.

Medicaid Application

1. *I got a letter saying I have an Act 421 CMO service offer. What should I do?*

If you are still interested in having Medicaid coverage for your child, follow the instructions on returning the offer letter. If you have misplaced the letter, call Medicaid at 1-800-230-0690, and you will be directed to someone who can help you.

Once you have returned your offer letter, go apply for Medicaid through our online self-service portal. Also, someone from your Local Governing Entity (LGE) will contact you regarding your level of care assessment and how to proceed.

2. *I received an Act 421 CMO service offer in the mail. How long is the offer good for? How long do I have to return the form?*

You should return the form by the deadline provided in the letter in order to be able to apply for and access Medicaid services.

3. *What happens after I return the offer?*

First, you should apply for Medicaid on behalf of the child (the Act 421 CMO applicant) through our online self-service portal: OLA. See section Eligibility – Basic Medicaid for more information on these standards.

Second, your child (the Act 421 CMO applicant) will be assessed for level of care eligibility by your local governing entity.

If the applicant has a Statement of Approval from OCDD / is on the OCDD Request for Services Registry, level of care is established via Form 90L. Have the applicant's physician complete the Form 90L and return the form to your LGE according to the instructions you receive from the LGE.

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.

The level-of-care assessment is for medical/disability certification only and will not affect access to benefits. Services and benefits are identical across all three levels of care.

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

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

4. *Does my eligibility expire?*

Eligibility for Act 421 CMO will be renewed annually per federal requirements. You will receive notice when it is time for the level of care re-assessment 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 are sometimes 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, which is sometimes also 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.

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

No. The level of care assessment provides medical/disability certification only and will not affect access to benefits. 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 contract 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.

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

Yes, as long as you meet the eligibility criteria for the waiver. If you need a new SUN assessment contact your LGE.

10. How do I request prior authorization for a service my child needs?

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?

Unless you qualify for a good cause hardship exception, 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 a good cause hardship exception 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.

If you qualify for a good cause hardship exception and do not enroll in LaHIPP, you will have no out-of-pocket costs.

For more information on the private insurance requirement, hardship exceptions, and LaHIPP, see section titled Private Insurance Requirement above.

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

Make sure that you have completed the full application process for the waiver. When the enrollee is enrolled in the new OCDD/OAAS 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 partnering with LDH to perform the level of care assessments for Act 421 CMO.

2. Who is my LGE?

LGEs are listed on LDH website 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 here on LDH online 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 priority requests, denial of Medicaid eligibility, placement in lockout, 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.